

# **UNGASS PAKISTAN REPORT**

**Progress Report on the  
Declaration of Commitment on HIV/AIDS  
For  
United Nations General Assembly Special Session on  
HIV/AIDS**



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# GLOSSARY

<b>AIDS</b>	Acquired Immuno Deficiency Syndrome
<b>ART</b>	Antiretroviral Therapy
<b>BSS</b>	Behavioral Surveillance Survey
<b>CIDA</b>	Canadian International Development Agency
<b>CRIS</b>	Country Response Information System
<b>DFID</b>	Department for International Development
<b>DHS</b>	Demographic and Health Survey
<b>DoC</b>	Declaration of Commitment on HIV/ AIDS
<b>EQAS</b>	External Quality Assessment Scheme
<b>FSW</b>	Female Sex Worker
<b>GIPA</b>	Greater Involvement of People with HIV/AIDS
<b>GFATM</b>	Global Fund for AIDS, Tuberculosis and Malaria
<b>HASP</b>	HIV/AIDS Surveillance Project
<b>HIV</b>	Human Immunodeficiency Virus
<b>HRG</b>	High Risk Group
<b>HSG</b>	Hijra Sex Worker
<b>IDU</b>	Injecting Drug User
<b>ILO</b>	International Labor Organization
<b>MARA</b>	Most At Risk Adolescents
<b>MARP</b>	Most at Risk Populations
<b>MIS</b>	Management Information System
<b>MoE</b>	Ministry of Education
<b>MoH</b>	Ministry of Health
<b>MTR</b>	Mid Term Review
<b>MSM</b>	Men who Have Sex with Men
<b>MSW</b>	Male Sex Worker
<b>NACP</b>	National AIDS Control Program
<b>NGO</b>	Non Governmental Organization
<b>NVP</b>	Nevirapine
<b>PHC</b>	Primary Health Centre
<b>PIP</b>	Program Implementation Plan
<b>PIU</b>	Provincial Implementation Unit
<b>PLHA</b>	Person Living with HIV / AIDS
<b>PLHIV</b>	Person living with HIV
<b>PPTCT</b>	Prevention of Parent to Child Transmission of HIV/AIDS
<b>RTI</b>	Reproductive Tract Infection
<b>SDP</b>	Service Delivery Project
<b>STD</b>	Sexually Transmitted Diseases
<b>STI</b>	Sexually Transmitted Infection
<b>UNAIDS</b>	United Nations Joint Program on HIV/AIDS
<b>UNFPA</b>	United Nations Population Fund
<b>UNGASS</b>	United Nations General Assembly Special Session
<b>UNICEF</b>	United Nations Children's Fund
<b>UNODC</b>	United National Office for Drugs and Crime
<b>USAID</b>	United States Agency for International Development
<b>VCTC</b>	Voluntary Counseling and Testing Centre
<b>WHO</b>	World Health Organization

# INTRODUCTION

In June 2001 Pakistan along with other member states of the United Nations adopted the Declaration of Commitment (DoC) on HIV/AIDS in the United National General Assembly Special Session (UNGASS) on HIV/AIDS. This was an effort to compliment the framework for achievement of the Millennium Development Goals for halting and beginning to reverse the spread of the HIV/AIDS epidemic by 2015 in all countries around the world.

According to the revised estimates by the WHO and UNAIDS globally there are an estimated 33.2 million people living with HIV/AIDS of whom 2.5 million were newly infected in 2007 alone. In adopting the DoC in UNGASS, the international community set common targets for reducing the prevalence and spread of HIV/AIDS and alleviating its impact. The DoC highlights areas where efforts need to be concentrated which include information dissemination, capacity building, gender equality and reducing poverty. It puts in place a guideline for UN agencies and UNAIDS co-sponsors to effectively respond to the problems arising from HIV/AIDS and to work together to fight the spread of the disease. A follow up to the DoC calls for careful monitoring of the progress achieved by individual member states and on the global scale on the agreed commitments which are thereby issued as periodic reports by the UN Secretariat. Reporting by UN Member countries are to be made biennially to the UNAIDS Secretariat where the reports are compiled to present a global picture. In 2002 the UNAIDS Secretariat in Geneva developed a series of core indicators common to all countries for measuring progress made on the specific areas in the DoC.

Pakistan has submitted progress reports on the DoC as required by the UNAIDS since 2003. These country reports thereafter form the basis of the overall progress report submitted by UNAIDS Secretariat to the following UN General Assembly High Level Meeting on AIDS.

In 2005 UNAIDS issued a document 'Guidelines on Construction of Core Indicators' in order to improve the quality of data and bring uniformity in reports to the submitted on DoC progress in 2006. The guidelines incorporated not only the government response but also the civil sector response in combating the epidemic. Moreover the indicators were separate for countries with low, concentrated and generalized epidemics. Recently for the 2008 report the 'Guidelines on Construction of Core Indicators' have been revised and while some indicators have been removed, new ones have been added to make reporting more specific. All indicators are to be reported upon by all countries unless data is either unavailable or not relevant to the country since there are no separate indicators for countries having low, concentrated or generalized epidemics. Moreover data collection for some indicators has also been redefined in the revised guidelines. The Pakistan Country Progress Report for 2008 has been prepared through collation and analysis of HIV/AIDS Surveillance Data, treatment and care monitoring data, transfusion screening assessment reports, data from VCT centers and sentinel surveillance data available with the National AIDS Control Program, Global Fund Project monitoring data, interviews

from key informants, bilateral and multilateral organizations and civil societies (through their consortia).

The HIV epidemic in Pakistan is presently concentrated in the Injecting Drug Users (IDUs) population and has reached upto 51% in certain urban areas. There is also indication of rising infections among the MSW (Hijras) population which is more visible in cities that have had an established IDU epidemic since 2-3 yrs. This is an alarming situation and a clear signal for urgent and focused actions in reducing rapid spillover of infection from these core groups to others and thereby to the general population.

In the present report not all indicators are relevant to the epidemic in Pakistan and for some data are not available due to a number of socio-cultural factors and gaps in surveillance data collection and analysis. Out of a total of 25 Country level indicators report is being provided on 18 indicators which would reflect the level and dimensions of the epidemic in Pakistan and progress by government and civil societies to address this issue.

## STATUS AT A GLANCE

Pakistan received the Guidelines for monitoring of core indicators for the Declaration of Commitment in June 2007. The National AIDS Control Program in coordination with the UNAIDS initiated the process for consultations with stakeholders in November 2005 with the involvement of the Planning Commission of Pakistan. Given the overall political situation in the country, there was considerable delay, however an informal meeting was held in the Planning Commission with UNAIDS and NACP in mid November 2007 which led to a larger stakeholder meeting on 10<sup>th</sup> December 2007 (minutes and details annex 1). During this meeting sources of data were identified and a core working group was identified for data collation and processing. A draft report was developed which was shared with a large number of stakeholders and inputs/comments from the same were sought in another meeting held on 26<sup>th</sup> January 2008. The inputs from all partners incorporated in the report which was then finalized.

Pakistan is still categorized as ‘concentrated epidemic country with HIV prevalence among the general population currently less than 1%. However due to the recent rise of HIV infections among IDUs, it has shifted into a stage of concentrated epidemic and is expected to closely follow the Asian Epidemic Model of initial IDU epidemics followed by epidemics in other associated MARPs with a time lag of 2-3 yrs between shifts from one to another group. Presently the overall sero prevalence of HIV among IDUs is 15.8% and among MSWs it is 1.5% - 1.8%. In line with the epidemic trend, there has been a renewed focus by the Government and Development Partners towards rapidly scaling up prevention and service delivery programs for most at risk populations particularly IDUs, nevertheless coverage is still a major challenge facing the AIDS Programs. In light of latest developments, the National Strategic Framework was recently revised and is the basis of a new five year initiative by the Government of Pakistan.

The following is a brief tabulation on the Core Indicators:

<i>National Commitment and Action</i>		
1.	<b>AIDS Spending by Categories and Financing Sources</b>	
2.	<b>National Composite Policy Index</b>	Annex-2
<i>National Program Indicators</i>		
3.	<b>% age of donated blood units screened for HIV in a quality assured manner</b>	87% (SOPs followed but no external quality assurance)
4.	<b>% age of adult and children with advanced HIV infection</b>	7.4% (550 adults and children currently on ART out of an estimated 7,500 people with advanced HIV infection)
5.	<b>% age of HIV positive pregnant women who received anti-retroviral drugs to reduce the risk of mother to child transmission</b>	The PPTCT program for HIV positive pregnant women was initiated in early 2007 and since then 100% of identified HIV positive pregnant women have received ART to prevent HIV transmission to the newborn. (too early to make the estimate)

6.	% age estimated HIV positive incident TB cased that received treatment for TB and HIV	Data on the indicator is not available since there is no established TB HIV collaborative program
7.	% age of women and men aged 15-49 who received and HIV test in the last 12 months and who know their results	Data on this indicator is not available. The Latest DHS report does not address this indicator
8.	% age most at risk populations (MARPs) who received and HIV test in the last 12 months and who know their results	<ul style="list-style-type: none"> <li>▪ FSWs (&lt;25 – 5.2%; &gt;25 4.6%)</li> <li>▪ IDUs (&lt;25 – 4.6%; &gt;25 4.1%)</li> <li>▪ MSWs (&lt;25 – 3.5%; &gt;25 5.5%)</li> <li>▪ HSWs (&lt;25 – 8.6%; &gt;25 9.6%)</li> </ul>
9.	% age most at risk populations reached with HIV prevention programs	<ul style="list-style-type: none"> <li>▪ FSW (&lt;25 – 1.1%; &gt;25 – 2.2%)</li> <li>▪ IDU (&lt;25 – 15.1; &gt;25 – 15.8%)</li> <li>▪ MSW (&lt;25 – 2.2%; &gt;25 – 4.3%)</li> <li>▪ HSW (&lt;25 – 6.9%; &gt;25 – 8.0%)</li> </ul>
10.	% age of orphaned and vulnerable children (OVCs) aged 0-17 yrs whose household received free basic external support in caring for the child	Data on the indicator is not available since the prevalence of HIV is still below 1% in the general population. There is also no information on HIV/AIDS orphans in Pakistan
11.	% of schools that provided life skills based HIV education within the last academic year	6% based on data from the Global Fund Project
<b>Knowledge and Behavior Indicators</b>		
12.	Current school attendance among orphans and non – orphans aged 10-14 yrs	There are no reports available regarding HIV/AIDS orphans and indicator cannot be reported – not relevant indicator
13.	% age of young women and men aged 15-24 yrs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Data on the indicator is not available, the complete DHS report has not been disseminated
14.	% of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	<ul style="list-style-type: none"> <li>▪ FSW (&lt;25 – 28.2%; &gt;25 – 23.4%)</li> <li>▪ IDU (&lt;25 – 16.7%; &gt;25 – 20.5%)</li> <li>▪ MSW (&lt;25 – 24.8%; &gt;25 – 28.4%)</li> <li>▪ HSW (&lt;25 – 13.1%; &gt;25 – 18.3%)</li> </ul>
15.	% age of young women and men aged 15-24 yrs who have had sexual intercourse before the age of 15	0.67% (data collected from only adolescents aged 13-19 yrs) <ul style="list-style-type: none"> <li>▪ Males 0.92%</li> <li>▪ Females 0.42%</li> </ul>
16.	% age of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Data on indicator is not available and cannot be collected through DHS due to socio-cultural factors
17.	% of women and men aged 15-49 yrs who have had more than one sexual partner in the past 12	Data on indicator is not available and cannot be collected through DHS due to socio-cultural factors

	<b>months and report the use of a condom during their last intercourse</b>	
<b>18.</b>	<b>% of female and male sex workers reporting the use of a condom with their most recent client</b>	<ul style="list-style-type: none"> <li>▪ FSW (&lt;25 – 50.5%; &gt;25 – 42.3%)</li> <li>▪ MSW (&lt;25 – 20.0%; &gt;25 – 23.3%)</li> <li>▪ HSW (&lt;25 – 21.4%; &gt;25 – 21.2%)</li> </ul>
<b>19.</b>	<b>% of men reporting the use of a condom the last time they had anal sex with a male partner</b>	<p>Data on this indicator are not available since MSM are not an identified population in Pakistan. The only visible population associated with MSM behavior are the MSWs and Hijra Sex Workers</p> <ul style="list-style-type: none"> <li>▪ MSW (&lt;25 – 23.0%; &gt;25 – 25.4%)</li> </ul>
<b>20.</b>	<b>% age of injecting drug users (IDUs) reporting the use of a condom the last time they had sexual intercourse</b>	<ul style="list-style-type: none"> <li>▪ IDU (&lt;25 – 13.%; &gt;25 – 22.7%)</li> </ul> <p>Male IDUs only</p>
<b>21.</b>	<b>% age of injecting drug users (IDUs) reporting the use of sterile injecting equipment the last time they injected</b>	<ul style="list-style-type: none"> <li>▪ IDU (&lt;25 – 29.5%; &gt;25 – 27.5%)</li> </ul> <p>Male IDUs only</p>
<b><i>Impact Indicators</i></b>		
<b>22.</b>	<b>% of young women and men aged 15-24 yrs who are HIV infected</b>	Age segregated data on indicator is not available since HIV status is not routinely tested among the antenatal clinic attendees – not relevant
<b>23.</b>	<b>% of most at risk populations who are HIV infected</b>	<ul style="list-style-type: none"> <li>▪ FSW (&lt;25 – 0.0%; &gt;25 – 0.0%)</li> <li>▪ IDU (&lt;25 – 18.3%; &gt;25 – 15.4%)</li> <li>▪ MSW (&lt;25 – 1.1%; &gt;25 – 2.8%)</li> <li>▪ HSW (&lt;25 – 1.9%; &gt;25 – 2.2%)</li> </ul>
<b>24.</b>	<b>% age of adults and children with HIV still alive and know to be on treatment 12 months after initiation of anti-retroviral therapy</b>	87% - data collected from only one treatment center; remaining 13% are either lost to follow up or have died
<b>25.</b>	<b>% age of infants born to HIV infected mothers who are infected</b>	Globally modeled data – not to be nationally estimated



# OVERVIEW OF THE HIV & AIDS EPIDEMIC IN PAKISTAN

By 2007 the total population of Pakistan is estimated to be about 164.74 million<sup>1</sup> with the average annual intercensal growth rate at 1.87% per annum (estimates for 2005), which places it at sixth among the most populous nations in the world. Of the total population only 30% resides in urban areas whereas the rest is rural population with limited access to health services. The first HIV positive Pakistani was identified in 1987 and since then an increasing number of positive individuals have been reported to the National AIDS Control Program. Currently an estimated 85,000 people are living with HIV/AIDS in the country with the HIV prevalence less than 1% in overall population. Although estimates for PLWHA and prevalence of HIV in general population has remained fairly constant over the years, there has been a shift from low prevalence to a concentrated epidemic due to rapid rise of infections among core risk groups in particular the injecting drug users in some cities.

