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The Increasing Vulnerability of Children in Nepal

Report of an Assessment of Children and Families Affected by HIV/AIDS in Nepal and the Response at Family, Community, District and National Level

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UNICEF Foreword

This assessment of *Children and Families Affected by HIV and AIDS* is one of UNICEF's contributions to His Majesty's Government of Nepal's National Strategic Plan on HIV/AIDS (2002-2006) and actions to meet its commitments from the UN General Assembly Special Sessions on HIV/AIDS (June 2001) on Children (May 2002) and the Millennium Development Goals and targets.

UNICEF is committed to support HMG/Nepal in the fight against the spread of HIV/AIDS and to ensure the care and support of those affected and infected. Based on this assessment, UNICEF will strengthen our work with government and non-governmental partners to implement policy and programme recommendations that have emerged appropriate within the context of Nepal's National Strategy.

The fight against HIV/AIDS is one of UNICEF's five global priorities under our 2002-2005 Medium Term Strategic Plan (MTSP). UNICEF's strategy, in line with international programming principles adopted by all UNAIDS co-sponsors, is to support and strength the capacity of individuals, families and communities to prevent HIV infection, and to protect and care for adults and children infected or affected by the disease. Under the MTSP by 2005 each UNICEF country office has committed itself to conduct an assessment of the impact of HIV/AIDS on families and children and develop a strategy for programming in prevention, protection, care, and impact mitigation.

To ensure protection, care and support of orphans and children in families made vulnerable by HIV/AIDS, UNICEF in Nepal is committed to work with partners to:

1. Review the need for policies and legislation;
2. Review and strengthen the adequacy of access to social services (health, nutrition, education, welfare, and information);
3. Review the equity of treatment of orphans and non-orphans;
4. Review the existence of, and strengthen mechanisms to protect them from violence, abuse and exploitation;
5. Develop ways to strengthen and support family and community capacity for care (vulnerability monitoring, leadership orientation, community facilitation, support for community initiatives, and home based care and support).

Most of UNICEF's country offices in sub-Saharan Africa completed their assessments in 1998 and 1999. In Asia, we are proud that Nepal is the first country to have completed the assessment.

Our appreciation is extended to the team of expert consultants who worked on the assessment, led by the internationally renowned Dr Susan Hunter. In addition, the strong and active involvement of the (then) Minister of Health and (then) Minister of Women, Children and Social Welfare, the Acting Director and staff of the National Centre for AIDS & STD Control, the Director of the Central Child Welfare Board, and a host of national and international NGOs was critical in ensuring that this assessment would be a major tool for moving ahead to ensure the protection, care and support of children and families affected by HIV and AIDS in Nepal.

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Assessment Team

The lead consultant for this assessment was **Susan Hunter, Ph.D.** Dr. Hunter has been working with UNICEF on the development of programmes for families and children affected by HIV/AIDS since 1989, when she worked with UNICEF's Kampala office to develop the first prototype programmes for the Eastern and Southern African Region. Dr. Hunter was principal author of the first two editions of ***Children on the Brink*** (1997 and 2000), and also wrote ***Reshaping Societies: HIV/AIDS and Social Change***, a study of the impact of HIV/AIDS on African societies, in 2000. She has worked for UNICEF, UNAIDS, USAID and a number of international NGOs at headquarters level and on residential and short-term missions in 24 countries, and has been team leader on assessments of families and children affected by HIV/AIDS in 14 countries. Most recently, she worked with the East Asia and Pacific Regional Office of UNICEF to assist Thailand, Vietnam, Cambodia and Myanmar in developing their national assessments of AIDS-affected children and families. She is a medical anthropologist and demographer with substantial publications in HIV/AIDS and health systems management, and is working on a book about AIDS in Africa scheduled for publication in September 2003.

Two consultants, **Patricia Lim Ah Ken** and **Sumi Devkota**, worked with Dr. Hunter on the study design, implemented all of the district and VDC level field research, and completed the data gathering and collation for the institutional response section of this report. **Patricia** comes to Nepal from child protection work with UNICEF in Afghanistan. Prior to that, Patricia was instrumental in developing Mozambique's national assessment of AIDS-affected children and families, and in working with government ministries to implement the strategic plan developed following the assessment. **Sumi Devkota**, a Nepali expert in social research, has focussed her most recent work in the HIV/AIDS area. She has extensive experience in HIV/AIDS related training, social research, life skills materials development and production, and has also worked on Safe Motherhood Programmes and prevention research among young people.

In UNICEF Nepal, the coordinator and the catalyst for undertaking the assessment was Ian MacLeod, the Senior Programme Officer. Strong support was provided by Samphe Lhalungpa (Education Section Chief), Noriko Izumi (Child Protection Officer), Naresh Gurung (DACAW Programme Chief) and Uddhab Khadka (Planning & Monitoring Unit), along with the Chiefs and staff of the four UNICEF Field Offices.

I. Purpose, Definition, Objectives, and Approach

A. Purpose of the Assessment

The purpose of this national assessment of children and families affected by HIV/AIDS is to contribute to the operationalisation of the National Strategic Plan on HIV/AIDS of His Majesty's Government of Nepal (HMG/N) through three main tasks:

1. To summarize the current and projected estimates of families and children affected by HIV/AIDS and better understand their situation and their needs;

2. To review Nepal's overall programming and policy for orphans and other children made vulnerable by the AIDS epidemic;

2. To identify opportunities for development of community based responses in a multisectoral planning context.

B. Objectives

The overall aim of the national assessment is to provide substance for the development of a national strategy and action plan on children and families affected by HIV/AIDS under the National Strategic Plan 2002-2006. The aim would be met through a quantitative and qualitative review of the situation of children affected by HIV/AIDS and the nature of their support mechanisms at family, community and district level.

The primary objectives of the assessment were:

1. To estimate the number of children in Nepal infected and affected by HIV/AIDS and identify their geographic locations;
2. To better understand the needs and vulnerabilities of these children relative to vulnerable children and to Nepalese children in general;
3. To investigate current mechanisms of support for AIDS-affected families and children at family, community and district level;
4. To investigate alternative mechanisms of support for community based programming for children and families affected by HIV/AIDS;
5. To review the extent and adequacy of safety nets for protection of vulnerable children in Nepal given the expected severity of the impact of the HIV/AIDS epidemic, including public welfare assistance, access to health, education and welfare systems, and food security;
6. To investigate the legal framework for protecting the rights of women and children, especially those made vulnerable by HIV/AIDS;
7. To make recommendations for changes in programmes and policies that would improve the situation of HIV/AIDS affected families and children;
8. To promote further development of explicit policy and strategies of support for community based programmes for families and children affected by HIV/AIDS.

The assessment also had several secondary objectives related to process:

1. To encourage sector specific planning to identify, project and monitor the impact of HIV/AIDS on the development, care and protection of children;
2. To heighten awareness of the importance of women's rights in child protection and care.

In undertaking the assessment, global principles, definitions and experiences from similar work were applied and taken into consideration within the recommendations.

C. International Programming Principles

Following a joint global consultative process that lasted two years UNAIDS promulgated "Programming Principles for Orphans and Other AIDS-Affected Children" in 2001. The following are key principles from global priorities that guided the development of this assessment:

1. **Families and communities are the first line of response**. It is in family and community settings that most HIV/AIDS-affected families and children are found and from these sources that most receive care. In Nepal, close to 98% of children are now living. By understanding the provision of care and current support mechanisms in these settings, external actors (both government and non-government) can better develop systems which support the natural care giving responses of families and communities;

2. **Programming should include all vulnerable groups, not just AIDS-affected families and children**. Programming for HIV/AIDS-affected children and families should be integrated with programming for other vulnerable children. HIV/AIDS-affected children and families can't be identified because of the lack of widespread voluntary counselling and testing, low access and utilization of health care facilities more generally. Nor should HIV/AIDS-affected children and families be singled out in a response because it increasing stigmatisation. Integration will lead to higher quality programming and programming that is more sustainable, affordable, and accessible in the long run;

3. **Programming should lead to strengthening or protection and care within families and communities**, including assistance with economic coping, psychological problems, access to education and other basic services. They should include actions to reduce gender-based discrimination and encourage participation of children and young people. Finally, such programming should not undermine the natural coping responses of families and communities;

4. **Programming should link prevention and care**, to reduce the impact of the "vicious circle" characterizing AIDS-affected children and families (noted in Nepal's National HIV/AIDS Strategy, see next section) and to become self-reinforcing, reducing transmission and the long term burden of care;

5. **Institutional care should be temporary and should always be the last resort** for most children; however, the role of institutional care in the overall system of family and community care should be deliberately and consciously developed so that

children in need of institutionalization are not denied access. This will be the subject of a later UNICEF-supported study, scheduled to take place in 2003.

D. Definition of AIDS-Affected and Other Vulnerable Children in Nepal

For purposes of analysis, children affected by HIV/AIDS (CABA) are distinguished from orphans and other vulnerable children (OVC) in the international guidelines:

HIV/AIDS Affected Children (CABA)	Orphans and other Vulnerable Children (OVC)
HIV + Children	Orphans of Other Causes
Children with HIV+ Parents or Guardians	Disabled Children
Children Orphaned by AIDS	Street Children
Children at risk of infection	Abandoned Children

There are a number of studies of vulnerable children in Nepal, including studies of street children, child sex workers, disabled children, and child labourers, but very few studies of AIDS-affected children.[1] The latter were used to inform development of the interview schedules for the field work in this study. In this assessment, vulnerable groups that have already been studied in some detail in Nepal were not included, although some children in these groups were members of families, communities and groups participating in the research. Children in institutions, some of whom are HIV+, were not studied in detail in this assessment because their situation will be the subject of a separate study.

This study focuses on children who are vulnerable but may or may not be HIV/AIDS-affected. Programming principles suggest that it is both unnecessary and inappropriate to identify HIV/AIDS-affected individuals for study, so no effort was made to single them out or otherwise identify them in this work. The work did include, however, many groups where HIV/AIDS infected individuals might be found (high risk groups), some of whom identified themselves as Persons Living with HIV/AIDS (PLHAs).

The table on the next page summarizes the approach taken in the assessment to learn more about groups of HIV/AIDS-affected children, other vulnerable children, and their families and communities:

Summary of Groups and Assessment Approach

HIV/AIDS Affected Groups and Other Vulnerable Children	Assessment Approach	Related Programmes or Studies
HIV-Infected Children	Estimates of number, brief descriptions of current status of community care from field portion of study	Nepal's PMTCT programme
Abandoned Children	Children abandoned by HIV+ mothers, not included unless mentioned in field research	Reduction of abandonment should be included in Nepal's PMTCT programme

HIV/AIDS Affected Groups and Other Vulnerable Children	Assessment Approach	Related Programmes or Studies
Children in Families with Infected Members	Numbers, locations, needs, problems, current methods of support to by families and communities	NGO studies and programmes
Orphans (AIDS and non-AIDS)	Numbers, locations, needs, problems, current methods of support to by families and communities	NGO studies and programmes
Child Care Institutions	Care provided to children in institutions and role of institutions in overall system of care; need for national standards of care	Separate UNICEF-sponsored study to be completed in 2003
Children at Risk of Infection	Not the focus of this study; findings should be integrated with prevention strategies	Government and NGO studies and programmes

E. The Assessment Approach

Design of this assessment was completed in August 2002 through a collaborative process of problem definition with members of the UNICEF/Nepal staff in various sectors, government personnel, non-governmental organisations, other UN agencies including UNAIDS, and bilateral donors in Kathmandu. A list of interviews and meetings conducted in the design process is shown in Appendix 3 and 4, which also describes the methodology of the assessment. A debriefing was held on 31 October 2002 to review findings and develop recommendations for inclusion in the assessment with government, NGO, bilateral donor and UN agency representatives.

Since the overall strategy of the assessment is to produce a national picture of the situation of HIV/AIDS-affected families and children, the consultants reviewed national demographic data and other quantitative evidence to produce a picture of the nature and location of vulnerable households and of children's living arrangements. Available AIDS-related data was reviewed to determine the number and location of AIDS-affected families and children. Documents and materials reviewed are listed in Appendix 2.

To obtain a richer picture of the situation and resources that could be used to support improvements in community-based care, the consultants conducted field assessments over the period of two months in six districts representative of the five regions of Nepal (Sunsari, Chitwan and Kathmandu, Kaski, Dang, and Dadeldhura). The findings are included in the body of the report, and more details of the district field work appear in Appendix 1, along with a list of people interviewed and meetings conducted.

II. The Changing Picture of HIV/AIDS in Nepal

A. The Changing Picture of Nepal's HIV/AIDS Epidemic

The lack of systematic collection of new HIV seroprevalence data over the past several years has complicated the picture of Nepal's HIV/AIDS epidemic, raising the possibility that the epidemic has already spread into the general population in the Far West Region. Until the late 1990s, the limited nature of seroprevalence data available confined the attention of experts to prevalence among "high risk" groups – sex workers and injecting drug users – in the nation's capital. Lack of availability of HIV diagnosis as well as AIDS case reporting, reinforce the notion that HIV was confined to small populations in Kathmandu, Pokhara, and on major transport routes and crossing points into India.

Major routes of transmission

It is presumed that the major route of transmission for HIV/AIDS remains heterosexual and through sexual contact, however, very little data exists to be able to clarify the extent of transmission via this route. Existing data indicates that the highest rates of infection are among injecting drug users and that IDU as well as sex work contribute to a large and significant proportion of HIV transmission. Recent studies in the far west region suggest that transmission among infected migrant labourers returning home from India could also contribute largely to a rise in HIV infection, however, more data is necessary to establish the extent of this transmission.

Table 1: General HIV/AIDS and STI Data for Nepal

Data	Number/Percent	Date
Cumulative Reported HIV cases	2,307	May 2002
Cumulative Reported AIDS cases	601	May 2002
Estimated cumulative AIDS cases	14,500	December 2001
Adults and children living with HIV/AIDS	58,000	May 2002
Cumulative adult and child deaths due to HIV/AIDS	2,958	May 2002
Proportion of reported deaths in 2001 Census		2001
Males, Total	.85%	
Males, 0-14	1.07%	
Males, 15-65	.89%	
Females, Total	.71%	
Females, 0-14	.44%	
Females, 15-65	. 89%	
Annual STI cases	200,000	2000
HIV Prevalence		
IDUs – Kathmandu and Terai	49-68%	2001
FSWs in Kathmandu	17.3%	2001
SWs in Pokhara	0.8%	2000
STI patients	0.7-6.6%	2000
Blood donors	0.28-0.48%	2000
ANC, 1996	0.2%	1996
ANC, 1999	0.2%	1999

ANC, 2000	0.2%	2000
FP clinic attendees	0.3%	1999

Sources: NCASC/UNAIDS "Country Profile" and US/AID Nepal, "HIV/AIDS Strategy 2001-2006", July 2002, p. 3; Nepal Census, 2001; Poudel, C. et. al, 2000, "HIV/STI prevalence and risk behaviours among migrants and non-migrants in Doti District"; USAID population survey in Accham District, 2001 reported in HIV/AIDS Strategy document.

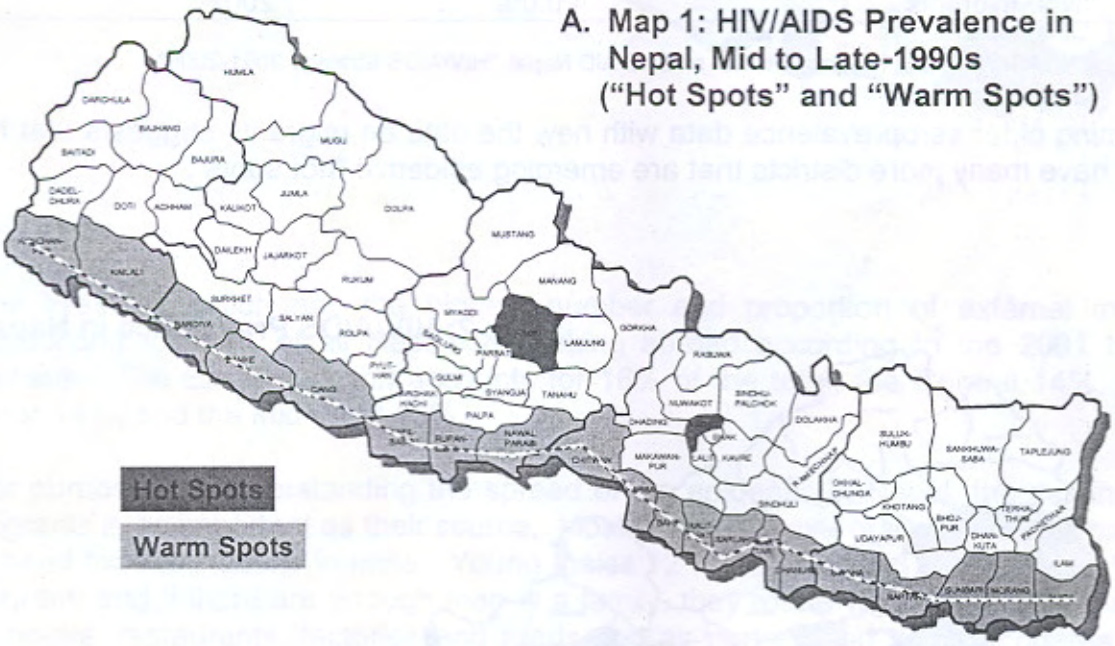
Table 2. HIV/AIDS Data for the Terai

Data	Percent	Date
Truckers in the Terai	1.5%	1999
FSWs in the Terai	3.9%	1999
FSWs returning from India	17.1%	2001

Sources: NCASC/UNAIDS "Country Profile" and US/AID Nepal, "HIV/AIDS Strategy 2001-2006".

A map of the "hot spots", where HIV prevalence is highest, and "warm spots", where it is increasing, may be developed from this data:

A. Map 1: HIV/AIDS Prevalence in Nepal, Mid to Late-1990s ("Hot Spots" and "Warm Spots")



1. **The Role of Migration**. Just as internal and external labour migration "constitutes the hidden or unrecognised dynamism of the real economy of Nepal"[2], it is now being identified as the hidden and unrecognised dynamic of the spread of HIV/AIDS in the country. Labour migration has been an important source of employment and economic opportunity for Nepali men and women for more than 200

years. While labour migration may be responsible for the "stagnation" of agriculture because migrants find it much more attractive to work abroad than to apply their energies on the farm, remittances from this source approach foreign exchange earnings from all other sources. In addition, over the past decade, it has changed the economic structure of the hinterlands by stimulating peri-urban investment and development.[3] New seroprevalence data gathered from districts with high numbers of labour migrants to India underscores the importance of this route of transmission for Nepal's growing epidemic:

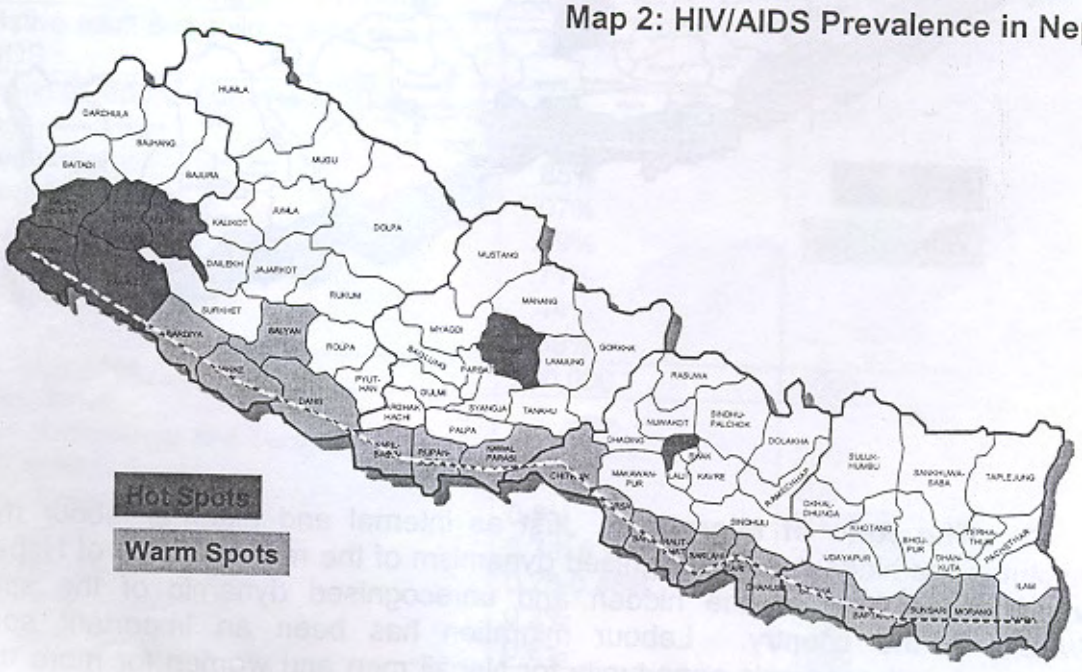
Table 3. HIV/AIDS Data for Returning Migrants in Nepal's Far West Region

Data	Percent	Date
FSWs returning from Mumbai	50%	2001
Labour migrants returning from Mumbai	10%	2000
General male population, Acham	2.3%	2001
Non-migrant males	0.7%	2001
Internal migrants	3%	2001
External migrants		
Returning migrants from India	4%	2001
From Maharashtra State	5.9%	2001
General male population, Kailali	9.3%	2001
Returning migrants	0.5%	2001
Non-migrants	0.0%	2001

Sources: NCASC/UNAIDS "Country Profile" and US/AID Nepal, "HIV/AIDS Strategy 2001-2006".

Mapping older seroprevalence data with new the data on migrants suggests that Nepal may have many more districts that are emerging epidemic "hot spots":

Map 2: HIV/AIDS Prevalence in Nepal, 2001



According to the 2000 Nepal National Census, the country has 762,000 external migrants[4] and an estimated 1.4 million internal migrants, male and female.[5] In the year prior to the Census, many districts, particularly in the West and Far West Regions, had at least 10,000 external migrants, and some substantially more than that:

Map 3: Areas with 10,000+ Migrants (External Migrants Only)

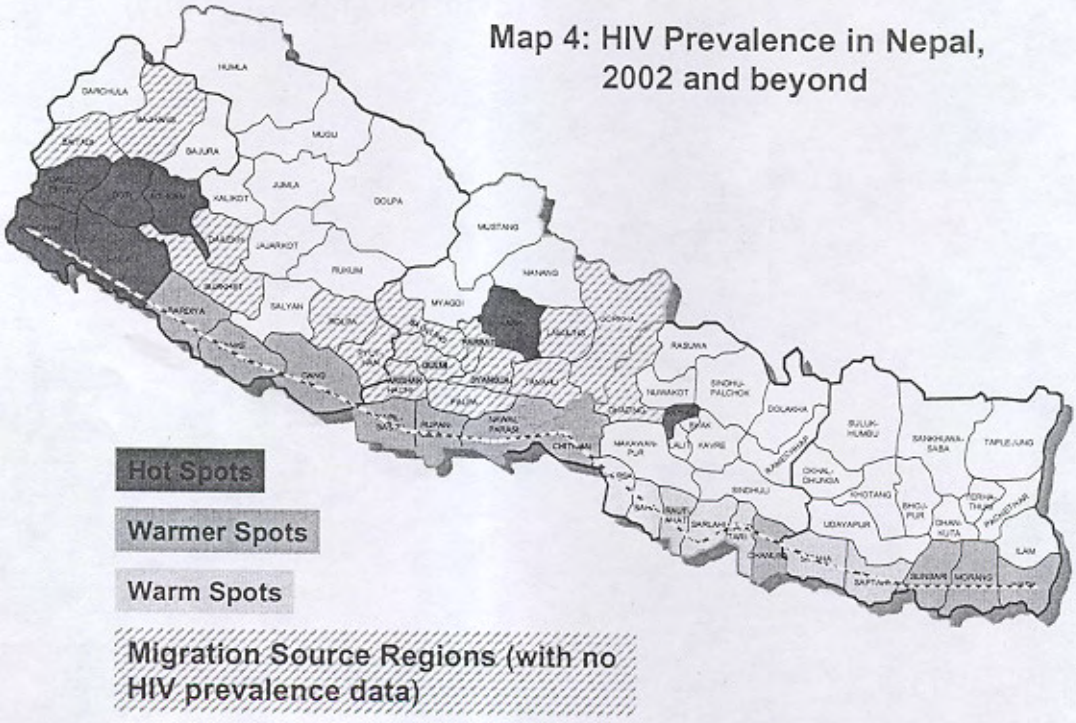
The Western region has the highest number and proportion of external migrants, accounting for 44% of all Nepalese working abroad according to the 2001 National Census. The Eastern region accounts for 16% of the total, the Central 14%, the Far West 14%, and the Mid West 13%.

For purposes of understanding the spread of the epidemic in Nepal, the destination of migrants is as important as their source. Most of Nepal's external migrants – some 77% -- head for destinations in India. Young males 12 to 18 years old are the most likely to migrant, and if there are enough men in a family, they rotate work on a job. They work in hotels, restaurants, factories and roads and as porters and security guards. More than half admit visiting brothels at least once in two months, and 50% do not use condoms.[6]

HIV/AIDS has been known as the "Mumbai disease" in Nepal's Far West region for almost a decade, signalling the high infection rates of returnees from that Indian city. USAID's 2001 HIV/AIDS strategy for Nepal notes that "the overall message of these surveys appears to be that while risk behaviours across migrants to different destinations may be common, high HIV infections have resulted among those who migrant to higher prevalence areas in India, e.g. Maharashtra and specifically Mumbai."[7]

Labour migration is a far more important dynamic force driving Nepal's HIV/AIDS epidemic than drug use or sex work because of large numbers of men and women work outside their home areas inside Nepal as well as in other countries. An ILO analysis of the new census data on external and internal migration is expected before the end of the year. Until that is available, a vision of HIV/AIDS's future spread in Nepal may be gained from combining the maps of HIV/AIDS "hot" and "warm spots" with that of external migration:

Map 4: HIV Prevalence in Nepal, 2002 and beyond



The December 2001 NCASC/UNAIDS Country Profile notes that "HIV infection has been noted in all regions of the country, although HIV infection appears to be concentrated in urban areas *and districts with high labour migration.*"[8] That report states that "the window of opportunity to contain the epidemic in the most vulnerable groups, in which it is currently concentrated, and to prevent a generalization of the epidemic is closing very quickly in Nepal."[9] Unfortunately, seroprevalence and migration data suggest that the window probably closed several years ago.

2. Epidemic Spread to Younger People. In addition, new surveys are reporting broad evidence of a more threatening scenario. Experimentation with sex among Nepal's young people is more widespread than previously realized:

Table 4. Sexual Behaviour among Young People in Nepal

Data	Percent	Date
Males		
Proportion of 12-18 year old *males* who have had sexual intercourse	22%	2001
STIs among male respondents who had had intercourse	At least once, 21.7% Not sure, 23%	2001
More than one partner (boys only)	51.7%	2001
Condom use reported	65%	2001
Females		
Proportion of 12-18 year old *females* who have had sexual intercourse	6%	2001
STIs among female respondents who had had intercourse	12.7% once Unsure, 16.4%	2001
More than one partner	31.5%	2001
Condom use reported	74.0%	2001
Pregnancies among female respondents who had had intercourse	13.5%	2001

Source: UNICEF/UNAIDS, A Survey of Teenagers in Nepal, 2001.

In addition, 13% of the teens admitted taking drugs; of these 5.4% had experimented with injecting drug use. More than 90% of teens knew that sex with multiple partners is a source of HIV infection, but only 5% knew that injecting drugs use was a source of transmission. Three-quarters of all teens knew that condom use could prevent HIV transmission.

B. The Growing Burden of Care

With growing understanding of the epidemic's potential growth and the existence of previously unrecognised risk groups in Nepal, understanding of the condition factors of the epidemic's spread is more comprehensive. In addition to injecting drug use and sex work, the spread of infection through the sexual behaviour of labour migrants and young people is a serious cause for concern. It is now known that Nepal's HIV/AIDS prevention strategy must be more comprehensive and have a broader reach than earlier realized, and many organizations are joining in the effort. The growing threat of the epidemic is also recognised in Nepal's National HIV/AIDS Strategy for 2000 to 2006, which notes that "in the absence of effective interventions, even a 'low to moderate growth scenario' would make AIDS the leading cause of death in the 15-49 year old population over the coming years."[10]

AIDS was responsible for less than 1% of deaths reported in Nepal's 2001 Census, although the reported rate among males age 0-14 was slightly higher, 1.07%.[11] However, the burden of care is larger than this for several reasons:

1. Many HIV infected people have higher morbidity (more illness) than non-infected individuals, and their families provide most of the care. Many are caring for sick family members now, and the number will increase exponentially over the next decade;

2. Many more children and adults are infected than currently reported, but are not identified in the official statistics because of the lack of diagnostic services;

3. Many children are already living in families affected by HIV/AIDS, and are suffering the loss of rights and trauma of that experience.

The chart on the following page provides a very rough estimate of the number of infected and affected adults and children who are in need of care and support. According to the NCASC, with a low or moderate growth strategy, 100,000 to 200,000 adults will become infected by 2005 and there will be an annual increases in AIDS cases of 10,000 to 15,000. "In Nepal," the report notes, "a generalized epidemic with high mortality in the productive age groups would start a 'vicious circle'. The impact of HIV/AIDS would increase poverty and vulnerability. This increased vulnerability would lead to more HIV infections and a higher impact. Besides the negative impact on socio-economic development and the loss of productive life, the burden of disease would change dramatically over the next 10 years, and would put further stress on the health sector and local communities."[12]

Table 4: Estimate of numbers of infected and affected adults and children in Nepal

Infected/ Affected Group	Infected Adults[1]	Total Children Born[2]	Infected Children[3]	Children with HIV+ Parents or Guardians[4]	Location
Infected Children and Children Living with HIV Positive Adults					
Sex Workers	1,700	3,400	1,000	2,400	Urban, periurban, Tarai
IDUs	15,000	30,000	10,000	20,000	Urban, periurban
Migrants	28,000 (ext) 38,000 (int)	112,000	37,000	75,000	All sources areas for migrant, especially West and Far West Regions
Total, (rounded to nearest '000)	73,000	146,000	48,000[5]	98,000	Urban, periurban, Tarai, West and Far West Regions
Orphans[6]					
Parents died of AIDS	--	13,000	0	13,000	Urban, periurban, Tarai, West and Far West Regions
Parents died of other causes	--	822,000	0	0	All regions
Total	--	835,000	0	13,000	All regions
Children at Risk of Infection[7]					
Sexual risk takers	--	5% of children 12-18 years old	Currently infected included in estimates above	--	Urban, periurban, Eastern Region
Vulnerable children (street, living with employer, trafficked girls)	--	Addressed in other studies; see existing literature	Currently infected included in estimates above	--	All regions
Total Currently Infected and Affected Children					
All groups	73,000	981,000	48,000	111,000	All regions

[1]Total estimated number of people in group (column 1) multiplied by the infection rate reported by NCASC and other sources; prevalence rates: for sex workers, 17.3% x 10,000; for IDUs, 70% * 10,000 for IDUs within Kathmandu and 40% x 20,000 for IDUs in other locations; for internal migrants, 2% x 1.4 million; for external migrants, 5% x 760,000

[2] Infected adults (column 1) multiplied by 2, the estimated fertility rate, which has not reached full reproductive potential.

