Survey Response Details

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Response Details

Page 1

1) Country

Nepal (0)

2) Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:

Mr. Sanjay Rijal

3) Postal address:

Rani Marg, Baluwatar, Kathmandu Nepal

4) Telephone:

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977-1-6227566, 977-1-4431042

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info@hivboardnepal.org

7) Date of submission:

Please enter in DD/MM/YYYY format

21/03/2010

Page 3

8) Describe the process used for NCPI data gathering and validation:

Government representative including DACC coordinators and Civil society representative from thirteen districts were invited into a workshop in Butwal (Dec 11 for Govt. officials and Dec for 12, 2009) and in Kathmandu on Dec 28 for Govt officials and 29 for Civil society representatives, where the process and UNGASS 2010 reporting requirement were shared along with the process and feed

back received in 2008 UNGASS report. The representatives agreed that the best way to complete the NCPI is through a “consensus” building process where every question would be discussed, debated and agreed by consensus. Though it took considerable time in debating on the questions, ultimately consensus was reached in each and every question. The whole process was both an interactive and a learning exercise where participants had opportunity to challenge, understand deeper and debate on issues and indicators. The details of the processes can be found in Annex 2.

9) Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:

This is the first time that such consultation was done outside the capital city (Kathmandu) and answers to NCPI questions were gathered. As described above, it was done by consensus after debate and discussion; the differences were resolved on the spot. The challenge however was combining the differences views from two consultations (Butwal and Kathmandu consultations) brought about by different players and with different perspective, into one – as there is no provision to report regional NCPI separately. The differences in scoring and answers were resolved by the following processes o During Kathmandu consultation which was organized after the regional one, the differences were shared with the larger group. o The reasons for such differences were discussed; is it because of factual information gap, (e.g. number of VCT, ART sites) or was it due to wrong understanding of certain information and function (e.g. function of ICC and VCT). o If it is factual differences, it is corrected jointly based on facts and figures. If the differences are related to the quality of services, availability of services, local policy and attitudes of authority, and other subjective views etc, differences are reported in comment sections, if resolution was not reached. For civil Society o A team consisting of civil society representatives looked into all the answers from both consultations in detail and marked differences between Kathmandu and Butwal answers and followed the same process as described above.

10)

Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):

o Majority felt that there is gap between Kathmandu (capital) and Butwal (region) mainly in access to information and level of engagement of civil society. Therefore, chances of misinterpretation are high. o Many information are centralized and there is no regional mechanism to carry out a regional analysis for local use. o Though programme reporting from the field is initiated by CSOs based on their work, but they are not engaged in analyzing and using such information.

Page 4

11)

NCPI - PART A [to be administered to government officials]

	Organization	Names/Positions	Respondents to Part A [Indicate which parts each respondent was queried on]
Respondent 1	Army Hospital	Dr. Sudarshan Lal Rajbhandari/ Brigadier General	A.I, A.II, A.III, A.IV, A.V

12)

	Organization	Names/Positions	Respondents to Part A [Indicate which parts each respondent was queried on]
Respondent	National Public	Mr. Purushottam Poudyal /Senior	A.I, A.II, A.III, A.IV, A.V

2	Health Laboratory	Medical Technologist	A.I, A.II, A.III, A.IV, A.V
Respondent 3	Ministry of Home Affairs	Mr. Sunil Khanal/Section Officer	A.I, A.II, A.III, A.IV, A.V
Respondent 4	District Public Health Office	Mr. Bisworam Shresthra/Chief	A.I, A.II, A.III, A.IV, A.V
Respondent 5	Ministry of Tourism	Mr. Guna Raj Shrestha/Legal Officer	A.I, A.II, A.III, A.IV, A.V
Respondent 6	Ministry of Local Development	Ms. Urmila Kaphle/Section Officer	A.I, A.II, A.III, A.IV, A.V
Respondent 7	Nepal Police Hospital	Ms. Meera Thapa	A.I, A.II, A.III, A.IV, A.V
Respondent 8	Armed Police Force	Mr. Birendra Khanal/Inspector	A.I, A.II, A.III, A.IV, A.V
Respondent 9	Ministry of Education	Mr. Keshar Mohan Bhattarai/ Under Secretary	A.I, A.II, A.III, A.IV, A.V
Respondent 10	Ministry of Law and Justice	Ms. Indira Dahal/ Under Secretary	A.I, A.II, A.III, A.IV, A.V
Respondent 11	HIV AIDS and STI Control Board	Mr. Damar Prasad Ghimire/Director	A.I, A.II, A.III, A.IV, A.V
Respondent 12	HIV AIDS and STI Control Board	Ms. Durga Mishra/Policy Officer	A.I, A.II, A.III, A.IV, A.V
Respondent 13	HIV AIDS and STI Control Board	Ms. Madhu Koirala/Programme Coordinator	A.I, A.II, A.III, A.IV, A.V
Respondent 14			
Respondent 15			
Respondent 16			
Respondent 17			
Respondent 18			
Respondent 19			
Respondent 20			
Respondent 21			
Respondent 22			
Respondent 23			
Respondent 24			
Respondent 25			

13) If the number of respondents to Part A is more than 25, please enter the rest of respondents for Part A in below box.

Participants in Region Consultations: Organization Name/Position WRHD, Pokhara Dr. Ashok Kumar Chaurasia /Director WRHD, Pokhara Dr. Pritam Kumar Sharma /Sr. Ayurved Officer DACC Gulmi Ms. Gita Aryal /Coordinator DHO Arghakhanchi Mr. Lilambar Rayarajmi /Public Health Inspector DHO Baglung Mr. Arjun Kumar Adhikari /Sr. Public Health Admin DACC Rupandehi Mr. Basanta M. Pokharel /Coordinator DACC Baglung Mr. Khadak Bdr Thapa /Coordinator DDCO

Baglung Mr. Bhesha Raj Sharma /Program Officer Manipal College Dr. Manu Shamsher Rana /Assistant Professor DHO Baglung Mr. Jeevan Shakya /Public Health Inspector DACC Lamjung Mr. Bishnu Bhadur Thapa /Program Coordinator DPHO Lamjung Mr. Laxman Basaula /HIV Focal Person DDC Lamjung Mr. Meghendra Pokharel /Program Officer DPHO Lamjung Mr. Tanka Prasad Chapagain /Sr. PHO DPHO Rupandehi Mr. Thaneshor Kharel /Sr. Assistant Health Worker DDC Gulmi Mr. Binod Marasini /Program Officer DDC Arghakhanchi Mr. Netra Khanal /Program Officer DHO Kapilvastu Dr. Anant Kumar Sharma /Medical superintendent DACC Kaski Mr. Kirti Sagar Baral /Coordinator DPHO Kaski Mr. Rajendra Prasad Poudel /Health Assistant Officer DPHO Rupandehi Mr. Ramchandra Kharel /Sr. Public Health Admintr DDC Rupandehi Mr. Durga Prasad Shrestha /Program Officer DACC Arghakhanchi Ms. Bhima Parasuli /Coordinator DHO, Kapilvastu Mr. Vishnu Poudel /Focal Person DDC Mr. Rajan K. Pokharel/Information officer/Focal person DHO Gulmi Dr. Anang Pangeni /Act. DHO DHO Tanahun Ms. Saraswati Paudel /Coordinator DHO, Arghakhanchi Dr. Chitra Prasad Sharma /District Heath Officer