Earlier on the majority of HIV positive cases reported to the National AIDS Control Program were among Pakistanis living or traveling abroad, who became infected through risky behaviors and were deported back to Pakistan. Presently there are more indigenously infected individuals reported particularly among those individuals who are classified as belonging to the most at risk population which include injecting drug users, sex workers, jail inmates and prisoners. Furthermore, province specific variations in the profile of the epidemic have also been observed, the Province of Sindh has shown higher HIV prevalence and multiple routes of HIV transmission with diversity within the Province and among other provinces. Following the trend seen in other countries in Asia, the epidemic in Pakistan is also characterized by rapid transmission of infection and high prevalence among the IDU population in the initial stages and potential spillover into other HRGs such as the female sex workers (FSWs), men who have sex with men (MSM) and thereafter through the bridging populations e.g. Clients of sex workers and truckers to the general population. The connections and overlap between drug use and sex work coupled with high prevalence unsafe sexual practices and low self risk awareness indicate that there is high potential for rapid spread of the HIV infection in these core groups.

In 2003 a major outbreak was reported among IDUs in the city of Larkana, Sindh Province where out of 175 tested 10% IDUs were found positive for HIV<sup>2</sup>. Following this the National AIDS Control Program has conducted 2 rounds of 2<sup>nd</sup> Generation HIV Surveillance from 2005-2007 and consistently found rising infections among the IDU groups in other cities also, moreover in cities with established HIV epidemics among IDUs, rising infections are now being recorded among associated MSM populations. Prevalence among Female Sex Workers is still low but there is low consistent condom

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<sup>1</sup> Federal Bureau of Statistics estimates 2007

<sup>2</sup> National AIDS Control Program 2003 project progress report

use and specific knowledge about HIV/AIDS which is an important finding and an indication to prioritize large scale HIV prevention programs for FSWs and their clients.

Pakistan has long since been categorized as a high risk country, particularly in view of similar borders and socio-cultural factors with neighboring India which is now estimated to have the second largest population of PLWHA after South Africa. In the early 1990's progress in HIV/AIDS prevention efforts was slow <sup>3</sup>however, towards the mid 1990's there was a gradual improvement in commitment which resulted in its inclusion in the Social Action Program Project financed by the World Bank and other donors. This resulted in an increased focus on health promotion and HIV/AIDS education aimed at raising awareness among the general public. In addition to this the National Program through its Provincial AIDS Control Programs has conducted training and awareness activities for health care workers, key district officials, travel agents and labor workers. There have also been extensive advocacy measures with the policy and decision makers at high level for greater involvement of various line ministries and associated departments. The current HIV prevention program gives a lot of attention to service delivery for HRGs in partnership with private sector organizations/NGOs. Results from the recent surveillance data have confirmed the presence of a concentrated epidemic among IDUs and which is expanding rapidly and is appearing in new cities. This serves to underline the need for rapidly scaling up interventions among vulnerable groups to prevent spillover into the general population

## **NATIONAL RESPONSE TO THE AIDS EPIDEMIC**

### **National Commitment and Action:**

The response to the HIV epidemic in Pakistan is a coordinated effort of the Government of Pakistan through its implementing body the National AIDS Control Program (MoH), the Provincial AIDS Control Programs, National and Provincial Consortia of NGOs and Civil Society, bilateral and multilateral donors and the UN System. The Government of Pakistan is nevertheless the biggest shareholder in all investments made for HIV prevention, care and support for both vulnerable populations as well as general population.

### **Early Phase of the Governments Response 1987-2003:**

The first HIV positive Pakistani individual was identified in 1987, soon after which laboratory based AIDS prevention activities were begun with assistance from WHO. The Federal Committee on AIDS (FCA) started functioning in 1987 and used to define the broad policy guidelines for the control of AIDS in Pakistan. The Program was mainly laboratory

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<sup>3</sup> World Bank AID Memoire 2003

oriented and technical support principally came through the World Health Organization (WHO) under its short and medium term plans (STP and MTPs)<sup>4</sup>. An AIDS prevention and Control Program was started in August 1987, and was made more realistic and dynamic through the PC-1 during 1994 with an estimated cost of Rs. 774.35 million which was approved by the executive committee of the national economic council (ECNEC) in November 1994. In contrast to the previous plans, the activities were implemented in the overall health care infrastructure to ultimately further strengthen it. The AIDS Control Program was brought under Social Action Program Project (SAPP) during 1994. The policy reform matrix explaining tasks, indicators, time frame and sources were developed upto 2003. The components of this Program included; Information, Education and Communication (IEC), Safe Blood Transfusion, Sexually Transmitted Diseases (STDs), Clinical Management, Counseling and Care, Surveillance and Monitoring, Training of the Health Professionals, Research and Program Management

In the initial stages of the epidemic in the country, the response by the government was slow in view of the small number of visible cases, later on however the enhanced commitment was reflected by increasing allocations of funds, expenditures and staffing level in the provincial programs. In 1999-2000 the GOP through a consultative process involving a large number of stakeholders developed a National Strategic Framework for HIV/AIDS that outlined broad strategies and priorities for effective control of the epidemic, which also provided for an increased focus on working with the vulnerable populations. The framework was formally endorsed and adopted by the GOP and its development partners. It formed the basis for the development of an Enhanced HIV/AIDS Control Program which laid emphasis on HIV preventive services and information provision to high risk groups such as commercial sex workers, injecting drug users, jail inmates, men who have sex with men and truck drivers.

## **2nd Phase of the Governments Response 2003-2007:**

In the 2<sup>nd</sup> phase of Pakistan's response to the HIV epidemic, the overall strategy of program implementation was shifted away from the previous program. The new Enhanced Program for HIV/AIDS prevention and control was developed on the recommendations of the National Strategic Framework and the agreements made by GoP in the UNGASS and Goal 6 of the MDGs. There was a renewed focus on identifying and mapping the core high risk groups in various cities of the country to assist in provision of services, assess the level of knowledge and attitudes in the general population to develop a specific and targeted behaviour change communication strategy and consequently a media awareness campaign at all levels with elements of BCC, focus of addressing capacity issues both within the National/Provincial AIDS Programs and among partner NGOs/private sector organizations, treatment care and support services to PLWHA and improving biological and behavioral surveillance and some support to blood transfusion safety. The main components of the program are as follows:

- Expansion of interventions among the general population

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<sup>4</sup> National AIDS Control Program

- Improved HIV prevention by the general public including youth and uniformed personnel
- Reduced HIV and STI transmission through improved blood safety
- Capacity development and program management

Many innovations that were adopted in the implementation of this project; the first and foremost being the implementation of public supported services through NGOs for high risk groups such as Female and Male Sex Workers (FSWs, MSWs), Injecting Drug Users (IDUs), Jail inmates, Men who have Sex with Men and Long Distance Truckers. Others include decentralization of the program to provincial levels (from the previous umbrella program 1997-2003), nationally implemented BCC campaign for general population and key policy/decision makers, implementation of a second generation surveillance system for both sero and behavioral surveillance among HRGs and capacity development of projects through a contract management firm. For implementation of services among HRGs a key initiative was the development of a defined package of services including information provision, skill development, distribution of condoms and preventive service and primary curative care in a setting which could also cater to the VCT needs of the target population. Each service package was specific to the target population and also comprised of Syringe Exchange Program and Drug Harm Reduction including detoxification program for IDUs. In the recent year this has become one of the priority areas of the program in light of recent epidemic trends among IDUs.

In addition to preventive services, treatment care and support services for people living with HIV were also initiated in this program. Five centers of excellence were identified and established in the national and provincial capitals to provide treatment of opportunistic infections and hospitalized care, although ART was not initially part of the program, the provision of ART to eligible patients was ensured through grant financing from the Global Fund Project Round 2. The training of doctors and nurses for these treatment centers on ART management was carried out at CARAT Institute India supplemented by follow up trainings on site. At present there are nine functional centers that are responsible for AIDS management and care including ART to roughly 500 patients about 20% of which are receiving 2<sup>nd</sup> line therapy according to national guidelines<sup>5</sup>. The Enhanced HIV Prevention Program has now been under implementation for 4 yrs and has gained considerable experience in service delivery for HIV prevention. It is now obvious that the epidemic in Pakistan is following the course as depicted by the Asian Epidemic Model and the program service delivery is geared towards addressing these issues. The first National Strategic Framework was developed in 2001 for five years. In 2006, the National AIDS Control Program undertook a mid term review (MTR) of the program services to evaluate if services were needs based and if any revisions or exploration of new areas were required. During the MTR the national estimates for target populations and HRGs were revisited on the basis of data from the service delivery projects (SDPs) and round 1 HIV/AIDS surveillance results. Following the MTR the process for revision of the National Strategic Framework was initiated and involved consultations with a wide group of stakeholders including government, private

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<sup>5</sup> NACP treatment center report

sector/NGOs, bilateral/international donors, UN Organizations and partner service delivery NGOs. As a result of the consultations the National Strategic Framework II has been drafted and endorsed by all partners for the next five years i.e. 2008-2012. The strategies identified in the NSF-II are the basis for the development of the expanded program for HIV prevention care and support program which is currently under discussions and in the process of finalization. In the NSF-II 3 new priority areas for intervention have been identified in addition to the ones outlined in the first strategic framework. The twelve priority areas in the NSF-II are as follows:

1. Expanded response
2. Vulnerable, target and bridging populations
3. Women, children and youth
4. Surveillance and Research
5. Sexually Transmitted Infections
6. General awareness
7. Blood and blood product safety
8. Infection control
9. Care and support
10. Institutional arrangements
11. Commodities and procurement
12. Management information systems

The following core strategies have been identified in the NSF-II for addressing the above 12 priority areas and which are the major components of the expanded response for HIV/AIDS 2008-2012:

- Creating an enabling environment
- Strengthening the institutional framework
- Building up the right capacity
- Scaling up program delivery

### **Role of the Private sector/civil society in the national response:**

Civil society is the frontline of national response to HIV epidemic. Over the years, civil society in Pakistan has grown and is now actively shouldering the implementation burden with public sector. The expansion of civil society has also led to the emergence of network structures like National and Provincial AIDS consortia that are playing critical role in facilitating and coordinating civil society efforts. The national and regional consortia of NGOs are working under the umbrella of Pakistan AIDS Control Federation (PNAC). PNAC is playing the role of a bridge between the public and private sector organizations and is involved in advocacy, networking and capacity building. PNAC advocates for access to care and support, preventive services and treatment for all those who need it, rights of key vulnerable populations and for greater involvement of people living with HIV and AIDS in all policy and decision making processes. Other organizations including Catholic Relief Services, Family Health International, Interact Worldwide, World Vision, Marie Stoops and Green Star Social Marketing franchise are

also implementing their own or government funded projects. Over the past few years the NACP and its provincial counterparts (PACPs) have entered into multiple engagements with private sector firms and large NGOs through public-private partnership (PPP) arrangements.

Although the civil society participation in the response has increased significantly over the past few years, practically the CSOs and NGOs are still seen as implementers and contractors. CSO engagement are expected to be involved in HIV/AIDS activities through a systematic approach so that participation at all levels is ensured i.e. policy, planning, design and M&E.

National NGOs that are involved in implementing the national program are:

- Marie Stopes Society (MSS), which is a sub-recipient working for establishing Voluntary Counseling Testing Centers (VCTs).
- Contech is working with female and male sex workers in Lahore and Faisalabad.
- PAVHNA is working for KVP vulnerable and adolescent youth in Karachi
- Nai Zindagi is working with IDUs in Lahore and three other cities of Punjab.
- Award is working with PLWHAs in North West Frontier Province (NWFP) and also has VCT center in one of the tertiary hospitals in Peshawar.
- ORA is implementing a project for MSM and FSWs in Peshawar
- PLYC is working for FSWs in Multan.
- SBDDS is working three jails of Sindh
- Pakistan Society is implementing project for IDUs in Karachi and Hyderabad.