[3] Total children born (column 3) multiplied by .30%, the estimated proportion of total children born who will be HIV+

[4] Total children born (column 3) minus HIV+ children

[5] The reported number of HIV+ children is 28. This estimate may well be too high. Exact estimate of HIV+ children requires time series data for HIV prevalence and detailed destination data for labour migrants, both external and internal.

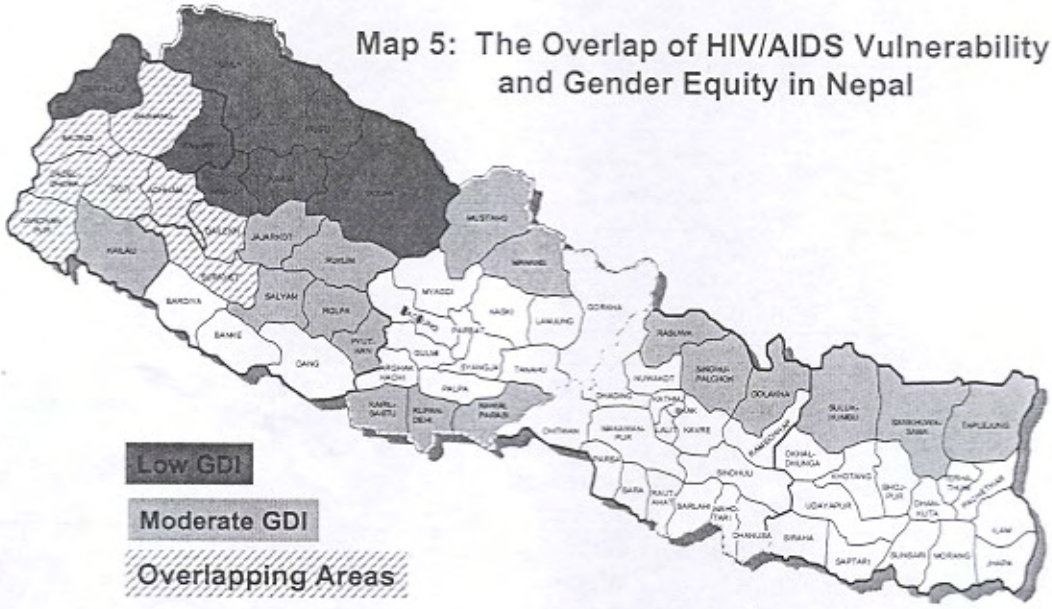
[6] All orphan estimates are from USAID's Children on the Brink 2002, and were developed by experts in epidemiology and demography from the US Census Bureau, UNAIDS and UNICEF, and are the best estimates available at this time given the limitations of Nepal's prevalence and case data and lack of Census or other survey data on orphans. They are adjusted every two years using updated seroprevalence data from the NCASC. By definition, these orphan estimates exclude HIV+ children in most cases.

[7] See UNICEF's 2001 Survey of Teenagers in Nepal.

C. HIV/AIDS and Other Vulnerabilities

To better understand the relationship between HIV/AIDS in Nepal and other social vulnerability, levels of gender development were plotted against the Map 4 (above) showing overall areas of vulnerability to HIV/AIDS in Nepal:

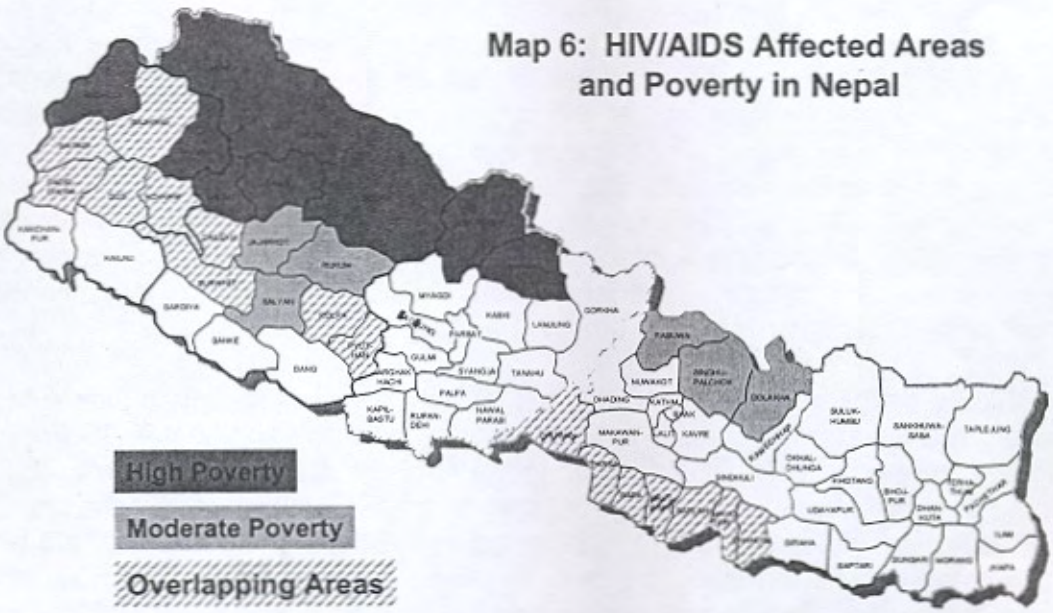
Map 5: The Overlap of HIV/AIDS Vulnerability and Gender Equity in Nepal



As noted in many development reports on Nepal, gender discrimination is high and substantially reduces women's ability to have their human rights fulfilled. In the Far West Region, where HIV/AIDS vulnerability is high, the Gender Development Index (developed by UNDP)[13] is low. This suggests that not only will women and girls be more vulnerable to HIV/AIDS infection, but that their burden of care will be higher and their access to resources and assistance lower. They will be less able to retain their property in the event of their husband's death, more vulnerable to property grabbing (see below), and much more likely to suffer severe discrimination, isolation, and blaming for HIV infection within the family. The interaction of gender discrimination and care is negative and severe, and will be discussed in more detail in the next section.

Poverty is a major barrier for HIV/AIDS affected children and families. To identify areas of high vulnerability, Nepali districts with high poverty levels were overlaid on the map of high HIV/AIDS vulnerability (Map 4):

Map 6: HIV/AIDS Affected Areas and Poverty in Nepal



38% of the population was below the poverty line at the end of the ninth plan (PRSP – Tenth Plan). [14] Income poverty is high in Nepal, and overlaps significantly with areas of HIV/AIDS vulnerability in the country. Poverty and the low employment opportunities within Nepal are major "push" factors in the surge of migrants who travel to India every year in search of new employment opportunities, and contributes to the entrance of women into commercial sex work, whether "voluntarily" or through commercialised trafficking. It also substantially reduces the ability of families to satisfy their need for food and other basic services, and will reduce their ability to provide care within their families or undertake voluntary activities of mutual support within the community for other families.

D. Nepal's Response to HIV/AIDS

Nepal's 2002-2006 National HIV/AIDS Strategy recognises the growing burden of care by making care for HIV/AIDS infected and affected children and adults the third priority area of concern, after prevention among vulnerable groups, including migrants, and prevention among young people. Developing support for community-based care of AIDS-affected adults and children is the third component, and it is hoped that this study will contribute to the operationalisation of the objective and strategies and mobilise consensus among partners for an expanded response. This and subsequent studies will provide guidance in conceptualising and implementing broad range strategies that break that "vicious circle", and lead to reduced care burdens, risk suffered by children,

and the broad social stigma that short circuits care efforts and creates more at risk people, described more fully in the next chapter.

At the international level, Nepal is a signatory to the United Nations General Assembly Special Session (UNGASS) Declaration of June 2001, and is a party to the "Melbourne Manifesto" from the 6th International Conference on AIDS in Asia and the Pacific of October 2001, which includes the GIPA – "Greater Involvement of People Living with AIDS Principle". These include principles of multi-sectoral engagement, broad political commitment, the involvement of civil society generally and PLWAs in particular, a human-rights based approach to prevention and mitigation, and use of the prevention to care continuum in strategy design. The National Strategy on HIV/AIDS in Nepal 2002-2006 (final draft, 26 May 2002) emphasises the prevention of STIs and HIV infection among vulnerable groups, prevention among young people, care and support for all affected and infected people, expansion of the knowledge through surveillance and research, and efficient management of an expanded response.

History of the Response. Since the global spread of the HIV epidemic, Nepal has been quick to set up structures for response. In 1987, the National AIDS Prevention and Control Programme (NAPCP), based in the Ministry of Health, was formed. During this time, a short term plan was elaborated to deal with the initial phases of the epidemic. The first cases of AIDS were detected in 1988 and the thereafter, the Ministry of Health established short-term and medium term plans to respond to the situation. In 1992, the first multisectoral body was formed headed by the Ministry of Health which brought together governmental and non governmental entities. This was called the National AIDS Co-ordination Committee (NACC).

In 1995, with the changing epidemic, the NACC was transformed into the National Centre for AIDS and STD control (NCASC). This centre was formed specifically for the co-ordination and implementation of AIDS related programmes. It was located within the Ministry of Health.

The Government adopted a national policy for AIDS prevention in 1995 with 12 key policy statements including:

- Priority to HIV/AIDS and STD prevention programmes
- Need for a multisectoral and decentralised response
- Acknowledgement of NGO implemented programmes
- Co-ordination
- Evaluation
- Services for people living with HIV/AIDS
- A non-discriminatory approach
- Confidentiality for test results
- Blood safety

Based on the National Policy, in 1997, the first national strategic plan on HIV/AIDS was launched for the years 1997 – 2001. During this time (1997-2001), a number of initiatives were launched by Government and non governmental organisations across Nepal. The majority of NGOs and programmes have dealt with the areas of awareness,

prevention and advocacy on HIV/AIDS. Many organisations and programmes dealing with reproductive health, STD or health based issues also integrated components of HIV/AIDS awareness into their work. A number of programmes targeting youth and adolescents in and out of schools were also launched. School based programmes carried out AIDS awareness with youth through peer education and IEC (information, education and communication).

More recently, Nepal has established a National AIDS Council which is chaired by the Prime Minister. This body is completely multisectoral with representations from government, non government organisations, private sector and civil society. Its aim is to give responsibility to a multi-sectoral response to HIV/AIDS in a co-ordinated manner.

The Nepal Initiative. In 2000, the Nepal Initiative was organised and launched by the Ministry of Health and supported by key donors such as: USAID, UNAIDS, DFID and AusAID. The objective of the Nepal Initiative was to carry out a co-ordinated rapid response to the alarming rise in prevalence among certain groups, namely sex workers and their clients and IDUs. The programme looks at harm reduction measures for these vulnerable groups as well as looks to expand the approach to additional vulnerable groups such as migrant labourers and their families. This initiative has now been integrated into the National Strategic Plan on HIV/AIDS.

The National Strategic Plan (NSP) on HIV/AIDS 2002-2006

Since the last National Strategic Plan, the situation of HIV/AIDS in Nepal has changed dramatically. The reasons for elaborating a new national strategic plan was because of the changes in the epidemic in Nepal, and the need to adapt and respond to these changes, but also to respond to global commitments that Nepal has made. Nepal has committed to the Millennium Declaration and the Millennium Development Goals as well as to the Declaration of commitment at the UNGASS on HIV/AIDS. Nepal's new 10th 5 year plan (poverty reduction strategy plan) also identifies HIV/AIDS as a cross cutting issue.

UN Millennium Development Goals
Combat HIV/AIDS, malaria and other disease – halt and begin to reverse the spread of HIV/AIDS by 2015

Declaration of commitment on children affected by HIV/AIDS
UNGASS on HIV/AIDS 2001

By 2003, develop and by 2005, implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans, girls and boys infected and affected by HIV/AIDS, including by providing appropriate counselling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance

The 10th Five Year Plan (Poverty Reduction Strategy Plan). Nepal's Tenth National Development Plan was initiated in mid-2001 to identify the much sought after poverty reduction approach for Nepal. The PRSP was finalised in 2002.

Poverty and HIV/AIDS in Development - It has long been recognised that poverty is both a driving force behind the epidemic and a consequence of the epidemic. Poor people who are affected by HIV/AIDS are driven further into poverty. Lack of access to basic services and to treat opportunistic infections means that poor people are the ones who suffer the most and whose children are most likely to become the most vulnerable. HIV/AIDS can also drive families who are not so poor into poverty by the sheer expenses for treatment and care as they loose their working capacity and their livelihoods.

Nepal is one of the poorest countries in the world. More than 40% of the Nepali population live below the national poverty line (HDR 2001). Nearly half of all children in Nepal are underweight and almost 60% of the entire adult population are illiterate. Women in general have a much lower status in society than men and consequently, Nepal is one of the few countries in the world where the life expectancy for women is less than that for men. Basic resources are scarce and mostly urban based. All these factors contribute fuel the HIV/AIDS epidemic in Nepal. In addition, poverty is a "push" factor contributing to high levels of internal and external migration. In Nepal, the internal conflicts have also pushed many people, especially men, to migrate either from rural to urban areas, or from Nepal to neighbouring countries.

Due to the fact that poverty and gender are linked, women and girls tend to be the ones to suffer the most. Poor women and children are often also given a lower status. Consequently, they are the ones who bear much of the responsibility of caring for sick family members, children bear more of the family workload. Many women get drawn into the sex trade for means of survival and women's low status also means that in most cases it is difficult for them to negotiate safe sex.

Provisions for Children and Women under the PRSP - Objectives in the PRSP for vulnerable women and children include:

- Increasing the women development indicator and women's rights by eliminating all forms of discrimination against women to create an equitable society
- Child Rights will be conserved and protected by removing all sorts of child related violence and discrimination, and by ensuring physical, mental, social and psychological development of the child.
- Eliminate the child labour currently engaged in menial jobs of various sectors in Nepal in the coming six years

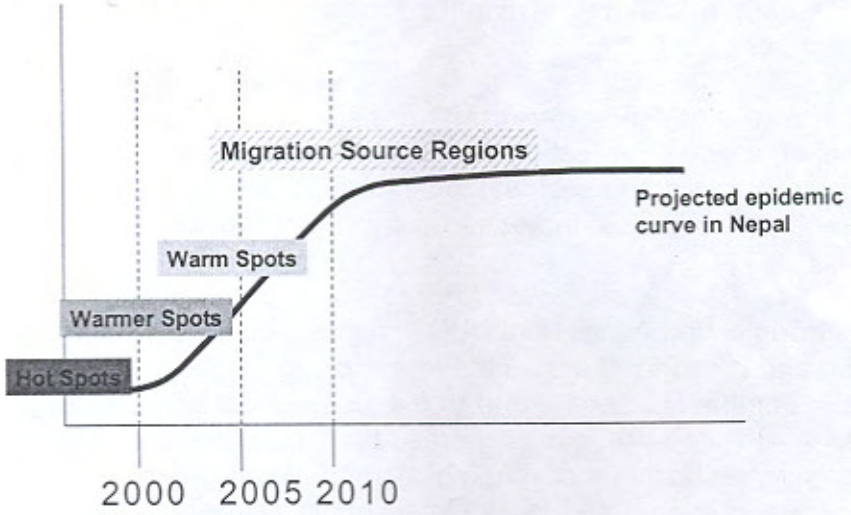
HIV/AIDS in the PRSP

The PRSP also recognises the importance of reducing the incidences of HIV/AIDS and STDs through a multisectoral co-ordination between Government and non Government Organisations to create a public awareness and bring about behavioural change as well as to provide adequate services.

The Timeline for Planning Effective Responses

To be effective, planning for community-based programmes for families and children affected by HIV/AIDS must be included in the current planning process at all levels, and interventions for care and support implemented immediately in the most affected areas such as the Far West, West and Tarai. Plans for families and children affected by HIV/AIDS must include consideration of the expanding view of the epidemic that has developed in Nepal over the past few years, and on the growing body of data that suggests that Nepal already has a much bigger problem than anticipated even two years ago.

Timeline for Strategic Action for Families and Children Affected by HIV/AIDS in Nepal



III. Children and Families Affected by HIV/AIDS

A. Introduction

In this section, a review of the situation of HIV/AIDS-affected and other vulnerable children taken from the literature is followed by a quantitative overview of their numbers and situation derived from national statistical sources, and by qualitative information from the field research. While HIV/AIDS-affected and other vulnerable children are the focus of this study, they were not singled out or deliberately identified in the field research. Limitations in national data systems make it impossible to develop quantitative data for this group.

B. Special needs of HIV/AIDS-Affected children and families in Nepal

At the same time that international guidelines promote programming to address the needs of HIV/AIDS-affected and other vulnerable children simultaneously, they recognise that children affected by HIV/AIDS have special needs not experienced by other vulnerable children:

HIV Positive Children – diagnosis, treatment; full care if they are abandoned by mothers or other care givers;

Children with HIV+ parents – assistance with care giving responsibilities for adults, loss of parental protection and love, isolation from the community due to stigma and fear of infection; trauma of watching parents and other relatives die and caring for them through that process; increased risk of infection, largely due to loss of parental protection;

Orphans – orphans from AIDS related diseases have often watched their parents die and cared for them as they were dying; because of decreasing capacity and resources within the household due to the loss of their parents, they may be withdrawn from school to help with extra chores; their nutrition and health care are usually neglected; they suffer the psychological and physical effects of isolation from the community due to stigma and fear of infection; increased risk of infection, largely due to loss of parental protection; forced into work or out on the street due to poverty and neglect; physical and sexual abuse.

Experts in Nepal have noted that "PLWA [persons living with HIV/AIDS] and their families have a variety of medical, psychological, social and economic needs. A programme of comprehensive care across a continuum from home to community to institutional services will ensure that the specific needs of clients and families are met as their HIV infection progresses and their needs evolve."[15] AIDS-affected families generally undergo a long process of loss of income, withdrawal, isolation, and can often fall into destitution. Children lose their own parents, and may lose other members of the extended family, depending on overall patterns of infection. Without assistance, they

may end up on the street without protection, engaged in a social web that places them at substantially higher risk of infection themselves.[16]

Children orphaned due to AIDS face special difficulties. They may be more likely to lose both parents due to AIDS with one parent likely to have infected the other and face great psychosocial stress when their parents start becoming sick. With a chronic illness such as AIDS, family roles within the household change dramatically, as does the socio-economic situation of the household. Compounded to this is the heavy discrimination and stigma related to AIDS that many children have to face during the illness of their parents and even once they have died.

In high prevalence countries, the proportion of children orphaned due to AIDS will remain disproportionately high through at least 2030. When the number of adults dying due to AIDS begins to increase, children will be without parental care, and will also be deprived of many basic rights such as shelter, food, health, education and love and affection. Many children are also heading households and struggling to survive as well as bring up their siblings. Children without parents or caregivers may be pushed onto the streets in search of work or income.

Even if the epidemic slows or halts within Nepal, the impact will still have devastating effects on children, when parents begin to get sick and die, children will start assuming the role of caregivers and become orphaned. There will be a multitude of effects on children:

Psychosocial distress due to parent's illness – When parents become sick, many children usually assume the roles of caregivers, generally girls. They have to assist in the household chores as well as care for the sick parent. This huge responsibility can have traumatic effects on the child who has to undertake adult roles as well as the pain of seeing their parent die. Support from outside is usually limited due to the stigma attached to HIV/AIDS, and the child him or herself may become discriminated against by their own communities and friends.

Economic hardship – The socioeconomic situation of the family will seriously worsen due AIDS. Once the parent becomes ill, their capacities as breadwinners, farm workers, or household managers and caregivers decline. In addition to the loss of income to the family from earnings and remittances, medical expenses are paid out to treat the opportunistic infections that accompany AIDS further impoverish families. This means that less money is made available for the basic survival of the family and the children, who most likely have to supplement the family income by engaging in labour.

Withdrawal from school – If there is a chronic illness within the family, children normally have to leave school to assist in the household work or to supplement the income of the household. Discrimination related to HIV/AIDS in schools also cause children to drop out of school. Girls will be the most affected since they will be the first to be pulled out of school to provide care for dying parents as well as to assist in household chores when capacity within the family falls.

Malnutrition and illness – In most cases, children living in families affected by HIV/AIDS will be deprived of their right to basic services such as proper health care and nutrition due to the increase in poverty in the family. In this case, children themselves may become malnourished and succumb more easily to illness and diseases.

Loss of inheritance – In many cases, when the parents die, children are taken in by relatives. If there is property attached to the child, the relatives are more ready to take them in, but in many cases, the relatives also steal or use the property of the orphan. Widows with orphaned children can also be subjected to discrimination and abuse and sometimes are rejected by the extended family.

Birth registration and citizenship – Orphaned children without parents, and especially without a father cannot be registered and therefore cannot be provided citizenship. So many of the most vulnerable children will be made even more vulnerable if they cannot access basic services due to lack of citizenship.

Loss of supervision and protection – Orphaned children often face resentment from step parents or relatives, and suffer from lack of affection. They are subject to abuse and exploitation. In many cases, relatives who take in orphans do not treat them well, most orphaned children are made to work from an early age, are taken out of school and are denied basic health and nutritional rights. Girls may have to engage in sex work or other forms of labour to earn money, and many orphans in general also run to the streets to escape mistreatment in the homes of their relatives. Many orphaned children will also be pushed into institutional care because there are no families to care for them, institutions will become overburdened and quality of care and protection may not be conducive to ensuring the basic rights of the child.

Discrimination – In most countries, there remains a very high stigma attached to HIV/AIDS. This is especially prominent in those countries where the population is just becoming aware of epidemic as in Nepal, and due to lack of awareness and fear of the unknown, there is a high discrimination against those affected by, or living with HIV/AIDS. Children, living in families affected by HIV/AIDS, where one or both parents may be infected will be subjected to discrimination from other members of the community. Many children will also be discriminated against in schools from their own friends. Orphaned children infected by HIV are also less likely to be taken in by relatives or adopted/fostered and many may be pushed into institutional care.

C. Other vulnerable children in Nepal

- 14% of the total population is made up of children under the age of 16 years
- Infant mortality in Nepal stands at 64 per thousand live births
- Child mortality is 100 per thousand live births
- Diarrhoea causes around 27 thousand child deaths each year
- Hepatitis B contributes to 13% of all child deaths
- 40,000 children die of pneumonia each year
- 64% of children in Nepal suffer from stunted stature
- Children in the mountain regions suffer more from colds and coughs, and those in the Terai tend to suffer more from acute respiratory infections

- 3,000 children die every year from vitamin A deficiency
- Out of 2.5 million disabled people, 5% are children
- 2.6 million children are engaged in different sectors of child labour
- Girls aged 10-14 work twice as much as boys in the same age group
- Every year, 12,000 women and children are trafficked to India
- 52% of the population do not have toilets
- 5,000 children are working and living on the streets

(CWIN – The State of the Rights of the Child in Nepal 2002, taken also from UNICEF, MoE, ILO, UNFPA FPP, Nepal Medical Association, National Federation of disabled association, NEPAS.)

Several groups of children have even higher vulnerability:

Children in early marriages. Many girls are married at a very early age through arranged or forced marriages in many areas of Nepal. Orphaned children, especially girls, are more likely to be given in early marriage. Early marriage usually denies girls education as they would drop out to get married, it also means they are more likely to have children at a very young age.

Street children. Nepal has an estimated 5,000 street children, 400 to 600 in Kathmandu alone. Children run to the streets for different reasons, but once they are there, they are exposed to further factors that contribute to high vulnerability, such as sexual abuse and exploitation, violence and drug use.

Child labour exploitation. There are currently around 2.6 million working children between the ages of 5-14 years in Nepal. 1.7 million of these children are estimated to by economically active (CBS, CDPS and ILO). These children include: trafficked children, rag pickers, child porters, child carpet weavers, domestic child labourers and children in mines.

Bonded child labourers. The children of the Kamaiya system are born into bondage and labour. They become "collateral" for the debts acquired by their parents through loans taken from their employers and cannot withdraw from their jobs until the loans are repaid. The debt is carried from one generation to another, keeping children and parents bonded to their employers for the duration of their lives.

Commercial sexual exploitation of children. About 20% of the 5,000 sex workers in Nepal are children below the age of 18 years. Furthermore, working girls are often subject to sexual exploitation, such as child domestic workers

Children with disabilities and mental problems. Children with disabilities are often seen as a burden on their families, carry the same stigma of bad luck as orphans (see below), and may be abandoned or neglected. The Nepal Federation for the disabled estimates that there are 250,000 disabled children under the age of 18 years.

Children affected by the armed conflict. Due to the Maoist uprising and consequent internal conflict situation in Nepal, more then 500 children have lost their parents and 1,500 have been abandoned by their parents. Children have also suffered directly by losing their lives in the crossfire, by bombs and landmines.

Lower Caste Children - The Dalit Occupational Caste Groups of Nepal

1. **Origins of the Caste System.** The field research also found that discrimination against members of lower castes was widespread in all districts visited, and that vulnerable children of these caste groups suffered additional discrimination because of their caste status. The Hindu caste hierarchy is based on the Varna system which comprises of four major castes:[17]

Brahman, Kshatriya, Vaishya and Shudra.
Brahman – priests and religious teachers
Kshatriya – kings, warriors and aristocrats
Vaishya – traders, merchants
Shudra – servants

According to the Varna/Vedas, God created Brahmans from his mouth, Kshetriya from his arm, Vaishya from his thigh and Sudra from his feet. Consequently, the Dalit, who belong to the Sudra, as considered the lowest in the caste structure.

The Nepali system divides the castes into a three tiered hierarchy:

Tagadhari (twice born castes) – Brahman, Thakuri and Chhetri
Matwalis – includes ethnic and tribal groups
Untouchables – includes Kami, Damai, Sarki, Gaine and others

2. **Legal framework.** The first legal code of 1854, compiled by the Prime Minister of Nepal, recognised the Dalits as 'untouchables' and they were treated as such. When the civil code was amended in 1963, the Dalits became the 'formerly untouchables' and equal to all others in society. While this should have banished the discriminatory practice, Dalits continued to be discriminated against. In 1990, the practice of caste discrimination and untouchability was declared illegal and punishable by law in Nepal by up to one year imprisonment or a find of Rs.3,000.

3. **Geographical location.** The occupational or Dalit caste make up 15.62% of the total hill castes, of which the Kami constitute 48.8%, the Damai 18.64% and Sarki, 13.99%. These three Dalit castes combined constitute 81.44% of the Hill Occupational Castes and 9% of the total population of Nepal. Other analyses provide in-depth discussions of the locations and numbers of castes and ethnic groups using data from Nepal's prior censuses.[18] Data from the 2001 Census has not yet been analyzed.

4. **Traditional Occupations of the Dalits.** The Dalits have always been linked to manual labour, and traditionally, within the Dalits, each different caste is also traditionally linked to specific occupations. As the tradition continued over time, so occupations and castes became hereditary. The role of the occupational caste in rural areas is indispensable. Traditionally, among some of the key castes, Kamis have been related to blacksmiths and goldsmiths, Damais to tailors and musicians and Sarkis to cobblers. As modern technologies have developed, the need for services provided by the occupational caste has decreased. Many from these castes have abandoned their

'traditional occupation' for something which brings in more money. Many have been obliged to undertake other types of work.

5. **Caste based discrimination.** Even though, according to law, the Dalit Occupational Caste are no longer considered 'untouchables', they are discouraged in many places from enter temples, houses, shops, cowsheds, or hotels, touching sources of drinking water and water pitchers, mixing in feast and festivals with 'higher caste' people, and selling milk and uncooked food.

Because of woman's role in the lower caste, she is relatively equal to her male counterpart. She is valued because she contributes to the majority of subsistence provision. Men normally do not possess land, which makes them weakened in power and reliant on women's role in the household. However, girl children from certain castes, such as the Deuki, Kumari, Jhuma and Badi, suffer discrimination.

6. **The Deuki**. In this traditional practice, girls are offered to the gods of a temple to be able to obtain cherished desires. The girls are either 'bought' or offered from their own parents to the temple. The girls then grow up in the temple itself. As they grow older, many of the girls are unable to provide for themselves and take up the sex trade to sustain themselves. Tradition also states that sexual relations with Deuki's will bring 'eternal bliss' which encourages this practice. The Deuki are forbidden to marry.

7. **Jhuma**. Similar to the Deukis, this is a Buddhist tradition whereby girls of the Sherpa community are offered to the Bhuddist temples under the 'Jhuma' custom. There they usually have sexual relationships with the Lamas.

8. **Kumari**. 'Virgin worship' dates back many years. The Kumari Goddess, the manifestation of the fierce female deity Durga, has been worshipped in Nepal for centuries. The living manifestation of the Kumari is a Buddhist girl of the Sakya cast. The young girl is thus chosen with particular criteria, perfect health, no serious illness, unblemished skin, black hair and eyes, premenstrual and having lost no teeth.
Once the 'living Kumari' is chosen, her life changes dramatically. She is placed away from the public, in the temple. She attends a few important festivals every year, and every day is visited by different people seeking her powers for healing. However, once the girl reaches puberty, or is no longer regarded to be a Goddess, she is returned to her family. This girl's life will never be the same again.

Having lived for many years in isolation of the general society, worshipped as a Goddess and waited on, it is extremely difficult for the girl to be integrated back into the lower caste society she came from. Marriage rarely occurs since many men fear ex-Kumaris knowing that the demon-slaying Durga once dwelt in them.

9. **Badi**. The Badi's are semi-nomadic community most prevalent in the mid-west region of the country. Traditionally, they were entertainers, singing and dancing for the richer families and houses. However, with the fast development of television, video and radio, their services were less and less in demand. To be able to keep their income, they had to change their occupations, and women started getting into sex work. This became openly acknowledged and husbands would very much depend on their

wives occupation for the household income. Girls were also initiated into sex work as soon as they were old enough to. Women who became pregnant due to their work were unable to get their children registered and provide citizenship for the fatherless child. This is still the case today and a big problem among the Badi children.

In some places, orphans of lower caste can be even more vulnerable, especially in certain districts. In Sunsari district, for example, the community recognised that the children of the '*Musahar*' caste, who are by tradition masons, were vulnerable because of their heavy workload. Community members believed that their life expectancy is lower due to the work, and their children orphaned earlier. In addition, children are less likely to attend school because of the need to help out with the labour.
The *Badi* community orphans are also vulnerable, especially the girls. First, the stigma against orphaned children in general is made much worse if they are also from the *Badi* community which is in general discriminated against. The situation of the *Badi* girls is more severe because orphaned girls are more likely to engage in sex work or be exploited at an earlier age to sustain themselves. This was found in the field work in Dang and Nepalgunj Districts.