14)

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

	Organization	Names/Positions	Respondents to Part B [Indicate which parts each respondent was queried on]
Respondent 1	NRCS	Dr. Manita Rajkarnikar/Blood Transmission Service Director	B.II

15)

	Organization	Names/Positions	Respondents to Part B [Indicate which parts each respondent was queried on]
Respondent 2	NANGAN	Ms. Tulasa Lata Amatya/President	B.II
Respondent 3	NAP+N	Mr. Sudin Sherchan/National Coordinator	B.III, B.IV
Respondent 4	Save the Children	Mr. Rabindra Bahadur Thapa/ Project Officer	B.III, B.IV
Respondent 5	UNICEF	Mr. Tara Banjade/Consultant	B.III, B.IV
Respondent 6	UNAIDS	Ms. Bina Pokharel/Senior Programme Coordinator	B.I
Respondent 7	NRCS	Mr. Bal Krishna Sedai/Senior Officer	B.III, B.IV
Respondent 8	NANGAN	Mr. Dal Bahadur G.C./Programme Coordinator	B.I
Respondent 9	NFWLHA	Mr. Krishana Gyanwali/Programme Coordinator	B.II
Respondent 10	FHI	Mr. Satish Raj Pandey/FHI-ASHA Project Deputy Director	B.III, B.IV
Respondent 11	WHO	Dr. Atul Dahal/National Programme Officer	B.III, B.IV
Respondent 12	USAID	Ms. Shanta Gurung/Programmme Coordinator	B.II
Respondent 13	Corporate Social Consortium	Ms. Reena Lama/Programme Manager	B.I
Respondent	Corporate Social		

Respondent 14	Corporate Social Consortium	Mr. Miraz Roshan/MD	B.III, B.IV
Respondent 15	FPAN	Ms. Sangita Khatri/HIV Focal Person	B.II
Respondent 16	UNDP	Mr. Dip Narayan Sapkota/Programme Officer	B.I
Respondent 17	Nepal HIV/AIDS Alliance	Mr. Rishi Ojha/President	B.III, B.IV
Respondent 18	Recovering Nepal	Mr. Rajesh Agrawal/Vice chair	B.II
Respondent 19	Recovering Nepal	Mr. Subash Rai/Member	B.I
Respondent 20	Nepal Harm Reduction Council	Mr. Bijay Pandey/Chair person	B.II
Respondent 21	Care Nepal	Mr. Arjun Aryal/Advisor	B.I
Respondent 22	Youth Vision	Mr Sushil Khatri/ Coordinator	B.III, B.IV
Respondent 23	Blue Diamond Society	Mr Jagadish Prasad Pant/ Admin Assistant	B.I
Respondent 24	FWLD	Rup Narayan Shrestha/Advocate	B.I
Respondent 25			

16) If the number of respondents to Part B is more than 25, please enter the rest of respondents for Part B in below box.

Participants in Region Consultations: Organization Name/Position Prerana Butwal Mr. Rajendra Upreti /Project Officer Nauloghumti Butwal Mr. Rajendra Bandnu Aryal /Program Coordinator Nava Kiran Plus Mr. Arjun Gyawali /Program Coordinator Blue Diamond Society Butwal Mr. Chals Bon Sijapati /Program Supervisor Prerana Arghakachi Mr. Dharma Raj Upreti /Program Supervisor Rural Community Development Center Mr. Rajendra Bohara /Chairperson Lamjung Shayogi Mr. Sadhuwam Pandit /Chairperson Community Support Group Mr. Dilip Gurung /Executive Director DPS Baglung Ms. Chadrik Devi Pathak /CM A.M.K Baglung Ms. Nunu Maya Thapa Magar /Program Coordinator Sakriya Mr. Hari Aryal /Coordinator Sakriya Sewa Samraj Mr. Bal Krishna Khatri /Project Coordinator Namuna KPL Mr. Ram Prasad Adhikari /District Coordinator INF Paluwa Kaski Mr. Bishwa Rai /Section Manager INF Paluwa Baglung Mr. Gyanendra Prasad Tripathi /Center In-Charge NANGAN Western Region Mr. Bishow Mohan Gauchan /Coordinator Oppressed and Trible Caste Development Council Mr. Bharat Boko /Field Coordinator Sandesh Sayog Samuha Ms. Birpana Thapa /Vice-Chair Sungawa Community Development Mr. Krishna Maya Karki /Joint Secretary Youth Vision Drug Treatment Rehabilitation Center Mr. Rajiv KC /Coordinator Youth Vision OST Program Mr. Bishal Gurung /Counselor MSMG Nepal Bhairawa Mr. Ashesh Rijal /Project Officer Centre for Rural Community Development Rupandehi Mr. Mukti Ram Pokharel /Executive Director Himalayan Association against STI-AIDS (HASTI) Ms. Rusha Aryal /Project Coordinator NAMUNA Rupandehi Ms. Gyanu Poudel /Chaiperson FPAN Rupendehi Ms. Niru Bajracharya /Supervisor NARDEC Gulmi Mr. Ram Bahadur Kunwar /Program Coordinator NEHA Gulmi Mr. Resham Kunwar /Member

Page 5

17)

Part A, Section I: STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes (0)

Page 7

18) **Part A, Section I: STRATEGIC PLAN**

Question 1 (continued)
Period covered:

2006-2011

19)

1.1 How long has the country had a multisectoral strategy?

Number of Years

10

20)

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

	Included in strategy	Earmarked budget
Health	Yes	Yes
Education	Yes	Yes
Labour	Yes	Yes
Transportation	Yes	Yes
Military/Police	Yes	No
Women	Yes	Yes
Young people	Yes	Yes
Other*	Yes	Yes

Page 8

21) **Part A, Section I: STRATEGIC PLAN**

Question 1.2 (continued)
If "Other" sectors are included, please specify:

Ministry of Home Affairs

22)

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

Mainstreaming HIV in other sector remains challenge in the country. Given the concentrated epidemic, most sectors may not be relevant for the mainstreaming the issue. Nonetheless, HIV/AIDS strategy and NAP aims to reach out in those sectors. Education – budget not adequate

(included only for teacher training) Most sectors have included/mainstreamed HIV in their regular activities (i.e. mostly in training related activities) but no specific budget allocated for HIV. Recently government has set up Ministry of Youth where HIV issues and some budgetary provision is reflected in the national youth strategy.

Page 9

23)

Part A, Section I: STRATEGIC PLAN

1.3 Does the multisectoral strategy address the following target populations, settings and crosscutting issues?

Target populations	
a. Women and girls	Yes
b. Young women/young men	Yes
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex workers	Yes
f. Orphans and other vulnerable children	Yes
g. Other specific vulnerable subpopulations*	Yes
Settings	
h. Workplace	Yes
i. Schools	Yes
j. Prisons	Yes
Cross-cutting issues	
k.HIV and poverty	Yes
l. Human rights protection	Yes
m. Involvement of people living with HIV	Yes
n. Addressing stigma and discrimination	Yes
o. Gender empowerment and/or gender equality	Yes

24)

1.4 Were target populations identified through a needs assessment?

Yes (0)

Page 10

25)

Part A, Section I: STRATEGIC PLAN

Question 1.4 (continued)
IF YES, when was this needs assessment conducted?