### **National HIV/AIDS Policy and Legislative Framework (2006-2007):**

In early 2006 an exercise was initiated to prepare a draft National HIV&AIDS Legislative framework for Pakistan, through international technical assistance and over a period of 2 yrs a draft Bill has been finalized and submitted to the Ministry of Law for vetting. The preparatory process involved individual interviews with key stakeholders in the federal as well as provincial areas and included officials from the public sector health and law departments, representatives of NGOs currently involved in HIV/AIDS work, people living with HIV/AIDS, office of the Attorney General, office of the Islamic Religious Council, health and human rights groups pertaining to HIV/AIDS. The initial draft was then shared with concerned stakeholders in a consultative meeting and recommendations from the consultations were made part of the final document. The document was finalized in 2007 and is titled “The HIV & AIDS Prevention and Treatment Act, 2007”. Currently the finalized text document is awaiting submission to the National Cabinet and Parliament as the ‘Rules’ under the law are still to be finalized. The basic provisions of the law focus on providing care, support and equitable access to treatment for people living with HIV/AIDS, services for vulnerable populations, services and information for reducing stigma and discrimination against PLWHA and HRGs, services for women, children and youth and services to general population to reduce their

vulnerability to HIV infection and improve their access to HIV specific knowledge and preventive services. The law is designed to support the government in providing services to marginalized populations (whose members have quasi legal status) and are at high risk of acquiring HIV infection due to their occupation and/or behavioral practices. The Act defines the establishment of National and Provincial AIDS Commissions to oversee the implementation of HIV & AIDS prevention and control programs and monitor the compliance with the Act in both public and private sectors.

Since the last quarter of 2005 another initiative undertaken by the National AIDS Control Program was to develop a National HIV & AIDS Policy document. The key aim of the policy framework is to provide and maintain an enabling environment for HIV and AIDS prevention and care programs and services and responding effectively to HIV and AIDS through a consistent approach across all sectors and at all levels of government and community. The policy framework was also developed through a participatory process with the involvement of national/provincial public sector HIV managers and implementers, PLWHA, bilateral and international donor community, legal experts and extensive review of relevant documents and best practices from policy documents of countries with the region and other Islamic countries. The Finalized Framework document has been prepared as a result of these participations and two (2) large consultative workshops from 2006-2007. The document has been presented to the Ministry of Health for review and approval before onwards submission to the Federal Cabinet for endorsement and adoption at the national level.

### **Changing face of the epidemic and recent developments:**

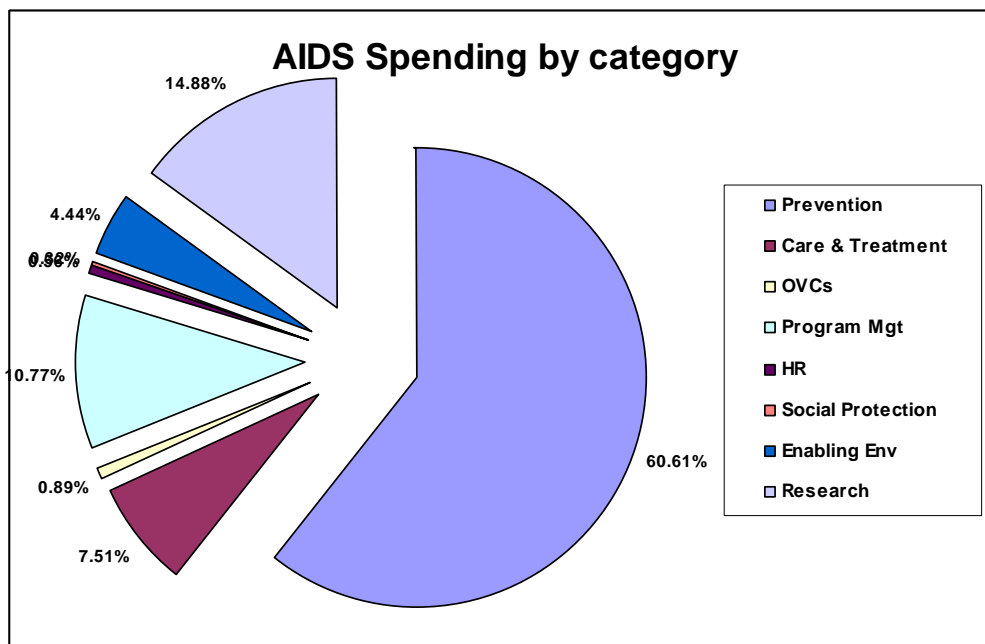
In July 2003 the detection of an HIV infection outbreak among a group of injecting drug users in the city of Larkana changed Pakistan's status of 'high risk – low prevalence' epidemic almost overnight into a 'high risk – concentrated' epidemic and subsequent national surveillance rounds have confirmed the presence of a concentrated epidemic among this population subgroup. Since 2005 till end 2007 two successive rounds of surveillance have been successfully completed and include collection of both biological and behavioral data from high risk groups. Bridging population as such are not included in data collection for annual rounds of HIV surveillance. In the latest round of 2<sup>nd</sup> generation surveillance, the key HRGs from whom data has been collected are FSWs, MSWs, Hijra Sex Workers and Injecting Drug Users in 12 major cities across all four provinces in the country. During the second round of surveillance a total of 114,637 persons engaged in high risk activities were mapped from a total of 18,728 spots. Among total mapped, 42.8% were FSWs, 27.5% were IDUs and 29.7% were MSW & HSW combined.

## National Program Indicators:

### Indicator No. 1 – National AIDS Spending Assessment

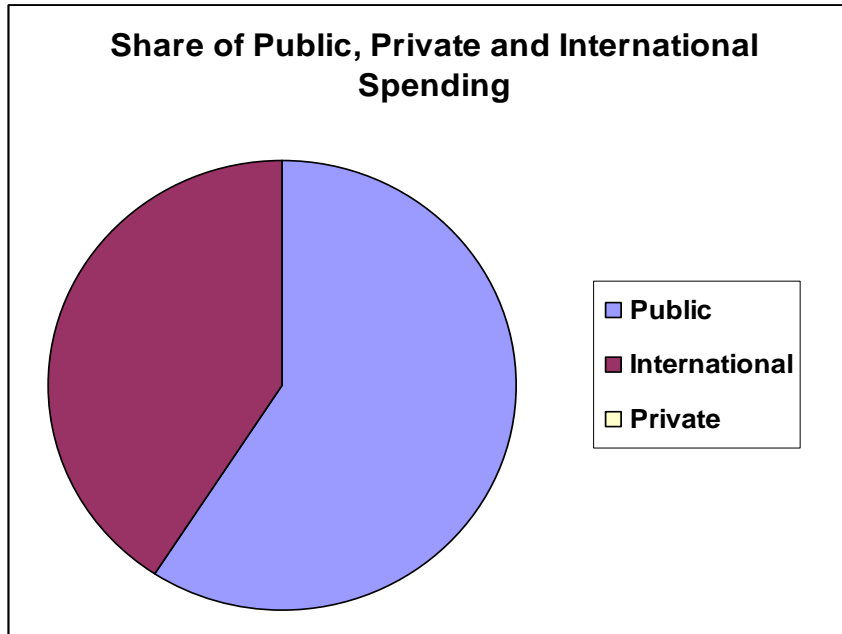
The investment in HIV/AIDS prevention and control activities have increased significantly over the years. For an assessment of spending in HIV/AIDS activities, a proforma based on the UNGASS requirement was circulated among all relevant stakeholders. The figures on spending were received from both national and provincial AIDS control programs, Pakistan National AIDS Consortium, UN system, donor agencies including CIDA, European Commission, DFID, ILO, the Global Fund and some private sector organizations including Concern and WFP. Data from most organizations was compiled for both 2006-2007; however some organizations submitted information for 2007 alone. It is to be noted that although majority of HIV/AIDS interventions in the vulnerable populations are being implemented through the private sector/NGOs, majority of funding for these services is by the government through its focal bodies the National and Provincial AIDS Control Programs.

A total of Rs. 1.85 billion were spent in 2006-2007 or USD 29.67 million; 60.67% spending was on HIV/AIDS prevention activities, 14.88% on research, 10.77% on program management and strengthening, 7.51% on care and treatment, 4.44% on enabling environment, 0.89% on orphans and vulnerable children, 0.56% on human resource, 0.32% on social protection and social services plus OVCs,

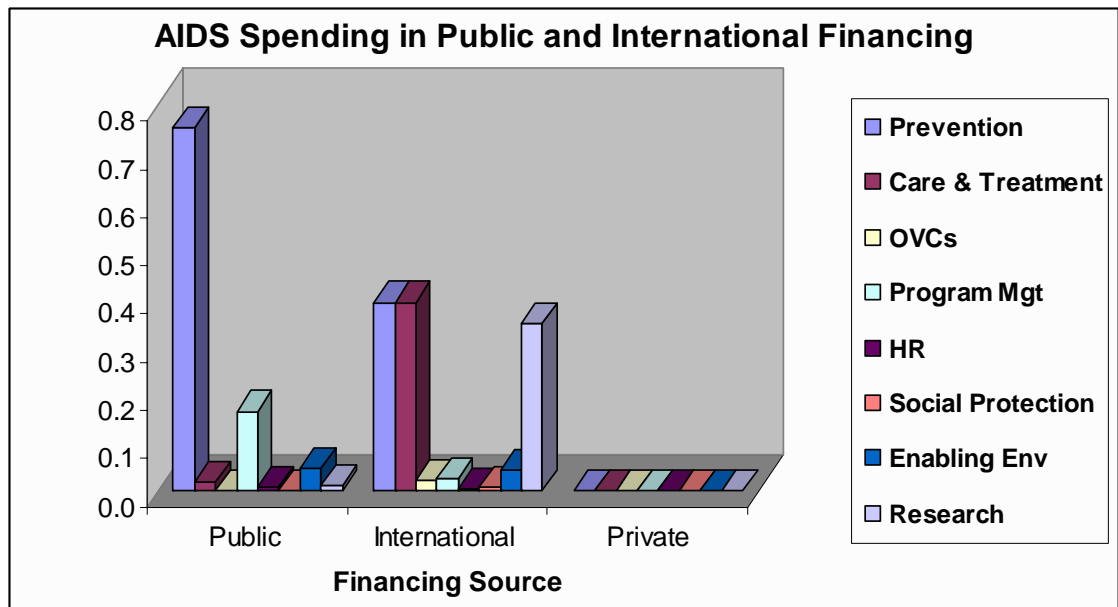




Assessment of spending within the public and private sectors and International agencies (including UN, bilateral and multilateral donors) indicates that public sector is the major financier of activities/interventions with a total of 62.2% financing by public sector, 37.7% by International source and 0% by private sector resources.



The following figure provides the breakup of spending priorities from different sources of funds in 2006-2007



## **Indicator No. 2 – Government HIV and AIDS Policies**

The National AIDS control program along with its provincial counterparts is a national response to the rising epidemic of HIV/AIDS in Pakistan. The Program has been under implementation since 1988 and since then has undergone many policy changes that reflect the overall change in the HIV/AIDS epidemic. Recently drafted National HIV Policy and Legislations are reflections of this effort; however they have yet to come into force.

For the purpose of the UNGASS, the National Composite Policy Index was compiled through interviews with relevant professional within the Public and Private sectors including the People Living with HIV/AIDS. The completed questionnaire for both parts A&B is placed at annex-2.

## **Indicator No. 3 – Percentage of Blood Screened in a Quality Assured manner**

Blood banking in Pakistan is managed through both public and private sectors, with the majority of needs being met by the Private Sector Blood Banks in the country. A total of 1.5 million Blood Bags are transfused annually in the country, of which 66% is contributed by the private sector. Screening reports are received on a quarterly basis from the public sector institutions/blood banks and is then compiled at the National AIDS Control Program. Private sector blood banking is not regulated in Pakistan and there is no mechanism for monitoring status of screening in these units. In 2005 a national survey of private sector blood banks was conducted with assistance from the Global Fund Mechanism which indicated the level of screening conducted in private sector. The results for this indicator has been obtained by compiling the quarterly reports from public sector institutions and the national private sector survey. HIV screening in Pakistan is roughly 87% and all institutions follow some form of documented SOPs for running the blood banks, however there is mechanism for external quality assurance in any of the blood bank surveyed including public sector institutions.

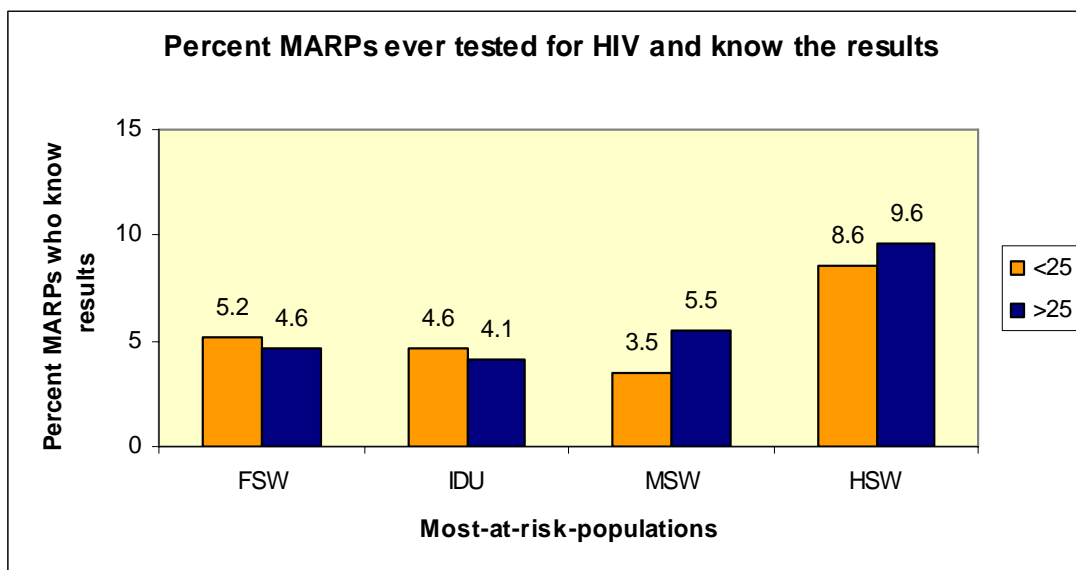
## **Indicator No. 4 – Percentage of adult and children with advanced HIV infection receiving antiretroviral therapy**

The National AIDS Control Program started providing Highly Active Retro-viral Therapy to HIV positive individual in 2005. The ARV treatment and treatment for opportunistic infections is provided according to National Guidelines for ART that were developed through a national level consultation. Since then, a total of 550 patients are receiving ARVs through nine treatment centers established under the government's AIDS Control Programs. The ARV drugs are procured through the Global Fund Project Round 2 proposal. For reporting on this indicator, an estimate of the denominator has been made since actual numbers of people with advanced HIV infection are not known. The total estimated people living with HIV in Pakistan are 74,000 according to NACP projections using WHO/UNAIDS model. The number of people (adults and children) with advanced HIV infection has been estimated by taking 10% of the 74,000 people – coming to nearly

7,500 people. Among those diagnosed with advanced HIV infection 550 are receiving ART; using this estimate approximately 7.4% of people with advanced HIV infection are currently receiving ART through National Program.