D. Estimates of HIV/AIDS-Affected and Other Vulnerable Children

While children affected by HIV/AIDS were not treated separately from other vulnerable children in the qualitative portion of the research, their numbers can be estimated by combining a variety of data sources. Data on infected adults and affected and infected children presented in Table 4 of Section II is summarized below. These estimates are preliminary, given the limited character of the data on both seroprevalence rates and orphans in Nepal. They are offered here as a starting point for a continuing discussion, and it is anticipated that the expertise and special knowledge of many organizations will improve these initial efforts. It is hope that this process can be undertaken in the near future because estimates of this nature are critical in planning a response.

HIV Infected Children. Given the large number of HIV infected adults in Nepal, that the 28 HIV positive children identified by NCASC reporting systems are only a fraction of the total number of HIV positive children in Nepal. They could number as high as 48,000 if the infected children of migrant labour families are included in the analysis; however (as noted in the notes to Table 4), this estimate depends on many assumptions and data not currently available in Nepal. This total was multiplied by 30%, which is the global proportion of children born infected to HIV+ mothers, to estimate the number of children who will be HIV+ from this source if there are no widespread antenatal prevention efforts. Other young people in Nepal are infected by other means, but these were not calculated because of the limited nature of the data.

Children Living with HIV+ Adults. Two-thirds of children born to HIV+ parents will not be infected at birth, and so they are included among "children living with HIV+ parents." Some 93% of all of Nepal's vulnerable children live with their parents or with members of the extended family according to the National Census, so it is fair to assume that most HIV+ children are in the same living arrangement. Some 98,000 children are living with HIV+ parents, including 20,000 with parent infected through injecting drug use, 2,400 through sex work, and 75,000 children in migrant labourer

families. While this category of children is separated from the category of HIV+ children, almost all of those children are also living with their nuclear or extended families, or in family-type groups.

Orphans of AIDS and Other Causes. The estimate for children who have been orphaned by AIDS is 13,000, and those orphaned by other causes is 822,000. The number of Nepali children whose mother has died (maternal orphans) is estimated to be 359,000 (including 2,000 AIDS orphans); the number whose father has died is estimated to be 513,000 (including 11,000 AIDS orphans); and the number of children with both parents dead (double orphans) is 37,000 (including 1,000 AIDS orphans). All of these estimates are taken from Children on the Brink 2002, which includes estimates for 88 countries and was developed by experts at UNAIDS, UNICEF, and the U.S. Census Bureau.[19]

Total AIDS-Affected and Other Vulnerable Children. The total number of AIDS-affected and other vulnerable children in Nepal is estimated to be 989,000. The footnotes in Table 4 in Section II of this report describe the estimation methods and displays the number of children in each category described above.

E. Living Arrangements of Children in Nepal

The table below summarizes the living arrangements of affected and infected and other vulnerable children. The box with the largest number of "x's" is that where the bulk of children in each category can be expected to be living:

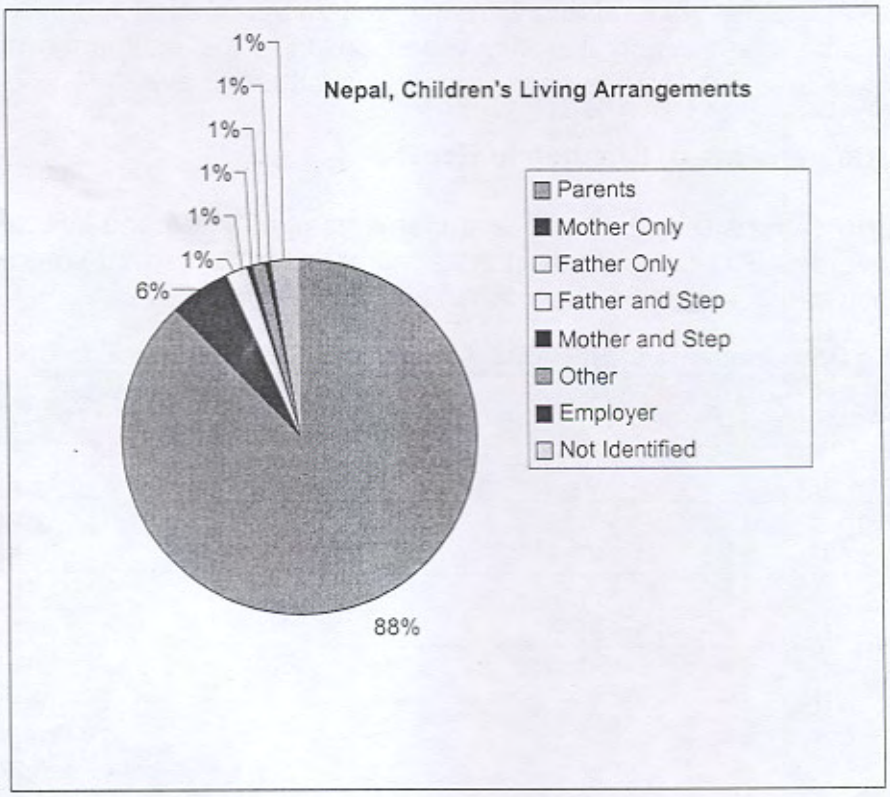
Table 5: Living Arrangements of HIV/AIDS-Affected and Other Vulnerable Children

Child Group	Place of Residence							
	Street	Institution	Synthetic "Family"	Nuclear Family	Extended Family	Employer	Location	Number
Children of Sex Workers	x	x	xxxx	x	x	x	Urban, periurban	3,400
Children of IDUs	x	x	xxxx	x	x	x	Urban, periurban	30,000
HIV+ Children	x	x	xxxx	x	x		Urban, periurban migrant districts	48,000
Children /HIV+ Parents	x	x	x	xx	xx	x	Urban, periurban migrant districts	98,000
Single orphans (maternal or paternal)	x	x		xx	xx		All areas	798,000
Double orphans				x	xxx	x	All areas	37,000

Since most Nepali children live in some type of family (nuclear or extended), it can be assumed that the children included in this assessment are described accurately by the

Census data on children who are not living with both parents. However, none of Nepal's official statistical sources, including the National Census, the Demographic Health Survey, UNICEF's BCHIMES system, the joint Nepal Info system, include information on orphaned children. This makes it impossible to distinguish orphaned children or children affected by HIV/AIDS and for statistical purposes, a problem which may be remedied in several upcoming surveys. Failure to identify whether or not a child's parents are living or dead may be due to the widespread stigma surrounding orphaned children in Nepal, which is discussed more fully below. For purposes of this assessment, then, presentation of quantitative data on children is limited to information on children's living status.

The 2001 Census shows that the vast majority (87%) of children in Nepal live within a nuclear or extended family, although 63,000 children (including 30,000 boys and 33,000 girls) are living with an employer:

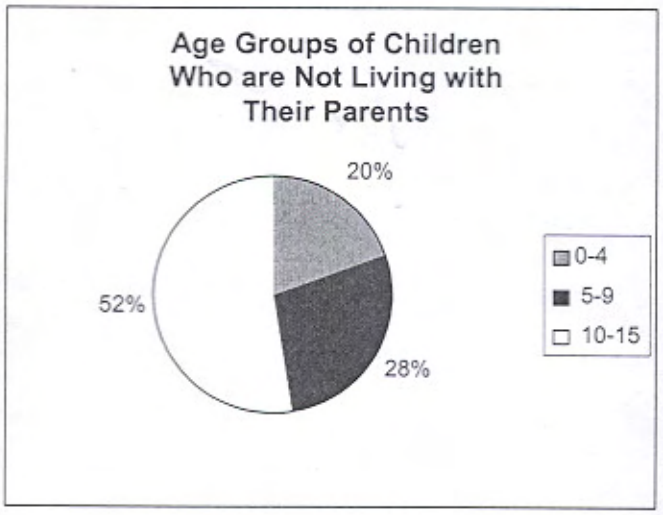


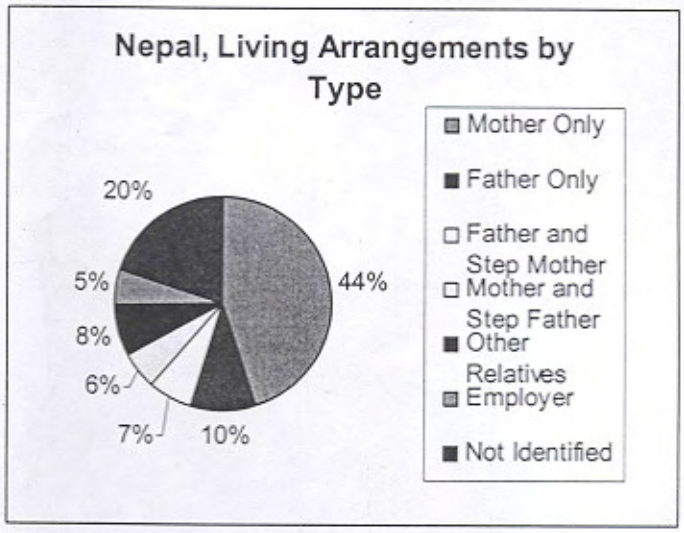
Source: 2001 National Census, Table 38

Some 88% of all Nepali children live with their own parents, and 12% with only their mother, or father, with step parents, other relatives, with employers or unidentified guardians. In the Western Region, the proportion of children who are living with their parents is much smaller, 83%, which is probably the result of the migration or death of one or both parents. In the Far West Region, 87% are living with their parents, and 13% with one parent and step parent or in other arrangements. The proportion of children living in other arrangements was similar in all but two of the districts included in the field research portion of this assessment, Chitwan, where the proportion was 13%,

and Kaski, where fully 23% of all children were living in some other arrangement. Chart 1, which shows the proportions for Nepal as a whole, for each Development Region and for each study district, may be found at the end of this section. Table 1 at the end of the report provides detailed information on children's living arrangements taken from the 2001 Census for Nepal for Nepal, each of the Development Regions.

According to the 2001 National Census, of the children who are not living with both of their parents, 20% are 0 to 4 years old, 28% are 5 to 9 and 52% are 10 to 15. The increasing proportion is a result of the natural increase in the number of children orphaned with age. It is likely that youngest children are living with their mother only or with their mother and step father. It was not possible to analyze current census data to determine the relationship of the child to the adults in the household, and this information was not available from any other source of statistical data, although in other countries it is typically included in household surveys like the Demographic and Health Survey. Lack of this type of data will hinder efforts to monitor the status of these children nationwide or to know on a more comprehensive basis about their living arrangements.

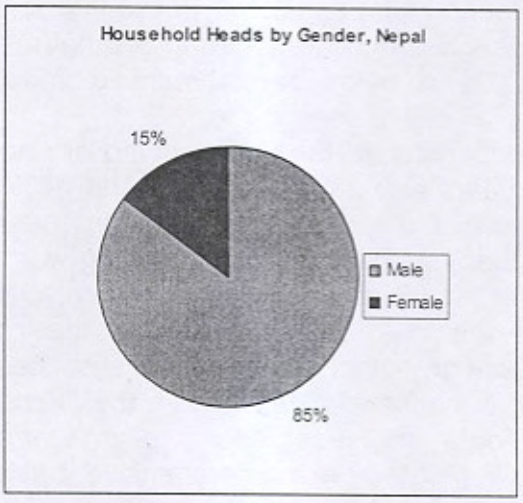




Source: 2001 National Census

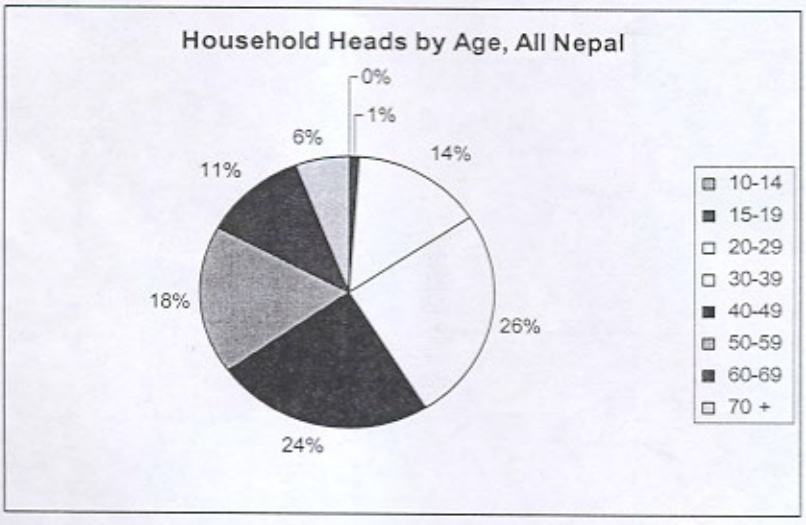
The age distribution of children who are not living with their parents was similar for all of Nepal's Development Regions, but data was not available from the Census to determine the age distribution of these children in the districts included for field research. The Census on age structure and living arrangements for Western and Far West regions, shows that the proportion of children not living with both parents is highest. Also shown are the proportion of children (of the total not living with both parents) who are living in other arrangements. Some 44% of all of these children are living with their mother only. This proportion is significantly higher in the Western Region (61%), where migration rates are high and the potential vulnerability to HIV/AIDS is greater. It is slightly higher in the Far West Region also, where migration and vulnerability are also greater (see Section II).

The majority of households in Nepal are headed by men:



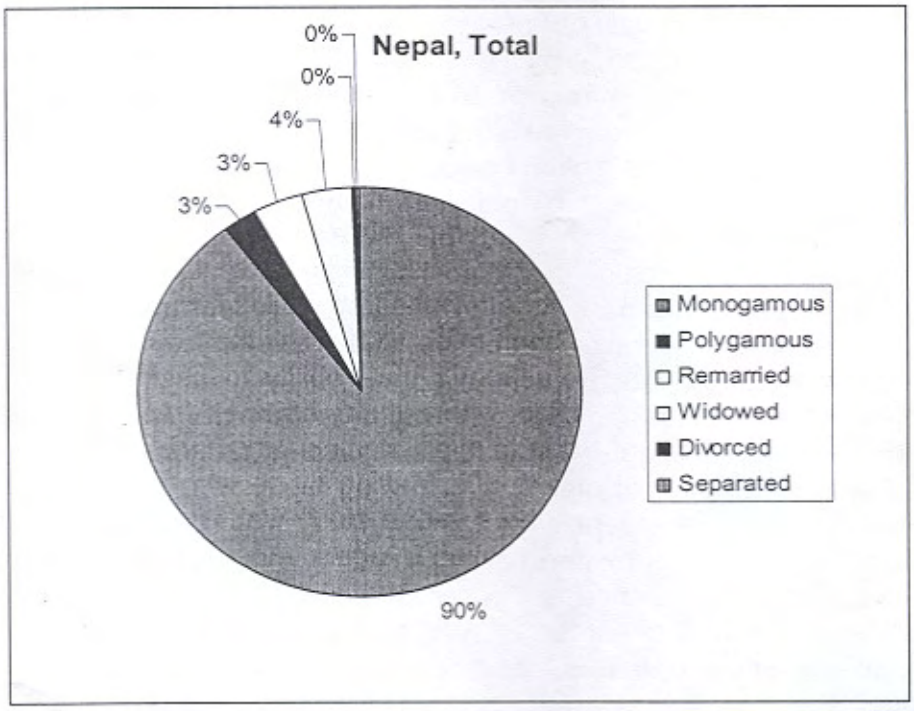
Source: 2001 National Census

In the Western Region, 23% of all households are female headed, which follows in the pattern of other data on the composition of those households. Despite the widespread existence of early marriage, few households are headed by children under age 15:



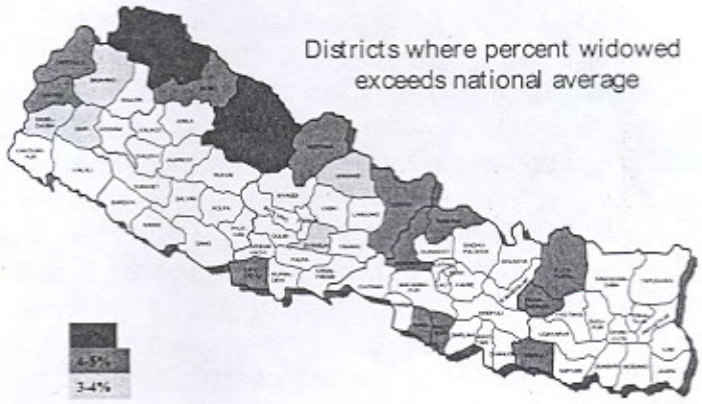
Source: 2001 National Census

Children married at a young age are probably living with older relatives in multiple family dwellings or compounds. The proportion of household heads age 15 to 19 is also very small, most likely because they remain in extended households until they are financially independent.



Source: 2001 National Census

Nine in ten married Nepalis are monogamous, including 92% of married women and 88% of married men. Some 3% of men and a very tiny proportion of women report themselves to be in a polygamous marriage, where the man has more than one wife, and the largest number of these relationships are found in the East and Western Region although the practice is found in all regions. In general, men who are divorced or widowed remarry, while women who lose a partner are discouraged from finding a new one. As a consequence, while the number of men and women reporting themselves as divorced is about equal. the proportion of women who report themselves widowed or separated is twice that of men. There are 308,451 widows in Nepal according to the 2001 census, 10,297 divorced women and 16,457 women who are separated (Table 5, end of Section). The most vulnerable families in Nepal are female headed because of the lack of access to resources under the law and lost of inheritance and property on separate from male partners or fathers. The literature on women in Nepal is extensive and is not covered here. An excellent although somewhat outdated review



may found in a 1998 study funded by the Asian Development Bank.[20] This review notes that trends toward the feminization of agriculture and poverty are increasing, not surprising given extensive migration by males, leaving women to maintain family farms. Violence against women is common in Nepal and is also well documented,[21] and includes emotional and psychological abuse as well as physical abuse and rape. Women are sometimes urged to commit suicide, a view mentioned by many women in the groups visited in the field research portion of this assessment.

Vulnerable households also include those "synthetic" families formed by commercial sex workers and drug abusers who have been rejected by their families. These groups form strong bonds of mutual assistance, although their ability to assist is limited by their meagre resources. Migrant households, where many other HIV/AIDS-affected children live, often have one parent missing due to migration, usually male. They lose members in the most productive age group (15 to 50), leaving those who are less able to work. Some 20% of migrant household members in one study were functionally disabled and unable to perform work. Few were employed in agriculture, and the households were not food secure although they owned houses, land, and livestock, and most reported spending 2 days a month with one meal or less. They were dependent on remittances, which are lost if the migrant becomes ill. While their monthly income was lower than families without migrating members, they had higher adult literacy and child school enrolment rates.[22]

Law and Policy provisions

Provisions for Orphans under the Child Act of 1992. Under the Child Act, when a child is orphaned, a guardian is appointed by the Child Welfare Officer. Usually this is a relative of the child.

The Child Act also specifies that if the orphan has any property, the child welfare officer or the Chief District Officer (CDO) prepares a statement of the property in the presence of at least two local witnesses. He keeps one copy in his office and the other one is given to the person or organisation responsible for upbringing and maintenance of the child. This statement will be given to the custody of the guardian or the institution taking care of the orphan. The responsibility to take care of or protect the property lies with the Children Welfare Officer and if he is not available, then with the CDO. The guardian or institution responsible for the maintenance, upbringing, education and health care of the child may use the income derived from the property.

Denial of Inheritance and Property Grabbing. Although property grabbing is not monitored or documented, it is widely known to exist. Guardians for orphans, whether they are relatives or others are more likely to take in orphans if they have property. Under the provisions of the Child Act, guardians can use the child's property for their upbringing, but in many cases, guardians also exploit this condition by falsifying expenses related to the orphans and using the income from the property for themselves. Discussions with groups in Dang revealed that this is especially so if the child is a girl. There are currently no mechanisms in place to monitor children's property and most orphans do not know their rights or where to go for assistance.

In all districts it was found that in areas where the communities are not close knit or where there is not a strong bond within the extended family, relatives and other guardians may be more likely to take advantage of the orphan's property. In rural areas where the extended family and community are closer, they are able to monitor the use of the orphans property and inheritance and ensure that the child receives their share justly.

Legal provisions for Widows

Under the recent amendment to the Country Code, widows now have full rights to their inheritance and are entitled to use it as they wish even if she remarries. In rural villages, widows are usually unaware of their legal rights and may never claim their property from their in-laws. They may also be cheated of their property. Findings from the assessment show that property and inheritance play a big part in the sustenance of poor families and children. Although there are laws governing the property and inheritance of children and women (Child Act 1992 and Country Code), at all levels and in all districts visited, it was clear that there are no mechanisms to monitor whether or not property is going to the right person (see Table 14).

- In Sunsari, meetings with the paralegal committee revealed that property grabbing is widespread. With no mechanisms however, to monitor this problem, it is impossible to say how many cases are happening. Relatives usually falsify bills for care of orphans as an excuse to use the money from orphans inheritance while the orphan him or herself usually does not benefit from this money but is treated badly. Cases were also reported of widows who have been thrown out of the house by her husband's relatives who have gone on to sell her property without her consent. Without structures in place to control property grabbing the laws and policies make no difference.

- In the Pokhara municipality, Kaski district, meeting with women's groups revealed again that property grabbing was common. They noted that there are no mechanisms in place to assist or monitor property. And even if the channels for putting a case forward exists, it is virtually impossible to fight it. And example given was that of a case of property grabbing by relatives of an orphan that was reported to the CDO (Chief District Officer and chairperson of the DCWC), the mechanism adopted by the CDO (which applies country wide) is to double check the claim by sending a representative of the ward level to the family in question. However, in these cases, the family or relatives of the orphans usually lie to the ward representative and if the case cannot be proved, it is left un-dealt with. This kind of mechanisms, while effective in a few cases, is time consuming and limited. Many orphans or widows do not even know how to fight for their rights, and most will not be able to reach the district HQ to plead the case with the CDO. The CDO also has little time to spend on settling these kinds of disputes. *(Kaski findings)*

- In Chitwan, Bharatpur, a meeting with the community legal resource centre and the paralegal committee indicated again that cases of property grabbing were occurring, but that no cases had been brought specifically to their attention. Nothing is being done to protect orphan or widow's property. The woman's group in Bacheuli VDC, Chitwan identified the police centre as a potential resource for cases concerning property.

- In Dang district, the team met with members of the DCWC including lawyers. The same problem concerning property grabbing occurred here too. The members indicated that some of the most common cases brought to lawyers are of property, land and ownership. They described several cases brought to them of property grabbing by relatives. One particular case was of a young girl who went to live with her uncle when her parents died. She had been left a substantial portion of land as her inheritance. However, her uncle took over the property and proceeded to marry the young girl off at the age of 16 years. She did not receive the property.

- In Dadeldhura, the study found different findings. This was the only case where property grabbing was not considered a problem. Women from the Nabadurga VDC noted that orphans usually received their property and that communities were able to monitor cases of property grabbing if they occurred. The community seemed closer knit with more internal social support. This type of community support could be used as an example to how the community can be mobilised to support each other and to look out for vulnerable children and women.

The field research found that when poor families fall ill, they are more likely to sell off their property. The meeting with an NGO working with drug users and people living with HIV/AIDS noted that once a person fell ill, they were forced to sell off their property for treatment. If the illness is chronic such as AIDS, the family is more likely to fall into severe poverty when forced to sell off all their assets.

Women's control over property is also questionable. Although by law (Country Code), women are entitled to half the share of her husband's property, in many cases, she is powerless to control what happens to it, and most of them time does not know what her entitlements are. A case in Sunsari noted by the CDO of a husband who was in debt from gambling and who wanted to sell off the families land to sustain his gambling addiction. Luckily, the CDO intervened to put a stop to it, but this is probably a rare case. Cases have also been noted where husbands sell off their property to supplement their drinking habit.

There is no specific legislation on HIV/AIDS in Nepal. However, a regional study done in conjunction with the Forum for Women and supported by UNDP (2001) has attempted to highlight the different laws and legislation which could be applied to the situation of HIV/AIDS including issues such as confidentiality, privacy, liberty, gender equality, economic and social equity and fundamental social obligations.

The study also highlights different contradictory laws in effect that could cause vulnerability to particular groups such as women and children, that are inconsistent with

international human rights instruments as well cause some amount of discrimination in relation to HIV/AIDS. The purpose of the study is to provide policy recommendations that provide a favourable environment to HIV/AIDS affected people and reduce the amount of discrimination.

Laws that relate to children's vulnerability to HIV/AIDS Laws relating to children may be conducive to vulnerability to HIV/AIDS as well as discriminatory to children affected by HIV/AIDS. The laws include:

- Low early marriage age which is 16 yrs for girls (Country Code on Marriage) – this may increase the risk young girls infection and lack of negotiating skills

- No health and safety rules for minor workers – the Child Labour Act (2000) does not provide requirements of health and safety for child workers. Children who are employed at an early age are vulnerable to exploitation and abuse and consequently to HIV infection.

- No provisions or guidelines for safe breastfeeding or policy on mother to child transmission of HIV/AIDS which increases the chances of infants being infected by HIV through MTCT

- Discrimination may be encouraged due to the Infectious Disease Act of 1963 which enables Government to segregate persons with infectious diseases to avoid contamination – this is particularly worrying for people who are unaware of the methods of transmission of HIV and wish to discriminate against people living with or affected by HIV/AIDS

- There are no provisions in the Civil Service Regulations (1993) for HIV in the workplace – workers who contract HIV/AIDS are not provided with any support or protected against discrimination which will affect their socio-economic status as well as impact heavily on their families

- There are no laws looking specifically at the ethics of orphans due to AIDS, including laws on consensual testing in institutions and hospitals of infants and children whose parents have died due to AIDS – this may result in random testing of children within institutions and in hospitals and without proper awareness of staff, may also cause a certain amount of discrimination to the children

- No guidelines or legislation consistent for all institutions housing orphaned or abandoned children – presently there is no consistent mechanism for ensuring that institutions housing orphaned or abandoned children are conforming with minimum standards of care and protection.

Revised laws for women in relation to HIV/AIDS Reforms incorporated in the Country Code (Eleventh amendment) that attempt to decrease the number of discriminatory laws against women. For the Bill to be effective however, it must be passed by the House of Representatives again. This has not been done yet. Some of

these reforms have legal implications to women made vulnerable to HIV/AIDS infection and impact, these include:

- ***Full right to widow in her inheritance*** – widows are now entitled to sure their share of their husband's inheritance even if they should remarry. There is also no age restriction

- ***Women's right to abortion up to 12 weeks of pregnancy*** - Women previously were not granted the right to voluntary abortion. Now, up to 12 weeks of pregnancy, she is entitled to voluntary abortion.

- ***Right to divorce in the situation of sexual intercourse with third person*** - The husband as well as the wife have the right to process a divorce if their partner has had sexual intercourse with any other person.

- ***Increment of punishment in rape case*** - The bill has increased the punishment for rape, it now provides a punishment of 10-15 years for the rape of a child below the age of 10 years, from 7-10 years in the case of a child between the age of 10 and 16 years and 5-7 years for any girls and women above the age of 16 years. Previously, rape charges were of a fine of Rs. 500 or imprisonment up to 1 year only. However, there is still a narrow definition of rape which does not take into account marital rape.

- ***Increased punishment for child marriage*** - The punishment for marriage of a child under the age of 16 years has increased to 3 years imprisonment and up to Rs. 10,000.

Birth registration and Citizenship Statistics from 2000 has shown that only 41.9% of children under the age of 1 year have been registered (CRC report). Every child has the right to a name and a nationality under the Convention of the Rights of the Child, ratified by Nepal.

Birth registration and citizenship play a big role in access to basic services. For example there is a compulsory submission of birth certificate for school enrolment purposes. Birth registration and citizenship still requires the name of the father or hospital records for the purpose. However, in many cases, especially in the case of sex workers and due to consequences of rape, women may not know the name of the child's father, or he may not consent to being the father of the child. In these cases, children remain unregistered and have no chance of securing their own citizenship.

Effective registration can protect children from a number of violations, such as child labour, trafficking, prostitution, early marriage, recruitment into armed forces etc. Moreover, the child is acknowledged when he or she has a citizenship. Children without registration or citizenship may be disadvantaged for the whole of their childhood and adulthood.

Provisions for vulnerable children under the Education policy The literacy rate in Nepal as a whole is of 53.7%, this is broken down to a rate of 65.8% in men and 42.5% in women (according to the Census 2001).

The Basic Primary Education Programme was established and launched to improve access, retention and learning achievement. Among the goals of the BPEP II (Basic Primary Education Programme, phase 2), a target has been set for attaining a gross enrolment rate (GER) of 100% for children belonging to the disadvantaged communities, such as the dalits (CRC report 2001).

As part of this initiative, scholarship programmes have been provided to dalit children and children of other ethnic disadvantaged groups. However, the reach of this programme is still to be determined as budgets are still underestimated for the number and needs of vulnerable children who are the first to drop out of school.

As of yet, there are no provisions, scholarships or other initiatives targeting vulnerable children as a whole, including orphaned children.

Non-formal education has attempted to reach children out of school. According to the goals set in Nepal's ninth plan, the Government had set a target to reach 784,000 out of school children. For this effect, a literacy campaign was launched in 20 districts under the National non-formal Education Programme. NGOs, orphanages and other rehabilitation centres also provide non-formal education to vulnerable children.

Provisions for vulnerable children under the Health Policy Presently in Nepal, there are around 4100 health institutions which range from hospitals, to health posts, to sub-health posts and also health extension workers. However, the situation is still not adequate for the needs of the most vulnerable. 6 of the 75 districts in Nepal still do not have district hospitals. The reach of the health services to basic grassroots levels is also not sufficient.

As part of the challenge to health care, Nepal's CRC report indicates that:

"There is inadequate basic infrastructure in the health system to meet the challenges. Where medical services are inefficient and expensive, the underprivileged children obviously suffer a lot. Children at risk, such as street children, child workers and other underprivileged children including children of Dalit communities are more prone to health risks due to the exposure to various hazardous conditions related to their work and lifestyle. They hardly ever get medical attention, which leads to various serious health problems"

Deficiencies in quantitative data on orphans and other vulnerable children is matched by an almost completed silence about their needs and living arrangements in the academic or policy literature. Literature on childhood vulnerability lumps orphaned children together with other vulnerable children. Because of these gaps, the field research portion of this assessment was especially valuable in closing a gap in information hindering programming and policy development for children in Nepal. Since orphans comprise an estimated 8.6% of vulnerable children,[23] the lack of data and information is

reinforcing the deliberate stigmatization of children that is universal in Nepal. Details of findings concerning the condition of orphans are provided below. Prevalence in the districts included in the field research is shown in Table 15 at the end of this section.

F. Stigma and Discrimination. The field research portion of this assessment has shown that orphans are a particularly vulnerable group nationwide, and that their stigmatization prevailed in all districts, cultural groups, and economic groups visited. Orphans are blamed for their parents' deaths, and orphans of all economic and social groups suffered extraordinary hardships and isolation. As part of religious and cultural beliefs they are considered bad luck and some held responsible for the death of their parents. Findings from the assessment and discussion groups with community members as well as children themselves have shown that orphaned children are usually denied food, schooling, love and affection, are beaten and are made to engage in labour as soon as they are able to do so (see Table 4).