Please enter the year in yyyy format

2000

Page 11

26)

Part A, Section I: STRATEGIC PLAN

1.5 What are the identified target populations for HIV programmes in the country?

MARPS Female/male sex workers (and their clients) Injecting Drug Users (and spouse) Men having sex with Men Mobile (including both external and internal migrants) populations and their spouse At risk population Prison population Youth (10 -24 yrs) Uniformed Services Trafficked Girls Vulnerable population OVC Street children PLHIV Though not a MARPs, but recognized as group needing special attention

27)

1.6 Does the multisectoral strategy include an operational plan?

Yes (0)

28)

1.7 Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	Yes
b. Clear targets or milestones?	Yes
c. Detailed costs for each programmatic area?	Yes
d. An indication of funding sources to support programme?	Yes
e. A monitoring and evaluation framework?	Yes

29)

1.8 Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?

Active involvement (0)

Page 12

30)

Part A, Section I: STRATEGIC PLAN

Question 1.8 (continued)
IF active involvement, briefly explain how this was organised:

• Civil Society were member in Strategy Development Task Force: 7 members from civil society out of 25 members • Additional civil society were members in Strategy Development Subgroups (i.e. Prevention, Treatment etc) during the strategy development • Wider civil society organizations were involved during national consultations, mini consultations, and during regional consultations. • Active involvement during drafting period and reviewing the draft before finalization. • Active engagement of civil society during the development of National Action Plan (2008-2011). • Civil society were also actively engaged during development of other strategies like National Advocacy Strategy of HIV/AIDS, National Advoacy Strategy for Reduction of Transmission of HIV among IDU/DU.

31)

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes (0)

32)

1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners (0)

Page 14

33)

Part A, Section I: STRATEGIC PLAN

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes (0)

Page 15

34)

Part A, Section I: STRATEGIC PLAN

2.1 *IF YES*, in which specific development plan(s) is support for HIV integrated?

a. National Development Plan	Yes
b. Common Country Assessment / UN Development Assistance Framework	Yes
c. Poverty Reduction Strategy	Yes
d. Sector-wide approach	Yes
e. Other: Please specify	

35)

2.2 *IF YES*, which specific HIV-related areas are included in one or more of the development plans?

HIV-related area included in development plan(s)	
HIV prevention	Yes
Treatment for opportunistic infections	Yes
Antiretroviral treatment	Yes
Care and support (including social security or other schemes)	No
HIV impact alleviation	No
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	No
Reduction of income inequalities as they relate to HIV prevention/treatment, care and/or support	No

Reduction of stigma and discrimination	No
Women's economic empowerment (e.g. access to credit, access toland, training)	No
Other: Please specify	

Page 16

36)

Part A, Section I: STRATEGIC PLAN

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

No (0)

Page 17

37)

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes (0)

Page 18

38)

Part A, Section I: STRATEGIC PLAN

4.1 *IF YES*, which of the following programmes have been implemented beyond the pilot stage to reach a signifi cant proportion of the uniformed services?

Behavioural change communication	Yes
Condom provision	Yes
HIV testing and counselling	Yes
Sexually transmitted infection services	Yes
Antiretroviral treatment	Yes
Care and support	Yes
Other: Please specify	

Page 19

39)

Part A, Section I: STRATEGIC PLAN

Question 4.1 (continued)
If HIV testing and counselling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g, indicate if HIV testing is voluntary or mandatory etc):

Test mandatory before departure and arrival from Peace Keeping deployment, Foreign training. But the result of such test is not used to bar or restrict or take any action regarding job placement, promotion and discontinuity of job. Countries receiving peace keeping force requested (through UN) to send peace keepers only if they are healthy. Even if found HIV+ they are not barred from deployment in peace keeping force as long as their health condition allows.

40)

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

No (0)

Page 21

41)

Part A, Section I: STRATEGIC PLAN

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Yes (0)

Page 22

42)

Part A, Section I: STRATEGIC PLAN

6.1 *IF YES,* for which subpopulations?

a. Women	No
b. Young people	No
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex Workers	Yes
f. Prison inmates	Yes
g. Migrants/mobile populations	No
Other: Please specify	

43)

IF YES, briefly describe the content of these laws, regulations or policies:

In free health care policy 2009, PLHIV is not included as the target beneficiaries. In Nepal, single women only above 60 years have the facility of single women allowance whereas most PLHIV single women are aged between 20-35, therefore are not eligible for single women allowance Narcotic Drug Control Act contradicts with Drug Control Policy and Harm Reduction Programme. As mentioned in UNGASS report 2008, obstacles have remained the same. No major changes were observed during this reporting period except that the TG is legally recognized as third gender by supreme court. Now National Citizenship Card will have three options in “sex” column i.e. Male, Female, Third Gender (TG).

44)

Briefly comment on how they pose barriers:

This has implications on resource allocations and open and free access to services.

Page 23

45)

Part A, Section I: STRATEGIC PLAN

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes (0)

Page 24

46)

Part A, Section I: STRATEGIC PLAN

7.1 Have the national strategy and national HIV budget been revised accordingly?

No (0)

47)

7.2 Have the estimates of the size of the main target populations been updated?

Yes (0)

Page 25

48)

Part A, Section I: STRATEGIC PLAN

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs (0)

49)

7.4 Is HIV programme coverage being monitored?

Yes (0)

Page 26

50)

Part A, Section I: STRATEGIC PLAN

Question 7.4 (continued)
(a) IF YES, is coverage monitored by sex (male, female)?

Yes (0)

51)

(b) IF YES, is coverage monitored by population groups?

Yes (0)

Page 27

52)

Part A, Section I: STRATEGIC PLAN

Question 7.4 (b) (continued)
IF YES, for which population groups?

FSW/MSW and their clients, IDUs, MSM, Migrants, Spouse of Migrants.

53)

Briefly explain how this information is used:

Prepare scaling up plan including Procurement plan.

Page 28

54) **Part A, Section I: STRATEGIC PLAN**

Question 7.4 (continued)
(c) Is coverage monitored by geographical area?

Yes (0)

Page 29

55)

Part A, Section I: STRATEGIC PLAN

Question 7.4 (c) (continued)
IF YES, at which geographical levels (provincial, district, other)?

Country is divided into four epidemic zones and monitoring is done accordingly by zone. Routing programme reporting however is monitored by Districts and by service site.

56)

Briefly explain how this information is used:

Information are used mainly for planning and resource mobilization (i.e. while preparing proposal like GFATM and other) besides using such information for diverse use (advocacy, training, preparation

of implementation plan, using in sectoral strategies etc).

57)

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes (0)

Page 30

58)

Part A, Section I: STRATEGIC PLAN

Question 7.5 (continued)
Overall, how would you rate strategy planning efforts in the HIV programmes in 2009?