**Indicator No. 8 – Percentage of most-at-risk-populations (MARPs) who have received and HIV test in the last 12 months and who know the results**

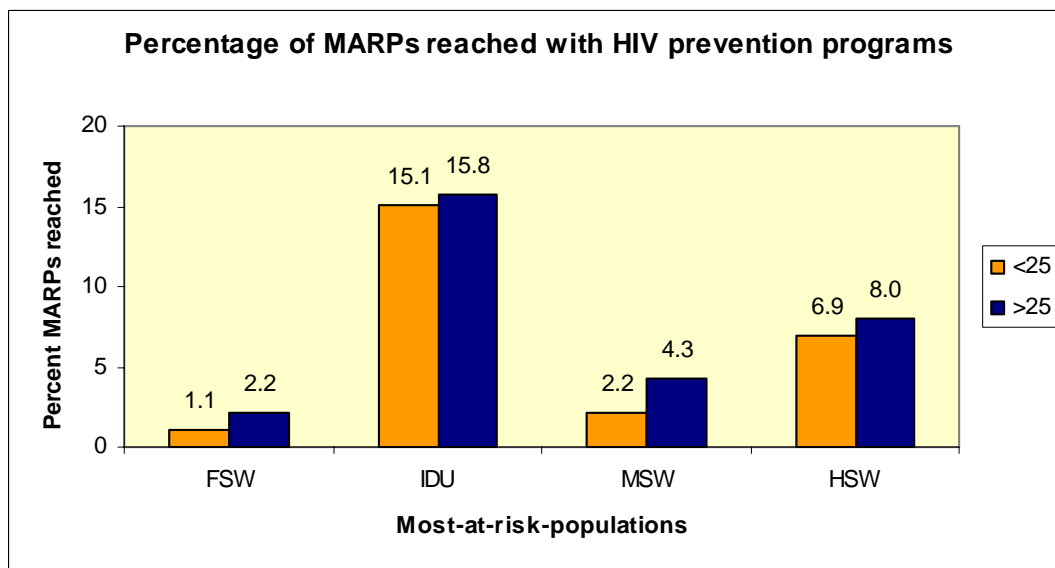
Keeping in view the trend of the epidemic, delivery of appropriate and targeted services have received a lot of focus in the current program for HIV/AIDS prevention. VCT is a key element of the defined package of services for these population sub-groups and they are being counseled for confidential testing. The data for this indicator has been collected from the round 2 HIV/AIDS Surveillance report. The MARPs for which the data has been collected are the FSWs, MSWs, HSWs and IDUs. The data has been analyzed according to category of MARP, there appears to be a higher uptake of VCT services among the FSWs and HSWs and the least uptake is seen among MSWs. However, the levels are still very low and less than 10% of individuals in any category have ever been tested for HIV and know the results; clearly indicating the need for improving self risk perception and improving VCT services for these population groups. Moreover, it must be kept in mind that this data provides information on ‘ever tested’ which is not completely in line with the requirements of the UNGASS (which needs ‘tested in the last 12 months’). The following figure depicts information on the indicator



**Indicator No. 9 – Percentage of most-at-risk-populations reached with HIV prevention programs**

The UNGASS requirements for this indicator require specific questions on services being availed by the MARPs. In the latest round of surveillance with MARPs, the assessment for coverage was defined by two specific questions; if the MARPs were aware of

government run service delivery projects and whether they utilized any of the services available onsite or through outreach activities. The question specifically asks about ‘government run projects’ and it is expected that this may be an underestimation of service coverage since there are a number of services being provided by NGOs or private sector organizations that might be excluded as a result. Highest coverage of services is seen among Injecting Drug Users (approx. 16%) followed by HSWs. FSWs have the least coverage of services. The figure below depicts the breakup according to age

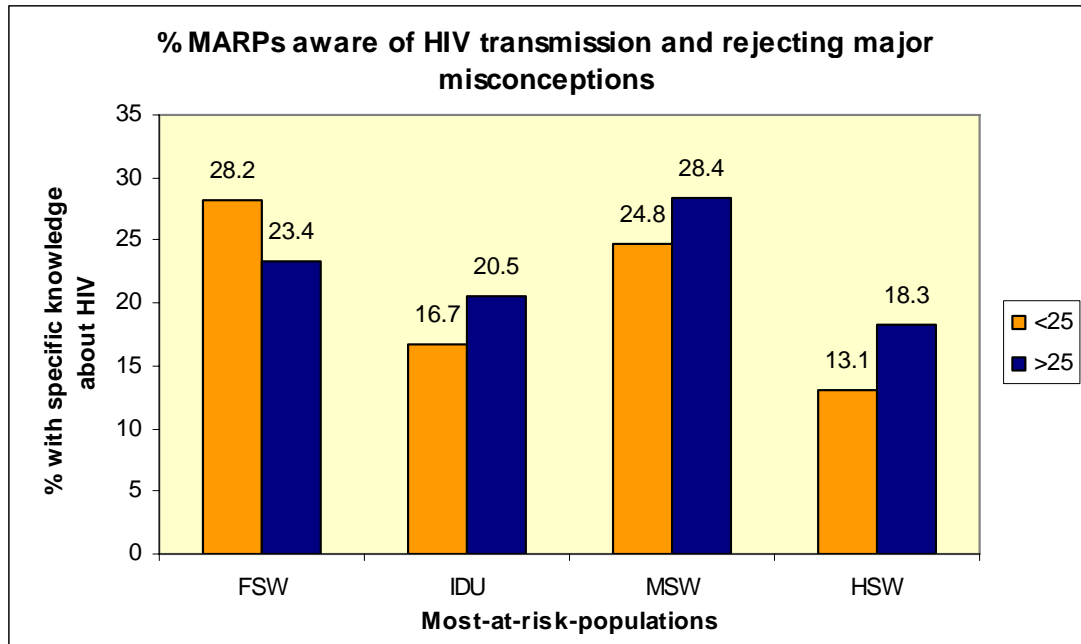


**Indicator No. 11 – Percentage of schools that provide life skills-based education in the last academic year**

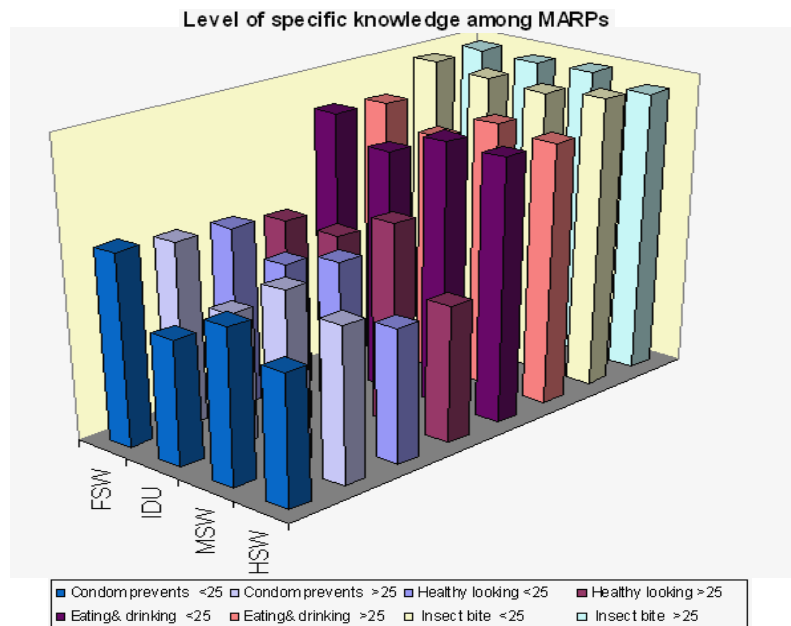
The National AIDS Control Program through successful application in the Round 2 of the Global Fund. As part of this proposal, the NACP developed a Life Skills based Education Curriculum in Collaboration with UNICEF. As per target the LSBE was applied in a total of 200 schools (secondary and higher secondary) in six (6) districts of the country’s northern areas. The project was implemented through contracting out services to the World Population Fund. Although accurate numbers are not available, the estimated number of public and private sector schools is 3375 which is being used as a denominator and thereby an estimated 6% of schools provided LSBE according to UNGASS indicator in the. It is however pertinent to note that this percentage is not reflective of the national prevalence since currently there are no national programs in place to provided life skills based education in public and private sector schools. Also these figures do not include any private sector response in this area. Although the NACP is collaborating with the Ministry of Education to provide LSBE among schools but the program is still in its inception phase and focuses mostly on public sector institutions.

**Indicator No. 14 – Percentage of most-at-risk-populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**

A detailed behavioral questionnaire was part of the Round 2 IBBS conducted in 2007. Specific questions were asked related to HIV/AIDS transmission and common misconceptions. However there are some differences among the questions included in the IBBS and the UNGASS requirement. The highest level of specific information was found among FSWs (<25 – 28.2%; >25 – 23.4%) followed by MSWs (<25 – 24.8%; >25 – 28.4%), IDUs (<25 – 16.7%; >25 – 20.5%) and lowest was in HSWs (<25 – 13.1%; >25 – 18.3%).



The following are the results of individual questions:

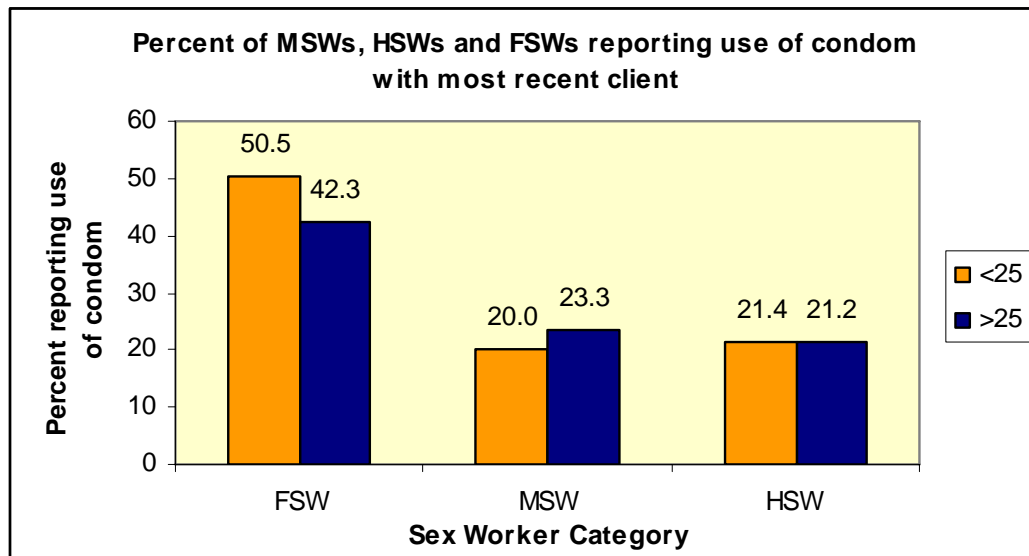


**Indicator No.15 – Percentage of young women and men aged 15-24 yrs who have had sexual intercourse before the age of 15**

The National AIDS Control Program in collaboration with UNICEF conducted a situation assessment of adolescents in 14 districts of Pakistan. The study was conducted to develop baseline for service delivery project for adolescents aged 13-19 yrs. Although the age group is not specific to the requirements of the UNGASS, the findings of the study indicate that overall 0.67% of adolescents reported having sex before the age of 15; males slightly more than females 0.92% Vs 0.42%.