B. Demographic Definition	C. Traditional Definition of Orphans in Nepal
Maternal orphan, mother dead	*Ama Tokwa*, mother eater, especially if the woman dies in childbirth or when the child is very young
Paternal orphan, father dead	*Babu Tokwa*, father eater
Double orphan	*Babu, Ama Tokwa*

Source: field visits in all districts

When his or her mother or father dies, the child is often held responsible for their death. If both parents have died, the child is seen as particularly unlucky, especially if he or she is orphaned at birth or as an infant. Orphans who have lost their mothers are vulnerable because fathers normally remarry and the orphans are very badly treated by their stepmothers (see Charts 1-3 at the end of this Section). Orphans who have lost their fathers are vulnerable because widows usually do not remarry, and there is usually a drop in family income. Widows also have a lower status in society and are also subject to severe discrimination.

Discrimination of widows in Nepal[24] Widows have a low status in Nepal. A widow is often considered as a bad omen and it is often believed that a widow killed her husband. Widows are called *Pol Tokwa*, husband eater, and other derogatory terms are used both in speaking about the woman and in addressing her. Women who are widowed younger are considered as having even worse luck and may be mistreated by their in-laws. In some areas, where child marriage is still practiced, children themselves can become widowed. In some cases, widows are accused of being witches, or '*bokshi*' and they can be blamed for witchcraft. The consequences of being labelled a witch are severe, and these women can be subject to physical abuse, discrimination, and even death.

A widowed woman is expected to remain chaste to her dead husband and live a life of mourning, never wearing bright clothes or make-up. Over and above the burden of being labelled and stigmatised as a widow, women who have lost their husbands are

also in a very fragile financial situation. Marriage to a widow is also considered unlucky in many cases. There are few exceptions. The field research found that in the Eastern Region of Nepal, widows in the Musahar caste community usually remarry, sometimes to their brother in laws.

Women who are widowed at a young age are particularly vulnerable. Firstly, they are more discriminated against by others, including their in-laws, they are less likely to have saved much money or acquired much in terms of property which leaves them more in financial need to raise their children. They usually have to raise their children on their own, sometimes getting help from their in-laws, but usually they left to their own devices. They have to earn enough money to keep the household going, as well as keep up the household chores. There is no special support for widows from the Government, unless husbands worked for organisations that provided for them. The woman's life is difficult even before her husband dies, if he dies because of illness, the burden of care falls on her and her children. This is especially difficult if it is a chronic illness where so much of her time is taken up caring for him. *(findings from the assessment)*

G. Care Practices for Vulnerable Children. Orphans who have lost both parents are the most vulnerable. In some cases, before the child is born, the astrology sign is determined and a particular sigh is deemed unlucky. If the child falls on this sign, they are termed '*Mulya*'. This means that they are bad omens and will bring problems to their parents. If the parents of the '*Mulya*' child dies, they are especially vulnerable since they may be looked upon as having killed their mothers and considered as bad luck. Children whose parents die while they are still very young, such as newborns or infants are more vulnerable to stigma and beliefs that they have killed their parents. This was found to be true in all six districts.

It was also found in all six districts that as infants, double orphans are usually taken in by relatives or grandparents, but are not treated well because they are unproductive at that age and cannot benefit the family in any way. This usually results in poor nutritional intake, little stimulation and care which effects in a negative developmental impact. As the child gets old enough to work, he or she is put to work either in their own household or employed by another household. These children very rarely get the chance to go to school, play, have access to health provisions or good nutrition.

In many cases, orphaned children, usually girls, are taken in by families as domestic workers once they are orphaned. Orphaned girls are also married off at an earlier age to relieve the family from the burden of an extra child in the household, and are subject to physical, sexual and emotional abuse.

Child care practices also vary between the urban and rural areas. In rural communities, there is a stronger community cohesiveness. Families tend to assist each other and in established communities, where families have known each other for generations. Extended families are much stronger and larger. When parents need to work or be away from the child, supervision can be arranged through the extended family, other families or established day care centres. Women will help each other if husbands are abroad for work. Although children may be involved in labour at a much younger age or

may have less access to health or educational facilities, they at least have some level of supervision and care.

In urban communities, although health and education facilities are more accessible, the situation of supervision and care for children in poor households is different. Many of the communities are composed of families that moved there from different rural areas at different times and there is little established community cohesiveness. Many families migrate to urban centres for work, leaving behind their extended families and community support. When they go to work there is no one to look after their children. In many cases, if families can afford it, they have to contract help for their children, or send their children to day care centres at a relatively high cost. Otherwise, children will look after their siblings. In the worst cases, children are unsupervised or are made to work themselves.

H. Families Affected by HIV/AIDS. Little information exists on the actual impact of HIV/AIDS on families in Nepal. Due to lack of testing, counselling services and follow up of families affected by HIV/AIDS as well as the high stigma attached to AIDS, it is difficult to get concrete cases of families affected. However, the socioeconomic situation of the family and the support structures surrounding the family provide a good indication of how well they would cope with the impact of HIV/AIDS and how children within those families would be affected:

Family Type – socioeconomic status	How they are affected by HIV/AIDS or made vulnerable	What are their coping mechanisms
Wealthy Families where the father or husband is working abroad and earning substantial income e.g. British Ghurka families Business men	- No supervision for their children and lots of money, therefore children may start taking drugs and drop out of school – children may become infected due to IDU - Wives who are alone may take in other sexual partners and become infected - Men may take in other sexual partners when abroad and return infected	- Have plenty of food - Live in good houses - Can afford health costs - Can afford educational costs - Can afford rehabilitation costs - Have money and savings - Have property and land - Parents and children are registered and have citizenship
Well off Other types of migrant workers, usually working in the far east and the middle east but earning enough money Sr. Government officials Business people	- No supervision for children at home and enough money to experiment with drugs – risk of infection from IDU and dropping out of school - Wives who are alone may take in other sexual partners - Husbands/fathers may take in other sexual partners when abroad and become infected	- Have food to eat - Live in relatively good houses - Can afford health costs - Can afford educational costs - Can afford rehabilitation - Have property and land - Have enough money and savings - Parents and children usually have citizenship

Family Type – socioeconomic status	How they are affected by HIV/AIDS or made vulnerable	What are their coping mechanisms
Poor Migrant labourers working in India Internal migrants who gravitate to the urban centres for work or due to the conflict situation Sex workers whose husbands do not know they are engaged in sex work to supplement their income People who peddle drugs	- Can come back from India infected with HIV and in turn infect their families - Men who migrate to urban centres may engage in sex with sex workers - Women who migrate can be at risk of being drawn into the sex trade - These women are at risk of being infected by their clients, and in turn infecting their husbands - They are at risk of getting involved or experimenting in drug use, and IDU and may become infected themselves	- Have limited food - Have limited labour capacities - Have shelter - May have some land and property - Have little money for health care - Have little money for educational costs - May have to sell their land/property for health care - Children may have to drop out of school to care for sick members of the family - No perception of legal rights - May have no citizenship and children may not be registered
Destitute Internal migrants who gravitate to the urban centres for work or because of the conflict, who are living in slums or are homeless ad who engage in daily wage jobs Sex workers who have been abandoned by their husbands and partners and who do not bring in a sufficient income Drug users who have been rejected by their families and who are living in the streets Street children, born on the streets, who have no families, or who have run away from their families Lower caste families who engage in hard labour	- Men may engage in sex with SW and risk infection - Women may be drawn into the sex trade and become infected - Children are more vulnerable because of no supervision during the day - Many children turn to the streets to work - At risk through sex work - Risk infecting other clients - Risk of infection through IDU - Women may turn to sex work to supplement their income for drugs - Children, especially girls may also get drawn into sex work if their mothers are in it - Children of drug users are unsupervised and are at risk of abuse and exploitation - These children are at risk of become involved in drug use and IDU - Girls may be drawn into the sex trade - Children are at risk of abuse and exploitation - Life expectancy is low due to hard labour and children may become orphaned earlier - Discrimination from access to basic services - No involved in any awareness campaigns	- No shelter - No financial assistance - No property/land - Cannot afford education - Cannot afford health costs - No perception of legal rights - No citizenship of parents or children - Children end up begging to survive - Children end up engaging in hard labour to survive

Global studies have shown that once parents begin to get sick because of AIDS, household roles and responsibilities dramatically change. Children are pulled out of school due to labour obligations at home, and care of younger children becomes increasingly difficult. In many cases, children will be looking after siblings and also their own sick parents, reversing the caring roles. When the caring capacity of the family decreased, the consequences are of poor nutritional status, poor health status, no educational status and lack of affection, care, support and recreational time for the child. In many cases, girls are the first to suffer, to be taken out of schools to care for siblings and sick parents. Girls may also be made to get married earlier as a coping mechanism to lessen the household running costs.

D. Summary of care practices of other families who are vulnerable to the impact of HIV/AIDS

Family type and socioeconomic situation	Care practices for children
Poor families	
Seasonal migrant labourers working in India	- Women engaged in agriculture and have little time to spend taking care of children - Children usually looked after by relatives, siblings or community members - If there is a day care centre, children may be looked after there - Children are usually left with someone else whilst women are working
Sex workers whose husbands do not know they are in the sex trade	- Children are usually left with someone else whilst women are working
Destitute families	
Internal migrants who come to urban areas and are living on the streets or in slums	- Children left to themselves during the day whilst parents are working - Children are made to work once they are big enough and supplement the family income - Children are made to beg for money - Older siblings look after the younger one
Sex workers who have been abandoned by their husbands/partners and who survive out of the sex trade	- Children are left unsupervised during the day while their mothers work - Hired help is contracted to look after the children when possible as there is no family support for these women - Older siblings are made to look after younger ones
Lower caste families who engage in hard labour	- Children are not enrolled into schools and made to work as soon as they are old enough

Institutional Care and Support. According to the Central Child Welfare Board, in Nepal there are over 140 orphanages, transit homes or rehabilitation institutes which house over 4000 children. Although, under the Child Act, the Child Welfare Board and the District Child Welfare Committees are responsible for providing institutions for the rehabilitation of vulnerable children, there are few Government institutions. Most institutions are run by NGOs, private individuals or religious bodies.

Although institutionalisation should be the last resort for children who have lost their parents, many abandoned children are taken there first. Institutions in general have been found to provide a very small and inadequate part of the response to HIV/AIDS. Costs for maintaining a child within an institution are very high and therefore unsustainable. Families may find it easier claiming their child is an orphan so that he or she receives free education and health, taking away the responsibility of the child from his or her family to the Institution. Children in general also do not get the same amount of care and attention in an institution as they would within a family environment and consequently, socialisation will be more difficult for children who have grown up in institutions. Many institutions may not have the capacity to carry out tracing of family members and ensure reintegration of children back to their family.

While Nepal's final draft report on the implementation of the CRC indicates that minimum standards for institutions (including orphanages) exist, there is no evidence of these and in practice. Without an instrument with which to monitor the quality of institutions, care varies considerably from one institution to another, with some providing top of the range quality, while others may be violating children's basic rights due to lack of the very basic minimum standards.

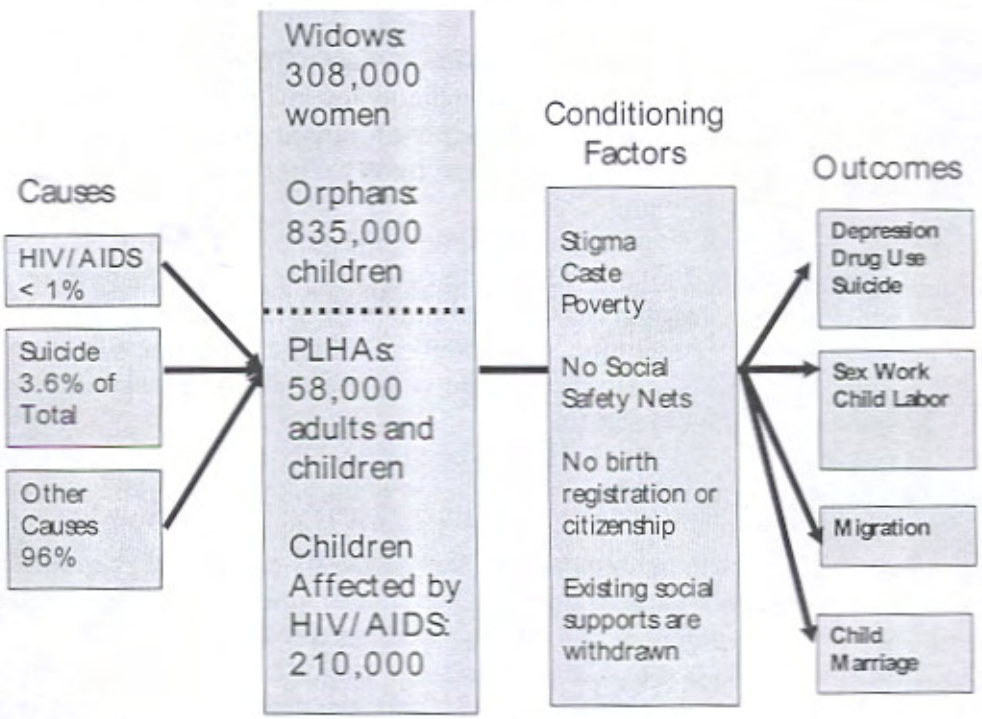
I. The Climate of Care in Nepal

Findings from the field assessments and limited published reports show that discrimination against widows and orphans (no matter what the cause of death of parent or partner) is nearly universal in Nepal, and creates similar barriers to any programme for family and community care. Table 3 lists the major barriers to care, including all of those noted above, notes the problems these barriers create for vulnerable groups, and specifies the legal framework that allows barriers to persist. In many cases, the legal framework is adequate, but enforcement is either weak or non-existent, so that the human rights of vulnerable groups are consistently violated by members of their families or members of the communities in which they live. Recommendations for action are provided in the final column of that Table, but they will also be revisited more fully in the final section of this report.

Discrimination, as was noted in the introduction to this report, is a two way street. It not only creates barriers to care and protection, but leads to the high potential of HIV infection among members of vulnerable groups. As the vision of vulnerable groups broadens in Nepal, widows and orphans— and, more generally, families affected by HIV/AIDS (especially the uninfected spouse) – must be given special attention in infection prevention in HIV prevention and protection as well as in the design of

programmes of care. There are no formal safety nets, such as benefit or pension programmes, to help widows caring for vulnerable children, and she and her children are more likely to find that their access to all basic services diminishes as family wealth declines. As social support from the surrounding community declines, the widows and children suffer increasing discrimination and can even experience physical and emotional violence of cruel proportions.[25] The case studies found at the end of this section, selected from the field research to illustrate the barriers listed in Table 3, provide a sense of the human devastation created and compounded in each woman's and child's life. Every incident of discrimination reinforces the "vicious circle" of infection which effective programmes of care can help to break.

Nepal's Vicious Circle of Infection



The report found, however, that community structures exist that can be supported by outside government and NGO actors to reduce these debilitating conditions and assist families and communities in marshalling their resources to provide care to HIV/AIDS infected and affected children and adults. These are described in the next section.

IV. Climate of Care and support

A. NATIONAL LEVEL – At the National level, the systems of support and care in the area of HIV/AIDS fall under the framework of the National Strategic Plan 2002-2006. Ensuring care and support for individuals and families affected by HIV/AIDS is one of the five key priority areas of the NSP.

The National Strategic Plan for 2002-2006 highlights 5 key priority areas:

- Prevention of STI and HIV infection among vulnerable groups
- Prevention of new infections among young people
- Ensuring care and support services are available and accessible for all people infected and affected by HIV/AIDS
- Expansion of monitoring and evaluation frame through evidence based effective surveillance and research
- Establishment of an effective and efficient management system for an expanded response

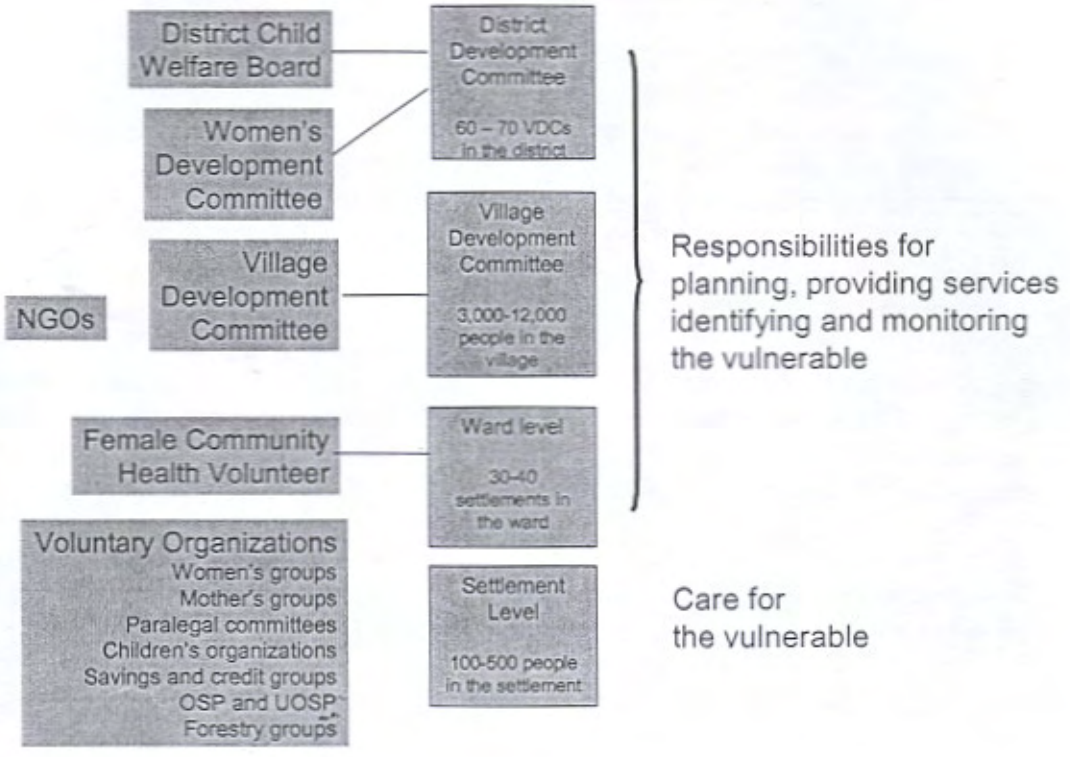
At the National level, the Central Child Welfare Board (CCWB) is also mandated to provide support to vulnerable children. The CCWB guiding document is the Child Act of 1992, elaborated specifically to respond to the rights of the child. The CCWB is represented by the District Child Welfare Committees (DCWC) at the district levels.

National level also sees the response of various donors to the HIV/AIDS epidemic. The response of Donors to date has been to support the Government initiatives. The Nepal Initiative is presently being supported by USAID, UNAIDS, DFID and AusAID.

Different Donors have also expressed interest in supporting the new National Strategic Plan for Nepal 2002 – 2006.

The UN system, through the United Nations Assistance Framework (UNDAF) for 2002 – 2006 has also outlined several objectives related to HIV/AIDS and vulnerable children and women.

In 1990, as part of the transition to multi-party democracy, Nepal introduced the new local government system in the form of Development Committees. In 1992, the local government legislation was replaced by a more comprehensive Act. This legislation outlined the different roles and responsibilities of the local government, made up of the District Development Committees, the Village Development Committees and the Municipalities. This decentralised government structure allows for a more comprehensive monitoring and supervision, as well as co-ordination of activities regarding women and children at District level down to Village level. Responsibilities for women and children are summarized in the chart below:



B. <u>DISTRICT LEVEL</u> – The District Development Committee (DDC) is the executive body responsible for the district. It comprises a Chairperson, a vice-chairperson (chosen from among the members of the VDC) and a member from each VDC and Municipality in the District. The DDC responds to the Central level National Planning Commission. The DDC must meet at least once a month, and has the following roles and responsibilities of the DDC relating to women and children:

- To prepare and implement a plan required for the uplifting of the women in the district development area
- To carry out acts on the protection of the orphans, helpless women, the aged, disabled and the incapacitated persons as per the national policy, and to carry out or cause to be carried out acts on the wiping out of the social ill-practices and the protection of the girls and the women

The members of the DDC also have the responsibility of supervising the different VDCs and municipalities as well as provide co-ordination among the VDC and the DDC and mobilise different organisations for development.

Other district level Government officials and bodies – roles and responsibilities

Chief District Officer (CDO):
The CDO is appointed under the Local Administration Act and form a key part of the local government system. The CDO has is responsible in many cases in making provisions available for vulnerable groups such as orphans (under the Child Act) and sick people.

Labour and Welfare Officers:
The Labour and Welfare officers have the responsibility under the Labour Act to protect the rights of workers and employees.

District Education Officer:
The DEO's functions, set under the Education rules of 1992 include the implementation of regional directives, formulation of an education plan for the district, submit annual data to the Ministry of Education and to improve the level of education in the district through capacity building and training.

Child Welfare Officers:
Mandated by the Child Welfare Act 1992, the child welfare officers are appointed to represent and work under the District Child Welfare Committee (DCWC) for the care and support of children, especially the most vulnerable children such as orphaned and abandoned children.

District Child Welfare Committee members:
Under the Child Welfare Act 1992, the members of the DCWC have the responsibility of ensuring that children's rights in the district, especially the most vulnerable are upheld and protected.

Child Welfare Home Administrators:
Under the Child Act of 1992, the child welfare home administrators have the responsibility of managing child welfare homes (otherwise known as orphans homes, orphanages or other institutions for vulnerable children). The child welfare home administrators have the duty of supervising these homes and ensuring good quality of care for the children.

Summary of key structures responsible for children and women at the district level

District level	Responsibilities relating to children and women
District Development Committee	Prepare and plan for all activities at the district level including for children and women and prepare budgets for the most vulnerable groups. Link up with the different organisations at the district level to the availability of services as well as co-ordinate the different activities carried out by organisations under the district plan Monitoring and evaluation of activities carried out at district level
Chief District Officer CDO	Responsible for provisions for vulnerable children, especially orphans and abandoned children - referring them to services and providing adoption or fostering
District child welfare committee DCWC	Responsible for children, especially vulnerable children at the level of the district in terms of planning, budgeting and linking to organisations to ensure that children receive care protection and secure their rights under the Child Welfare Act
Woman's Development Officer WDO	Responsible for the protection and development of women, especially vulnerable women at the level of the district - supervising and co-ordinating the different women's committees
District Education Officer DEO	Formulate the education plan at district level as well as improve the level of education Co-ordinate with different organisations and the DDC
District Health Officer DHO	Formulate the health plan at the district level as well as improve the level of health services Co-ordinate with different organisations and the DDC

The District Child Welfare Board. The Child Act was established in 1992. It is governed at Central level by the Central Child Welfare Board, part of the Ministry of women, children and Social Welfare. At district level, the responsibility for children lies with the District Child Welfare Committee. Under the Child Act, a child is any persons under the age of 16 years. The main objective of the Child Act is to promote the physical, mental and intellectual development of the children and to make timely provisions in order to protect the rights and interests of the children. The District Child Welfare Committee (DCWC) is established under the Chief District Officer (CDO) who is the chairperson of the DCWC unless someone else is appointed for this position.
The DCWC should, under the Child Act, have the following constitution:

- Persons involved in social service
- Social workers involved in the works relating to the rights and interests of the child
- Women social workers

- Medical practitioners
- Child psychologist
- Teachers

The tenure of the DCWC is for four years and the DCWC has to submit annual reports relating to district level activities in the area of children to the central child welfare board

Summary of provisions for vulnerable children under the Child Act 1992:

Protect the Rights and interests of the child
The DCWC has the mandate to ensure that the rights of the child are being upheld, including the following:
- Right to a name, maintenance, upbringing, education and health care
- No discrimination between girls and boys in all matters
- No discrimination made between children born out of wedlock or in lawful wedlock or between an adopted and a natural child
- Prohibition on exploitation and abuse of the child through employment, begging, cruel treatment, punishment or other means
- Enforcement of rights in court

Protection of orphaned children and appointment of guardians
The DCWC has the mandate to appoint a guardian for orphaned children, without any parents. Ideally, the guardian should be of the same family as the child, however, if this is not possible, other persons can be appointed.

The guardian has custody of the child's property until he/she is old enough to claim it. The guardian must safeguard the rights of the child, including his/her property.
If the guardian is seen to be violating the rights of the child, he/she can be removed by the DCWC,

Provisions for orphaned and other abandoned children
The DCWC has the mandate to establish, monitor and supervise orphanages, centres and other institutions that house orphaned, abandoned children or vulnerable children.

The DCWC also must appoint a Child Welfare Officer who will carry out the inspection of the children's homes to ensure that proper care is being provided.
Provisions on work and leisure of children
The DCWC has the mandate to regulate the persons who engage children in employment or labour by monitoring working hours, time for leisure and ensuring that children are not exploited or abused

Children in conflict with the law
The DCWC has the mandate to ensure that the administration of justice for minors (children) is done so according to the law in a way that does not encourage unnecessary punishment and ensuring the minimum time for investigation and processing of cases.

Constraints of response of the DCWC. Meetings with members of the DCWC and FGDs from the assessment have shown that the there are various constraints to implementation of the mandate of the DCWC. Lack of funding as well as co-ordination mechanisms are lacking. The CDO in many cases is busy with other tasks in the district to dedicate the appropriate time to issues regarding children under the Child Act 1992.

In some districts, the DCWC has been more active than in others. However, establishment of proper mechanisms to identify vulnerable children and assist them in accessing basic services has been difficult. Mechanisms that also monitor and evaluate activities regarding vulnerable children has also been difficult in many cases.

C. VILLAGE LEVEL – The Village Development Committee. Each district in Nepal consists of different village development areas administered by the local government structure, the Village Development Committee (VDC). The VDC consists of 11 members, of which 9 come from each of the ward committees. There is also a Chairman and a Vice-Chairman of the VDC. The VDC responsibilities are for the general management and co-ordination of activities at the village level, including co-operation with NGOs and other organisations for development work. The VDC also has responsibility for children and women in the following areas:

Education:

- Establish pre-primary schools, operate and manage them;
- To supervise the running of schools;
- To assist in providing primary level education in the village development area;
- To assist establishment of non formal education;
- To make arrangements for providing scholarships to the students of oppressed ethnic communities.

Health services:

- To coordinate programmes on family planning and maternal and child care.

Vulnerable groups:

- To carry out activities regarding the protection of orphan children, helpless women and the old, disabled and incapacitated persons in line with the national policy and to carry out or cause to be carried out acts regarding the wiping out of social ill-practices and the protection of girls and women
- To maintain the inventory of the helpless, orphan and disabled children within the village development area and to make arrangements for keeping them in appropriate place.
- To prepare necessary plans for the uplifting of women within the village development area and to implement the same.

Other areas concerning children:

To register birth, death and other personal events in the accordance with the prevailing law.

Concerning village response and development:

- To provide assistance to co-operatives
- To develop human resources, to make arrangements for making available employment and self-employment opportunities
- To encourage or cause to be encouraged to carry out cooperative, industrial and commercial activities generating income to the Village Development Committee with the investment of private sector as well.
- To formulate various programmes based on cooperativeness and to carry out or cause to be carried out the same.

The VDC has the responsibility to formulate annual and periodic plans for each other Village Development Areas. These plans include priorities for women and children as stated, and in their plans, the Village Development Committee are to include:

- Projects providing direct benefits to the women as well as backward class and children
- Projects in areas comprising backward castes, tribes and poor people and various development works done or required to be done in such areas;
- Income generating and skills orientated development projects for women and children.

All plans and estimated budgets are then submitted to the district level committee (DDC) for approval and review who will then allocate the budget on the basis of priorities.

Summary of responsibilities of the VDC relating to children and women

VDC	**Responsibilities relating to children and women**
	Establishment of pre-primary schools
	Establishment of non formal education
	Supervise running of schools
	Provide scholarships for vulnerable children in the VDC
	Launch programmes on maternal and child care
	Operate and manage health services
	Protection of orphaned children, the disabled and disadvantaged women and girls
	Maintain an inventory of helpless, disabled and orphaned
	children with the VDC and refer them to necessary services
	Birth registration
	Planning for vulnerable children and women as priorities
	Income generating activities for women and children

D. **COMMUNITY LEVEL** – Communities in Nepal range from tiny mountain settlements, clusters of ten to 12 households related by blood, to large urban and peri-urban settlements. Population and settlement density is highest in Kathmandu Valley and other urban areas, but 80% of the population lives in rural areas with much lower densities.

Awareness and perception of vulnerable children at the level of the community

FGDs and interviews with women, children and CO at the level of the community in district surveyed have indicated their perception of who vulnerable children are.

FGDs were carried out with child clubs, in and out of school, including vulnerable children – domestic workers, child labourers, street children. FGDs were also carried out with women's organisations, paralegal organisations and forestry groups in the different districts.

In general the views of who vulnerable children are do not differ geographically or whether in urban or rural areas. The perceptions of communities on vulnerable children, are consistent across the country. In the majority of cases, orphans are seen as the most vulnerable children. The differences that do occur are in identification of different lower caste ethnic groups that vary geographically across Nepal.

Differences between children's perceptions and adults perceptions also did not vary greatly, the majority stated the same problems that children faced. Children however were more likely to include the problems that children faced due to lack of love and affection as opposed to adults who saw the problem as mostly lack of services.

Summary of who are the vulnerable children as perceived by children and community – findings from assessment

District surveyed	Who are the most vulnerable children according to CO and child groups
Sunsari district	Orphans from 0-5 years who are not productive and cannot help in labour Children without parents (orphaned children - known as anath) Children who are deprived of basic rights such as food and education Children who are beaten or mistreated Disabled children Lower caste children (dalits), in this area, the Musahar group Children who are exploited in labour or employment
Kaski district	Children without parents (orphans - known as anath) Children who are homeless or street children Children who have lost their mother and whose father has remarried Orphans over the age of 5 years who are made to work Children who are deprived of basic rights such as education and health Children who are displaced due to the conflict Children of the lower caste – Dalites Children whose parents are in jail Children without supervision, whose parents work on daily wages

Chitwan district	Children who have lost their parents (orphans) Children who have lost their mother and whose father has remarried Children deprived of basic rights such as education and nutrition Children whose parents are alcoholics Children who have been abandoned Children whose fathers have a chronic illness Children whose parents are working in daily wages and cannot be supervised Disabled children
Dang district	Children who have lost their parents (orphans) Children who live with grandparents or relatives (orphaned children) Children who are made to work Disabled children Children from the Badi community - lower caste Children of bonded labourers Street children Children deprived of education
Dadeldhura	Children who have lost both parents (orphans) Children who have lost their mother and whose father has remarried Dalit children Children who are working

Perception of AIDS affected families and children:

During the assessment, the surveys attempted to find out what level of perception that communities and children themselves had about HIV/AIDS and its effects on families and communities.