8 (8)

59)

Since 2007, what have been key achievements in this area:

• HSCB established • MSM recognized as third gender • Reduced stigma • DACC Strategy plan for many Districts • Initiatives to mainstreaming HIV in key sectoral ministries

60)

What are remaining challenges in this area:

• Institutionalizing three one principle • Translating policy commitments into actions has not been effective. Such actions is not reflected in resource allocation, deployment of health professional as required • Over 90% of AIDS spending is financed and managed by international agencies, outside the public sector • Budgetary limitation

Page 31

61)

Part A, Section II: POLITICAL SUPPORT

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

President/Head of government	Yes
Other high officials	Yes
Other officials in regions and/or districts	Yes

62)

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?

Yes (0)

Page 32

63)

2.1 IF YES, when was it created?

Please enter the year in yyyy format

2002

64)

2.2 IF YES, who is the Chair?

Name	Mr. Madhav Kumar Nepal
Position/title	Prime Minister

65)

2.3 IF YES, does the national multisectoral AIDS coordination body:

have terms of reference?	Yes
have active government leadership and participation?	Yes
have a defined membership?	Yes
include civil society representatives?	Yes
include people living with HIV?	Yes
include the private sector?	Yes
have an action plan?	No
have a functional Secretariat?	No
meet at least quarterly?	No
review actions on policy decisions regularly?	No
actively promote policy decisions?	No
provide opportunity for civil society to influence decision-making?	No
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	No

Page 33

66)

Part A, Section II: POLITICAL SUPPORT

Question 2.3 (continued)
If you answer "yes" to the question "does the National multisectoral AIDS coordination body have a defined membership", how many members?

Please enter an integer greater than or equal to 1

41

67)

If you answer "yes" to the question "does the National multisectoral AIDS coordination

body include civil society representatives", how many?

Please enter an integer greater than or equal to 1

13

68)

If you answer "yes" to the question "does the National multisectoral AIDS coordination body include people living with HIV", how many?

Please enter an integer greater than or equal to 1

1

Page 34

69)

Part A, Section II: POLITICAL SUPPORT

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes (0)

Page 35

70)

Part A, Section II: POLITICAL SUPPORT

Question 3 (continued)
IF YES, briefly describe the main achievements:

• NAC, NACC, CCM, HSCB • Partnership forum • DACC • Thematic groups (SIT WG; FSW; MSM/TG; IDUs; treatment care and support;)

71)

Briefly describe the main challenges:

Coordination, harmonization and role clarification of different entities and activating some of the bodies (Mainly of NACC, NAC) 1. Internalization of the issues is limited among the members representing non health and non government sectors 2. No regularity of meetings, and often low attendance in the meeting, 3. Inadequate representation as newly emerged networks, and groups are yet to be included as member 4. Consistency and continuity of the members in the meeting is low. Turnover of the members attending the meeting from the same organization is very high, resulting into communication gap and limited contribution in the decision making process 5. No secretariat means maintaining regular communication with members and flow of information to members are limited.

72)

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

Please enter the rounded percentage (0-100)

85

73)

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	Yes
Technical guidance	Yes
Procurement and distribution of drugs or other supplies	Yes
Coordination with other implementing partners	Yes
Capacity-building	Yes
Other: Please specify	

74)

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

No (0)

Page 38

75)

Part A, Section II: POLITICAL SUPPORT

Question 6.1 (continued)
Overall, how would you rate the political support for the HIV programmes in 2009?

5 (5)

76)

Since 2007, what have been key achievements in this area:

• NAC meeting: recent meeting made further commitments • HSCB formation- promoting multisectoral engagement and harmonisation • DACC active (some has strategy and resource allocation)

77)

What are remaining challenges in this area:

• Political commitment not reflected in budget allocation and action

Page 39

78)

Part A, Section III: PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the *general population*?

No (0)

Page 40

79)

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes (0)

Page 41

80)

Part A, Section III: PREVENTION

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes (0)

81)

2.1 Is HIV education part of the curriculum in:

primary schools?	No
secondary schools?	Yes
teacher training?	Yes

82)

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes (0)

83)

2.3 Does the country have an HIV education strategy for out-of-school young people?

No (0)

84)

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk or other vulnerable sub-populations?

Yes (0)

Page 42

85)

3.1 IF YES, which populations and what elements of HIV prevention do the policy/strategy address?

Check which specific populations and elements are included in the policy/strategy

Targeted information on risk reduction and HIV education	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Other populations
Stigma and discrimination reduction	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates, Other populations
Condom promotion	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates, Other populations
HIV testing and counselling	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates, Other populations
Reproductive health, including sexually transmitted infections prevention and treatment	Injecting drug user, Men having sex with men, Sex workers, Clients of sex workers, Prison inmates, Other populations
Vulnerability reduction (e.g. income generation)	
Drug substitution therapy	Injecting drug user
Needle & syringe exchange	Injecting drug user

Page 43

86) **Part A, III. PREVENTION**

Question 3.1 (continued)
You have checked one or more policy/strategy for "Other populations". Please specify what are "other populations".

- Seasonal Labour Migrants and their spouses.

Page 44

87)

Part A, III. PREVENTION

Question 3.1 (continued)
Overall, how would you rate the policy efforts in support of HIV prevention in 2009?

6 (6)

88)

Since 2007, what have been key achievements in this area:

• OST rolled out in two centres Kathmandu and Pokhara • Increased coverage and distribution of needle syringe

Page 45

89)

Part A, III. PREVENTION

4. Has the country identified specific needs for HIV prevention programmes?

Yes (0)

Page 46

90)

Part A, III. PREVENTION

Question 4 (continued)
IF YES, how were these specific needs determined?

Needs are based on number studies (IBBS, programme reports, sectoral studies i.e. CABA situation assessments) and routing programme reporting where coverage, access and quality is monitored.

91)

4.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access
Blood safety	Agree
Universal precautions in health care settings	Agree
Prevention of mother-to-child transmission of HIV	Don't agree
IEC* on risk reduction	Agree
IEC* on stigma and discrimination reduction	Don't agree
Condom promotion	Agree
HIV testing and counselling	Agree
Harm reduction for injecting drug users	Agree
Risk reduction for men who have sex with men	Agree
Risk reduction for sex workers	Agree
Reproductive health services including sexually transmitted infections prevention and treatment	Don't agree
School-based HIV education for young people	Don't agree
HIV prevention for out-of-school young people	Don't agree
HIV prevention in the workplace	Don't agree
Other: please specify	

Page 47

92)

Part A, III. PREVENTION

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

7 (7)

93)

Since 2007, what have been key achievements in this area:

1. Service outlets have increased 2. ART sites 23, PMTCT 17, VCT 169, CD4 services 7

94)

What are remaining challenges in this area:

• Service expansion • Removing barriers to accessing services (economic is the main one

Page 48

95)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes (0)

Page 49

96)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

1.1 IF YES, does it address barriers for women?

Yes (0)

97)

1.2 IF YES, does it address barriers for most-at-risk populations?

Yes (0)

98)

2. Has the country identified the specific needs for HIV treatment, care and support services?

Yes (0)

Page 50

99)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

Question 2 (continued)
IF YES, how were these determined?