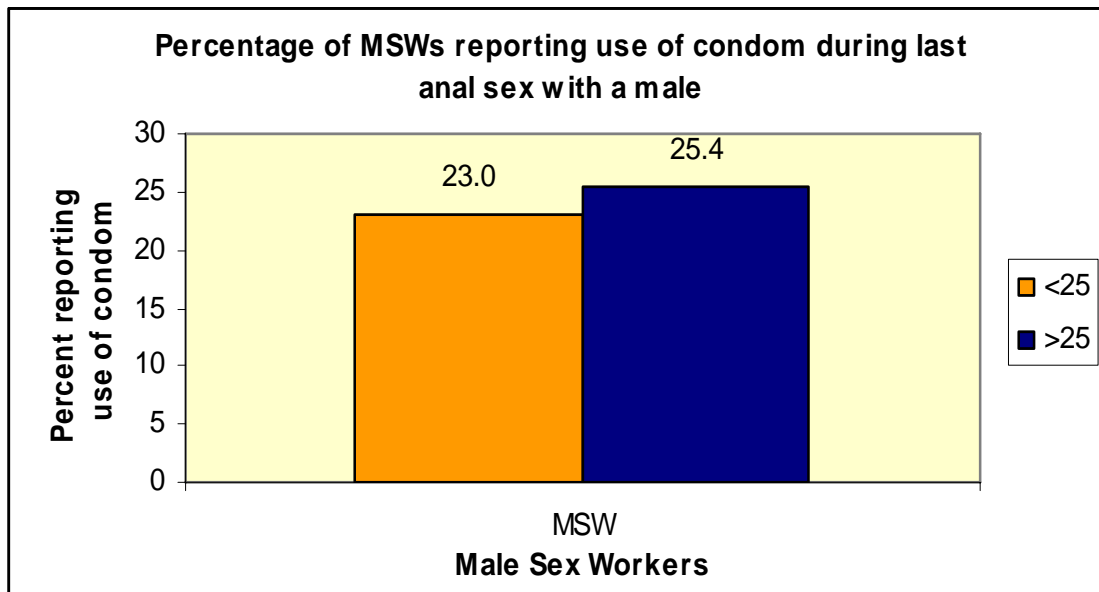
**Indicator No. 18 – Percentage of Male and Female Sex Workers reporting the use of a condom with their most recent client:**

In 12 cities mapped in second round of surveillance, FSWs were the highest HRG with an estimated total of 49,037 at 7,598 spots. On average FSWs were found to serve  $2.6 \pm 1.8$  clients per day, brothel based FSWs had about 4.3 clients per day. Condom use during sexual activity was found to be low, overall only 22.6% FSWs reported always using condom with their clients and consistent condom use with clients was highest for brothel based FSWs (42%) and lowest for home based FSWs at 19%. 45% FSWs reported condom use during vaginal sex, while condom use during anal sex was v low (7.9%). Condom use during last sexual intercourse/with most recent client was assessed and data was analyzed according to FSW typology; brothel based FSWs had highest condom use with a paying client (67.1%), lowest condom use was seen with street and home based FSWs. A total of 19,320 MSWs and 14,725 Hijra Sex Workers (HSWs/Unix) were mapped during the second round of surveillance. MSWs reported an average of 2.1 clients ( $\pm 1.5$ ) per day and HSWs 2.5 ( $\pm 2.1$ ) per day; HSWs on average had a higher client volume as compared to MSWs. Roughly 35% MSWs and 33% HSWs reported having had sex with at least one non paying client in the last month. Condom use during sexual activity was generally low for both MSWs and HSWs; overall 7.7% MSWs and HSWs reported always using condoms with their clients. Condom use during last sexual intercourse/with last client was less than 22% for both MSWs and HSWs, however, while there was variation in condom use according to age in MSWs (less use among younger compared to older MSWs), this was not seen among HSWs.



**Indicator No 19 – Percentage of Men who report the use of condom the last time they had anal sex with a male partner**

In Pakistan there is no defined or visible population of men who have sex with men and who fall into the category of ‘Gays’. The only sub-group/population that is accessible to services and research and are associated with MSM are the Male Sex Workers, Hijra Sex Workers do not fall into this category. Among these 23.0% aged less than 25 yrs used condom the last time they had anal sex and 25.4% aged more than 25 yrs used condom the last time they had anal sex with male partner

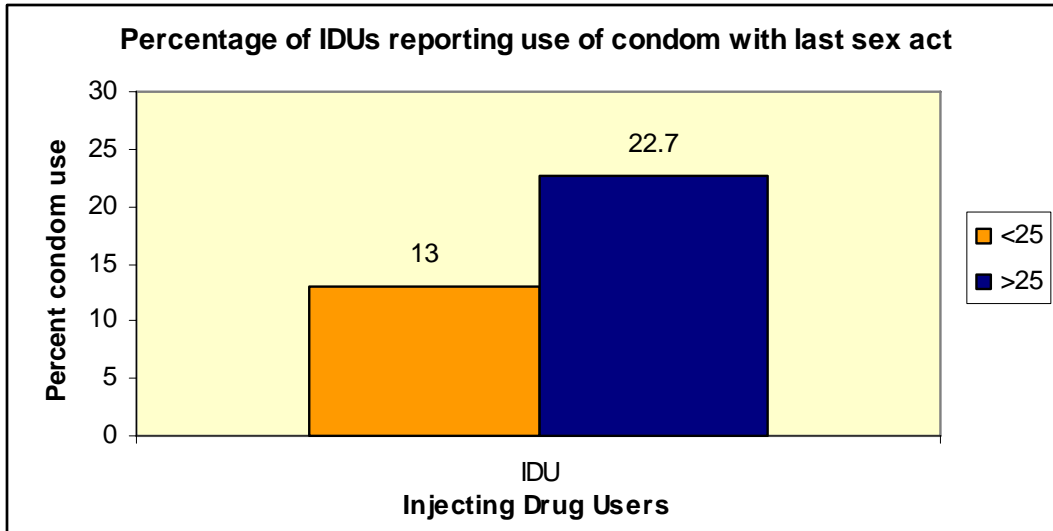


**Indicator No. 20 – Percentage of Injecting Drug Users reporting the use of a condom the last time they had sexual intercourse**

The definition for Injecting Drug User in Pakistan is different from that defined by the UNGASS monitoring report. In HIV/AIDS Surveillance Round 2, anyone injecting in the past 6 months is included in the category of IDU since there is considerable switching from injecting to non injecting drug use among drug users depending upon the quality and availability of drugs. A non injector may shift to injecting if quality of available drug is poor or drug of choice is not available and by limiting the definition of IDUs we may not be able to get a true picture of behavioral practices.

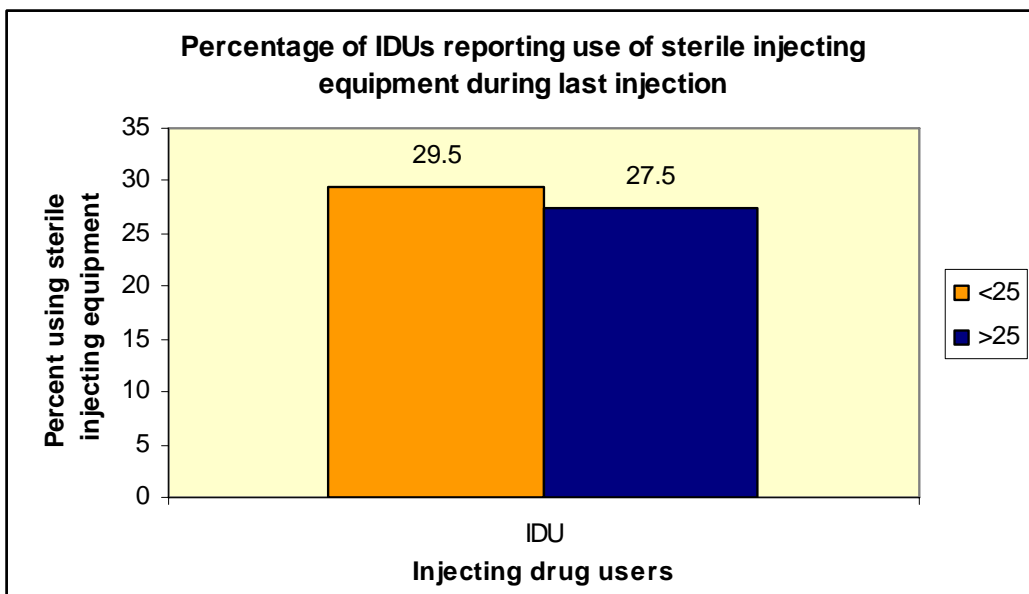
Mapping exercise found that IDUs are the second largest HRG in Pakistan, overall estimate of 33,000 from 12 cities mapped at 4,261 spots. Approximately 86% of IDUs were reportedly sexually active and 46% reported sex with a regular female partners and condom use with regular sex partner during last contact was only 16.5%. While 27% of IDUs reported paying FSWs for sex in the past 6 months, of these only 21% used

condoms, among those having had contact with MSW/HSW only 13% reported having used condoms



**Indicator No. 21 – Percentage of Injecting Drug Users reporting the use of sterile injecting equipment the last time they injected.**

The average number of injections per day for IDUs was  $2.2 \pm 1.7$  per day and average number of injections per day did not differ by age group. 15% IDUs reported injecting once per day in the last 6 months, 67% twice a day and 18% more than three times per day. Most common drug injected was Avil, but there was significant use of Heroin in 2 cities that were surveyed and which are also HIV epidemic hotspots. Use of professional injectors/street doctors was uncommon with only 3.6 % reporting exclusive reliance on such services.

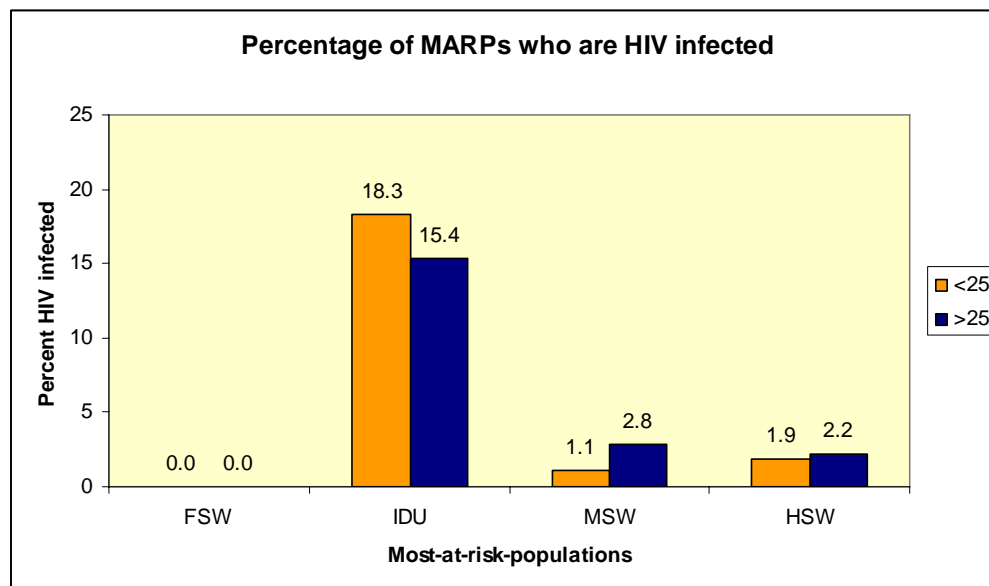




Overall approximately 41% IDUs reported always using a new syringe in the past month; only 5.3% reported always reusing/sharing syringe. There was little difference in needle sharing practices across age groups; however findings indicate lesser use of new injecting equipment in the 25-29 yrs age group. 27.5% reported having injected with a used needle/syringe on their last injection; 25% reported needle sharing with another IDU and 8% reported sharing other injecting equipment in their most recent/last injection. 19% IDUs reported having shared with two or more people during last injection.

**Indicator No. 23 – Percentage of Most-at-risk-populations who are HIV infected:**

From a randomly selected sample of 4,639 FSWs in 12 cities only one FSW tested positive viz 0.021%, whereas the overall HIV sero prevalence among IDUs was 15.8% (95% CI 14.7%, 16.9%), however since the survey some 12 FSWs have tested positive for HIV in one city (Faisalabad). A high degree of variability was seen between cities, with the city of Sargodha having the highest prevalence – 51.3% followed by Karachi – 30.1%; HIV prevalence among IDUs was less than 5% in the cities of Gujranwala, Peshawar and Bannu. Among the MSWs overall HIV prevalence was 1.5% (95% CI 1%, 2%) and among HSWs HIV prevalence was 1.8% (95% CI 1.3%, 2.5%). The city of Karachi registered the highest number of positive MSWs – 7.5% followed by Bannu – 4%. For HSWs the highest prevalence was recorded in city of Larkana – 14%. The following chart indicates the prevalence of HIV among MARPs (<25 yr; >25yr)



**Indicator No. 24 – Percentage of adults and children with HIV still alive and know to be on treatment 12 months after initiation of anti-retroviral**

Reports from the treatment centers are patchy and discontinuous, an estimate obtained from one major center that caters to about 30% of the total patients on ART, indicates that of patients on ART for 12 months or more 87% of them are still receiving ART and follow up at the treatment center. The remaining 13% are either lost to follow up or have died, but conclusive information is still missing.

## **HIV/AIDS RESPONSE – BEST PRACTICES**

Pakistan is closely following in the Asian Epidemic Model and primarily the HIV epidemic is contained within the vulnerable/high risk groups particularly the Injecting Drug Users with potential for spillover into the general population. Harm reduction is one of the success stories in Pakistan and HIV prevention services were started in 2002-2003 as part of harm reduction services to DU/IDUs in 7 cities of the country with financial assistance from DFID. Since then Pakistan has gained considerable experience in harm reduction activities and is now set to pilot drug substitution among drug users in joint partnership program involving the National/Provincial AIDS Control Programs, Anti Narcotics Force, Ministry of Narcotics Control and the UNODC. Harm reduction services are being implemented by partner NGOs. Although coverage of these programs is still low compared to requirements as per targets, biological and behavioral surveillance studies have shown increase in knowledge regarding HIV/AIDS, increase in condom use and decreased sharing of syringes/needles for injecting among IDUs/DUs exposed to the program activities. There has been a decrease in unsafe practices and increase in risk perception among members of this vulnerable sub-group as a result of harm reduction services being implemented in comparison to cities where such services are not available.