In the majority of the cases, communities had little or no knowledge about HIV/AIDS. In most cases they may have heard about it through the radio and other channels, but did not know enough to be able to foresee what kinds of impacts it could have on children and families.

In certain urban areas where there is a higher prevalence of HIV/AIDS in groups that engage in high risk behaviour, such as in Kathmandu valley or in Pokhara, or where there is a high level of seasonal migration to India such as in Dadeldhura, communities had heard of families where one member had died of AIDS. In these cases, they stated that the biggest problems affecting the family and the children was discrimination. Once there was a relation to HIV/AIDS, there was also a stigma attached. Communities noted that the children of these families had also been discriminated at school by their peers. However, the knowledge of the number of these families existed very little.

Where do people access information about HIV/AIDS – rural vs. urban

In the rural area, there exists few mechanisms to access comprehensive information about HIV/AIDS. In the majority of the cases, information is accessed through the radio, however, in many rural areas, villages may have different dialects and certain radio programmes are on different frequencies. Furthermore, the information in many cases is not comprehensive, and means that people gain only a little insight into what HIV/AIDS is but still do not understand it fully. This may lead to misinterpretation and discrimination. For example, most villages have heard that AIDS is a 'deadly disease' which is incurable. This leads many to fear rather than understand the meaning of HIV/AIDS. Many are also unaware of the different transmitting routes, again leading to misunderstandings.

In urban areas, it is easier for the population to access FM radio as well as some form of television. Printed material is also more available with a larger number of organisations based in the urban areas. However, even though the channels of communication are more accessible, many people also misunderstand the meaning of HIV/AIDS through lack of thorough awareness.

Children in schools have a much better understanding of what HIV/AIDS is. They can access information from school (as a small part of the health curriculum) as well as by talking to their peers and reading certain materials. Children out of schools also have more information if they are part of a child club or are involved in informal lessons. Through this group, they learn about HIV/AIDS.

In Kathmandu valley, it is obviously much easier for people to access information on HIV/AIDS. Through radio, television, printed material, billboards and posters, through trainings, campaigns, schools, different organisations and other educational activities.

Summary of where people will access information on HIV/AIDS from Findings from assessment

District	Where did children and communities hear about HIV/AIDS FGD with child clubs and women's CO
Sunsari district	- Radio - Television (where accessible) - NGOs - Teachers (in the case of school going children)
Kaski district	- Radio - Television - Posters - Reading material
Chitwan	- Radio - Television (where accessible) - Trainings that have occurred
Dang	- Predominantly through the radio
Dadeldhura	- Radio - Village facilitator

The Impact of Migration on Communities in Nepal

"The so-called 'stagnation' of agriculture is actually a consequence, in part, of more attractive opportunities outside agriculture being taken up by an increasing proportion of the rural population," showing the potential for more dynamism and growth than agriculture.[26] Declining rural food self-sufficiency is not necessarily bad if there is other income coming in, and may be a "matter for congratulation (revealing a significant shift away from the agrarian base to an economy more reliant on other sources of income)".[27]

Women migrants were employed mainly in agriculture (77%), while men worked mainly outside agriculture (57%). Migrant workers employed in rural parts of Nepal were mostly working in agriculture, accounting for 62% of their remittances. Those in urban areas, mostly worked in the service sector (56%) or industry (33%), with only 2% of remittances coming from agriculture. "The best known (although still poorly documented) form of employment [for women] is in the commercial sex industry, although it is probable that this involves only a minority of Nepali female migrant workers."[28]

In general, it is the wealthier and higher class families that can take the most advantage of outside employment opportunities, "The more disadvantaged groups have the greatest difficulty in obtaining anything other than low paid and insecure employment...the very poorest appear to be the least involved in labour migration,"[29] and usually seek agricultural or casual wage labour employment in neighbouring villages.

This may note be true for the families who remain at home and don't get remittances, often true of families affected by HIV/AIDS. The most comprehensive information on communities affected by HIV/AIDS comes from Bhattachan, K., I. Gautam, and J. Khadka, 1998, "Impact of Emigration on Children and Women: A Qualitative Study of Selected VDCs of Surkhet and Accham Districts, Save the Children Fund/UK, Nepal and

According to the DFID study, remittances from those working more than 6 months of the year away from home (internal and external migrants) constitutes more than 25% of household income for almost one-quarter of rural households. According to the 1996 NLSS, 38% of all remittances were from India, 33% from other rural areas in Nepal, and 26% from urban areas. Remittances from other areas of Nepal account for 44% of total income from remittances.[30] These intra-village transfers "[arguably reinforce] fundamental structural inequalities, between social classes and between ethnic and caste groups."[31]

Community Support Structures

The field research found that structures exist that could act as resources for monitoring property grabbing and for assisting orphans and widows their entitlements, including the District courts, under the jurisdiction of the Ministry of Justice; private lawyers, including members of the Nepal Bar Association, which has legal representatives at the VDC level, accessible at the ward level in some districts; the VDC chairperson who is able to mediate at some level concerning property issues; and police, who to some extent, may be able to enforce existing laws.

The Local Government structures stop at the village level. Within the village area, there are a number of wards. Usually from around 9-11 wards. Each ward has its own management structure, usually headed by a chairperson. This person automatically becomes a member of the VDC. The wards also comprise of a number of different settlements or communities.

Within the different communities or settlements, activities are usually organised through different committees. Nepal consists of many different community committees or community organisations (CO). There are a number of women's organisations, forestry groups, paralegal committees etc. which vary in number from village to village and from ward to ward. These structures are in place to provide a channel to the community or act as an extension of the government structures. The different CO are usually also represented at the level of the ward and VDC by certain members.

CO generally speaking are involved in credit schemes, usually saving schemes that benefit the members of the CO and provide loans. Some of these CO have expanded to include other programmes such as weighing of children for the monitoring of malnutrition, as well as providing loans to other members of the community for income generating activities.

Registering and monitoring mechanisms for protection of vulnerable children

(Findings from assessment)

At community level, there exists no or very little mechanisms that can identify, monitor and protect vulnerable children. The government body with that responsibility is the DCWC at district level and the VDC at the village level, however, this task is large and there is simply not enough capacity at the VDC level to undertake constant monitoring of vulnerable children. Community organisations do not in general look after issues pertaining to vulnerable children, only if they are integrated into other programmes such as the weighing of children for malnutrition monitoring.

In districts where paralegal committees exist, these have attempted to stop trafficking of girls to India, with some success, but again the groups are small and have little capacity or power to carry out interventions on a large scale. Children themselves also are unable to access any structures that might assist them if they are in need of protection. Knowledge of central level laws and legislation hardly ever trickles down to the community and most children and families are unaware of their own rights.

Protection of property rights

At community level there is no mechanism for the protection of property of orphaned children. Globally, the impact of HIV/AIDS on children has indicated that property grabbing of property pertaining to orphans by their relatives or other guardians is widespread. Given the vulnerability of orphans, it is crucial that their property is maintained for their future.

Under the Child Act 1992, orphan's property should be maintained by their guardian, either relative or someone else, until the child is old enough to claim it. However, in reality, in many cases, orphans who have property are cheated out of them by their relatives and guardians and many of the guardians will be more willing to take in orphans knowing that they have property attached.

In rural areas, the situation is not as severe. A stronger community cohesiveness and family networks ensures that property remains with the child after the death of his or her parents.

NGO and Community-Based Organizations

Community Organisations – Within the different communities or settlements, activities are usually organised through different committees. Nepal consists of many different community committees or community organisations (CO). There are a number of women's organisations, forestry groups, paralegal committees etc. which vary in number from village to village and from ward to ward. These structures are in place to provide a channel to the community or act as an extension of the government structures. The different CO are usually also represented at the level of the ward and VDC by certain members.

CO generally speaking are involved in credit schemes, usually saving schemes that benefit the members of the CO and provide loans. Some of these CO have expanded to include other programmes such as weighing of children for the monitoring of malnutrition, as well as providing loans to other members of the community for income generating activities.

Responses of NGOs at the Local Level – There has been a variety of activities in the area of HIV/AIDS and also in the area of vulnerable children at the level of the district and the village. However, in many cases, without a proper framework to work under and without proper co-ordination mechanisms, many activities have been carried out ad hoc. The majority of activities in the area of HIV/AIDS have been carried out on prevention, awareness and advocacy, usually linked or targeting groups who engage in high risk behaviour. Little work has been done on the actual care and support for people living with HIV/AIDS.

NGOs in some areas have established voluntary counselling and testing facilities but these facilities do not extend to providing care and support for people living with HIV/AIDS within their own families.

Awareness of HIV/AIDS among the general community is also weak, with people having different view and ideas of what HIV/AIDS is, and consequently creating an environment of stigma and discrimination which is unfavourable to those who might be affected by HIV/AIDS.

V. Recommendations

A. National Policy and Co-ordination

1. Formation of a technical working group under the National Strategic Plan, chaired by the Ministry of Women, Children and Social Welfare, to develop a strategy and guide development of an action plan for orphans and children living in families affected by HIV/AIDS.

2. Review the Child Care Act of 1992 to strengthen and clarify the care and protection of vulnerable children, especially in terms of: Birth registration and citizenship; mechanism to identify vulnerable children in the communities; mechanisms to monitor the situation of property and inheritance of orphans; mechanisms to provide services to orphans and vulnerable children.

3. Strengthen the capacity of the Central Child Welfare Board and of the District Child Welfare Committees to carry out the mandate of the Child Act of 1992, including the role of monitoring and supervision of vulnerable children.

B. Institutional care

1. Development of standards and guidelines for institutions and institutional care – through the Ministry for Women, Children and Social Affairs and the Central Child Welfare Board.

2. Carry out a rapid assessment of the conditions of existing institutions for children.

C. District Co-ordination and Planning

1. Orientation of the DDCs and line Agencies on basic rights and provisions for orphans and children affected by HIV and AIDS.

2. Training of the District Child Welfare Committee members on the use of standard guidelines for institutional care of children.

3. Strengthening information systems for better flow from VDCs to the DCWC on orphaning and on orphans.

D. In UNICEF/HMG DACAW districts – VDCs

1. Expand and accelerate capacity of the DCWB staff to undertake their duties in relation to the Child Care Act of 1992
2. Ensure that an information system is in place from the ward levels to the VDCs and the DCWCs in relation to orphans (their situation, access to basic services)

3. In DACAW CAP VDC's, carry out the orientation of Village Facilitators and Community Mobilisers on orphaning and linkage with basic services.
4. In select DACAW CAP VDC's where there is a higher prevalence of HIV and AIDS, undertake a rapid assessment through the Village Facilitators and the Community Mobilisers on orphans, living conditions and access to basic services.
5. In DACAW CAP VDCs, include orphans, disaggregated by age, in community information boards (CIBs) in CAP Community Organisations
6. Strengthen the involvement of Child Clubs in raising awareness on HIV, including reduction of discrimination.

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[23] Children on the Brink 2002.
[24] The sources for this section include field research findings and articles from the The Weekly Telegraph of Nepal on the status of widows by the Women for Human Rights, Kathmandu, 19 June 2002.
[25] Samuha, S., ed., 2002.
[26] Seddon et. al, 2000, p. 11-12
[27] Seddon et. al, 2000, p. 15.
[28] Seddon et. al, 2000, p. 19.
[29] Seddon et. al, 2000, p.43.
[30] Seddon et. al, 2000, p. 8.
[31] Seddon et. al, 2000, p. 51.

Chart 1: Orphaned children who have lost their mother

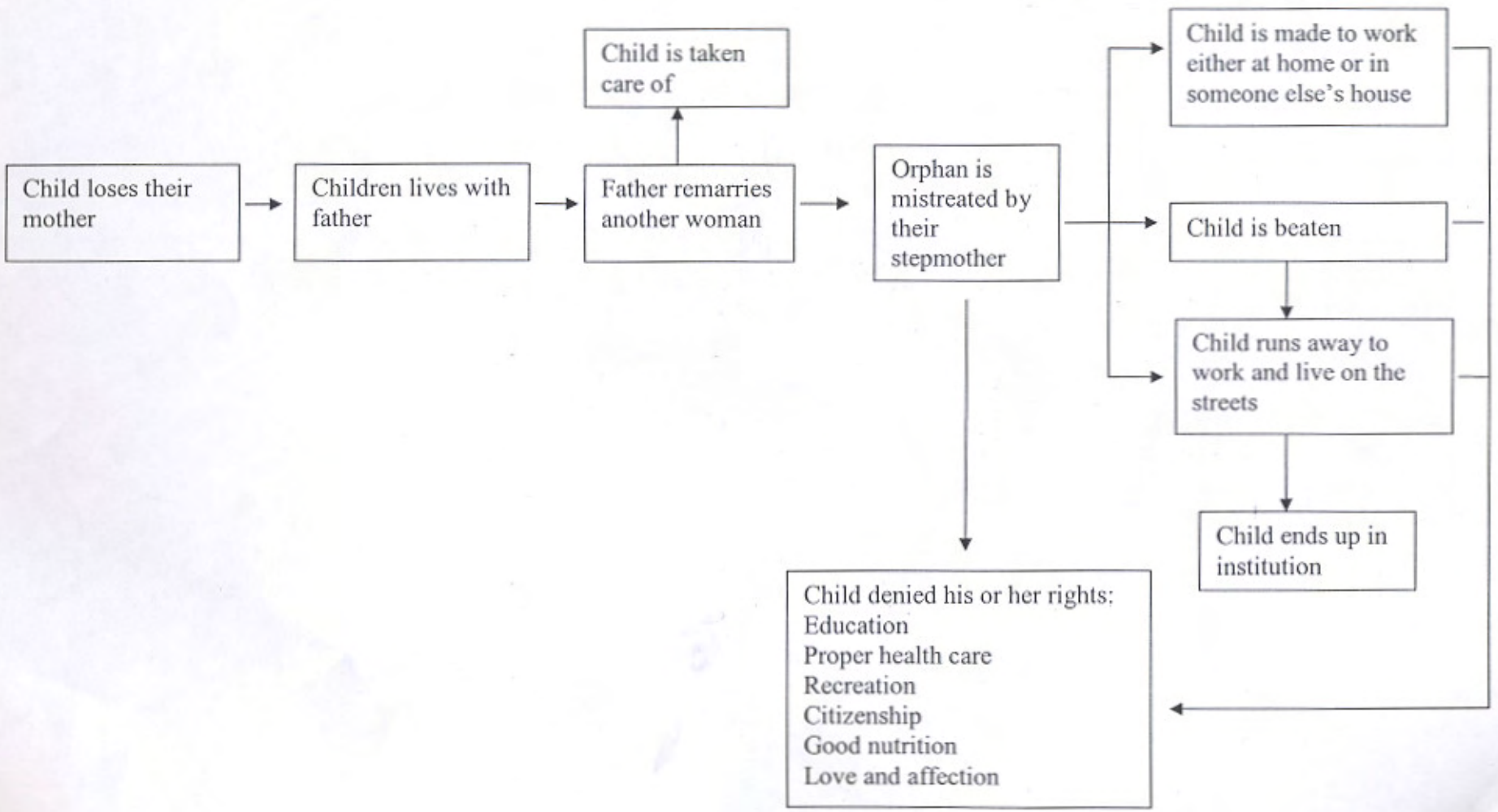

Chart 2: Orphans who have lost their father

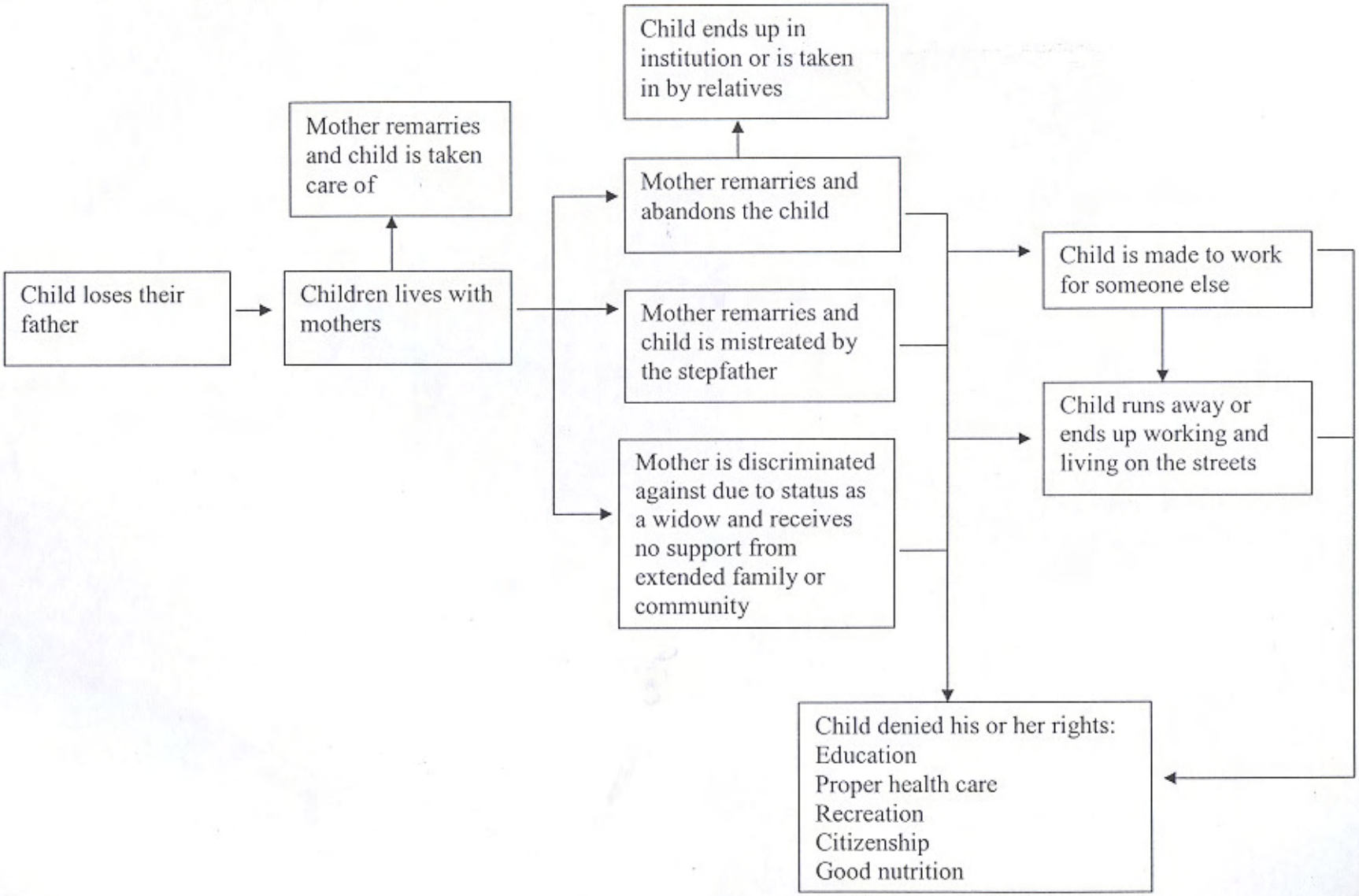

Chart 3: Orphans who have lost both parents

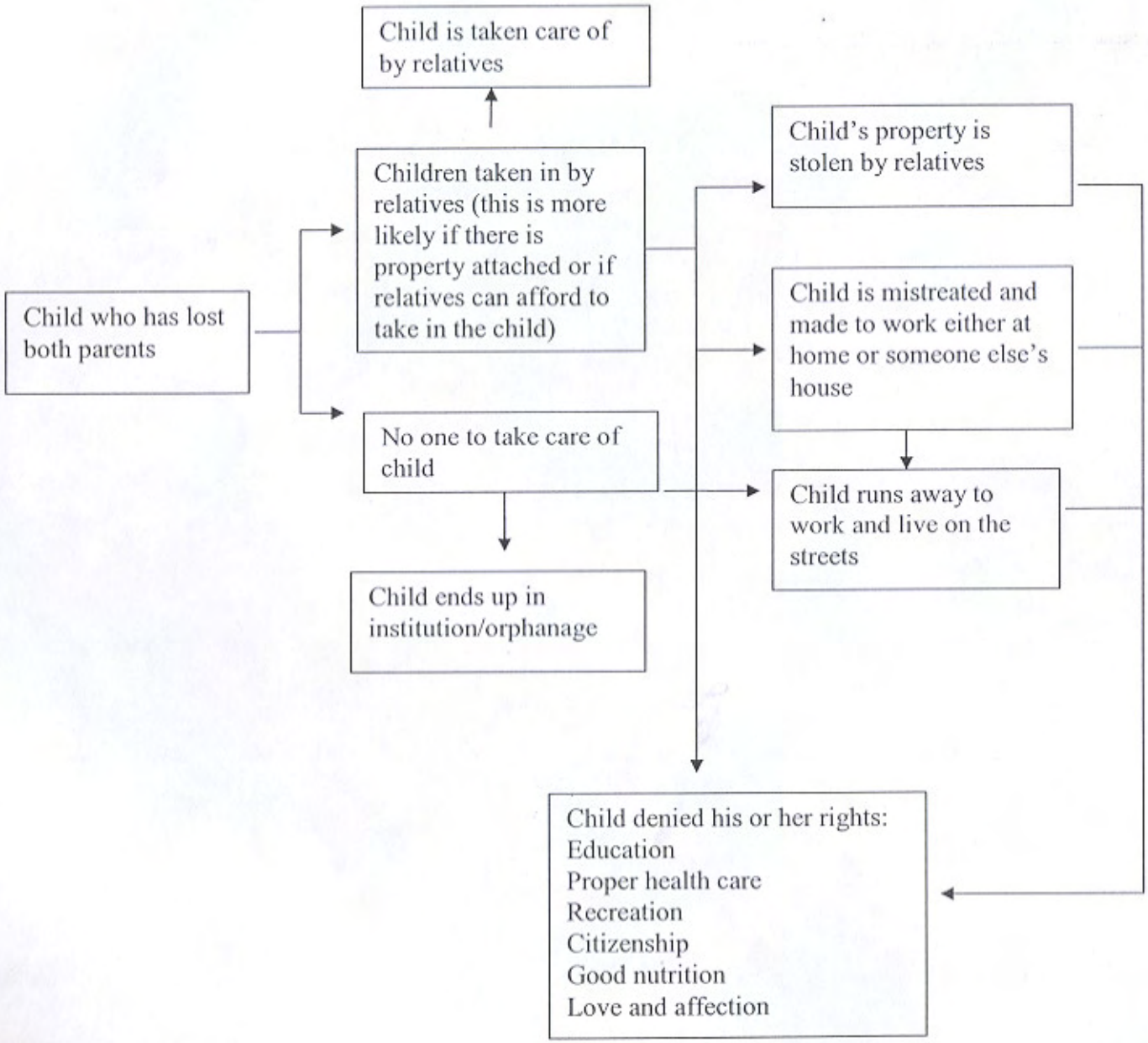

Table 1

Living Arrangements of Children Under 16 Years Old in Nepal's Development Regions and for Selected Study Districts

	Total Children	With Both Parents	% of Total	With Mother	% of Total	With Father	% of Total	Father and Stepmother	% of Total	Mother and Stepfather	% of Total	Other Relatives	% of Total	Employer	% of Total	Other	% of Total
Nepal	9,475,896	8,305,234	87.65%	525,890	5.55%	114,351	1.21%	78,844	0.83%	64,441	0.68%	89,813	0.95%	63,227	0.67%	234,105	2.47%
Eastern Region	2,155,970	1,898,716	88.07%	105,193	4.88%	27,459	1.27%	17,527	0.81%	13,806	0.64%	22,934	1.06%	13,895	0.64%	56,443	2.62%
Sunsari*	253,935	225,887	88.95%	10,963	4.32%	2,128	0.84%	1,827	0.72%	1,441	0.57%	2,887	1.14%	1,857	0.73%	6,945	2.73%
Central Region	3,201,301	2,878,686	89.92%	105,413	3.29%	37,683	1.18%	26,656	0.83%	23,016	0.72%	30,583	0.96%	23,631	0.74%	75,627	2.36%
Kathmandu	327,554	292,262	89.23%	9,056	2.76%	3,439	1.05%	2,276	0.69%	1,815	0.55%	3,451	1.05%	4,693	1.43%	10,562	3.22%
Chitawan*	183,171	157,757	86.13%	10,388	5.67%	2,341	1.28%	2,025	1.11%	1,608	0.88%	2,207	1.20%	858	0.47%	4,999	2.73%
Western Region	1,933,938	1,611,258	83.31%	196,071	10.14%	22,135	1.14%	15,536	0.80%	11,905	0.62%	16,792	0.87%	10,514	0.54%	49,736	2.57%
Kaski*	142,051	110,003	77.44%	20,250	14.26%	1,612	1.13%	1,489	1.05%	1,083	0.76%	1,788	1.26%	996	0.70%	4,830	3.40%
Mid West Region	1,205,519	1,069,571	88.72%	58,788	4.88%	14,329	1.19%	9,976	0.83%	8,089	0.67%	10,139	0.84%	8,502	0.71%	26,127	2.17%
Dang*	204,457	180,044	88.06%	11,490	5.62%	1,849	0.90%	1,425	0.70%	1,093	0.53%	1,817	0.89%	2,200	1.08%	4,538	2.22%
Banke	164,988	145,363	88.11%	5,327	3.23%	2,593	1.57%	1,862	1.13%	1,695	1.03%	1,940	1.18%	1,781	1.08%	4,428	2.68%
Far West Region	979,168	847,003	86.50%	60,425	6.17%	12,745	1.30%	9,149	0.93%	7,625	0.78%	9,365	0.96%	6,685	0.68%	26,172	2.67%
Dadeldhura*	58,020	51,398	88.59%	3,796	6.54%	552	0.95%	320	0.55%	280	0.48%	389	0.67%	233	0.40%	1,053	1.81%

*UNICEF DACAW Districts

Table 2

Marital Status of People 10 Years Old and Above in Nepal's Development Regions

	Total	Single	% of Total	Monogamous	% of Total	Polygamous	% of Total	Remarried Monogamous	% of Total	Widow/ Widower	% of Total	Divorced	% of Total	Separated	% of Total	Unknown	% of Total
Nepal	16,770,279	5,821,893	34.72%	9,751,053	58.14%	279,622	1.67%	367,941	2.19%	420,452	2.51%	20,775	0.12%	25,411	0.15%	83,134	0.50%
Eastern Dev. Region	3,527,925	1,315,815	37.30%	1,972,768	55.92%	64,517	1.83%	71,302	2.02%	79,748	2.26%	4,153	0.12%	6,732	0.19%	12,891	0.37%
Taplejung	98,322	39,592	40.27%	49,828	50.68%	1,786	1.80%	3,918	3.98%	2,585	2.61%	153	0.16%	151	0.15%	349	0.35%
Panchthar	147,315	61,930	42.04%	71,734	48.69%	2,452	1.66%	6,678	4.53%	3,654	2.48%	223	0.15%	501	0.34%	143	0.10%
Ilam	215,425	90,503	42.01%	108,938	50.57%	4,093	1.90%	5,990	2.78%	4,378	2.03%	300	0.14%	588	0.27%	634	0.29%
Jhapa*	493,900	191,303	38.73%	267,983	54.26%	9,666	1.96%	8,682	1.76%	11,883	2.41%	739	0.15%	1,352	0.27%	2,286	0.46%
Morang	642,580	230,526	35.88%	373,757	58.17%	11,151	1.74%	10,330	1.61%	12,209	1.90%	488	0.08%	982	0.15%	3,137	0.49%
Sunsari	465,067	168,163	36.16%	272,180	58.52%	7,769	1.67%	5,775	1.24%	8,995	1.93%	378	0.08%	714	0.15%	1,113	0.24%
Dhankuta	126,394	50,863	40.08%	66,793	52.85%	2,283	1.81%	2,507	1.98%	3,098	2.45%	301	0.24%	314	0.25%	435	0.34%
Terhathum	85,422	33,963	39.76%	45,145	52.85%	1,895	2.22%	2,902	3.40%	1,052	1.23%	62	0.07%	132	0.15%	271	0.32%
Sankhuwasabha	118,508	45,996	38.81%	64,921	54.78%	2,839	2.40%	1,879	1.59%	2,112	1.78%	196	0.17%	198	0.17%	368	0.31%
Bhojpur	152,002	60,174	39.58%	79,238	52.13%	4,281	2.82%	4,056	2.67%	3,452	2.27%	219	0.14%	406	0.27%	177	0.12%
Solukhumbu	80,008	32,626	40.78%	40,857	51.07%	1,580	1.97%	1,849	2.31%	2,621	3.28%	167	0.21%	214	0.27%	95	0.12%
Okhaldhunga	114,460	41,841	36.56%	62,150	54.30%	2,467	2.16%	3,539	3.09%	3,803	3.32%	167	0.15%	197	0.17%	296	0.26%
Khotang	167,296	64,747	38.70%	86,973	51.99%	3,535	2.11%	5,967	3.58%	4,895	2.93%	353	0.21%	423	0.25%	382	0.23%
Udayapur	208,421	78,382	37.61%	114,802	55.08%	5,008	2.40%	4,171	2.00%	4,177	2.00%	257	0.12%	257	0.12%	1,357	0.65%
Saptari	412,785	125,406	30.38%	267,467	64.80%	3,732	0.90%	3,039	0.74%	10,850	2.63%	140	0.03%	303	0.07%	1,848	0.45%
Central Dev. Region	6,367,706	2,131,580	33.47%	3,837,871	60.27%	93,150	1.46%	93,204	1.46%	161,393	2.53%	5,968	0.09%	8,978	0.14%	35,560	0.56%
Siraha*	407,953	116,291	28.50%	265,924	65.18%	4,976	1.22%	5,017	1.23%	11,367	2.79%	343	0.08%	327	0.08%	3,739	0.92%
Dhanusa	479,561	145,093	30.26%	305,819	63.77%	4,920	1.03%	5,138	1.07%	12,956	2.70%	205	0.04%	531	0.11%	4,896	1.02%
Mahottari	395,531	112,736	28.50%	257,806	65.18%	4,214	1.07%	4,261	1.08%	13,091	3.31%	234	0.06%	336	0.08%	2,854	0.72%
Sarlahi	453,231	130,164	28.72%	296,033	65.32%	5,948	1.31%	5,344	1.18%	11,188	2.47%	288	0.06%	539	0.12%	3,731	0.82%
Sindhuli*	197,595	72,525	36.70%	109,935	55.64%	5,442	2.75%	5,194	2.63%	3,335	1.69%	248	0.13%	193	0.10%	724	0.37%
Ramechhap	153,938	56,073	36.43%	87,269	56.69%	3,797	2.47%	3,176	2.06%	2,574	1.67%	217	0.14%	172	0.11%	659	0.43%
Dolakha*	153,006	47,840	35.97%	77,337	58.15%	2,019	1.52%	1,259	0.95%	3,242	2.44%	173	0.13%	208	0.16%	928	0.70%
Sindhupalchok*	219,195	73,056	33.33%	126,079	57.52%	6,637	3.03%	6,497	2.96%	4,365	1.99%	578	0.26%	348	0.16%	1,640	0.75%
Kavre	288,887	109,090	37.76%	158,947	55.02%	4798	1.66%	5,950	2.06%	8,146	2.82%	260	0.09%	906	0.31%	789	0.27%
Lalitpur	277,634	105,754	38.09%	159,868	57.58%	3,371	1.21%	2,442	0.88%	4,933	1.78%	203	0.07%	373	0.13%	689	0.25%
Bhaktapur	183,053	70,694	38.62%	103,733	56.67%	1,625	0.89%	1,356	0.74%	4253	2.32%	125	0.07%	236	0.13%	1,030	0.56%
Kathmandu	892,981	357,879	40.08%	496,592	55.61%	10,386	1.16%	6,709	0.75%	15,673	1.76%	884	0.10%	1,510	0.17%	3,348	0.37%
Nuwakot	215,576	75,694	35.11%	121,810	56.50%	4,841	2.25%	5,083	2.36%	6,158	2.86%	396	0.18%	229	0.11%	1,364	0.63%
Rasuwa	33,381	11,145	33.39%	19,488	58.38%	681	2.04%	726	2.17%	1,075	3.22%	67	0.20%	110	0.33%	89	0.27%
Dhading	248,281	85,980	34.63%	136,757	55.08%	6,155	2.48%	10,206	4.11%	7,916	3.19%	399	0.16%	417	0.17%	451	0.18%
Makwanpur	287,899	110,700	38.45%	155,449	54.03%	4,729	1.64%	6,836	2.38%	7,890	2.74%	338	0.12%	754	0.26%	1,004	0.35%
Rautahat	385,772	103,772	26.90%	260,433	67.51%	3,465	0.90%	2,761	0.72%	12,585	3.26%	274	0.07%	260	0.07%	2,223	0.58%
Bara	396,454	111,943	28.24%	161,832	40.82%	4,014	1.01%	3,758	0.95%	13,118	3.31%	208	0.05%	403	0.10%	1,178	0.30%
Parsa	355,370	100,316	28.23%	237,122	66.73%	3,459	0.97%	3,410	0.96%	9,343	2.63%	140	0.04%	330	0.09%	1,249	0.35%
Chitwan	362,574	134,835	37.19%	199,641	55.06%	7,675	2.12%	8,081	2.23%	8,186	2.26%	385	0.11%	796	0.22%	2,975	0.82%