Country is divided into four epidemic zones considering the concentration of risk behavours and vulnerable population. Besides, number of studies have identified certain districts are more vulnerable than others in terms of HIV transmission and impact of it. Besides, MARPs and infected groups have also contributed in identifying specific area where increased attention is required.

100)

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

	The majority of people in need have access
HIV treatment, care and support service	
Antiretroviral therapy	Don't agree
Nutritional care	Don't agree
Paediatric AIDS treatment	Don't agree
Sexually transmitted infection management	Don't agree
Psychosocial support for people living with HIV and their families	Don't agree
Home-based care	Don't agree
Palliative care and treatment of common HIV-related infections	Don't agree
HIV testing and counselling for TB patients	Don't agree
TB screening for HIV-infected people	Don't agree
TB preventive therapy for HIV-infected people	Don't agree
TB infection control in HIV treatment and care facilities	Don't agree
Cotrimoxazole prophylaxis in HIV-infected people	Don't agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Don't agree
HIV treatment services in the workplace or treatment referral systems through the workplace	Don't agree
HIV care and support in the workplace (including alternative working arrangements)	Don't agree
Other: please specify	

Page 51

101)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

No (0)

102)

4. Does the country have access to *regional* procurement and supply management

mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?

No (0)

Page 53

103)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

6 (6)

Page 54

104)

Part A, Section IV: TREATMENT, CARE AND SUPPORT

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

No (0)

Page 57

105)

Part A, Section V: MONITORING AND EVALUATION

1. Does the country have *one* national Monitoring and Evaluation (M&E) plan?

Yes (0)

Page 58

106)

1.1 IF YES, years covered:
Please enter the start year in yyyy format below

2007

107)

1.1 IF YES, years covered:
Please enter the end year in yyyy format below

2011

108)

1.2 IF YES, was the M&E plan endorsed by key partners in M&E?

Yes (0)

109)

1.3 IF YES, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes (0)

110)

1.4 IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners (0)

Page 60

111)

Part A, Section V: MONITORING AND EVALUATION

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy	Yes
a well-defined standardised set of indicators	Yes
guidelines on tools for data collection	Yes
a strategy for assessing data quality (i.e., validity, reliability)	No
a data analysis strategy	No
a data dissemination and use strategy	No

Page 61

112)

Part A, Section V: MONITORING AND EVALUATION

Question 2 (continued)
If you check "YES" indicating the national M&E plan include <u>a data collection strategy</u>, then does this <u>data collection strategy</u> address:

routine programme monitoring	Yes
behavioural surveys	Yes
HIV surveillance	Yes
Evaluation / research studies	Yes

113)

3. Is there a budget for implementation of the M&E plan?

Yes (0)

Page 62

114)

Part A, Section V: MONITORING AND EVALUATION

3.1 IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

Please enter the rounded percentage (1-100). If the percentage is less than 1, please enter "1".

2

115)

3.2 IF YES, has full funding been secured?

No (0)

116)

3.3 IF YES, are M&E expenditures being monitored?

Yes (0)

Page 64

117)

Part A, Section V: MONITORING AND EVALUATION

Question 3.2 (continued)
IF you answer "NO" i.e., indicating the full funding has NOT been secured, briefly describe the challenges:

o National Action Plan (2008-2011) has full costing of the activities related to M and E as well as calculation of total resource required and committed pledged for this components from national and international partners. Total cost of SI Including M and E (2008-2011): US$ 2,856,342 Total commitment from EDPs: US$ 2,282,439 Total gap: US$ 573,903

118)

4. Are M&E priorities determined through a national M&E system assessment?

No (0)

Page 65

119)

IF NO, briefly describe how priorities for M&E are determined:

Although a assessment as such has not yet been done, but the priorities are normally decided through a regular and systematic process like regular review of M and E practices, revision of health sector response Using MESS tools Programme review where M and E always features high in agenda like ART, PMTCT

120)

5. Is there a functional national M&E Unit?

Yes (0)

Page 66

121)

5.1 IF YES, is the national M&E Unit based

in the National AIDS Commission (or equivalent)?	Yes
in the Ministry of Health?	Yes
Elsewhere? (please specify)	

122) **Number of permanent staff:**

Please enter an integer greater than or equal to 0

1

123) **Number of temporary staff:**

Please enter an integer greater than or equal to 0

7

Page 67

124)

Part A, Section V: MONITORING AND EVALUATION

Question 5.2 (continued)
Please describe the details of <u>all</u> the permanent staff:

	Position	Full time/Part time?	Since when? (please enter the year in yyyy format)
Permanent staff 1	Senior Public Health Officer	Full time	2009
Permanent staff 2			
Permanent staff 3			
Permanent staff 4			
Permanent staff 5			
Permanent staff 6			
Permanent staff 7			
Permanent staff 8			
Permanent staff 9			
Permanent staff 10			
Permanent staff 11			
Permanent staff 12			

Permanent staff 13
Permanent staff 14
Permanent staff 15

125)

Please describe the details of <u>all</u> the temporary staff:

	Position	Full time/Part time?	Since when? (please enter the year in yyyy format)
Temporary staff 1	M&E Officer	Full time	2009
Temporary staff 2	M&E Officer	Full time	2009
Temporary staff 3	Surveillance Officer	Full time	2009
Temporary staff 4	Data Analyst	Full time	2009
Temporary staff 5	M&E Associate	Full time	2009
Temporary staff 6	M&E Assistant	Full time	2009
Temporary staff 7	M&E Assistant	Full time	2009
Temporary staff 8			
Temporary staff 9			
Temporary staff 10			
Temporary staff 11			
Temporary staff 12			
Temporary staff 13			
Temporary staff 14			
Temporary staff 15			

Page 68

126)

Part A, Section V: MONITORING AND EVALUATION

5.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes (0)

Page 69

127) **Part A, Section V: MONITORING AND EVALUATION**

Question 5.3 (continued)
IF YES, briefly describe the data-sharing mechanisms:

o HMIS is widely used by major partners to get data o Co infection (HIV/TB) data is shared by National Tuberculosis Centre

128)

What are the major challenges?

o There are almost 200 CSO partners implementing different programme activities in the field. Ensuring same level of understanding on M and E and keeping all in the same pace has been

challenge. o Since M and E activities are not fully funded, many activities either partially completed or never started. o Multisectoral indicators are not well established. o Health sector indicators and reporting is improving but capacity of human resource is challenge.

Page 70

129)

Part A, Section V: MONITORING AND EVALUATION

6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

Yes, but meets irregularly (0)

130)

6.1 Does it include representation from civil society?

Yes (0)

Page 71

131) **Part A, Section V: MONITORING AND EVALUATION**

Question 6.1 (continued)
IF YES, briefly describe who the representatives from civil society are and what their role is:

SITWG is comprised of among other following major partners o Red Cross Society o KYC o FHI o UNAIDS o WHO o HMIS o TU Teaching Hospital o NCASC and o HSCB Besides, there is Core Team who meets regularly to review the process, and discuss issues and challenges faced in the implementation, data flow, quality and dissemination process as appropriate. Other technical partners and implementing NGOs/organisation are also invited to contribute in relevant part of the agenda. For example, if ART is discussed, agencies directly related to ART services are invited.