In addition, another best practice that has emerged in the past few years is the country specific 2<sup>nd</sup> generation surveillance interventions for tracking trends in the epidemic. This is a five year project for biological and behavioral surveillance with grant financing from the Canadian International Development Agency. The project has developed country specific methodology for surveillance with mapping of high risk groups in the first phase and collection of behavioral and biological data after mapping has been completed. As a result of the exercise, upto date size estimates are available with the program regarding major high risk groups in the country and the National Program has been able to use the data to direct its response for service delivery and effective outcomes. The project has also been able to provide data related to program activities and coverage of services among the FSWs, IDUs, MSWs and HSWs. As part of the second phase of future collaboration with CIDA, the project is being further scaled up to develop capacity of both national and provincial programs in the field of surveillance and institutionalize surveillance activities in the programs for HIV/AIDS prevention and control

## **MAJOR CHALLENGES:**

In 2006, the government of Pakistan undertook a detailed situation and response analysis followed by a mid term review of the national HIV response by engaging a team of independent experts. The team reviewed available data, ongoing interventions and undertook broad based consultations with UN system, bilateral donors, NGOs, People living with HIV and AIDS, and other public and private sector stakeholders. The reports prepared by the team identified a number of gaps and constraints which include:

1. **Denial:** Despite the fact that Pakistan’s status has changed from that of a ‘high risk, low prevalence’ country to one that has a concentrated epidemic, there is still a reluctance to accept that there is a danger of a generalized epidemic
2. **Cultural and social factors:** Cultural, social and religious taboos concerning the discussion of sexual behavior have inhibited the public discussion of reproductive health and sexual behaviors
3. **Low coverage of services for target populations:** The coverage of HIV prevention and control services among target populations especially high-risk groups (HRGs) remains low, both in terms of numbers and types of target populations
4. **Little or no services for bridge populations:** Long distance truckers are the only bridge populations that are being addressed under current programs, others such as clients of sex workers, men on the move have yet to receive focus
5. **Lack of targeted services for youth:** Youth is very broadly categorized and implementation of interventions to educate youth on reproductive and sexual health is still not very specific
6. **Low quality of care:** Quality of care in counseling and treatment services remains an issue.
7. **Minimal public-private partnerships:** although there has been greater involvement of private sector/NGOs/CBOs in prevention efforts, they have yet to develop themselves and are still very much dependent on public sector and donor support
8. **Program implementation:** lack of technical expertise, effective monitoring and evaluation systems and effective communication programs are programmatic issues that hamper program interventions and hinder expansion of coverage of services
9. **Capacity issues:** There is limited availability of human resources with right skills mix throughout the country. Four major areas of capacity gap that have been identified include: (i) critical shortage of technically qualified persons (ii) lack of knowledge about HIV and STIs among government health workers and private medical care workers (iii) limited NGOs capacity to effectively scale up successful interventions, and (iv) management capacity gaps among NACP and PACPs staff

Based on the constraints and gaps identified in the Situation and Response analysis and Mid Term Review of the National Response, the following strategies are proposed in the revised National Strategic Framework for expanding the scope of services and scaling up HIV/AIDS interventions in Pakistan:

1. Scaling up program delivery:
  - a. Expansion in the level of existing services to provide greater coverage both geographically and numerically
  - b. Expansion in the range of services based on the needs of the target group and linking them to the formative and operational research for refinement
  - c. Greater focus on quality of services while ensuring minimum standards set for service delivery
2. Create an enabling environment
  - a. Legislation to provide overarching framework and protect the rights of individuals
  - b. The development of a wide range of rules for institutions, practitioners etc

- c. Increasing awareness and changing behaviors to reduce stigma and discrimination associated with HIV infection
- 3. Build the right capacity
  - a. Availability of sufficient and suitably qualified, trained and experienced personnel
  - b. Availability of suitable equipment and supplies
- 4. Strengthen institutional framework
  - a. Allocation of roles, responsibilities and reporting relationships
  - b. Strengthening structures that formulate and establish rules i.e. regulating activities and developing quality standards

## **SUPPORT FROM COUNTRY'S DEVELOPMENT PARTNERS**

Bilateral and multilateral donors have been key collaborators in Pakistan's national response to the HIV epidemic. Since the beginning of the epidemic they have extended their support for HIV/AIDS prevention services in the country and supporting positive policy and legislative environment for people living with and affected by HIV/AIDS. In recent years their inputs in terms of both financial and technical assistance for HIV prevention efforts have increased and there is a willingness to develop annual workplans that are in line with the National Strategic Framework. There has been extensive involvement of development partners in the revision of the NSF and it is envisaged that throughout the period of NSF-two i.e. 2007-12, this partnership would continue to attain the goal, objectives and, ultimately the success of the national response. Development partners are expected to work in close collaboration with government and other partners to establish what roles they may be in a position to play within the national response and where they can offer strategic technical and financial support based on their comparative advantage. A key role as defined in the NSF for Development Partners is not only be to seek out and make available innovations that assist in the implementation of the national response, but also to provide technical guidance that directs the government in attainment of national goal and the MDG targets pertaining to HIV/AIDS epidemic. Following are some important roles and responsibilities of development partners as envisaged in the the NSF:

- Forge partnerships to address emerging or unattended priorities;
- Ensure, within the context of their existing agreements, adaptability to respond to emerging priorities;
- Support the modalities of the national response that government partners see as core challenges, but are excluded in their program development; and
- Channel their assistance through a single entry point for HIV and AIDS interventions in the country to avoid duplication and ensure sustainability of services.

## **MONITORING AND EVALUATION**

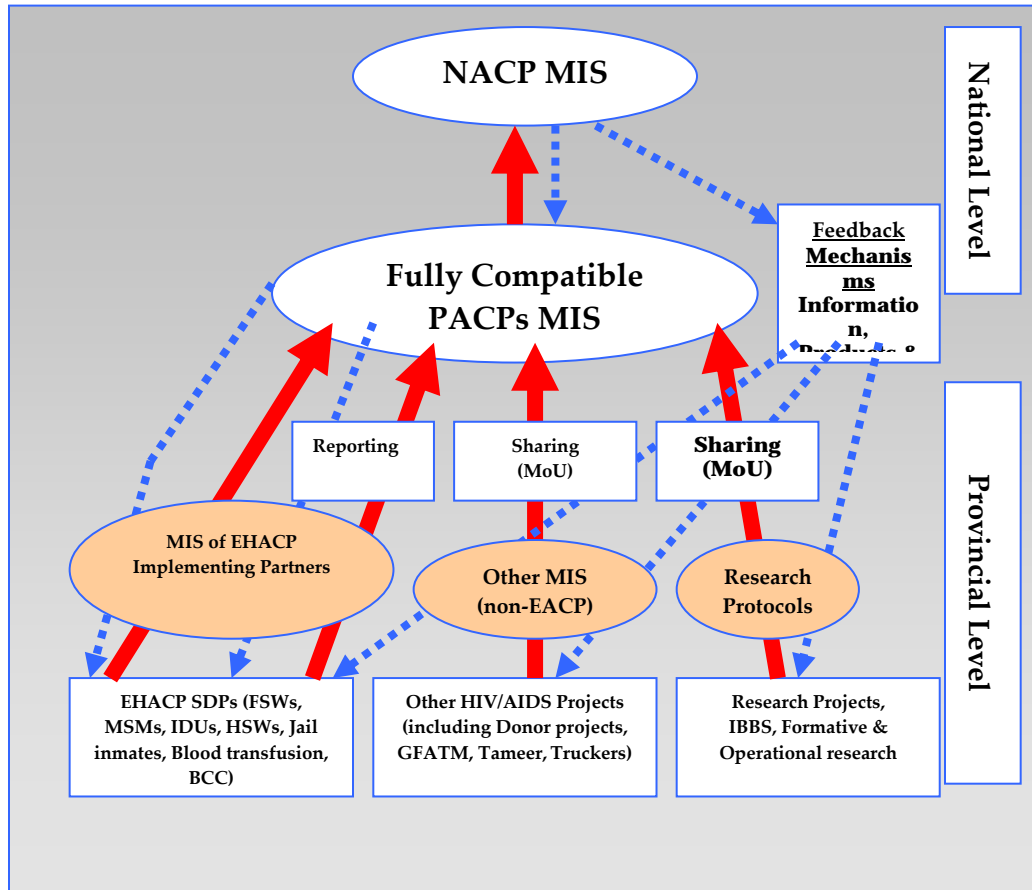
The Enhanced HIV/AIDS Prevention Program included mechanism for effective monitoring and evaluation of the project activities. Detailed indicators for M/E were outlined separately for each component against which the activities were regularly monitored by the federal and provincial implementation units. In addition the Program also engaged a firm/organization for third party evaluation of the progress on the project activities for 3 major areas i.e. Blood Safety, VCT services and STI services. The following are the indicators:

1. HIV prevalence among vulnerable populations
2. STI (syphilis) prevalence among vulnerable populations
3. HIV prevalence among women attending ANC
4. Condom use during last sex act among vulnerable populations
5. Use of clean needles during last week by IDUs
6. Percent of blood transfusion in the public sector screened for HIV in labs meeting QA standards
7. Level of knowledge about HIV/AIDS including correct identification of modes of transmission of HIV
8. Percent of general population expressing positive attitude towards AIDS patients
9. Among general adult population admitting to sex with non-regular partner, proportion using a condom

The M & E activities including surveillance are also coordinated by M&E sub-committee of TACA that has representation from public and private sectors including PLWHA, and developmental partners. This M & E sub-committee is mandated to provide technical inputs and guide the national monitoring and evaluation and surveillance efforts to track the epidemic and steer the Program interventions accordingly. The M & E unit manages a central national data base and surveillance system which is established at the National AIDS Control Program and also coordinates activities with the HIV/AIDS Surveillance Project

The indicators mentioned above were developed at the time of the project inception with a view to monitoring progress of the project, however they lacked a holistic approach for a monitoring and evaluation system that could cater to information generated from all relevant sources that may not be directly linked to the NACP. In 2005, the NACP developed a comprehensive Monitoring and Evaluation Framework through technical assistance. The National M&E framework outlines a comprehensive M&E system that collates information related to the epidemic and performance indicators of the national response from all relevant sources including service delivery projects, sentinel surveillance site, donor supported projects being implemented in the private sector, HIV/AIDS surveillance activities in vulnerable populations, small research projects/small grants project and national studies. The NSF – II has also identified the M&E framework as a crucial element to the national response with the development of an appropriate and

uniform MIS system. The following figure provides a representation of the flow of information for assessing the national response<sup>6</sup>



<sup>6</sup> National Strategic Framework 2007-2012

## **ANNEX-1 CONSULTATION PROCESS:**

The National AIDS Control Program in coordination with the UNAIDS initiated the process for consultations with stakeholders in November 2005 with the involvement of the Planning Commission of Pakistan. Given the overall political situation in the country, there was considerable delay, an informal meeting was held in the Planning Commission with UNAIDS and NACP in mid November 2007 which led to a larger stakeholder meeting on 10<sup>th</sup> December 2007. During this meeting sources of data were identified and a core working group was identified for data collation and processing. A draft report was developed which was shared with a large number of stakeholders and inputs/comments from the same were sought in another meeting held on 26<sup>th</sup> January 2008. The inputs from all partners were incorporated in the report for finalization.

### **Meeting of stakeholders on UNGASS Country Reporting for 2008**

Date: December 10<sup>th</sup> 2007

Venue: Committee Room of the National AIDS Control Program

#### **Attendance:**

1. Dr. Hassan Abbas Zaheer, National Program Manager, NACP
2. Mr. Asghar Abbasi, Dty Chief (II), Planning Commission
3. Dr. Ayesha Rasheed, Epidmeiologist, NACP
4. Dr. Muhammad Saleem, M&E Officer, UNAIDS
5. Dr. Quaid Saeed, HIV/AIDS Officer, WHO
6. Dr. Nasir Sarfaraz, Program Officer (Punjab), UNAIDS
7. Dr. Salman Safder, Program Officer (Sindh), UNAIDS
8. Mr. Aftab Awan, CE , PNAC
9. Dr. Faran Emmanuel, Field Epidemiologist, HASP
10. Dr. Shazia Shehzad, Consultant, NACP

#### **Proceedings:**

The following were the proceedings:

1. Introduction of the participants
2. Presentation of by Dr. Muhammad Saleem on the process for the UNGASS reporting including the deficiencies and issues with the report for the year 2006. Also identified TA assistance from the UNAIDS for the development of the report and training and entry on the CRIS
3. Presentation by Dr. Ayesha Rasheed on the Country level indicators for 2008 and conducted a detailed discussion on the sources for each indicator including those available with the NACP

#### **Decisions reached:**

1. For indicator Nos 6, 10, 12, 15, 16, 17 & 22 data is either not available or the indicator is not applicable in the Pakistani context



2. For indicator No.1 information on private sector funding sources and areas of intervention, Mr. Aftab from PNAC would provide all relevant information from the NGOs and other private sector organizations and provide the information by December 18<sup>th</sup>
3. Data for indicator Nos 8, 9, 14, 18, 19, 20, 21 & 23 can be obtained from the data available with HASP
4. For data on indicator No 4 the contact people are Dr. Ayesha Khan and GFATM; also some information can be obtained from the Universal Access report
5. For data on indicator No 5 the contact people are UNICEF and Dr. Ayesha Khan
6. For data on indicator Nos 7&11 data can be collated from Global Fund VCT Centers and their LSBE project; Contact GFATM
7. For indicator No 3 the denominator needs to be estimated and numerator collected from AFIT, Hussaini and AKU blood banks
8. The international consultant will be in Pakistan from 11-13<sup>th</sup> January 2008 for data entry and training on CRIS

**Follow up actions:**

1. Letter of introduction for PNAC to collect data on national AIDS spending from private sector organizations
2. Interviews with key people in private sector organizations for the NCPI part B to be completed by December 18<sup>th</sup>