Marital Status of People 10 Years Old and Above in Nepal's Development Regions

	Total	Single	% of Total	Monogamous	% of Total	Polygamous	% of Total	Remarried Monogamous	% of Total	Widow/ Widower	% of Total	Divorced	% of Total	Separated	% of Total	Unknown	% of Total
Western Dev. Region	3,379,674	1,18,2002	34.97%	1,932,040	57.17%	67,488	2.00%	84,320	2.49%	90,233	2.67%	4,791	0.14%	5,099	0.15%	13,701	0.41%
Gorkha	215,991	76,337	35.34%	121,113	56.07%	6,373	2.95%	4,744	2.20%	5,644	2.61%	288	0.13%	291	0.13%	1,201	0.56%
Lamjung	134,975	46,587	34.59%	74,525	55.21%	3,106	2.30%	5,276	3.91%	4,033	2.99%	239	0.18%	321	0.24%	788	0.58%
Tanahu	235,093	82,843	35.24%	133,496	56.78%	5,877	2.50%	6,277	2.67%	4,706	2.00%	320	0.14%	216	0.09%	1,364	0.58%
Syangja	234,991	87,291	37.15%	124,490	52.98%	5,005	2.13%	5,900	2.51%	10,950	4.66%	306	0.13%	414	0.18%	525	0.22%
Kaski	297,066	108,370	36.48%	168,475	56.71%	8,056	2.71%	4,648	1.56%	5,220	1.76%	472	0.16%	567	0.19%	1,258	0.42%
Manang	5,153	3,843	47.14%	3,857	47.31%	54	0.66%	166	2.04%	331	4.06%	44	0.54%	51	0.63%	6	0.07%
Mustang	12,251	4,906	40.05%	6,208	50.67%	229	1.87%	200	1.63%	488	3.98%	78	0.64%	124	1.01%	18	0.15%
Myagdi	84,546	30,386	35.94%	45,875	54.26%	2,063	2.44%	3,901	4.61%	1,519	1.80%	342	0.40%	314	0.37%	146	0.17%
Baglung	197,319	72,273	36.63%	108,815	55.15%	4,181	2.12%	5,872	2.98%	4,801	2.43%	410	0.21%	207	0.10%	761	0.39%
Gulmi	213,897	75,886	36.88%	114,529	53.54%	5,304	2.48%	9,631	4.50%	4,737	2.21%	215	0.10%	90	0.04%	505	0.24%
Palpa	196,248	75,446	38.44%	105,270	53.64%	3,806	1.94%	5,651	2.88%	4,754	2.42%	234	0.12%	198	0.10%	890	0.45%
Nawalparasi	414,184	133,377	32.20%	247,582	59.78%	7,410	1.79%	11,714	2.83%	11,366	2.74%	729	0.18%	535	0.13%	1,470	0.35%
Rupandehi	521,731	184,088	35.28%	305,719	58.60%	7,382	1.41%	7,823	1.50%	12,615	2.42%	539	0.10%	786	0.15%	2,774	0.53%
Kapilbastu	344,966	99,757	28.92%	224,240	65.00%	2,636	0.76%	3,957	1.15%	12,370	3.59%	289	0.08%	604	0.18%	1,104	0.32%
Arghakhanchi	151,124	54,519	36.08%	84,505	55.92%	3,555	2.35%	5,063	3.35%	2,695	1.78%	89	0.06%	153	0.10%	545	0.36%
Mid West Dev. Region	1,939,441	666,282	34.35%	1,092,489	56.33%	32,299	1.67%	82,313	4.24%	48,030	2.48%	4,527	0.23%	3,085	0.16%	10,434	0.54%
Pyuthan	147,217	50,983	34.63%	80,050	54.38%	2,849	1.94%	8,675	5.89%	3,752	2.55%	373	0.25%	169	0.11%	367	0.25%
Rolpa	147,360	46,770	31.74%	80,326	54.51%	3,489	2.37%	11,453	7.77%	3,884	2.64%	820	0.56%	159	0.11%	459	0.31%
Rukum	137,718	47,392	34.41%	80,071	58.14%	1,857	1.35%	4,018	2.92%	2,901	2.03%	490	0.36%	191	0.14%	899	0.65%
Salyan*	44,354	15,210	34.29%	25,906	58.41%	533	1.20%	1,646	3.71%	816	1.84%	104	0.23%	17	0.04%	123	0.28%
Dang	334,737	118,079	35.28%	187,333	55.96%	5,757	1.72%	12,649	3.78%	8,110	2.42%	503	0.15%	621	0.19%	1,685	0.50%
Banke	280,821	101,882	36.31%	159,842	56.89%	3,295	1.17%	4,028	1.44%	8,207	2.92%	433	0.15%	501	0.18%	2,633	0.94%
Bardiya	275,985	94,446	34.22%	163,593	59.28%	4,411	1.60%	8,729	2.44%	4,073	1.48%	387	0.14%	317	0.11%	2,029	0.74%
Surkhet*	194,081	67,644	34.85%	107,890	55.59%	3,904	2.01%	9,375	4.83%	3,715	1.91%	272	0.14%	455	0.23%	825	0.43%
Dailekh	1,155,290	50,901	4.41%	80,429	6.96%	3,318	0.29%	14,416	1.25%	5,080	0.44%	365	0.03%	233	0.02%	546	0.05%
Jajarkot	97,553	33,684	34.49%	57,299	58.67%	516	0.53%	2,734	2.80%	2,591	2.65%	305	0.31%	123	0.13%	411	0.42%
Dolpa*	16,160	5,648	34.95%	8,178	50.61%	231	1.43%	884	5.47%	939	5.81%	118	0.73%	106	0.66%	56	0.35%
Jumla*	49,016	15,122	30.85%	28,905	58.97%	770	1.57%	2,417	4.93%	1,462	2.98%	151	0.31%	56	0.11%	132	0.27%
Kalikot*	8,271	2,433	29.42%	5,046	61.01%	223	2.70%	259	3.13%	127	1.54%	14	0.17%	-	0.00%	169	2.04%
Mugu*	21,806	6,245	28.64%	11,941	54.76%	472	2.16%	2,020	9.26%	977	4.48%	93	0.43%	37	0.17%	20	0.09%
Humla	29,162	9,843	33.75%	15,860	54.39%	647	2.22%	1,010	3.46%	1,496	5.13%	99	0.34%	100	0.34%	80	0.27%
Far West Dev. Region	1,555,534	526,214	33.83%	915,905	58.88%	22,168	1.43%	36,802	2.37%	41,047	2.64%	1,336	0.09%	1,517	0.10%	10,548	0.68%
Bajura*	70,103	21,559	30.75%	41,012	58.50%	1,717	2.45%	3,369	4.81%	2,076	2.96%	122	0.17%	50	0.07%	198	0.28%
Bajhang	116,800	33,721	28.92%	69,888	59.84%	2,672	2.29%	6,228	5.34%	3,647	3.13%	73	0.06%	148	0.13%	223	0.19%
Achham	160,579	51,230	31.90%	92,804	57.79%	2,438	1.52%	8,182	5.10%	4,637	2.89%	307	0.19%	225	0.14%	757	0.47%
Doti	149,206	46,404	31.10%	91,545	61.35%	1,849	1.24%	2,343	1.57%	5,443	3.65%	102	0.07%	118	0.08%	1,403	0.94%
Kailali	441,578	158,055	35.79%	259,987	58.86%	6,233	1.41%	6,524	1.48%	5,886	1.33%	301	0.07%	322	0.07%	4,370	0.99%
Kanchanpur	272,320	96,538	35.18%	159,096	58.42%	3,487	1.28%	2,656	0.98%	5,322	1.95%	166	0.06%	241	0.09%	2,814	1.03%
Dadeldhura	88,789	31,050	34.97%	51,755	58.30%	988	1.11%	1,297	1.46%	3,215	3.62%	106	0.12%	112	0.13%	257	0.29%
Baitadi	158,320	57,695	34.28%	98,195	58.34%	1,930	1.15%	2,954	1.75%	6,860	4.08%	70	0.04%	123	0.07%	493	0.29%
Darchula	97,939	27,962	31.86%	51,613	58.69%	854	0.97%	3,249	3.69%	3,961	4.50%	59	0.10%	178	0.20%	33	0.04%

Table 3: Key barriers to family and community based care for HIV/AIDS affected children and families from field research for National Assessment of Families and Children Affected by HIV/AIDS

	Geographic location and data/estimates	Problems	Primary needs	Legal framework/barriers	Existing structures and safety nets	Recommendations and opportunities
Vulnerable groups						
Orphans	835,000 orphans from all causes; 13,000 orphans due to AIDS	Heavy generalised discrimination against orphans country-wide; Orphans are sometimes held responsible for the death of their parents and considered 'parent eaters' –'mulya' and bad omens; Orphans are mistreated; Orphans are ashamed to disclose their origins later in life e.g. that they are orphans; Problems of registration and citizenship;	Food; Shelter; Education; Registration and citizenship; Care and love; Health care and nutrition;	Child Act of 1992 Country Code Bill and Women's rights No provisions by the state for caregivers of orphaned children; No mechanisms or monitoring systems at district/VDC and community levels for the identification and monitoring of vulnerable children; No policy on orphans; No national legal instrument for the minimum standards and guidelines of institutions housing orphaned and abandoned children; Single orphaned children with one parent cannot be given up for adoption; A separated or divorced women can adopt a child only if she does not have her own son; In the case of adoption, the child should be from the	Informal: Most orphaned children taken in by family and community; Institutions for children; Children's organisations. Formal: Some provisions in health and education sector for vulnerable children; DCWC in all districts; NGOs/INGOs and other donors in districts serving children; Children's organisations.	Strengthen capacity of primary caregivers of orphans, family and communities; Work through existing community organisations to be able to identify vulnerable children and provide services to them; Strengthen the DCWC as a co-ordinating body for children; Strengthen DDC and VDC and other government structures to plan and prioritise for vulnerable children; Work through children's organisations to assist vulnerable children.

	Geographic location and data/estimates	Problems	Primary needs	Legal framework/barriers	Existing structures and safety nets	Recommendations and opportunities
				men's relative if possible.		
Widows	308,000 widows; 112,000 widowers.	Stigma and discrimination generalised for widows; Widows can be seen as bad omens who are somehow responsible for the deaths of their husbands; Widows are mistreated by the relatives of the deceased husband; Widows are expected to stay chaste to their dead husbands and remarriage is not looked upon well by society; Most widows are expected not to wear bright colours and sometimes are prohibited in participating in religious and other functions; Widows can be exploited (both physically and sexually) by other members of the family; Widows have to bring up a family on their own and often without support of the family.	Financial support; Skills for employment; Legal guidance; Community support.	Country Code Bill with provisions pertaining to widows such as changes in property laws to benefit widows; A widow is entitled to use her share of the inheritance as she wishes even if she gets remarried; No special support to widows from the Government; Elderly widows can receive some money from the Government; Widows are unaware of their rights and consequently many do not claim their share of the property when their husbands die; In the Nepal army and police, widows are compensated if their husbands die on duty, but the amount is variable (this is particularly important in relation to the present conflict);	Informal: Family network; Women's organisations or community level committees; Formal: NGOs/INGOs and donors; WDO in the districts Legal networks or NGOs/INGOs working on women's legal issues.	
Lower Caste	The most common occupational lower caste found in Nepal are the Kamai, Damai	Generalised discrimination nationwide; Problems relating to registration and citizenship; Access to education, health care and other basic services;	Community support; Access to opportunities	Legal code (1990) that declares caste discrimination illegal and punishable by law (up to 1 year imprisonment or fine)	Informal: Children's organisations that provide literacy and education for vulnerable children (usually these are the Dalit children);	Expansion of child clubs to create more opportunities whereby the most vulnerable can have access to

	Geographic location and data/estimates	Problems	Primary needs	Legal framework/barriers	Existing structures and safety nets	Recommendations and opportunities
	and Sarki who are spread all over Nepal. The occupational caste make up 15.6% of the total hill caste. These three castes constitutes 9% of the total population. (SASON.1999). In the Western and the Far Western Regions, we find the 'Kamaiyas' who are the bonded labours. In Dang, there are 2,416 Kamaiya Households. (ILO 2001).	Lack of participation and respect within communities			Women's groups with lower caste representation. Formal: Education scholarship funds for Dalit children provided by the Ministry of Education; NGOs/INGOs and donors.	education/literacy and recreation etc.
Conditioning Factors						
Lack of legal protection: Inheritance/ Property Grabbing	There is no proper mechanism for monitoring these cases	Guardians of orphans are allowed to use their property and inheritance for their maintenance including education and upbringing, but many times, expenses used for orphans are falsified and orphans receive nothing whereas guardians take the money; Orphans and families have little knowledge on their legal rights concerning property and inheritance.	Local enforcement	Child Act 1992 states that the guardian has the responsibility of taking care of the orphan's property until he/she is old enough to claim it (usually 16 years old); No mechanism to monitor the care of property of orphans by guardians; CDO responsible for	Informal: Community members monitor orphan's property Formal: DCWC; District courts; BAR association; Lawyers;	Strengthen the DCWC to monitor property of orphans; Awareness on legal rights of orphans concerning property including existing legal services.

	Geographic location and data/estimates	Problems	Primary needs	Legal framework/barriers	Existing structures and safety nets	Recommendations and opportunities
Birth Registration and Citizenship	1,1,8,441 are not registered 66% < 5 years	Children cannot be registered or given citizenship without father's name; No citizenship means no access to some key services such as education, nationality, access to open bank accounts; Children of lower caste who are fatherless (such as Badi) are more vulnerable to no registration and citizenship as well as discrimination;	Local Monitoring	monitoring and protecting property, but usually he is too busy; Little knowledge of existing legal services Under Child Act 1992, all children have the right to be registered and have citizenship	Formal: Registration services at National, district and VDC levels through the national and district registrars and the VDC; NGOs/INGOs and donors support to increase access to registration; Some orphanages provide registration of orphans in the name of the institution.	
Conflict	More than 500 children have lost their parents and about 1500 children have been abandoned by their parents. About 55 suffered directly (14 children lost lives in cross fire, 25 children were injured in explosions, 13 of them died due to landmine explosions). Source:CWIN- 2000	Children orphaned due to conflict; Migration of men, leaving behind women and children; Children conscripted into the army (child soldiers); Parents abandon children to escape the conflict; Children can be killed in the conflict.	Protection	Child Rights Convention ratified by Nepal in 1990.	Formal: DCWC to protect children; NGOs/INGOs and donors;	
Poverty	42% below poverty line					

	Geographic location and data/estimates	Problems	Primary needs	Legal framework/barriers	Existing structures and safety nets	Recommendations and opportunities
Outcomes/coping strategies						
Migration	1.5 to 2 million migrants estimated 762,000 are external migrants Source: Census 2000	Women are left to carry the burden of family and work on their own; Due to conflict, many men are not returning to Nepal, sending letters or sending money home to their wives; More young men migrating to India and internally due to the conflict; Migration causes women and children to be abandoned; Migration and vulnerability to HIV/AIDS.			Informal: Women's organisations; Solidarity amongst women whose husbands are in India or migrated elsewhere.	
Suicide	598 females; 894 males 10th leading cause of death in males and females 0-14 years; 6th leading cause of death for men 15-65 years; 14th leading cause of death for females of 15-65 years; Mortality rate for suicide is 4 times more than that for AIDS for both males and females					
Child Labour	The total number of working children between 5 to 14 years is 2.6 million (25,96,000) of which	Socio-cultural acceptance of child labour; Lack of parental education or good and meaningful education; Family in debt (bonded labour);	Education; Access to basic services.	Children's Act of 1992 which states that child labour is prohibited; Child Labour (prohibition and regulation) Act 2000 to	Informal: Children's organisations; Community members monitor. Formal:	Strengthen existing structures to be able to better monitor the situation of child labour;

	Geographic location and data/estimates	Problems	Primary needs	Legal framework/barriers	Existing structures and safety nets	Recommendations and opportunities
	the economically active children are 1.7 million (1,66,0000). Trafficking in children for commercial sexual exploitation, rag picking, child porter, child labour in carpet factories, domestic child labour, children in mines and porter children sums to 127,000.	Lack of alternative for survival; Orphans made to work; No access to basic services for child labourers such as medical care, shelter and education; Exposure to crime, drugs, trafficking and other forms of exploitation.		protect children (this Act is in the process of further amendment); Children under 14 years prohibited to be employed as a labourer.	DCWC; Paralegal committees; NGOs/INGOs and donors; Out of school classes and children's organisations.	Expand the work done by the children's organisations to reach more child labourers.
Sex Work	10,000	Vulnerability to HIV/AIDS; Stigma and discrimination against sex workers; Sex workers may not have anyone to supervise their children; Sex workers daughters may get into sex work themselves;	Protection from infection; Treatment facilities;	Illegal	NGOs working with Sex Workers	Decriminalisation
Trafficking	Estimated 5,000 children below 16 years trafficked to India each year (CWIN)	The majority of trafficked girls and women are forced into prostitution; High vulnerability to HIV/AIDS; Carpet industries can be used as a transit place for trafficking; Many women and girls who are victims of trafficking come from lower caste community.	Prevention; Protection from infection; Treatment;	The Constitution (under article 20/1) guarantees the right against exploitation; The article prohibits 'the traffic in human beings, slavery and serfdom or forced labour in any form'; Trafficking is a criminal offence punishable under law Civil code (Muluki Ain) of 1964 defines trafficking as a crime punishable by 10 to 20	Informal: Community members; Paralegal committees; Women's groups. Formal: DCWC; WDO; NGOs/INGOs; Justice system.	

	Geographic location and data/estimates	Problems	Primary needs	Legal framework/barriers	Existing structures and safety nets	Recommendations and opportunities
				years imprisonment; Human Trafficking Act 1986 prohibits trafficking; The Human Trafficking Act has no provisions for the punishment of persons involved in the purchase of the women and girls for prostitution; The victim of trafficking is not protected under the State if she/he becomes a witness in a court case; Enforcement of the laws against trafficking is poor.		
Injecting Drug Users	Total number of Drug Users are 50,000 all over Nepal and among them 20,000 are IDUs. Source: CHR.2002	Stigma and discrimination; High vulnerability to HIV/AIDS; No support structures; Rejected from family and community; Difficulty in caring for children; No supervision for children; Children are abandoned; Children of drug users may themselves get into drug use; Decrease in socio-economic status.	Rehabilitation; Children need supervision, care and support	Illegal	NGOs working with IDUs Rehabilitation Centres	Decriminalisation
Child Marriage		The custom of 'child marriage' prevails from ancient Hindu laws that practice marriage of girls before they reach puberty; The tradition is linked to ensuring that girls are still virgins when they marry; This tradition still continues today although less so than before, it is most		The Civil Code of 1963 has the legal age of marriage from the age of 16 years for girls with the consent of parents and 18 years without their consent; The penalty for violation of the law and the punishment	Informal: Community members; Women's groups; Paralegal committees. Formal: DCWC; Police and Justice.	

	Geographic location and data/estimates	Problems	Primary needs	Legal framework/barriers	Existing structures and safety nets	Recommendations and opportunities
		commonly carried out in the Indo-Aryan orthodox Hindu communities; Boys can also marry as a child, but it is more common for girls to be married off earlier; Girls who marry early are deprived of their education; The many responsibilities that a girl takes on after marriage can be very stressful psychologically if she is not old enough; Childbirth for young girls is a health hazard and complications in child birth can be more severe.		depends on the age of the girl involved; The mechanisms to enforce the laws, especially in rural areas are weak; The punishment for persons arranging a marriage for a girl under 10 years is from 3 months to 3 years, which is a very big difference,		

Table 4: Findings from the Field Research on Attitudes towards Orphans from Discussion Groups with Women, Community Organizations, and Children's Groups

Attitude towards orphaned children									
District	Orphans treated badly	Orphaned girls married earlier	Orphans with stepmothers are treated badly	Orphans are cheated of their property	Orphaned children end up as working children	Orphans from the lower caste are more vulnerable	Orphaned children, especially newborn are considered bad luck	Orphaned children are not given enough food	Orphans are denied education
Sunsari	X	X	X	X	X	X	X		X
Chitwan	X			X	X				
Kathmandu *No data*									
Kaski	X			X		X	X		
Banke						X			
Dang	X	X			X			X	
Dadeldhura	X		X		X				X

Table 5

	Total Population	Total	Widow/ Widower	Divorced	Separated	Percent of Total
Male	8,330,576	131,433	112,001	10,477	8,955	1.58%
Female	8,439,703	335,205	308,451	10,297	16,457	3.97%
Eastern Region	3,935,908	102,667	91,115	4,494	7,058	2.61%
Male	1,956,424	27,588	23,420	2,104	2,064	1.41%
Female	1,979,484	28,182	20,799	2,389	4,994	1.42%
Central Region	5,959,722	164,305	150,028	5,626	8,651	2.76%
Male	3,055,621	46,732	40,371	3,098	3,263	1.53%
Female	2,904,101	117,572	109,657	2,528	5,387	4.05%
Western Region	3,379,674	100,124	90,234	4,790	5,100	2.96%
Male	1,593,539	27,626	23,547	2,213	1,866	1.73%
Female	1,786,135	72,498	66,687	2,578	3,233	4.06%
Mid West Region	1,939,441	55,644	48,029	4,529	3,086	2.87%
Male	962,300	18,265	14,653	2,481	1,131	1.90%
Female	977,141	37,380	33,376	2,048	1,956	3.83%
Far West Region	1,555,534	43,898	41,046	1,335	1,517	2.82%
Male	762,692	11,220	10,010	581	629	1.47%
Female	792,842	32,676	31,035	754	887	4.12%

Case Studies

Case Studies from Field Research, Nepal Assessment of Families and Children Affected by HIV/AIDS

Orphans

Ramita lives in a rural VDC in Chitwan. She was only 3 years old when her mother died. Her brothers were only 8 and 10 years old at the time. Her father was sick with a chronic illness and was unable to work. Her two brothers had to work in other people's houses to provide income for the family. Even though neighbours would sometimes come to help in the house, Ramita had to do the household chores as soon as she was old enough and was not able to go to school. Later when her brothers were older, they started working in the factory and life became a little easier for the family. She feels very sad that she nor her brothers were able study.

Chandramaya is left with her 3 grandsons. Her son was a drug user who died last year. He was her only child. The mother of the children cannot take care of them as she works daily from house to house to provide a meagre income. Two boys are going to school for disadvantaged children. One was going to a school but recently ran away because he does not want to study.

Kale is 5 years old and his brother Hari is 7. Their mother died only last year and their father remarried another women. Their stepmother treated them very badly and refused to look after them, they were sent to be taken care of by their maternal grandmother. Kale and Hari lived in the slums with their grandmother for 3 months until she could no longer support them. With no one to leave them with, and with no other support, she abandoned the two boys in the streets in Kathmandu. The two boys were picked up by the police and taken to the orphanage where they now both live.

Widows and sex work

Shanti is a beautiful sex worker who is 29 years old. Her husband died a few years ago leaving her with two children. The only way she could support her children was to engage in sex work. Now she leaves her children with her mother in the village while she works on the highway route. If anything happens to her, she feels that her mother will look after her children.

Widows and suicide

Kanchi's mother has been taking care of her 3 grandchildren since Kanchi committed suicide last year. It all started when Kanchi's husband died of cancer. Her in-laws accused her of being a bad omen and blamed her for the death of their son. They mistreated and her children. Finally, she took the children and went to stay in her mother's house. She managed to make a small living from running a tea shop. Soon she fell in love with a man in the village and got

pregnant. The man was married and denied the relationship. Soon Kanchi was being ostracized by the whole community and even accused of being a prostitute and threatened. Her tea shop business closed down because no-one wanted to be associated with her. She fell into a deep depression and eventually committed suicide.

Child Labour

Shyam's father died two years ago. He was 11 years old at the time. His father used to work in a factory. His mother did not work. He has a smaller sister. After his father's death, his mother started working as a domestic worker to earn money. Last year, it became very difficult to run the household with his mother earning so little so Shyam had to leave school and also do some work. Now he does work in a little teashop. He washes the dishes and does cleaning. With his mother's income and his, they can just survive. He misses going to school.

Inheritance and Property Grabbing

Anil has grown up in an orphanage. He lost his mother when he was 1 years old. Unfortunately his father died in an accident when he was 3 years old. Now that he is 16 years old he has been sent back to his community and is living with his Uncle's (father's brother) widow. He helps his aunty and goes to college too. He has two cousins who are studying. Anil has come to know from the neighbours that his father had saved a good sum of money and had some property. The house that his uncle's family is living in belonged to his grandfather and he also has the right to a share of it. The neighbours pointed out some land that his father had bought. He understands that the property should rightfully be his but cannot do anything about it because he does not have the money or support to fight a case against his relatives. He is sad and frustrated because he has nowhere else to go and must live with his uncle's family. He wonders why he was sent to orphanage.

Migration

Four years back, Pritam was diagnosed HIV positive. He is now sick with AIDS. He used to work in India for two years and once in a while visited brothels. He has a wife and a daughter. His parents and wife know about his status. He came to live in the city because he feels that if the village people come to know about his status, he will be treated very badly. Recently, his wife has been behaving very badly and does not even give him enough food to eat. Because he is getting weaker, he is not able to do much work. His wife accuses him of not being able to earn enough for the family and therefore mistreats him. She has stared working too. He is very depressed and wants to go to live with his parents who will provide the support he does not get from his wife. He also visits a counselling centre from where he gets some moral support.

Conflict

Anju lives with her old grandparents. She is 9 years old and her brother is 5 years old. Her father has run away to the city because he is scared of the Maoist. Her mother has also gone to the city to do domestic work and earn some money. Anju misses her mother and father. She helps her grandparents to look after her little brother. She also washes the dishes of other household and they give her food to eat. There is nobody to work in the field. Her grandparents are old and cannot do much. They are waiting for the parents to come and get them and take them to the city.

Drug Use

Hari is a drug user in Kathmandu. He is in his mid-30s. He has a son who is 7 years old. His wife abandoned him and their son a few years ago due to his drug habit and currently he is unable to look after his son because of his addiction. He has sent his son to his elder bother, but knows that there he is not treated well. He is sad that his son is being mistreated, but he can see no other option.

Anju is 20 years old and living with HIV. She used to be an injecting drug user but since the birth of her son, she has stopped. She left home when she started taking drugs, and now she is currently being supported by an organisation that provides shelter for women substance users. She says that the birth of her son has changed her life. She wants to be clean and to be able to provide for the future of her son, however, she does not know whether her son is HIV infected. The baby's father has refused to assume responsibility for the child. She is alone, without employment or family and unsure about her future and the future of her child. However, she feels optimistic that she wants to help other women in her situation from falling into the same trap.

Appendix 1. District Reports

DISTRICT REPORTS

SUNSARI

	Area in sq.km	1,257
	Elevation (m)	152-914
	District Headquarter	Dharan
	Number of VDC/Municipality	49/3
	Number of Constituency (ies)	5
	Total Population	625,633
	Sex Ratio (M/F)	1.02
	Under 14 population (%)	38.4
	Elderly population (60+) (%)	5.6
	Annual Growth Rate (1999-2001) (%)	3.04
	Number of household	120,295
	Average Household size	5.2
	Population Density (persons/sq km)	498
	Urban Population (%)	25.53
Ranking among Districts	By Population	7
	By Area	58
Proportion to National Figure (%)	By Population	2.7
	By Area	0.85
	Both sex	60.38
Literacy (%)	Male	70.64
	Female	50
Net Enrolment Ratio	Primary	79
	L. Secondary	35.8
	Secondary	25.9
	Human Development Index	0.38
	Population per Doctor	69,515
	Population per Hospital Bed	830
	Household with access to Toilet Facilities (%)	52.88
	Population with access to Safe drinking water (%)	72.44
	Population Influenced per Km of Road	984
	Total Road (Km)	471

DISTRICT REPORTS

Socio-economic situation of Sunsari district

Sunsari district lies in the Eastern development region with its Headquarters in Dharan. It covers an area of 1,257 Sq.Km and is predominantly terai with altitudes between 152 and 914 m. It is bordered by Morang district in the east, Saptari and Udyapur districts in the west and Dhankuta district in the north. It borders India in the south.

Sunsari is made up of 49 VDCs and 3 municipalities which comprise 120,295 households and a population of 625,633 people, 315,530 males and 310,103 females. Of the total population, 253,935 are children and 38.4% of the total population is under the age of 14 years. It has a population density of 498 persons per sq km, and 25.5% of the population live in urban areas. It is the 7th most populous district in Nepal and has a Human Development Index of 0.38. The average household size is 5.2 which is lower than the national average of 5.6.