132)

7. Is there a central national database with HIV- related data?

Yes (0)

Page 72

133)

Part A, Section V: MONITORING AND EVALUATION

7.1 IF YES , briefly describe the national database and who manages it:

• NCASC maintains data base for health sector response • HSCB maintains data base for non health sectors indicators and overall M and E indicator as part of “three ones”

134)

7.2 IF YES, does it include information about the content, target populations and

geographical coverage of HIV services, as well as their implementing organizations?

Yes, all of the above (0)

Page 73

135)

7.3 Is there a functional* Health Information System?

At national level	Yes
At subnational level	Yes

Page 74

136) **Part A, Section V: MONITORING AND EVALUATION**

For Question 7.2, you have checked "Yes, but only some of the above", please specify what the central database has included.

For Question 7.3, you have indicated "Yes" to "subnational level", please specify at what level(s)?

o HMIS is a national system which network is up to VDC level (Sub Health Post)

137)

8. Does the country publish at least once a year an M&E report on HIV, including HIV surveillance data?

Yes (0)

138)

9. To what extent are M&E data used

9.1 in developing / revising the national AIDS strategy?:

4 (4)

139)

Provide a specific example:

o Annual report of Monitoring information as such is not produced, but major HIV data and information is included in Annual Report of Department of Health Services, Ministry of Health and population regularly. o Fact Sheets are regularly updated and widely shared through NCASC website o UNAIDS and WHO produce country information in their relevant document periodically. o Current HIV Strategy is up to 2010, and the country is planning to review it soon. Besides, the National Action Plan will be reviewed in 2010 to update the information and included new funding commitments from EDP, therefore so far M and E information has not been used to revise Strategy per se, but programme planning, proposal preparation and other such activities heavily

relies on data generated by M and E system.

Page 75

140) **Part A, Section V: MONITORING AND EVALUATION**

9.2 To what extent are M&E data used for resource allocation?

4 (4)

141)

Provide a specific example:

o Priority setting, target setting and cost calculation heavily relied on data from M and E system during development of National Action Plan (2008-2011

142)

What are the main challenges, if any?

o Despite regular effort in improving M and E system and utilisation of data for policy and strategy development, limited funding allocated for M and E has impeded rapid progress in this aspect.

Page 76

143)

Part A, Section V: MONITORING AND EVALUATION

9.3 To what extent are M&E data used for programme improvement?:

4 (4)

144)

Provide a specific example:

o From the routing monitoring it was found that VCT utilisation is less than optimal despite rapid expansion of VCT. This prompted a question why the uptake is lower than expected. This resulted in increase in frequency of field visit and mentoring from M and E officers as well as on site coaching to staff in the field. This resulted in improvement in service uptake as well as regularity of data reporting.

Page 77

145) **Part A, Section V: MONITORING AND EVALUATION**

10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?:

Yes, at all levels (0)

Page 78

146)

10.1 In the last year, was training in M&E conducted

At national level?	No
At subnational level?	Yes
At service delivery level including civil society?	Yes

Page 79

147) **Please enter the number of people trained <u>at subnational level.</u>**

Please enter an integer greater than 0

120

148) **Please enter the number of people trained <u>at service delivery level including civil society.</u>**

Please enter an integer greater than 0

24

Page 80

149)

Part A, Section V: MONITORING AND EVALUATION

10.2 Were other M&E capacity-building activities conducted other than training?

Yes (0)

Page 81

150) **Part A, Section V: MONITORING AND EVALUATION**

Question 10.2 (continued)
IF YES, describe what types of activities:

o Regular field visits, Regular supervision and mentoring o On site coaching o Participation in seminar and meetings as well as M and E retreat o M and E included in other service site trainings o Regional sharing (first time in the country) started

Page 82

151) **Part A, Section V: MONITORING AND EVALUATION**

Question 10.2 (continued)
Overall, how would you rate the M&E efforts of the HIV programme in 2009?

8 (8)

152)

Since 2007, what have been key achievements in this area:

o Functional M and E set up at NCASC and HSCB o During 2008-2009 efforts were focused in setting up system and strengthening it. As such M and E units are fully staffed with experienced team. o National HIV/AIDS Data base is in place. The web based data based can be accessed from service site and selected information can be directly uploaded. o 35 District AIDS Coordination Committee is now reporting regularly to national M and E system. o 6 pilot districts have been selected, staff trained, stakeholders oriented. In the pilot districts new M and E system (web based system) will be tested. o Modular training package for M and E prepared o Standardised monitoring tools with clear job descriptions o Standardised training curriculum for basic M and E and data base ready for roll out.

153)

What are remaining challenges in this area:

o Capacity building at all levels including implementing partners (CSOs) o Funding for full implementation of M and E plan o Ensuring quality of data and validation process Additional Comments: Question 7.2 The system includes content, target population, geographical coverage of HIV services, name of implementing organisation by district and region. The priority is the indicators set in National M and E framework/plan. Question Number 10 o Yes there is a plan at all levels. The plan particularly focuses on number of human resources required for M and E in each level, training and mentoring to staff, tools and guideline specifically designed for each level and physical set up. o National Action Plan (2008-2010) has clearly highlighted key monitoring activities including research and studies.

Page 83

154)

Part B, Section I: HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifi cally mention HIV, focus on schooling, housing, employment, health care etc.)

No (0)

Page 84

155)

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

No (0)

Page 86

156)

Part B, Section I. HUMAN RIGHTS

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

Yes (0)

Page 87

157)

Part B, Section I. HUMAN RIGHTS

3.1 *IF YES,* for which subpopulations?

a. Women	No
b. Young people	No
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex Workers	Yes
f. prison inmates	Yes
g. Migrants/mobile populations	No
Other: PLHIV	Yes

158)

IF YES, briefly describe the content of these laws, regulations or policies:

In free health care policy 2009, PLHIV is not included as the target beneficiaries. In Nepal, single women only above 60 years have the facility of single women allowance whereas most PLHIV single women are aged between 20-35, therefore are not eligible for single women allowance. Narcotic Drug Control Act contradicts with Drug Control Policy and Harm Reduction Programme. As mentioned in UNGASS report 2008, obstacles have remained the same. No major changes were observed during this reporting period except that the TG is legally recognized as third gender by supreme court. Now National Citizenship Card will have three options in “sex” column i.e. Male, Female, Third Gender (TG).

159)

Briefly comment on how they pose barriers:

Free health care policy is not explicit on ART; this is covered under essential drug list. Free health care policy needs to include target groups i.e. PLHIV so that their rights to treatment is ensured in policy documents.

Page 88

160) **Part B, Section I. HUMAN RIGHTS**

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes (0)

Page 89

161)

Part B, Section I. HUMAN RIGHTS

Question 4 (continued)
IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

It is mentioned in National AIDS Policy (2052) and NSP as a guiding principle. o The response to HIV/AIDS will be rights based with a specific focus on the rights of people infected and affected by HIV/AIDS.

162)

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?