**Consultative meeting on UNGASS Country Reporting for 2008**

Date: January 26<sup>th</sup> 2008  
 Venue: Best Western Hotel Islamabad

**Attendance:**

1. Mr. Fazl-e-Hakim, Deputy Chief, Planning Commission
2. Dr. Hassan Abbas Zaheer, National Program Manager, NACP
3. Dr. Parveen Farooq, Provincial Program Manager, (AJK)
4. Mr. Arkadius Majsuk UNAIDS Country Coordinator
5. Dr. Ayesha Rasheed, Epidemiologist, NACP
6. Mr. Naeem Akhter, Health Education Officer, NACP
7. Dr. Muhammad Saleem, M&E Officer, UNAIDS
8. Dr. Quaid Saeed, HIV/AIDS Officer, WHO
9. Ms. Bettina Schunter, UNICEF
10. Mr. Mathew Cook, Consultant, UNAIDS Geneva
11. Dr. Salman Safder, Program Officer (Sindh), UNAIDS
12. Mr. Aftab Ahmed Awan, CE, Pakistan National AIDS Federation
13. Dr. Pashmina Ata, Field Epidemiologist, Provincial AIDS Program (Punjab)
14. Dr. Shazia Shehzad, Consultant, NACP
15. Dr. Rajwal Khan, Provincial Program Officer, WHO

16. Dr. Muhammad Zakir, Provincial Coordinator, PACP, Sindh
17. Dr. Khurram Shahzad, Program Officer, FHI
18. DrMr. Adil Sheraz, Program Manager, CRS
19. Mr. Sajjad Akbar, Finance Manager, AMAL
20. Ms. Fauzia Akbar, Program Manager, Contech Int. Lahore
21. Dr. Nauman, Deputy Program Manager, ACP, FATA
22. Dr. Ghous Malik, Project Manager, Al-Nijat Welfare Society
23. Dr. Mubarak Ali, Deputy Project Manager, Pakistan Society
24. Dr. Nasira Malik, Medical Superintendent, FPAP
25. Ms. Sophia, Manager PMER, Dost Foundation
26. Mr. Muhammad Ayub, Program Director, Dost Foundation
27. Dr. Asma Ali, Project Manager, ORA International
28. Ms. Mariam Jamal, Communication Officer, WPF
29. Dr. M. Irshad Danish, Project Manager, Legends Society

### **Proceedings:**

The following were the proceedings:

1. Introduction of the participants
2. Remarks by the National Program Manager, National AIDS Control Program
3. Remarks by the UNAIDS Country Coordinator
4. Presentation of by Dr. Muhammad Saleem on the process for the UNGASS reporting including the deficiencies and issues with the report for the year 2006.
5. Presentation by the UNAIDS CRIS TA, on the CRIS reporting system
6. Presentation by Dr. Ayesha Rasheed on the Country level indicators for 2008 and conducted a detailed discussion on the data being used for the indicators and other possible sources
7. Detailed discussion on the questions for the NCPI, which was shown on the screen for all the participants. All questions of both parts A&B of the NCPI were reviewed and changes were made in the CRIS according to the inputs and agreements of the participants
8. Mr. Aftab Awan intimated that the efforts of the private sector organizations were not reflected in the narrative part of the report and he would provide a brief write up for incorporation in the report within 1-2 days
9. Discussions were also held regarding on all the reportable indicators among all participants and additional sources for data generation were identified.

### **Decisions reached/follow up actions:**

1. Participant who felt they could add additional data in the report would provide the required data for entry into the CRIS within two (02) days after conclusion of the workshop
2. The PNAC would provide the write up on behalf of private sector/NGOs for inclusion in the report as well as possible constraints and areas for donor inputs
3. The narrative report would also include some write up on AIDS Spending assessment and highlight that although a multisectoral strategy for HIV/AIDS prevention and control exists in the country, spending on AIDS is mainly through

the health budget and HIV/AIDS is still seen primarily as a health priority in Pakistan.

4. Additional corrections in the report as identified by the participants would be made in the narrative document
5. All comments on the narrative report would be submitted to the focal person by January 29<sup>th</sup> after which the report would be finalized and thereafter submitted to UNAIDS by January 30<sup>th</sup>, 2008

The workshop ended with a vote of thanks from the Deputy Chief, Planning Commission who again stressed the need for collaborative efforts in the national response to HIV/AIDS

## ANNEX-2 NATIONAL COMPOSITE POLICY INDEX

# NCPI

Custom Analysis Extract of :  
NCPI - Pakistan

### NCPI – Contact Details

**COUNTRY:**

Pakistan

**Name of the National AIDS Committee Officer in charge:**

Dr. Hasan Abbas Zaheer, National Program Manager

**Postal address:**

National AIDS Control Program, NIH, Chakshahzad, Islamabad 44000, Pakistan

**Tel:**

+92-51-9255096, +92-51-9255367-8

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+92-51-9255214

**E-mail:**

hasan@isb.comsats.net.pk

**Date of submission:**

1/30/2008

### NCPI Respondents

[Indicate all respondents whose responses were compiled to fill out (parts of) the NCPI in the below table]

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

Organisation	National AIDS Control Program
Name/Position	Dr. Hasan Abbas Zaheer, National Program Manager
Respondents to Part A [indicate which parts each respondent was queried on]	A.I / A.II
Organisation	Planning Commission of Pakistan
Name/Position	Mr. Fazle-Hakeem, Deputy Chief
Respondents to Part A [indicate which parts each respondent was queried on]	A.I / A.II
Organisation	National AIDS Control Program
Name/Position	Mr. Naeem Akhter, Health Education Officer
Respondents to Part A [indicate which parts each respondent was queried on]	A.III
Organisation	National AIDS Control Program
Name/Position	Dr. Ayesha Khan, HIV/AIDS Treatment Specialist
Respondents to Part A [indicate which parts each respondent was queried on]	A.IV
Organisation	National AIDS Control Program
Name/Position	Dr. Aliya Rabbani, Field Epidemiologist / M&E Officer
Respondents to Part A [indicate which parts each respondent was queried on]	A.V

**Other respondents to Part A**

Participants of the National Consultative Workshop for UNGASS, list provided in the narrative report

**NCPI - PART B [to be administered to nongovernmental organizations, bilateral agencies, and UN organizations]**

Organisation	Human Rights Commission
Name/Position	Mr. Zia Awan
Respondents to Part B [indicate which parts each respondent was queried on]	B.I
Organisation	FHI
Name/Position	Mr. Nasiruddin Nizamani
Respondents to Part B [indicate which parts each respondent was queried on]	B.I / B.II / B.III / B.IV
Organisation	UNODC
Name/Position	Dr. Nadeem ur Rehman
Respondents to Part B [indicate which parts each respondent was queried on]	B.I / B.II / B.III / B.IV
Organisation	PACF
Name/Position	Mr. Aftab Awan
Respondents to Part B [indicate which parts each respondent was queried on]	B.II / B.III / B.IV
Organisation	UNICEF
Name/Position	Ms. Bettina Schunter
Respondents to Part B [indicate which parts each respondent was queried on]	B.III
Organisation	UNFPA
Name/Position	Dr. Safdar Kamal Pasha
Respondents to Part B [indicate which parts each respondent was queried on]	B.III
Organisation	WHO
Name/Position	Dr. Qaid Saeed
Respondents to Part B [indicate which parts each respondent was queried on]	B.IV
Organisation	PLWHA
Name/Position	Ms. Shukriay Gul
Respondents to Part B [indicate which parts each respondent was queried on]	B.IV
Organisation	PLWHA
Name/Position	Mr. Nazir Maseeh
Respondents to Part B [indicate which parts each respondent was queried on]	B.IV

#### Other respondents to Part B

Participants of the National Consultative Workshop for UNGASS, list provided in the narrative report

#### Part A. Section I. Strategic plan

#### PART A

[to be administered to government officials]

## I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy/action framework to combat AIDS?

Yes

IF YES, period covered:

2007

IF NO or N/A, briefly explain

IF YES, complete questions 1.1 through 1.10; otherwise, go to question 2.

1.1 How long has the country had a multisectoral strategy/action framework?

7

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

Health	Strategy/Action framework	Yes
	Earmarked budget	Yes
Education	Strategy/Action framework	Yes
	Earmarked budget	Yes
Labour	Strategy/Action framework	Yes
	Earmarked budget	Yes
Transportation	Strategy/Action framework	No
	Earmarked budget	No
Military/Police	Strategy/Action framework	Yes
	Earmarked budget	Yes
Women	Strategy/Action framework	Yes
	Earmarked budget	No
Young people	Strategy/Action framework	Yes
	Earmarked budget	Yes
Agriculture	Strategy/Action framework	No
	Earmarked budget	No
Finance	Strategy/Action framework	No
	Earmarked budget	No
Human Resources	Strategy/Action framework	No
	Earmarked budget	No
Justice	Strategy/Action framework	No
	Earmarked budget	No
Minerals and Energy	Strategy/Action framework	No
	Earmarked budget	No
Planning	Strategy/Action framework	Yes
	Earmarked budget	No
Public Works	Strategy/Action framework	No
	Earmarked budget	No
Tourism	Strategy/Action framework	No
	Earmarked budget	No
Trade and Industry	Strategy/Action framework	No
	Earmarked budget	No

**IF NO earmarked budget, how is the money allocated?**

Add comment:



**Part A. Section I. Strategic plan**

**1.3 Does the multisectoral strategy/action framework address the following target populations, settings and cross-cutting issues?**

a. Women and girls	Yes
b. Young women/young men	Yes
c. Specific vulnerable sub-populations [3]	Yes
d. Orphans and other vulnerable children	Yes
e. Workplace	No
f. Schools	Yes
g. Prisons	Yes
h. HIV, AIDS and poverty	Yes
i. Human rights protection	Yes
j. Involvement of people living with HIV	Yes
k. Addressing stigma and discrimination	Yes
l. Gender empowerment and/or gender equality	Yes

[3]Sub-populations that have been locally identified as being at higher risk of HIV transmission (injecting drug users, men having sex with men, sex workers and their clients, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners, etc.).

**1.4 Were target populations identified through a process of a needs assessment or needs analysis?**

Yes

IF YES, when was this needs assessment /analysis conducted? Year:

2006

IF NO, how were target populations identified?

**1.5 What are the target populations in the country?**

Female Sex Workers Injecting Drug Users Men having Sex with Men (Male sex workers) Hijra Sex Workers ( transvestites/Unix) Long Distance Truckers Prisoners/Jail Inmates Uniformed Personnel Migrant workers/labour sector Coal miner and fishermen Young people Women through women associations

**Part A. Section I. Strategic plan**

**1.6 Does the multisectoral strategy/action framework include an operational plan?**

Yes

**1.7 Does the multisectoral strategy/action framework or operational plan include:**

- |  |     |
|--|-----|
| a. Formal programme goals?                         | Yes |
| b. Clear targets and/or milestones?                | Yes |
| c. Detailed budget of costs per programmatic area? | Yes |
| d. Indications of funding sources?                 | Yes |
| e. Monitoring and Evaluation framework?            | Yes |

**1.8 Has the country ensured “full involvement and participation” of civil society[4] in the development of the multisectoral strategy/action framework?**

Moderate involvement

**IF active involvement, briefly explain how this was done:**

**IF NO or MODERATE involvement, briefly explain:**

The multisectoral strategy/action framework was developed through technical assistance obtained by National AIDS Control Program. The activity was multistage, in the initial phase, individual consultations were conducted with all stakeholders which included civil societies and People Living with HIV. Following this consultation, meetings/workshops were conducted to develop consensus and finalize the documents.

**[4]Civil society includes among others: Networks of people living with HIV; women’s organizations; young people’s organizations; faith-based organizations; AIDS service organizations; Community-based organizations; organizations of key affected groups (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.**

**1.9 Has the multisectoral strategy/action framework been endorsed by most external Development Partners (bi-laterals; multi-laterals)?**

Yes

**Part A. Section I. Strategic plan**

**1.10 Have external Development Partners (bi-laterals; multi-laterals) aligned and harmonized their HIV and AIDS programmes to the national multisectoral strategy/action framework?**

Yes, all partners

**IF SOME or NO, briefly explain**

**2. Has the country integrated HIV and AIDS into its general development plans such as:**

- a) National Development Plans,
- b) Common Country Assessments/United Nations Development Assistance Framework,
- c) Poverty Reduction Strategy Papers,
- d) Sector Wide Approach?