The literacy rate among males is 70.6% and 50% among females and the net enrolment ratio is 79 for primary education but down to 35.8 for lower secondary and 25.9 for secondary education. The HDI is 0.382.

34.8% of the households have no agricultural land, livestock or poultry. 72.4% of the population have access to safe drinking water, but only 52.88% of households have access to toilet facilities.

Summary of responses:
There are currently around 350 NGOs working in Sunsari, 35 NGOs are under the umbrella of the NGO cc (co-ordinating umbrella network). 11 NGOs are working in the area of HIV/AIDS and in Dharan, there is an attempt at establishing a support group for people living with HIV/AIDS. 11 organisations have undergone training on HIV/AIDS although many other individuals have also participated in training sessions. 2 organisations, the CLRC (community legal research centre) and the CICSA (centre for information, communication and social awareness) work on legal issues pertaining to both women and children among other issues. There are 2 orphanages in Sunsari, the SOS children's Village and the Anathashram in Dharan. There are presently more than 150 women's groups in Sunsari formed through different programmes and 25 different child clubs in the communities. There are 65 child clubs in schools, of which 35 are rural and 30 are urban based. There are also 20 paralegal committees in the rural areas.
(Collated by the UNICEF field office in Biratnagar)

Findings in Sunsari
The team visited various community organisations, child clubs, Government entities and NGOs in Sunsari.

Proximity to the border of India means that there are a number of migrant labour to India, as well as a high level of cross border activity. Drug accessibility is also easier due to proximity to the border. Many internal migrants also come to Sunsari as it is in the terai with more opportunities for work.

DISTRICT REPORTS

Response of NGOs

Most of the organisations visited work around the area of advocacy, prevention and awareness around HIV/AIDS. They also worked mainly with groups exposed to high risk such as sex workers and drug users, including injecting drug users. The team visited Help Group Nepal, Community service centre, Drug rehabilitation centre, ActionAid who were all involved in creating awareness on HIV/AIDS within particular groups such as sex workers and drug users as well as within the community.

Dharan municipality has a high concentration of drug use due to its proximity to the Indian border and the high prevalence of wealthy families who live in the area. The youth therefore have more money to spend and tend to experiment with drugs whilst in schools. The **Drug rehabilitation** in Dharan called Poonarjeevan Kendra provides treatment and in-care rehabilitation for injecting drug users and also works with people living with HIV/AIDS who have been infected due to drug use. The rehabilitation provides counselling to drug users as well as to their families. The Drug rehabilitation centre is also supported by ActionAid to try and set up a PLWHA association.

The team met also with **sex workers** in Sunsari. These usually hide the status from their families and husbands since it is so stigmatised. Their work is usually operated out of hotels and dance bars through a network co-ordinated by pimps. The community service centre works with these sex workers to provide awareness on HIV/AIDS as well as condom use.

(See annex for a list of people and NGOs met and their specialised areas.)

Response of community organisations:

The team met with a **woman's organisation** in the Singha VDC. This woman's group is involved in a saving scheme to be able to empower the women from the group through revolving loans for IGAs. With the support of UNICEF, they have also set up a day-care centre for children whose parents cannot supervise them during the day due to work constraints. This day care centre has a 5 year support from UNICEF after which it will continue to be run by the women's group.
Although the women's group does not specifically look at assisting vulnerable children, the notion was there that if a child was seriously sick, they would mobilise funds to treatment. This serves as a good opportunity for the identification and assistance to vulnerable children.

The **paralegal committee** works on issues pertaining to domestic violence against women, child and women's rights training and the prevention of trafficking of girls from the community. The members of the committee are made up of various VDCs, wards and schools and provide a body to which women who are abused can turn to for support. The committee attempts to mediate domestic disputes as well as domestic violence through talking to both parties involved. Although some laws are available for women, these are not functional at the community level and usually the community attempt to mediate conflicts internally.

The team visited 2 **UOSP (urban out of school) child clubs**. These child clubs provide the most vulnerable children with opportunities of education, recreation and care. The majority of the children in the child clubs are made up of child labourers;

domestic workers, grass cutters, rat pickers and mill grinders. They are between the ages of 10-14 years. The child clubs are co-ordinated through the municipality and run for 2 hours daily. The children come from the most disadvantaged families, many are from the lowest castes and many are also orphaned children. The value of the child club is high. The children felt that they had at least an opportunity during the day where they were not working and could learn and interact with each other.

The team also visited an in **school child club** supported by UNICEF. This club was for girls and boys from 11-18 years who engaged in different activities such as raising awareness on child rights to other peers through the elaboration of newspapers and booklets. The children also fundraised to assist vulnerable children such as orphans and those unable to go to school.

Response of Government

The team met with the district child welfare committee (**DCWC**). This body is responsible for the issues pertaining to children at the district level. The chairperson is the chief district officer (CDO). The DCWC Sunsari has existed for 4 years. Its mandate is governed by the Child Act of 1992.

The DCWC has not been very active in the past. Due to lack of funds and poor organisation and co-ordination, they have been unable to accomplish all the tasks set out by the Child Act. They have no annual plans as such but would like to prepare one. However, the opportunities for their use are very important since they have the responsibility for children. During the time of the visit, they were in the process of collating information on all children in the district through the NGO UPCA which will help towards elaborating their annual plan.

The DCWC noted that monitoring and evaluation on the situation of vulnerable children was an especially weak area in which no mechanisms were in place. The same was said for institutions for children, namely orphanages that were not monitored and badly run.

The district education office (**DEO**) provided a scholarship scheme for the lower caste (Dalit) children in Sunsari. However, the children first have to enrol into school to qualify for the scholarship which provides them with a small fund for uniforms and stationary.

The Government were not involved in supporting activities surrounding HIV/AIDS.

The team also managed to visit the **DDC of Morang district**, neighbouring Sunsari district. The reason was that the DDC was actively involved in HIV/AIDS awareness and advocacy activities. This was an imitative first started by the NCASC supported by UNDP, however funding has since stopped, but the DDC Morang have taken it upon themselves to continue with these activities. Presently support is limited and is provided in part by the DDC themselves and by ActionAid. The DDC carries out activities in the area of HIV/AIDS awareness, training and providing counselling services for STD and HIV/AIDS.

DISTRICT REPORTS

CHITWAN

Area in sq.km		2,218
Elevation (m)		244 - 1,945
District Headquarter		Bharatpur
Number of VDC/Municipality		36/2
Number of Constituency (ies)		3
Total Population		472,048
Sex Ratio (M/F)		0.99
Under 14 population (%)		36.4
Elderly population (60+) (%)		6.7
Annual Growth Rate (1999-2001) (%)		2.84
Number of households		92,863
Average household size		5.08
Population Density (persons/sq km)		213
Urban Population (%)		26.93
Ranking among Districts	By Population	17
	By Area	23
Proportion to National Figure (%)	By Population	2.04
	By Area	1.51
Literacy (%)	Both sex	70.76
	Male	78.82
	Female	62.84
Net Enrollment Ratio	Primary	93.9
	L. Secondary	45.4
	Secondary	29.5
Human Development Index		0.37
Population per Doctor		14,752
Population per Hospital Bed		2,348
Household with access to Toilet Facilities (%)		79.05
Population with access to Safe drinking water (%)		44.15
Population Influenced per Km of Road		444
Total Road (Km)		798

DISTRICT REPORTS

Chitwan lies in the Narayani Zone for the Central Development Region. Chitwan has an area of 2218 sq. km It is bordered on the east by Makwanpur and Parsa districts, on the west by Nawalparasi and Tanahu districts, on the north by Dhading and Tanahu districts and on the south by India. Roughly 14% of the district lies in the Terai and in the mid Mountain. The remaining 86% lies in the inner Terai region. It has 36 VDCs and two municipalities. Bharatpur is the District Headquarter.

Chitwan has a population of 472,048 of which male are 235,084 and females are 236,964 and under 14 population are 36.4%. The literacy rate is 70.76%. The numbers of households are 92,863 and the average household size is 5.08.

The population density of Chitwan is 213 persons per sq. km and 26.93% of the population live in the urban areas. The literacy rate for males is 78.82% and 62.84% for females. The net enrolment ratio is 93.9 for primary, 45.4 for lower secondary and 29.5 for secondary. Only 44.15% of the population have access to safe drinking water and 19.5% of all households do not have agricultural land, livestock or poultry.

Findings

The **NGOCC (NGO Co-ordination Committee)** gave us a brief picture of the existing support that exists in the district regarding vulnerable children. There are 320 NGOs working in the district. There are 20 child care centres for OSP classes. There are 2 transit centres for street children, but these don't provide food. There is 1 orphanage run by Koreans with 170 children that provide food, lodging which is called the 'Asha centre'. There is also the Balmandir orphanage. SNV also support the running of a residential school for the Praja (lower caste) children. There are around 400 children in that school. There are around 20-22 child serving NGOs, some run OSP classes. There are 15 community based child development centres in 7 VDCs, mainly pre-school for children between the ages of 3 and 5 years.

The **Paralegal committee** is very active in the District. They have a resource centre in Bahratpur. The committee works mostly with women for issues of violence and abuse against women. The paralegal committee also has presence at the ward, the VDC and the district levels. When the paralegal committee has many cases of violence against women, they take it up with the ward/VDC but also speak to the households themselves to stop the violence.

GWP (General Welfare Pratisthan) works in the following areas:

- Peer education training on HIV/AIDS
- Outreach work to FSWs and their clients in the major highway routes (including training on HIV/AIDS and peer education)
- IEC development and production
- Condom promotion and distribution
- Drop in centre for drug users and SWs
- Referrals for STD treatments
- Awareness raising through festivals, street drama and film shows

Meeting with FSWs:

The sex workers we met explained that most of the SWs started to engage in SW for financial support, and mostly since their husbands died, as a way of coping to support themselves and their children. There is a SWs community which service the truckers

and drivers along the highway route, so there is support amongst themselves, they provide support to each other. The orphaned children are looked after by the community until they are around 6-7 years old and can work, then they are responsible for themselves.

Meeting with IDUs:
The IDUs explained that there is a lot of discrimination against them as IDUs. Their children don't go to schools. The main problems for children are: no schooling and lack of love. Most drug users are unmarried. There is not much knowledge on HIV/AIDS, e.g. difference between HIV and AIDS. They hear about HIV/AIDS from the television, radio and through friends. AMDA provides health care including STD treatment. The IDUs all lived with their families, either extended or close and are provided with support from their families

Meeting with person living with HIV:
She has one son. She lives with her in-laws. She and her son have both been tested negative. They went twice for testing in KTM. The DDC gave her Rs.10,000 'compensation' for assisting her after her husbands death. The in-laws have been supportive towards her.

Meeting with OSP classes children
The OSP was for children between the ages of 8 and 14 years. They explained that they enjoy coming for the classes and enjoy singing and playing games. Most of the children that come there are involved in chores e.g. sweep, wash dishes, cut grass, take cattle out, cook, catch fish, look after siblings etc.

Meeting with woman's group of the same VDC
This group started around 4 years ago. The group saves around Rs.20 a month from the members. The group carries out adult literacy classes. The group have a fund that have saved Rs.30,000 within their committee. The money is used for IGAs but also as a fund for various expenses including when someone is sick and funeral and marriage expenses

Meeting with the LDO (Local Development Officer)
The LDO informed that the DACC (District AIDS Co-ordination Committee) has made some commitments towards HIV/AIDS (although not active yet):

- Awareness raising
- Rehabilitation of PLWHA
- Families where one member has died of AIDS

The DACC members are made up of line ministries, NGOs and the DDC chairperson is the DACC chairperson. The DACC gave Rs. 10,000 to one widow of AIDS and Rs. 5,000 to another family affected by AIDS

Visit to the DPHO
The DPHO informed that all health posts have provisions for families who are so poor they cannot afford treatment, however, in practice this has not happened because the criteria of selection is a fine line and cannot be made – also very politicised.

Some of the members of the above have received training on HIV/AIDS such as the TBAs and the FHCVs which came as a package together with main training from regional level. Most health workers have not been trained on HIV/AIDS or universal precautions. There is no blood screening facilities at district level, except at the Red Cross for the blood bank where around 40 cases have been notified to date. .No testing facilities exists for voluntary testing.

KATHMANDU

Area in sq.km		395
Elevation (m)		1,372 - 2,732
District Headquarter		Kathmandu
Number of VDC/Municipality		57/2
Number of Constituency (ies)		7
Total Population		1,081,845
Sex Ratio (M/F)		1.14
Under 14 population (%)		28.1
Elderly population (60+) (%)		5.4
Annual Growth Rate (1999-2001) (%)		4.82
Number of households		235,387
Average household size		4.6
Population Density (persons/sq km)		2,739
Urban Population (%)		64.11
Ranking among Districts	By Population	1
	By Area	73
Proportion to National Figure (%)	By Population	4.67
	By Area	0.27
Literacy (%)	Both sex	77.07
	Male	86.35
	Female	66.44
Net Enrollment Ratio	Primary	85.9
	L. Secondary	61.5
	Secondary	51.9
Human Development Index		0.603
Population per Doctor		3,948
Population per Hospital Bed		616
Household with access to Toilet Facilities (%)		92.41

Population with access to Safe drinking water (%)	84.15
Population Influenced per Km of Road	840
Total Road (Km)	804

Socio – economic situation of Kathmandu

Kathmandu has an area of 395 sq. km . It is bordered by Bhaktapur, Latipur and Kavrepalanchok districts in the east, Dhading and Makwanpur districts in the west, Nuwakot and Sindhupalchok districts in the north and Bhaktapur, Lalitpur and Makwanpur districts in the south. It is in the mid-mountains with an elevation of 1,372 to 2,732 m variation. It has 57 VDCs and two municipalities. Kathmandu is the District Headquarter. It has a population of 1,081,845 of which male are 576,010 and females are 505,835 and 28.1% of the population are under the age of 14 years. The literacy rate for males is 86.35% and 66.44% for females. The net enrolment ratio is 85.9 for primary, 61.5 for lower secondary and 51.9 for secondary.

The numbers of households are 235,387 and the average household size is 4.6. The population density is 2,739 persons per sq. km and Kathmandu is the most populous district in Nepal. 64.11% of the population live in urban areas.

75.5% of all households do not have agricultural land, livestock or poultry. 84% of the population have access to safe drinking water and 92.4% of households have access to toilet facilities.

Findings

A number of donors, multilateral, bilateral and international/National NGOs are supporting and promoting various initiatives aiming at preventing the spread the epidemic in Nepal. The intervention are mainly in the area of targeted interventions for vulnerable groups, IEC, condom promotion, STD control, testing and counselling, surveillance and operational research. Some of the major organisations working in the area are: WHO, UNICEF, UNFPA, UNDP, ILO, AusAid, USAID< DFID, European Commission, FHI, Save the Children, CEDPA, UMN, Asia Foundation and Redd Barna. All the organisations head office is in Kathmandu. Most of them have subcontracted projects to various Local NGOs who work in the districts. Local NGOs like CWIN are very actively working with vulnerable children. They have a helpline which has proved to be very successful. There is the Central Child Welfare Board which has been reactivated under a very enthusiastic and committed director.

The ex drug users that we met lived with their families. They were married with children and were living in extended families. They were supported by their parents to go to rehabilitation centres even when they relapsed more than eight times.

DISTRICT REPORTS

KASKI

Area in sq.km		2,017
Elevation (m)		450 - 7,939
District Headquarter		Pokhara
Number of VDC/Municipality		43/2
Number of Constituency (ies)		3
Total Population		380,527
Sex Ratio (M/F)		0.95
Under 14 population (%)		34.7
Elderly population (60+) (%)		7.7
Annual Growth Rate (1999-2001) (%)		2.64
Number of households		85,075
Average household size		4.47
Population Density (persons/sq km)		189
Urban Population (%)		51.95
Ranking among Districts	By Population	23
	By Area	30
Proportion to National Figure (%)	By Population	1.64
	By Area	1.37
Literacy (%)	Both sex	71.9
	Male	83.03
	Female	61.52
Net Enrollment Ratio	Primary	90.7
	L. Secondary	61.4
	Secondary	35.7
Human Development Index		0.45
Population per Doctor		7,180
Population per Hospital Bed		1,197
Household with access to Toilet Facilities (%)		80.29
Population with access to Safe drinking water (%)		-
Population Influenced per Km of Road		715
Total Road (Km)		410

DISTRICT REPORTS

Socioeconomic situation of Kaski district

Kaski district lies in Nepal's Western Development Region. It is bordered on the east by Lamjung and Tanhu districts, on the west by Parbat district, in the north by Manag and Lamjung districts and in the south by Tanahu and Shyanja districts. Almost 39 percent for Kaski 's land area lied in the Middle Mountain region where the population density is high. The remaining 30 percent comprises the high Himalayan region and the remaining 31 percent , the high mountains. The altitude varies from 450 - 7,939m in elevation.

The district has 43 VDCs and two municipalities. Pokhara is the district's head quarters. It has a total population of 380, 527. The number of female population is 195,532 and male population is 184,995 and under 14 population is 34.7%. The average household size is 4.47. Kaski is the 23rd most populous district in Nepal and 51.95% of the population live in the urban areas.

The literacy rate among men is 83.03% and 61.52% among women. The net enrolment ratio is 90.7 for primary, 61.4 for lower secondary and 35.7 for secondary. The district ranks third out of 75 districts on the Human Index Ladder.

39% of households do not have agricultural land, livestock or poultry.

Findings

Pokhara is a place where most of the 'Lahure' from the British Gorkha stay. These British Gorkha people earn a lot of money abroad and have beautiful houses in Pokhara. At the same time, many people have small restaurants and hotels to cater to the tourist. A major source of income in this area is tourism.

There are two reasons why Pokhara is looked as a 'hot spot' for HIV/AIDS. Many of the children of the British Gorkha's have plenty of money to play with so often they fall into the trap of drug use. Also, they are educated abroad and get bored back home and get restless. There are plenty of kids of the Gorkha's fallen into this trap of drugs. Tourism has encouraged a lot of women to get into sex work. Tourism sex is very popular. Therefore, Pokhara has a high prevalence of drug use and sex work .

In relation to HIV/ AIDS, the NGOs are working with mainly the sex workers and Injecting drug users.

SEDA is a local NGO working on issues of STD and HIV/AIDS, groups engaging in high risk behaviour, their clients and communities. Few components that they are working on are:

- Peer education and communication
- Counselling and voluntary testing
- STD treatment clinic
- Referral services to other hospitals and health facilities
- Outreach work
- Condom promotion – including beginning social marketing of condoms
- Microfinance – loans to the poorest SW through financial intermediary NGO to around 36 SW

DISTRICT REPORTS

- Worked with women's committees in the slums in Pokhara through the urban services programme of Pokhara municipality (funded by UNICEF)
- SEDA have tried to lobby for rights of SW's (including citizenship) to the district officials, including CDO and also to central level.

The Red cross programme has mainly the component of youth/child awareness in schools
They have the child to child programme linked to HIV/AIDS which has been running for around 1 year

The INF (International Nepal Fellowship) programme has 2 departments, one on Drug rehabilitation and one on HIV/AIDS care and support (VCCT programme and PALUWA counselling centre, home based care).

The ex chairperson of DDC heads the NGO on Prevention of Drug Abuse. They mainly work with teachers and students on raising awareness on the harms caused by drug abuse.

Children Nepal is a local NGO working with the following issues:

- This child serving organisation was established around 4 years ago
- They work with families and communities and vulnerable children
- The big problems affecting children are conflicts between parents, such as fighting and drinking
- They carry out family counselling and encourage skills for business
- They also work with families to refer them to any free/subsides services that might be available
- They have admitted 349 children to schools, either hostels where they can stay and learn, or assist parents by contributing to some of the school costs such as for stationary
- They have a social mobilisation programme funded by UNICEF that seeks to advocate to local government at different levels to allocate a budget for children and make sure that children are in their plans
- They work with 18 wards which have 2 social mobilisers in each ward
- They have set up 42 self help children's groups made up of: 5 groups for domestic workers, 7 groups for children from the slums, 2 groups for street children, 4 groups for community children, 13 government in-school groups, 3 groups for private boarding school children, 4 groups for out of school children and 1 group for disabled children
- These groups are trained on the CRC and also assist other children through advocacy and lobbying with local level authorities
- Some of these self help groups also contribute a small portion to fundraise for other vulnerable children
- CN have also helped set up a 'child protection' committee in 9 wards made up of a ward representative, NGO, a woman (compulsory), member of a youth organisation and one or two members from the toles (lower than ward) and representation from the mothers groups
- This CP group puts pressure on the municipality to set aside money for vulnerable children
- The CP group also helps identify vulnerable children in need of protection

DISTRICT REPORTS

- The ward usually have Rs.5,000 in their budget for children, so the CP group help channel this money to the most needy to enrol them into schools

CN also have a small transit centre which is used as an emergency shelter and a socialisation centre where counselling is available, it is also a contact point

The child welfare scheme started in 1995 with the set up of various child day-care centres in different VDCs. Together with the day-care (preschool) centre was attached a clinic run by CMA workers. These centres are now being handed over to the community. The centres are for children of 0-5 years

The child welfare scheme is now running Vocational training centre which was opened in May 2002. This is for vulnerable youth of 14-20 years, more specifically, for street youth, trafficked girls and youth from the slums

Women's Groups

The women's group usually run saving and credits programmes. Sometimes the vulnerable children are identified through the women's group who has the responsibility for women and children in their ward. The women identify the children and refer them to NGOs or government. Some women's group had set up a day-care centre for the children of the most vulnerable households especially those who have no-one to care for their children during the day. Orphans are also taken care of in the day-care centre. One example of a women's group is where they look after around 25 children. These 9 women who started this initiative rotate in bringing food for the children daily. The children range from between 2-4 years of age. There are problems now because the women are unable to fundraise within the village for food for the children.

The **Kaski District Child Welfare Board** has in active in many ways. These are few of its works:

- 5 year plan has been made for the future work of the DCWC
- 5 year plan has been made for the future work of the DCWC
- Encourage child participation in various gatherings
- The DCWC advocates to the community to support the helpless children
- The DCWC organised the participation of 69 child clubs in a child conference where the children identified some key issues and their own solutions

DISTRICT REPORTS

BANKE

Area in sq.km		2,337
Elevation (m)		129 - 1,290
District Headquarter		Nepalgunj
Number of VDC/Municipality		46/1
Number of Constituency (ies)		3
Total Population		385,840
Sex Ratio (M/F)		1.06
Under 14 population (%)		40.5
Elderly population (60+) (%)		5.6
Annual Growth Rate (1999-2001) (%)		3.16
Number of households		67,269
Average household size		5.74
Population Density (persons/sq km)		165
Urban Population (%)		14.91
Ranking among Districts	By Population	20
	By Area	18
Proportion to National Figure (%)	By Population	1.67
	By Area	1.59
Literacy (%)	Both sex	57.36
	Male	65.3
	Female	48.95
Net Enrollment Ratio	Primary	61.8
	L. Secondary	22.1
	Secondary	11.8
Human Development Index		0.309
Population per Doctor		12,446
Population per Hospital Bed		2,427
Household with access to Toilet Facilities (%)		50.37
Population with access to Safe drinking water (%)		90.1
Population Influenced per Km of Road		842
Total Road (Km)		339

DISTRICT REPORTS

Socio-economic situation of Banke district

Banke district lies in the Mid West Development Region with its headquarters in Nepalgunj. It is in the mid-mountains with a population of 385,840 with a geographical area of 2,337 sq. km and with altitudes varying from 129 to 1,290 m. It is bordered on the east by Dang and Salyan district, as well as India, on the west by Bardia district, in the north by Surkhet, Salyan and Dang district and in the south by India.

Banke is made up of 46 VDCs and 1 municipality which comprises 67,269 households with each average household size being 5.74. The population is made up of 198,231 males and 187,609 females, as well as 164,988 children. Of the total population 40.5% are children under the age of 14 years. Banke has a population density of 165 persons per sq. km and 14.91% of the population live in the urban areas. Banke is the 20th most populous district in Nepal.

The literacy rate among males in Banke is 65.3% compared to 48.94% in females. Net enrolment ratio for primary education is 61.8 which lowers to 22.1 in lower secondary and only 11.8 in secondary education. The HDI is 0.309.

26.5% of all households in Banke do not own agricultural land, livestock or poultry. 90% of the population have access to safe drinking water, but only 50.37% of households have access to toilet facilities.

Findings

The team only had one day in Banke district, so visits where directed to Nepalgunj. The district was not a chosen one, but due to the fact that the team was already situated there, they took the opportunity to visit various NGOs in Nepalgunj. Nepalgunj is also a regional headquarters and has many more NGOs and response systems, as well as the only surveillance site in the region. During the short time the team were in Nepalgunj, they managed to meet with the NGO working closely with the Badi community, SAFE, as well as together with members of the Badi community.

NGO and community response for the Badi population

The team visited the SAFE NGO which is an NGO that works predominantly with the lower caste Badi community. This is a community that has experienced a lot of discrimination from others and outsiders because of their links to sex work as a tradition. SAFE management is made up of members of the Badi community and their objectives are to eliminate discrimination, child prostitution and provide skills and alternatives for women and girls to get out of sex work. SAFE works with Badi communities in 6 districts – Banke, Bardia, Dang, Kailali, Surkhat and Sallyan. The Child protection programme is being supported by SC Norway and UNICEF. There are currently 300-350 children from the Badi community who are fatherless and consequences of sex work. These children cannot receive birth registration due to the fact that they do not have recognised fathers, and therefore cannot have access to basic services such as education. SAFE raises awareness on rights of the Badi people, as well as advocates strongly for birth registration and citizenship for fatherless children. Women's groups formed by the Badi community also lobby for women's

rights as well as raise awareness on issues of safe sex and condom use. There are also child clubs in the Badi community who work on raising awareness on child rights.

Government response

The team met with the STD clinic and also the Nepal STD and AIDS research centre. This centre and NGO are placed in the zonal hospital. The hospital has the only surveillance site for the region. From 1991 to June 2002, a total of 153 cases have been reported from 12,000 tested from the region. 12 out of 15 districts have reported HIV cases. No home based care facilities are available anywhere in the district although there are around 30-40 people living with HIV/AIDS who are seeking services. There are 15 children affected by HIV/AIDS who are being supported through scholarships. There are shortages of testing kits for HIV and confirmatory tests have to be done in Kathmandu which involves a lengthy process of sending samples to Kathmandu and sometimes, in waiting too long, these samples get spoilt.

DANG

Area in sq.km		2,955
Elevation (m)		213 - 2,058
District Headquarter		Tribhuwannagar
Number of VDC/Municipality		39/2
Number of Constituency (ies)		4
Total Population		462,380
Sex Ratio (M/F)		0.98
Under 14 population (%)		41.8
Elderly population (60+) (%)		4.8
Annual Growth Rate (1999-2001) (%)		2.67
Number of Households		82,495
Average Household size		5.6
Population Density (persons/sq km)		156
Urban Population (%)		16.65
Ranking among Districts	By Population	18
	By Area	11
Proportion to National Figure (%)	By Population	2
	By Area	2.01
	Both sex	57.7
Literacy (%)	Male	68.98
	Female	46.72
	Primary	82.6
Net Enrolment Ratio	L. Secondary	24.7

Secondary	12.1
Human Development Index	0.299
Population per Doctor	46,238
Population per Hospital Bed	5,780
Household with access to Toilet Facilities (%)	38.64
Population with access to Safe drinking water (%)	77.88
Population Influenced per Km of Road	669
Total Road (Km)	530

The socio-economic status of Dang

Dang district lies in the Mid Western development region. It covers a geographical area of 2,337 sq. km and is bordered by Argakhanchi and Kapilvastu districts in the east, Banke district in the west, Salyan, Pyuthan and Rolpa districts in the north and Banke district and India in the south. It is in the mid-mountains, with altitudes varying from 213 to 2, 058 m.

Dang district Headquarters can be found in Tribhuvannagar and it is made up of 39 VDCs and 2 municipalities. It has a population of 462,380 people, 228,958 males and 233,422 females. Of the total population, 204,457 are children under the age of 16 years, and 41.8% of the whole population is under 14 years of age. Dang has a population density of 156 persons per sq. km and 16.65% of the population live in the urban areas. It is the 18th most populous district in the country and has a Human Development Index of 0.299.

The literacy rate amongst males is 68.98% compared to 46.72% for females. The net enrolment ratio for primary education is 82.6, 24.7 for lower secondary and 12.1 for secondary, demonstrating a large amount of drop-out from school at the primary level. Dang is made up of 82,495 households with an average household size of 5.60.

13% of all households have no agricultural land, livestock or poultry. 77.88% of the population have access to safe drinking water, but only 38.64% of households have access to toilet facilities.

Findings in Dang

Dang district has no testing facilities. For this reason, it is extremely hard to know the what the impact of HIV/AIDS has been. Testing is referred to Nepalgunj in Banke. However, there are quite a few NGOs working in Dang on HIV/AIDS prevention, awareness and advocacy. There is also widespread consensus among many working in this area that testing is a very important need.

Seasonal migration occurs for both men and women in Dang, such as in the Daoughani valley to India to work on agriculture. This type of migration lasts only a few months.

out a monthly saving scheme. The money is used to provide loans to the women from the group for IGAs such as buffalo and pig raising. The women collect around Rs.25-50 from each member per month. This women's group have also expanded their activities to include growth monitoring of children, a fund to help sick women and children in their community and working to fight domestic violence and alcoholism. They have also managed to demand services from their VDC such as clean water programme. This group showed much potential to be able to identify and support vulnerable children and women.

An **urban out of school programme** (UOSP) is currently being co-ordinated by the Tribhuvan municipality. The UOSP has been running for over 3 years and hold between 17-23 classes a year. The UOSP assists children from vulnerable communities, such as children from the lower caste, bonded labourers, domestic workers and agriculturists to provide them with education and other skills, notably: reading, writing, health and sanitation messages, child rights, parenting skills to parents and even a small component on HIV/AIDS awareness.

A meeting with children from the UOSP classes revealed that the children were not only vulnerable because they were child labourers or children from the lower caste, but also because many of them were orphaned or abandoned children living with relatives, grandparents or employers. These children engage in hard labour daily with little time to spend being children, learning and interacting with others. The UOSP provides this small 'luxury' to them for 2 hours daily.

Response of Government

The team met with various members of the local government as well as members of the DCWC. The **DCWC** has until now been concentrating its activities on providing information and training on Child Rights and on Child Labour. It also supports the Nabjagaran Bal Ashram hostel with minimal funds. The annual budget for the DCWC has been Rs.25,000 and they have not yet received funds for this running year. The DCWC has little funds and capacity to fulfil its mandate as set out by the Child Act of 1992. The members feel powerless to assist orphaned children and as yet there is not mechanism to be able to identify or assist vulnerable children.