No (0)

Page 90

163)

6. Has the Government, through political and fi nancial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

Yes (0)

Page 91

164)

Part B, Section I. HUMAN RIGHTS

Question 6 (continued)
IF YES, describe some examples:

MARPs representatives or their networks are regularly involved in all activities ranging from policy development, proposal writing and implementation, and monitoring of the implementation. MARPs are represented in policy bodies NAC, HSCB and DACC at the district level. As for the financial support, PLHIV and MARPs networks are funded by various agencies to implement specific activities (capacity building, advocacy, treatment and care, treatment literacy, CHBC). Other financial support is very nominal and often MARPs do not have capacity to raise fund independently.

165)

7. Does the country have a policy of free services for the following:

a. HIV prevention services	Yes
b. Antiretroviral treatment	Yes
c. HIV-related care and support interventions	Yes

Page 92

166)

Part B, Section I. HUMAN RIGHTS

Question 7 (continued)
IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

Current free health policy has broad mandate to provide free primary health services as well as some specific treatment like tuberculosis, malaria and ART.

167)

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

No (0)

Page 93

168)

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes (0)

Page 94

169)

Part B, Section I. HUMAN RIGHTS

Question 9 (continued)
IF YES, briefly describe the content of this policy:

It is not explicitly mentioned in the policy but equal access is mentioned in strategy and its being practiced too health delivery – policy need to be revise

170)

9.1 IF YES, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

Yes (0)

Page 95

171)

Part B, Section I. HUMAN RIGHTS

Question 9.1 (continued)
IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

National HIV/AIDS strategy and National Action Plan have clearly recognized the need for specialized approaches so that those who are not reached by general programme can be reached. Given the high degree of stigma and discrimination attached to certain groups which hinders them to access the services, such specialized approaches are specifically mentioned for MSM, IDUs, FSWs. Programmes are designed to specific MARPs .

172)

10.Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes (0)

173)

11.Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes (0)

Page 96

174)

Part B, Section I. HUMAN RIGHTS

11.1 IF YES, does the ethical review committee include representatives of civil society including people living with HIV?

No (0)

Page 97

175)

– Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes (0)

176)

– Focal points within governmental health and other departments to monitor HIV-

related human rights abuses and HIV-related discrimination in areas such as housing and employment

No (0)

177)

– Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

No (0)

Page 98

178)

Part B, Section I. HUMAN RIGHTS

Question 12 (continued)
IF YES on any of the above questions, describe some examples:

- National Human rights commission - Law reform commission

Page 99

179)

Part B, Section I. HUMAN RIGHTS

13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?

Yes (0)

180)

– Legal aid systems for HIV casework

No (0)

181)

– Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes (0)

182)

– Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes (0)

183)

15. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes (0)

Page 100

184)

Part B, Section I. HUMAN RIGHTS

Question 15 (continued)
IF YES, what types of programmes?

Media	**Yes**
School education	**Yes**
Personalities regularly speaking out	**Yes**
Other: Only in private sector law firms provide legal support to MARPS and other vulnerable group in reduced cost. State has not yet formed such arrangement for free legal services for AIDS related hearing or court cases. But CSO outside the capital perceive that such mechanism exist. Besides, community outreach programmes are regularly empowering the group on their rights and ways to seek such services.	**Yes**

Page 101

185)

Part B, Section I. HUMAN RIGHTS

Question 15 (continued)
Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

4 (4)

186)

Since 2007, what have been key achievements in this area:

- National advocacy plans - National policy revision in progress - Drafting of HIV rights bill in progress - Affirmative Judicial decision on HIV law, HIV testing, homosexual issues - National action plan - 2008

187)

What are remaining challenges in this area:

- Update new policy taking into consideration of new challenges and unfolding realities - Endorse and Enactment of policy and laws - Include HIV in free health care policy - A clear legal framework that not only protects the rights of MARPs and PLHIV, but also accelerate the access to all type of services through appropriate institutional mechanism Additional note: - The overall rating by regional CSOs was higher (rating score 6) than the rating of CSOs in capital city. Such difference is largely due to the fact that implementation at the field level has received much support from authority and political people. Whereas at the central level the rating considered actual environment in law and regulation where not much difference was noted from previous reporting.

Comments on Question No.5. Nevertheless, Civil Society Organizations at local and central level is recording and documenting specific cases. Similarly PLHIV networks also publish such cases regularly in their newsletters. Media group are also regularly reporting cases of abuse and discrimination. Comments on Question No.11.1 No representative of PLHIV in the National health research council and ethical committees. The practices however have been to invite as and when necessary to discuss on ethical issue regarding research related to AIDS.

Page 102

188)

Part B, Section I. HUMAN RIGHTS

Question 15 (continued)
Overall, how would you rate the efforts to enforce the existing policies, laws and regulations in 2009?

4 (4)

189)

Since 2007, what have been key achievements in this area:

• Effort continued to set up and strengthen institutional arrangements including setting up HSCB. • NHSP Phase II incorporated HIV as an important element to be funded through pool funding mechanism. • National AIDS Council (NAC) meeting held in October 2009 further reiterated the needs, commitment and political support at all levels.

190)

What are remaining challenges in this area:

Despite policy commitments of top leaders at various documents and forum, translating such policy has remained a manor challenge in the scaling up the response. Such policy commitment should be reflected in programme and planning documented backed up by resources from government.

Page 103

191)

Part B, Section II: CIVIL SOCIETY* PARTICIPATION

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

3 (3)

192)

Comments and examples:

o Civil society has been involved actively in policy and strategy formulation e.g. the nutrition policy formulation, drug policy reform, NAP, UNGASS reporting, o The civil society is represented in the composition of the HSCB o Home ministry participated and addressed the conference organized on Harm reduction o HIV AIDS bill o Recognition of third gender o III National AIDS Conference o Higher contribution of civil societies seen in policy and strategy development than strengthening

political commitments.

Page 104

193)

Part B, Section II. CIVIL SOCIETY PARTICIPATION

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

4 (4)

194)

Comments and examples:

• In-depth consultations with civil society for development of NAP 2008-11 • Representation in the CCM and other national proposal development consultation • Involvement of CCM in national day observations

Page 105

195)

a. the national AIDS strategy?

4 (4)

196)

b. the national AIDS budget?

4 (4)

197)

c. national AIDS reports?

4 (4)

198)

Comments and examples:

• 80% of all prevention activities are being implemented by CSO • 80% of HIV fund is also managed by CSO. • Strategic plan, budget projection, reporting are all ased on the reports of CSOs from field.

Page 106

199)

a. developing the national M&E plan?

4 (4)

200)

b. participating in the national M&E committee / working group responsible for coordination of M&E activities?

4 (4)

201)

c. M&E efforts at local level?

2 (2)

202)

Comments and examples:

• M&E system and structure is in place • NGOs has been involved in M&E curriculum development and training. • All reporting done to national apex body. • M&E at local level is low priority – for timely reporting, information sharing and analysis as a result, the Regional CSOs scored some what lower (2 or 3) than central level CSOs

Page 107

203) **Part B, Section II. CIVIL SOCIETY PARTICIPATION**

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

3 (3)

204)

Comments and examples:

• Programme for SW exists but they are not actively involved. • Service providers are diversed and include FBO • IDUs rehab shelters run by Faith Based NGO • Inclusion of diverse section appeared higher at Regional level (scored 4 in the Regional consultation)

Page 108

205)

a. adequate financial support to implement its HIV activities?

4 (4)

206)

b. adequate technical support to implement its HIV activities?

3 (3)

207)

Comments and examples:

• Majority of HIV programme implemented by CSO. • The desired technical support is not adequate • The technical support is not need based. • Timely capacity building activities are conducted to some extent but not sufficient.

Page 109

208) **Part B, Section II. CIVIL SOCIETY PARTICIPATION**

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for youth	25-50%
Prevention for most-at-risk-populations	
- Injecting drug users	>75%
- Men who have sex with men	>75%
- Sex workers	>75%
Testing and Counselling	>75%
Reduction of Stigma and Discrimination	>75%
Clinical services (ART/OI)*	<25%
Home-based care	51-75%
Programmes for OVC**	>75%

Page 110

209)

Part B, Section II. CIVIL SOCIETY PARTICIPATION

Question 7 (continued)
Overall, how would you rate the efforts to increase civil society participation in 2009?

7 (7)

210)

Since 2007, what have been key achievements in this area:

• Most prevention of HBC efforts contributed by CSO. • CSO have addressed stigma and discrimination • National workplace policy development and related activities

211)

What are remaining challenges in this area:

• Sustainability (funding, governance) • Role clarification on service delivery between govt and cso; • National standard reporting of all HIV services. • Self regulatory mechanism • Meaningful participation of civil societies in coordination, Additional note: • There are some variations on scoring on 7 above done by Regional CSO and Kathmandu based CSO. Regional scoring is generally towards lower side whereas Kathmandu based CSOs have scored towards higher side. Kathmandu based CSOs have wider national views and better access to information compared to regional CSOs – therefore the differences in scoring.

Page 111

212)

Part B, Section III: PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes (0)

Page 112

213)

Part B, Section III: PREVENTION

Question 1 (continued)
IF YES, how were these specific needs determined?

• In the National Strategy • In the National Action Plan • During development of national strategy • Based no. of MARPs working group (IDU, PLHIV, sex worker, MSM, migrant + PMTCT, prison who actually contributed in deciding specific need for HIV prevention programme for various groups.

214)

1.1 To what extent has HIV prevention been implemented?

	The majority of people in need have access
HIV prevention component	
Blood safety	Agree
Universal precautions in health care settings	Don't agree
Prevention of mother-to-child transmission of HIV	Don't agree
IEC* on risk reduction	Agree
IEC* on stigma and discrimination reduction	Don't agree
Condom promotion	Agree
HIV testing and counselling	Don't agree
Harm reduction for injecting drug users	Don't agree
Risk reduction for men who have sex with men	Don't agree
Risk reduction for sex workers	Agree
Reproductive health services including sexually transmitted infections prevention and treatment	Agree
School-based HIV education for young people	Don't agree
HIV prevention for out-of-school young people	Don't agree
HIV prevention in the workplace	Don't agree
Other: OVC, positive prevention among PLHIV and prevention among prisoners do not have majority of preventive access	Don't agree

Page 113

215)

Part B, Section III: PREVENTION

Question 1.1 (continued)
Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

6 (6)

216)

Since 2007, what have been key achievements in this area:

• Blood Safety Policy • Massive expansion of VCT sites, utilization and positivity yield is low • HIV information included in School Curriculum included • Community Based PMTCT piloted • PMTCT site expanded -17 • PMTCT,STI, VCT etc services National review • For labour migrants programme other funding agencies (CARE) have poured resources • Positive prevention • Prison population are included and being expanded in prison outside Kathmandu

217)

What are remaining challenges in this area:

• Lack of Risk reduction among MARPS • Out of School programme inadequate • Implementing the Strategy in its full • Quality of prevention program not closely monitored • Mass media communication strategy is inadequate Additional Comments Comment for Question 1: • Geographical expansion based on researched data and programme data • Service site expansion based on programme reporting and need expressed by the group • Expansion of implementing partners as more and more partners are coming up front to address the challenges • Involving the networks of MARPS as well as institutions (NGOs) run by the MARPs groups.

Page 114

218)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes (0)

Page 115

219)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

Question 1 (continued)
IF YES, how were these specific needs determined?

• In the National Strategy • In the National Action Plan • During development of national strategy • Based no. of MARPs working group (IDU, PLHIV, sex worker, MSM, migrant + PMTCT, prison) who actually contributed in deciding specific need for HIV Care Support and Treatment programme for various groups.

220)

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

HIV treatment, care and support service	The majority of people in need have access
Antiretroviral therapy	Agree
Nutritional care	Don't agree
Paediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree
Psychosocial support for people living with HIV and their families	Agree
Home-based care	Agree
Palliative care and treatment of common HIV-related infections	Agree
HIV testing and counselling for TB patients	Agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	Don't agree
TB infection control in HIV treatment and care facilities	Don't agree
Cotrimoxazole prophylaxis in HIV-infected people	Agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree
HIV care and support in the workplace (including alternative working arrangements)	Don't agree
Other: please specify	

Page 116

221)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

Question 1.1 (continued)
Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

6 (6)

222)

Since 2007, what have been key achievements in this area:

• ART scaled up to 23 sites • Maintenance site scaled up • Community based ART initiated • National Review of guidelines making it more need based • OVC- expanded but not yet fully rolled out • CHBC coverage scaled • OI national Guideline rolled out • Logistic Management has improved • Care home, crisis care establishment • PMTCT scaled up • STI scaled up • Start up of Nutritional support • TB HIV collaboration • GFATM round 7 rolled out

223)

What are remaining challenges in this area:

• All above expansions in services needs scaling up, current support at time is too small. • Integration of TB and HIV need more focus • Nutrition in HIV care programme to be strengthen and

expanded • Disparity in Treatment (More male only) needs to be addressed • Comprehensive care beyond ART not in place

Page 117

224)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes (0)

Page 118

225)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

2.1 IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes (0)

226)

2.2 IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes (0)

227)

2.3 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes (0)

Page 119

228)

Part B, Section IV: TREATMENT, CARE AND SUPPORT

Question 2.3 (continued)
IF YES, what percentage of orphans and vulnerable children is being reached?

Please enter the percentage (0-100)

1

229)

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?

4 (4)

230)

Since 2007, what have been key achievements in this area:

• Resource allocated in National Action Plan for OVC- 3-4 activities • OVC (CABA) guideline in preparation • CABA working group in place • Nutritional Program running in some places • Early Infant diagnosis started • National CABA study conducted • OVC focused programme in certain community

231)

What are remaining challenges in this area:

• Despite some isolated study, true picture of CABA is not available • Stigma and discrimination is very high, some cases of expulsion from schools reported • Programme and funding for CABA has been very patchy and most donor shy off saying this is a long term commitment that country has to take actions Additional note: • Regional CSOs scored very low for OVC (score 2) compared to Central level CSOs (score 4) Comments for Question No. 2.3 * 0.90% of spending is based on 2007 NASA * Actual number and percentage of OVC reached is unknown.