Meeting with the **Woman's Development Officer** in Dang (WDO) showed that there is huge opportunity for mechanisms of identification and monitoring through the WDO. This is because they carry out household surveys of various VDCs to be able to select poor household for bank loans. The households surveys reveal the household composition, as well as the status of poverty in that household, whether children go to school or if they are orphaned. Unfortunately, due to lack of resources, this kind of information has not been collated and analysed for alternative use and currently sits in questionnaire format. The opportunity this provides will be beneficial to both the WDO as well as other government bodies such as the DCWC and NGOs. The WDO also co-ordinates various women's groups that engage in saving schemes and IGAs. The WDO Dang has a total of 463 women's groups in 9 VDCs and 2 municipalities. These groups have also expanded their mandate to include activities on growth monitoring for children, sanitation campaigns and health awareness. Sometimes, the women's groups also form child clubs to assist the most vulnerable children.

DISTRICT REPORTS

The **District Education Office** (DEO) currently assist children from the lower caste to continue their education in schools by providing scholarships. Other vulnerable children also qualify for scholarship, such as children without fathers, working children and those who have lost their parents due to the conflict. The DEO currently has the scholarship fund running in 19 different VDC primary schools. There are around 500 scholarships given out, although the amount is minimal. The children receive Rs. 250 a year for school uniforms and stationary which is not enough.

Meeting was held also with the **District Health Office** (DHO). Blood screening for HIV for transfusion purposes started around 3 months ago. This programme runs only in Gohari and no cases of HIV have been reported yet. There is no counselling service at the blood bank. There are no voluntary testing facilities in Dang although there have been some people who have requested tests. The DHO also runs an STD clinic assisted by GWP. Around 20-25 patients are received weekly at the clinic, but there is a problem surrounding confidentiality as the ward is not private. The DHO however, provides a subsidised treatment rate for STD treatment of high risk groups referred to them by GWP.

DADELDHURA

Area in sq.km		1,538
Elevation (m)		457-2,439
District Headquarter		Dadeldhura
Number of VDC/Municipality		20/1
Number of Constituency (ies)		1
Total Population		126,162
Sex Ratio (M/F)		0.94
Under 14 population (%)		43.8
Elderly population (60+) (%)		6.3
Annual Growth Rate (1999-2001) (%)		1.91
Number of Households		21,980
Average Household size		5.74
Population Density (persons/sq km)		82
Urban Population (%)		14.52
Ranking among Districts	By Population	62
	By Area	46
Proportion to National Figure (%)	By Population	0.54
	By Area	1.04
Literacy (%)	Both sex	51.62
	Male	71.93
	Female	33.06

Net Enrolment Ratio	Primary	93.3
	L. Secondary	33.2
	Secondary	16.6
Human Development Index		0.265
Population per Doctor		42,054
Population per Hospital Bed		1,941
Household with access to Toilet Facilities (%)		35.96
Population with access to Safe drinking water (%)		89.64
Population Influenced per Km of Road		622
Total Road (Km)		168

The socio-economic situation of Dadeldhura

Dadeldhura is situated in the Far West Development Area. Its headquarters are in Dadeldhura and it covers an area of 1,583 sq.km. It is in the hills with altitudes from 457 to 2,439 m in elevation. It is bordered by Doti and Kailali districts on the east, Baitadi district and India in the west, Baitadi district in the north and Kanchanpur district in the south. Dadeldhura district comprises 20 VDCs and one municipality with a total of 21,980 households and a total population of 126,162 people, 60,965 males and 65,197 females. There are 58,020 children and 43.8% of the population are under the age of 14 years. The average household size is 5.74 and the population density is 82 persons per sq. km. Only 14.58% of the population reside in the urban areas which makes the population predominantly rural.

Dadeldhura ranks 59 out of Nepal's 75 districts on development related indicators and is the 62nd most populous district in the country. The sex ratio is of 931 women for 1000 men. 71.93% of males are literate compared with only 33.06% of women, and net enrolment ratio for primary education is 93.3 compared with 33.2 for lower secondary and only 16.6 for secondary education.

Only 5% of all households do not have agricultural land, livestock and poultry. 89.64% of the population have access to safe drinking water but only 35.96% of all households have access to toilet facilities.

Findings from Dadeldhura

Dadeldhura has one voluntary testing site in TEAM hospital. There are very few NGOs working in Dadeldhura and none working on the issue of HIV/AIDS although Dadeldhura has a high percentage of migration into India for work. The prevalence of HIV in Dadeldhura is unknown due to the lack of testing facilities and surveillance site, but most HIV cases noted were from migrant labourers returning from India.

Response from NGOs

The Rural Women's Development and Unity Centre (RWDUC) is an NGO that works in the area of protecting women. It works with stopping violence against women,

advocating for women's legal rights, as well as providing health facilities for women in the form of a birthing centre. The programme works with 15 community motivators in rural areas in 9 VDCs in Dadeldhura and 1 municipality. The motivators monitor and assist women who are being abused and also refers them for legal assistance in the district. RWDUC also has a scholarship programme for vulnerable children, mostly children from the lower caste (Dalits). At the moment, the programme supports 65 students in Dadeldhura in the form of uniform, school fees, stationary and food. This programming has been running for 4 years.
(see annex on NGOs met and people interviewed)

Response from the community

A meeting with the Nabadurga **women's group** revealed that a lot of solidarity and mutual support exists here among women who want to help each other. This is a VDC where most men have migrated to India for work, leaving behind the women to sustain themselves and their children. Life is not easy as Dadeldhura is extremely hilly and agriculture is dangerous work. Accidents and falls contribute to the top 10 causes of deaths in Dadeldhura, according to the TEAM hospital. The women's group was formed with the support of UNICEF and engages in savings and credit schemes. There are 27 members of the group and each of them contributes Rs10 a month to the saving scheme. With the collective effort, loans can be used for IGAs for the members of the group. Loans are also provided to other members of the community, at an interest of 2% within 2 months, rising to 5% after 2 months repayment. Most loans are used for IGAs to buy livestock and for land work. Loans have also been used for expenses incurred for funerals and weddings. According to the women, most of the husbands who migrate go to Punjab. There they work as domestic workers or manual labourers for up to 8 years or more. Remittances are sent home every few months, depending on the type of work and the amount earned. The conflict has had a severe impact on migration with women noting that fewer remittances where being sent back as people are too scared to come across. Men are also staying longer to avoid the conflict and others are migrating out of Nepal for the same reason. Men normally return home for big events such a weddings, funerals and during key farming times, as well as when they become sick. The women noted that there is far more external migration to India than internal migration to other parts of Nepal.
The women from the community whose husbands are in India form a solidarity group, they support each other and each other's children if needed. The community cohesiveness is much stronger and the women noted that although orphans were not treated as well as other children, they were always taken in by relatives and always received their share of the property and inheritance.

Government response

The **TEAM hospital** is supported by Canadian missions. It is the only hospital or centre that provides voluntary testing and counselling in Dadeldhura. There have been 16 cases reported for the past 2 years. These are usually referred for testing once a risk assessment is done and always when the patient is already very sick with AIDS. The TEAM hospital supports the purchasing of HIV kits and testing costs R.150 for the first test and a confirmatory test, as well as counselling services. The TEAM hospital is part of the Government structure although its support is predominantly external, it works closely with the district hospital.

DISTRICT REPORTS

The **DCWC** have carried out a survey and collection of all children in Dadeldhura, including the number of orphans supported by UNICEF. Presently there are 351 orphaned children noted in Dadeldhura. This situation analysis was done in 2001. The DCWC have not been very active thus far. They have a plan for the present year, but no funds to run it. Funding from central level has not arrived yet. The plan includes setting up billboards on child rights on 5 key road junctions as well as street drama. They hope to raise the money from local and international NGOs in Dadeldhura. The CDO is chairperson of the DCWC and is often too busy to be able to co-ordinate or organise activities for the DCWC, furthermore, funds are very low.

Meeting with the **district education office** (DEO) noted that here in Dadeldhura, there is also a scholarship fund for lower caste children to maintain them in the school system. Rs.250 per child is given out to cover costs of uniform and stationary. A total of 1,804 scholarships have been distributed.

The previous UNDP supported programme on HIV/AIDS working through the DDC carried out many awareness programmes in Dadeldhura. This is the only HIV/AIDS that has been done in Dadeldhura, but since the funding stopped, activities have not been sustained. During this programme, 6 VDCs set up village AIDS co-ordination committees (VACC) to carry out some awareness on HIV/AIDS with NGOs, VDC members as well as FCHV and some health staff.

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Appendix 3. Methodology

Methodology of assessment

A. Selection of Districts and VDCs

Field work was undertaken in the 5 regions of Nepal: Eastern, Central, Western, Mid-West and Far West. One district in each region was selected for complete profiling. Districts were selected according to the following criteria:

- Presence/absence of UNICEF DACAW program
- High prevalence of HIV/AIDS due to presence of commercial sex workers and intravenous drug users (IDU's)
- Presence of migrant populations

The following districts were selected:
Eastern region – Sunsari
Central region – Chitwan and Kathmandu
Western region – Kaski
Mid West region – Dang
Far West region – Dadeldhura

B. Study Methods

At the District and VDC level, the study methods were primarily qualitative and participatory to best capture different perceptions and views.

C. Study methods at the District level

1. Focus group discussions were be carried out with:
   - District Child Welfare Committee (DCWC)
   - UNICEF staff
   - Commercial sex workers (CSW's)
   - Intravenous drug users (IDU's)

2. Interviews with key informants will be carried out with:
   - District Social Welfare officer
   - District education officer
   - NGOs
   - CBOs
   - District level committees
   - Closed child care homes or orphanages

D. Study methods at the VDC level

The following methods were used at the village level to gather qualitative information on the situation of vulnerable children and coping mechanisms:

1. Focus group discussions with:
   - Children themselves
   - Families and households
   - CSWs and their families
   - IDUs and their families
   - Members of the VDC
2. Interviews with key informants were be carried out with:
   - Children – through the child clubs
   - Caregivers
   - Members of NGOs/CBOs
   - Paralegal committees
   - Women's groups
   - CSW
   - IDU

3. Analysis on support given to orphans and vulnerable children (OVC) in institutions were analysed through discussions with:
   - Closed child care homes or orphanages
   - DCWC members

Appendix 4. People and Organisations met

Persons interviewed and meetings attended in Kathmandu

Name/title/Organisation	Date	Topic (in relation to HIV/AIDS and/or children)
Ian MacLeod Senior Programme Officer UNICEF CO Noriko Izumi Child Protection Officer UNICEF CO	30 July	▪ Overview of the HIV/AIDS epidemic in Nepal ▪ Overview of UNICEF projects and programme at Central and Field levels ▪
Dr. Michael Hahn Country Programme Advisor UNAIDS	30 July	▪ Dr Hanh gave an overview of the HIV/AIDS Epidemic in Nepal and the response by the various stakeholders till now. ▪ Constraints caused by the lack of management capacity of the National Centre for AIDS and STD Control (NCASC) ▪ Content of the revised National Strategy. ▪ A brief introduction of the assessment to be conducted by the Team by Susan took advise on whom the Team should meeti during her present visit
Ian MacLeod Senior Programme Officer UNICEF CO Noriko Izumi Child Protection Officer UNICEF CO	31 July	▪ Susan presented the objectives of the study and had some discussions and revised them ▪ Presented the identified target population to be included for the study ▪ Presented some rough estimation of orphans that the country might face in the coming years. The figures were derived from the exisiting datas in the country

Name/title/Organisation	Date	Topic (in relation to HIV/AIDS and/or children)
Naresh Gurung Head of DACAW section UNICEF CO	1 August	▪ Naresh presented briefly Nepal's Constitutional Bodies from the Central to the local Level and their functions ▪ How DACAW works and its coverage
Bill Musoke UNFPA representative UNTG on HIV/AIDS chair	1 August	▪ Pointed out the positive changes in the political commitment regarding the epidemic in Nepal ▪ In brief the HIV/AIDS situation in Nepal ▪ Susan explained the objective of the study ▪ Further detailed discussion will be done with Dr. Peden from UNFPA who is also responsible for the HIV/AIDS work in Nepal
Anjani Bhattarai HIV/AIDS focal point UNDP	1 August	A very brief introduction on previous UNDP supported HIV/AIDS programme.
Dr. James Ross Country Director FHI	2 August	Dr. Ross gave a research background of the HIV/AIDS in Nepal. He tried to summarize a very realistic picture regarding the various data portrayed in the different studies Future VCT initiatives in FHI
Uddhab Khadga Planning Section UNICEF CO	2 August	Brief meeting to learn about the Nepalinfo and we could use the software for the study. He explained how the team could place the requirements to him and he could work on it. He demonstrated few features of the software

Name/title/Organisation	Date	Topic (in relation to HIV/AIDS and/or children)
Communication Section Team: Wing-Sie-Cheng/Head Chai Chai/ lifeskills consultant Sidhhi Aryal Smriti Aryal	2 August	The team briefed about their communication initiative for young people which comprises of the radio chat program, TV Soap Opera and the supplementary IEC materials. They gave an overview of the Young People of Nepal and their concerns etc and how UNICEF is trying to address it through the life Skill Project. Possibilities were seen by both the teams to use the listeners groups and the chat program as channels to get the children's voice for the assessment
Prakash Tuladhar F.O. Chief Eastern Region UNICEF CO	2 August	Prakash gave an overview of the division of the various regions, its ethnic groups, district covered by the DACAW, structure of staffing etc. Detailed information on how the DACAW regions implement the activities and their partiners especially in the Eastern Region Charted out who could be the possible informants for the assessment
Gauri Pradhan Director Tara Nath/ Advocacy CWIN	5 August	Tara Nath briefed on CWIN,s Program Both the team talked about the possiblilities of using some of the channels of CWIN to get the voice of the Street Children for the assessment
Cathy Thompson Head of Health USAID	5 August	Susan briefed about the study. Cathy was keen for a de-brief before Susan left. They shared the USAID's new strategy. She informed about their suppport to SCF/US for a pilot project regarding 22 AIDS orphans in Kanchanpur
Dr. Mishra Director/ NCASC Dr. Digvijay Rana Dr. Dhruva Singh	6 August	Dr. Mishra talked about the revised strategy and its implementation plans and the time frame. He positively talked about the exisitng political will for the issue. He informed that CIPLA company of India has committed to supply free Nevripane to Nepal. He talked about the Government's VCT program in the 28 distri ct and its need and importance for the future. Susan talked about the assessment but there might be a need for further debriefing.

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Vijay Raj Bhattrai Secretary Ministry of Women and Children Social Affair Ritu Raj Bhatta Sudha Neupane	6 August	It was a brief meeting but he wants to support the assessment by facilitating the meeting with the Child Welfare Committees in the Districts where the assessment is being done. The Child Welfare Commitees comprises of the CDO as the Chairperson and other line Ministries as members and also has representation of few NGOs. This would be a good forum for advocacy purpose too
Alex Harp Deputy Director DFID	7 August	Talked about the epidemic in Nepal and DFID's commitment through the 'Nepal Initiative' which is a multidonor basket fund. Alex gave a very clear picture of the insurgency in Nepal and how possibly donors could successfully carry on their future program being sensitive to this issue. He was showed keen interest on the orphan issue. The relationship between the conflict situation and development work and the need to take this into account
Dr. Arju Deuba Honorary Chair-person Safer Mother Network RUDWC NGO	7 August	She was very informative in regards to women's status in the Country. She gave us the detail about the work RUDUC, their NGO is doing in Dadeldhura. She personally feels that Orphans are one of the most vulnerable groups to address in this country and they are going to increase. She also shared some research documents they have done regarding orphans.
Dr. Narayan Khadga Vice Chairperson National Planning Commission	7 August	Susan briefed about the assessment. He felt this was an upcoming serious issue for the country to look at. He was ready to support the study and its finding in anyway he could
Frances Winter Social Development Advisor DFID	13 August	DFID social development programme Different community based organisations and their functions
KARUNA Hospice for women and children	14 August	Hospice caring for mainly women living with HIV/AIDS, either drug users or sex workers and also some children living with HIV/AIDS
Mahesh Bhattarai Director GWP (General Welfare Prathistan)	15 August	Programme that works closely with groups that engage in high risk behaviour such as transport drivers, sex workers and drug users nationwide

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Komal Sharma Nirmala Adhikari SCF UK CO	15 August	SCF UK programme in Acham district and in Sunsari district working with a net work of volunteers to disseminate information and awareness on HIV/AIDS
Savitra Pandey Bal Mandir orphanage	15 August	The situation of children in the orphanage Number of children and the activities carried out by Bal Mandir Efforts for reintegration and reunification
Deepak Sapkota Executive Director Central Child Welfare Board	15 August	Mandate of the CCWB New membership of the board Organise district meetings with the DCWC members
Chandra Kant Jha CARE Nepal	15 August	Working in Bhajang and Doti supported by FHI on integrated programme including HIV/AIDS
Bobbi Limbu Director LALS	15 August	Working with IDU on harm reduction programme and needle exchange Education and awareness Counselling services and condom distribution
Abhiyan Rana ECD Project Officer UNICEF CO	15 August	Situation of birth registration in Nepal and UNICEF programme on ECD Situation of the Badi community in the mid west
Charu Biste Programme Assistant ILO	16 August	Have worked together with UNAIDS on HIV/AIDS in the workplace Have carried out various studies on vulnerable child labourers (IPEC)
Inda Lal Singh F.O. Chief Central level office UNICEF CO Sabina Joshi APO Central Office UNICEF CO	16 August	Brief about the research to be carried out in the Central Region Selection of district in which to carry out research Organisation of the visit
Vijay Rajkumar HIV/AIDS regional advisor SCF UK regional office	02 September	Brief about the UNICEF study SCF regional are looking to do something similar in Acham and possibly Doti which could complement the UNICEF findings as well as in the region

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Shobha Khadga National Programme Officer, Centre for Harm Reduction	03 September	Work in awareness raising Drug prevention programmes Counselling, needle exchange and training
Iwana Lohar Richmond Fellowship programme for women	03 September	Richmond has a shelter for women drug users – most vulnerable Many of the women are HIV + Work with women drug users in KTM valley Work with women sex workers and IDU
Raju Outreach worker Richmond Fellowship programme for women	04 September	Gave his first hand experience of drug use, IDU and how he gave up Explained his part as an outreach worker and how he helps others
PRERNA Association of people living with HIV/AIDS	04 September	Activities carried out by PRERNA Membership of PRERNA Social stigma against PLWHA
Ujwal Karmacharya Richmond Fellowshop programme for men	05 September	Drug rehabilitation programme for male drug users Drop in centre Counselling services Outreach activities to drug users in the community
Doris Grote HIV/AIDS regional advisor UNICEF regional office	06 September	Brief about the study and the progress to date Collect information and material for the study from the regional office
Sita Ghimire Project Officer Save the Children Norway	10 September	Brief about the UNICEF study SCF Norway are starting to work in the area of HIV/AIDS and would like to do something with children They want to start doing a compilation of who does what
Shibesh Regmi Director ActionAid Nepal	10 September	Planning on HIV/AIDS activities within ActionAid as a priority Promoting support for PLWHA across the country in the areas that work in Would like to carry out research on HIV/AIDS related to migration
Sapna Malla Lawyer Forum for women, Law and Development	30 September	Reforms incorporated into the country code for women's rights Lobby and advocacy for women's rights Carried out research on laws in relation to HIV/AIDS
Savitri Pandey Bal Mandir	10 September	How do orphaned children come to the orphanage. Where are the children found and who brings them to the orphanage

Persons interviewed and meetings attended in the districts

Name/Title of organisation	Date	Topic (in relation to HIV/AIDS and/or children)
SUNSARI		
Prakash Tuladhar Chief of Field Office Eastern region UNICEF CO Bhanu Pathak Assistant Project Officer Eastern region UNICEF CO	19 August	Briefing on HIV/AIDS assessment to be carried out in Sunsari Assistance from Eastern region office for organising and co-ordinating the visit including accompaniment by Bhanu Pathak
Dr. Samsuddin Bishnu Sharma Help Group Nepal Biratnagar	19 August	HIV/AIDS prevention Harm Reduction awareness for IDU Awareness on trafficking
Ram Yakhkhya President Community service Centre Itahari	19 August	HIV/AIDS awareness and training with female sex workers, IDUs and other vulnerable groups
Women Federated Groups Syniya VDC	19 August	Credit and savings scheme for the women members
Paralegal committee Bhasi	19 August	Issues of violence against women Girl trafficking Mediate local conflicts Carry out trainings on CRC and CEDAW
Mr. Khila Nath Niraula Programme Co-ordinator FOHREN 2 UOSP	20 August	Out of school child club with vulnerable children, mostly child workers
Poonarjeevan Kenda Bijaya Limbu Programme Co-ordinator Drug Rehabilitation Centre Dharan Municipality	21 August	Rehabilitation of IDU Work with people living with HIV/AIDS Counselling services Narcotics Anonymous Harm reduction programme Outreach programme for drug users
Meena club in school	21 August	Child club Help raise money for needy children Prepare awareness booklets and wall newspapers on different issues

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G.B Adhikari ActionAid Biratnagar	22 August	Carried out baseline survey on HIV/AIDS Integrated HIV/AIDS into AA work Awareness raising for women, SW, IDU, rickshaw pullers Support Morang DDC HIV/AIDS programme Want to set up a PLWHA association together with the Drug Rehabilitation Centre in Dharan
Chief District Officer and chairperson of the DCWC	22 August	Carried out survey to register all disabled children Working with the NGO cc to carry out survey on identifying all children
District Education Officer	22 August	Scholarship scheme for Dalit children Compilation of all children in and out of school by VDC for Sunsari
District Health Officer	22 August	No programme on HIV/AIDS No provisions or subsidies for medicines and treatment for the very vulnerable Blood bank in Biratnagar screens blood
Ms. Usha Koirala Project Co-ordinator HIV/AIDS Morang district DDC	23 August	Awareness, IEC and advocacy activities on HIV/AIDS in the district with vulnerable groups
KASKI		
Sundar Gurung Field Office Chief Western Region UNICEF CO Shanta Kadghi Assistant Project Officer Western Region Office UNICEF FO	26 August	Briefing on HIV/AIDS assessment and organisation during the visit
Mr. Rajendra Adhikari SEDA	26 August	Awareness on HIV/AIDS and STD Work with sex workers Counselling and testing STD treatment Outreach work
Mr. Khem Raj Sapkota Branch manager Red Cross Nepal	27 August	Programme in schools on HIV/AIDS awareness with youth and peer education Screening of the blood bank for HIV/AIDS

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Bishwa Rai – AIDS care officer Som Lal Ojha – Rehabilitation officer International Nepal Fellowship (INF)	27 August	Drug rehabilitation programme HIV/AIDS awareness Voluntary testing and counselling Harm reduction programme Family counselling
Ramesh Raj Pondel Heading the NGO on Prevention of Drug Abuse and ex-DDC chairperson	28 August	Awareness on drug prevention Some components on HIV/AIDS Targeting women's groups, teachers, communities
Women's group Ward 2, Pokhara municipality	28 August	Day care centre for children Credit saving scheme
Woman's group Supported by Red Cross Lekhnath municipality	29 August	Collection of funds and saving scheme to assist vulnerable children to enrol in schools and other activities
Child Welfare Scheme – vocational training centre	29 August	Child day care centres Vocational training centre for vulnerable youth, especially street children
Women's development Office	29 August	Micro-credit programmes and saving schemes for women's groups Baseline surveys of vulnerable HH to access credit
AIDS control organisation NGO made up of voluntary members from the district/teachers, doctors, lawyers etc..	30 August	Training and awareness on HIV/AIDS with teachers, schools, mothers groups
Mr. Shiva Sharma Children Nepal Meeting with the Children Nepal child club	30 August	Works with vulnerable children such as street children, child labourers etc. Child clubs with children Transit centre Work with communities on awareness Helps identify and assist vulnerable children
Deepak Sapkota – executive director (central level) Tika Ram Aryal – CDO Helamba Koirala - Chairperson DCWC members	31 August	District Child Welfare Committee is responsible for co-ordinating issues on all vulnerable children in the district

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CHITWAN		
Lilendra Joshi Assistant project officer Central region office UNICEF CO	12 September	Accompanied the delegation to Chitwan
Community Legal Resource Centre (CLRC) Bharatpur Paralegal committee	12 September	Works with women on issues of violence and abuse
General Welfare Pratisthan (GWP)	13 September	Peer education and training on HIV/AIDS Outreach work with FSW and their clients on major highway routes IEC production and development Condom promotion and distribution IDUs – drop in centre Awareness programmes and counselling
NGO cc VDC facilitators	13 September	Co-ordination of national organisations in the district
OSP Bacheuli VDC	14 September	Out of school programme for vulnerable children
Women's group Bacheuli VDC	14 September	Savings and credit scheme Adult literacy Weighing of children/ECD
OSP indigenous children	14 September	Out of school child club for the lower caste children
Local Development Officer	14 September	Heading the DACC, however no activities have been carried out
District Public Health Officer	14 September	
DANG		
Anita Dahal District Field Officer Dang district UNICEF CO	18 September	Accompanied during the visit and survey and translated
Woman's group Dhikpur VDC – in Gohari	18 September	Woman's group members of lower caste Co-ordinated by the WDO structure Saving and credit scheme
Mr. Kumar Shrestha Member secretary of DCWC	18 September	DCWC carry out awareness programmes on child rights
Ms. Maya Lohani Woman's Development Officer	18 September	Improve economic situation of women through institutional development programmes and women's groups

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Hari Prasad Pande – administrator Prakash Bisnu Ravana – focal point for UOSP Subodhreg – facilitator for UOSP Tribhuvan municipality	19 September	Co-ordination of the UOSP classes for children out of school in that municipality
UOSP children	19 September	Children from the urban out of school programme, mostly vulnerable children from lower caste
Rarishi Raj Jungali – ex president Birmala Yogi – Secretary Menuka Giri – Office secretary NGO cc	19 September	Carry out district wide awareness programmes when supported by different NGOs Carried out awareness for 1st December Distribution of posters and pamphlets on different issues
Sabita Regmi – nurse Laba Shrestha – male counsellor Family Planning Association	19 September	STD treatment and counselling ANC programmes Youth peer education programmes Reproductive health, including HIV/AIDS awareness
Nima Nadabhusal Primary education co-ordinator District Education Office	19 September	Scholarships for children of the dalit caste Few teachers have been trained on HIV/AIDS
Prabhu Raj Poudyal Strategic Planning HIV/AIDS advisor RUPP (Rural-Urban Partnership Planning)	19 September	Mainstreaming HIV/AIDS into RUPP programmes Carry out training on HIV/AIDS with community groups
Sarb Deogha Local Development Officer	20 September	Member of the DACC
Shiba Yogi – outreach worker Nimkang Regimi – outreach worker GWP – General Welfare Prathistan	20 September	Work with transport drivers, FSWs, hoteliers Drop in centre for counselling on HIV/AIDS and STD Peer education training and activities Case management of STD
Woman's group Lalmatiya VDC	20 September	Members are mostly from the Chaudhary caste – lower caste Savings and credit scheme for members of the group as well as loans to members of the community Credit is used for IGAs
OSP Lalmatiya VDC	20 September	Members of the out of school child club are also part of the lower caste
District Health Officer	21 September	Member of the DACC The DACC is not functioning anymore

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Nabarang Lamichane – chairperson and member of DCWC Kumar Schaha – treasurer Sita Dhital – general secretary Tika Ram Khadka – supervisor of the hostel Nabjagaran Bal Ashram orphanage Children from the hostel	21 September	Orphanage and hostel for vulnerable children, mainly from the lower caste
Indra Chaudhary – warden Krishna Nepali – Accountant Janak Bishnu Karma – project manager Badi girls hostel FGD with the girls	21 September	Hostel and orphanage for girls from the Badi community
Nepalgunj – BANKE		
Suk Lal Nepali SAFE	22 September	Working with the Badi community to eliminate caste discrimination, eliminate child prostitution and provide skills to children for education and further education or vocational training
Meeting with members of the Badi community	22 September	2 committees that lobby for the rights of the Badi community Discourage Badi women from getting into sex work Try and find other forms of employment for Badi women and girls
Badi girls hostel	22 September	The hostel provides education and lodging for girls from the Badi community and other lower caste communities
Dr. G. Raj. Shakya N'SARC and STD clinic	22 September	NGO works on HIV/AIDS awareness STD treatment Testing surveillance site Works with people living with HIV/AIDS in terms of follow up
Nepalgunj		
Rajendra Shakya Field Office Chief Mid/Far West Regional office UNICEF CO	23 September	Briefing on the assessment and what are the plans for Dang and Dadeldhura

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DADELDHURA		
Gopal Thapa District Field Officer Dadeldhura district UNICEF CO	23 September	Briefing of the visit and accompaniment and translation for the duration of the visit
Woman's group Nabadurga VDC	24 September	Women's group have carried out trainings on CRC and CEDAW, growth monitoring of children, credit and saving schemes
Community Medical Assistant Nabadurga VDC health post	24 September	
Ex - DDC chairperson	24 September	Was formerly involved in the previous UNDP programme
Dave and Randy from the TEAM hospital	24 September	Carry out voluntary testing and counselling on HIV/AIDS STD diagnosis and treatment Subsidised or free treatment for very vulnerable populations, including children
RUDWC NGO	25 September	Work on violence against women programme IGA programmes for women School scholarship programmes for vulnerable children Birthing centre
Facilitators of the UOSP	25 September	Facilitators of the urban out of school programme for vulnerable children
Bed Prakash HIV/AIDS counsellor TEAM hospital	25 September	TEAM and the previous UNDP programme had designed a risk assessment counselling guidelines for counsellors on HIV/AIDS
Lok Raj Paneru District Health Officer	25 September	
CDO and chairperson of the DCWC	25 September	The DCWC has not been very active In 2001 a situation analysis on vulnerable children was carried out Activities mostly include awareness on children's rights
Shiva Raj Upreti District Education Officer	25 September	Scholarship programme for Dalit children
Programme officer and focal point for HIV/AIDS in DDC	25 September	Not much HIV/AIDS work done since the ending of the UNDP supported programme

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Village facilitators supported by the UNICEF programme	25 September	Have had training on HIV/AIDS
Laxmir Devi Manhal – RUDWC programme officer Hira Devi K.C – Rishi Kola and Heranti NGO as part of the forestry committee	25 September	Training on women's rights and gender Programmes on violence against women Campaigns and awareness raising mostly on women's issues
Anita Aair Woman's Development Officer	25 September	Nutrition programme Child care centres Women's groups Working against discrimination of women
Member of the woman's deliverance society (WDS)	25 September	Saving and credit programme for women Violence against women Gender training
Bhuban Aryal Local Development Officer and chairperson of the DACC	25 September	No programmes on HIV/AIDS since the end of the UNDP supported programme
Nepalgunj		
Bipul Basnet APO – Mid/far West office Surendra Rana APO – Mid/far West office Amir Rajbhandari APO – Mid/far West office Maduri Sharma Project Assistant Mid/far West Office	25 September	De-brief of the visit to Dang and Dadeldhura