Yes

**2.1 IF YES, in which development plans is policy support for HIV and AIDS integrated?**

- a) National Development Plans
- b) Common Country Assessments/United Nations Development Assistance Framework
- c) Poverty Reduction Strategy Papers

**2.2 IF YES, which policy areas below are included in these development plans?**

HIV Prevention	Development Plans	a) / b) / c)
Treatment for opportunistic infections		a) / b)
Antiretroviral therapy		a) / b)
Care and support (including social security or other schemes)		a)
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support		a)
Reduction of stigma and discrimination		a) / b)
Women's economic empowerment (e.g. access to credit, access to land, training)		a) / b) / c)

**Part A. Section I. Strategic plan**

**3. Has the country evaluated the impact of HIV and AIDS on its socio-economic development for planning purposes?**

No

**3.1 IF YES, to what extent has it informed resource allocation decisions?**

**4. Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?**

Yes

**4.1 IF YES, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of one or more uniformed services?**

Behavioural change communication	Yes
Condom provision	Yes
HIV testing and counselling(*)	Yes
STI services	No
Treatment	No
Care and support	No

**(\*)If HIV testing and counselling has been implemented for uniformed services beyond the pilot stage, what is the approach taken?**

**Is it voluntary or mandatory (e.g. at enrolment)? Briefly explain:**

HIV testing in Pakistan is conducted according to the National Guidelines. The method identified in the National Guidelines is in line with the university accepted "Voluntary Counseling and Testing Approach" while maintaining confidentiality of the patient. HIV testing among Peace keeper force for the UN is mandatory. HIV testing for migrant workers going to the middle east is mandatory as per visa requirements of the recipient countries

#### **Part A. Section I. Strategic plan**

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

Yes

**5.1 Has the National Strategic Plan/operational plan and national AIDS budget been revised accordingly?**

Yes

**5.2 Have the estimates of the size of the main target population sub-groups been updated?**

Yes

**5.3 Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?**

Estimates and projected needs

**5.4 Is HIV and AIDS programme coverage being monitored?**

Yes

**(a) IF YES, is coverage monitored by sex (male, female)?**

Yes

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

Yes

**IF YES, which population sub-groups?**

Female Sex Workers Injecting Drug Users Men having Sex with Men and Male Sex Workers Hijra Sex Workers Jail inmates

**(c) IF YES, is coverage monitored by geographical area?**

Yes

**IF YES, at which levels (provincial, district, other)?**

At provincial and city level

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

Yes

#### **Part A. Section I. Strategic plan**

**Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2007 and in 2005?**

2007	7
2005	6

**Comments on progress made in strategy planning efforts since 2005:**

**Part A. Section II. Political Support**

**II. POLITICAL SUPPORT**

**Strong political support includes government and political leaders who speak out often about AIDS and regularly chair important meetings, allocation of national budgets to support the AIDS programmes and effective use of government and civil society organizations and processes to support effective AIDS programmes.**

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

President/Head of government	No
Other high officials	Yes
Other officials in regions and/or districts	Yes

**2. Does the country have an officially recognized national multisectoral AIDS management/coordination body? (National AIDS Council or equivalent)?**

Yes

**IF NO, briefly explain:**

We are referring here to "National Steering Committee"

**2.1 IF YES, when was it created? Year:**

2003

**2.2 IF YES, who is the Chair?**

Title/Function	Federal Minister of Health
----------------	----------------------------

**2.3 IF YES, does it:**

have terms of reference?	Yes
have active Government leadership and participation?	Yes
have a defined membership?	Yes
include civil society representatives? (*)	No
include people living with HIV?	No
include the private sector?	No
have an action plan?	No
have a functional Secretariat?	Yes
meet at least quarterly?	No
review actions on policy decisions regularly?	Yes
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?	Yes

**(\*) If it does include civil society representatives, what percentage?**

**Part A. Section II. Political Support**

**3. Does the country have a national AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/ programmes?**

Yes

**3.1 IF YES, does it include?**

Terms of reference	Yes
Defined membership	Yes
Action plan	Yes
Functional Secretariat	Yes
Regular meetings (*)	Yes

**(\*)If it does include regular meetings, what is the frequency of the meetings:**

biannually

**IF YES, What are the main achievements?**

Streamlining bottlenecks in implementation through technical sub-committees Improving coordination with the private sector and bilateral/multilateral donors Focusing on needs of PLHIV and speeding up the process for ARV provision to PLHIV Improving the M&E mechanism of the National Program

**IF YES, What are the main challenges for the work of this body?**

Lack of appropriate coordination between different stakeholders and bringing uniformity in the AIDS response Limited prior technical experience, given the state of the epidemic Need to focus on priority issues

**Part A. Section II. Political Support**

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

60%

**5. What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?**

Information on priority needs and services	Yes
Technical guidance/materials	Yes
Drugs/supplies procurement and distribution	No
Coordination with other implementing partners	Yes
Capacity-building	Yes
Other::BCC activities	Yes
Other::Financial support through small grants	Yes

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

Yes

**6.1 IF YES, were policies and legislation amended to be consistent with the National AIDS Control policies?**

No

**6.2 IF YES, which policies and legislation were amended and when?**

**Part A. Section II. Political Support**

**Overall, how would you rate the political support for the HIV and AIDS programmes in 2007 and in 2005?**

2007	6
2005	4

**Comments on progress made in political support since 2005:**

**Part A. Section III. Prevention**

**III. PREVENTION**

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

Yes

**1.1 IF YES, what key messages are explicitly promoted?**

Be sexually abstinent

Be faithful

Engage in safe(r) sex

Abstain from injecting drugs

Use clean needles and syringes

Fight against violence against women

Greater acceptance and involvement of people living with HIV

Greater involvement of men in reproductive health programmes

Other::Safe blood transfusion

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

Yes

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

Yes

**2.1 Is HIV education part of the curriculum in**

primary schools?

No

secondary schools?

Yes

teacher training?

Yes

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

Yes

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

Yes

**Part A. Section III. Prevention**

**3. Does the country have a policy or strategy to promote information, education and communication (IEC) and other preventive health interventions for vulnerable sub-populations?**

Yes



**IF NO, briefly explain:**

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

Targeted information on risk reduction and HIV education	IDU Sex workers Prison inmates Other sub-populations (*)
Stigma & discrimination reduction	IDU Sex workers Prison inmates Other sub-populations (*)
Condom promotion	IDU Sex workers Prison inmates Other sub-populations (*)
HIV testing & counselling	IDU Sex workers Prison inmates Other sub-populations (*)
Reproductive health, including STI prevention & treatment	IDU Sex workers Prison inmates Other sub-populations (*)
Vulnerability reduction (e.g. income generation)	IDU Sex workers
Needle & syringe exchange	IDU

**(\*)If Other sub-populations, indicate which sub-populations**

Long Distance Truck Drivers

**Overall, how would you rate policy efforts in support of HIV prevention in 2007 and in 2005?**

2007	6
2005	3

**Part A. Section III. Prevention**

**4. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV prevention programmes?**

Yes

**IF NO, how are HIV prevention programmes being scaled-up?:**

**IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts\* in need?**

	The activity is available in	
Blood safety		most districts* in need
Universal precautions in health care settings		some districts* in need
Prevention of mother-to-child transmission of HIV		most districts* in need
IEC on risk reduction		most districts* in need
IEC on stigma and discrimination reduction		most districts* in need
Condom promotion		most districts* in need
HIV testing & counselling		most districts* in need
Harm reduction for injecting drug users		most districts* in need
Risk reduction for men who have sex with men		N/A
Risk reduction for sex workers		most districts* in need
Programmes for other vulnerable subpopulations		some districts* in need
Reproductive health services including STI prevention & treatment		some districts* in need
School-based AIDS education for young people		some districts* in need
Programmes for out-of-school young people		some districts* in need
HIV prevention in the workplace		N/A

\* Districts or equivalent geographical/de-centralized level in urban and rural areas

**Part A. Section III. Prevention**

**Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?**

2007	5
2005	4

**Part A. Section IV. Treatment, care and support**

**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

**1.1 IF YES, does it give sufficient attention to barriers for women, children and most-at-risk populations?**

Yes

**2. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?**

Yes

**IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?**

**IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts\* in need?**

Antiretroviral therapy	The service is available in	some districts* in need
Nutritional care		some districts* in need
Paediatric AIDS treatment		some districts* in need
Sexually transmitted infection management		some districts* in need
Psychosocial support for people living with HIV and their families		some districts* in need
Home-based care		some districts* in need
Palliative care and treatment of common HIV-related infections		some districts* in need
HIV testing and counselling for TB patients		N/A
TB screening for HIV-infected people		some districts* in need
TB preventive therapy for HIV-infected people		N/A
TB infection control in HIV treatment and care facilities		some districts* in need
Cotrimoxazole prophylaxis in HIV-infected people		some districts* in need
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)		some districts* in need
HIV treatment services in the workplace or treatment referral systems through the workplace		some districts* in need
HIV care and support in the workplace (including alternative working arrangements)		N/A

\*Districts or equivalent de-centralized governmental level in urban and rural areas

**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?**

Yes

**4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral drugs, condoms, and substitution drugs?**

Yes

**4.1 IF YES, for which commodities?:**

ARV drugs and HIV, Hepatitis B&C screening kits

**Part A. Section IV. Treatment, care and support**

**Overall, how would you rate the efforts in the implementation of HIV treatment, care and support services in 2007 and in 2005?**

2007	5
2005	3

**Comments on progress made since 2005:**

**Part A. Section IV. Treatment, care and support**

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

Yes

**5.1 IF YES, is there an operational definition for OVC in the country?**

No

**5.2 IF YES, does the country have a national action plan specifically for OVC?**

No

**5.3 IF YES, does the country have an estimate of OVC being reached by existing interventions?**

Yes

**IF YES, what percentage of OVC is being reached?**

**Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?**

2007	2
2005	0

**Comments on progress made in efforts to meet the needs of OVC since 2005:**

The National Program is initiating service delivery packages for Most At Risk Adolescents (as part of vulnerable children) in a collaborative program with UNICEF. The program will first be piloted in selected districts of the country and with then be scaled up

**Part A. Section V. Monitoring and Evaluation**

**V. MONITORING AND EVALUATION**

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

Yes

**IF YES, Years covered:**

3

**1.1. IF YES, was the M&E plan endorsed by key partners in M&E?**

Yes

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

Yes

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

Yes, but only some partners

**2. Does the Monitoring and Evaluation plan include?**

a data collection and analysis strategy	Yes
behavioural surveillance	Yes
HIV surveillance	Yes
a well-defined standardized set of indicators	Yes
guidelines on tools for data collection	Yes
a strategy for assessing quality and accuracy of data	Yes
a data dissemination and use strategy	Yes

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

In progress

**IF YES, Years covered:**

**3.1 IF YES, has funding been secured?**

No

**Part A. Section V. Monitoring and Evaluation**

**4. Is there a functional M&E Unit or Department?**

In Progress

**IF NO, what are the main obstacles to establishing a functional M&E Unit/Department?**

**4.1 IF YES, is the M&E Unit/Department based**

in the NAC (or equivalent)? Yes

in the Ministry of Health? No

**4.2 IF YES, how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?**

**Number of permanent staff:**

9

Position		Field epidemiologist (4)
	Full time/Part time	Full time
	Since when?	September 2007
		Epidemiologist CDCU (1)
	Full time/Part time	Full time
	Since when?	Early 2006
		Data Manager/ Entery (2)
	Full time/Part time	Full time
	Since when?	Early 2006
		Assistant (2)
	Full time/Part time	Full time
	Since when?	Early 2006
	Full time/Part time	Full time

**Number of temporary staff:**

**Part A. Section V. Monitoring and Evaluation**

**4.3 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/Department for review and consideration in the country's national reports?**

No

**IF YES, does this mechanism work? What are the major challenges?**

**4.4 IF YES, to what degree do UN, bi-laterals, and other institutions share their M&E results?**

0

**5. Is there an M&E Committee or Working Group that meets regularly to coordinate M&E activities?**

Yes, but meets irregularly

**IF YES, Date last meeting:**

early 2007

**Part A. Section V. Monitoring and Evaluation**

**5.1 Does it include representation from civil society, including people living with HIV?**

Yes

**IF YES, describe the role of civil society representatives and people living with HIV in the working group**

It doesnot include PLHIV

**6. Does the M&E Unit/Department manage a central national database?**

N/A

**6.1 IF YES, what type is it?**

**6.2 IF YES, does it include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations?**

**6.3 Is there a functional Health Information System (HIS)?**

National level

Yes

Sub-national level (\*)

Yes

**(\*)If there is a functional sub-national HIS, at what level(s) does it function?**

Dsitrit Health Information system

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

Yes

#### **Part A. Section V. Monitoring and Evaluation**

**7. To what extent are M&E data used in planning and implementation?**

2

**What are examples of data use?**

1. Bio-behavioral surverillance used for assessing program effectiveness and monitoring trends in epidemic. 2. Data from service delivery projects is used to monitor coverage of services and potential gaps

**What are the main challenges to data use?**

1. Operational issues 2. No homogenity or uniformity in monitoring reports from intervention sites. 3. Interrupted data flow 4. Technical competency to collect, analyze and present data specific to audience 5. Limited data sharing



**8. In the last year, was training in M&E conducted**

At national level?	Yes
IF YES, Number of individuals trained:	30
At sub-national level?	Yes
IF YES, Number of individuals trained:	25
Including civil society?	Yes
IF YES, Number of individuals trained:	10

**Overall, how would you rate the M&E efforts of the AIDS programme in 2007 and in 2005?**

2007	6
2005	1

**Comments on progress made in M&E since 2005:**

**Part B. Section I. Human rights**

**PART B**

**[to be administered to representatives from nongovernmental organizations, bilateral agencies, and UN organizations]**

**I. HUMAN RIGHTS**

**1. Does the country have laws and regulations that protect people living with HIV against discrimination? (such as general non-discrimination provisions or provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)**

No

**1.1 IF YES, specify:**

In the draft form, policy in place

**2. Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations?**

No

**2.1 IF YES, for which sub-populations?**

**IF YES, Briefly explain what mechanisms are in place to ensure these laws are implemented:**

Although there are no specific laws per se in the country for the protection of vulnerable sub population against discrimination but the Constitution of Pakistan has a general policy of human rights which declares equal rights for all.

**IF YES, Describe any systems of redress put in place to ensure the laws are having their desired effect:**

**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 vulnerable sub-populations?**

No

**3.1 IF YES, for which sub-populations?**

**IF YES, briefly describe the content of these laws, regulations or policies and how they pose barriers:**

There are no such laws that are against the HIV prevention but the fact that Injecting drug use and sex work is illegal in the country which presents a barrier to the service delivery to these sub populations.

**Part B. Section I. Human rights**

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

Yes

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

No

**IF YES, briefly describe this mechanism**

There is no formal system to record, document and address the cases of discrimination. However such cases if brought to light are reported at National AIDs control program. Some NGOs working for PLWHA are recording and reporting these cases on a regular basis.

**6. Has the Government, through political and financial support, involved most-at-risk populations in governmental HIV-policy design and programme implementation?**

Yes

**IF YES, describe some examples**

MARPs have been involved in HIV policy design and program implementation, specifically PLWHA have been involved to a significant extent but it still needs to be more organized and more extensive.

**Part B. Section I. Human rights**

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

HIV prevention services	Yes
Anti-retroviral treatment	Yes
HIV-related care and support interventions	Yes

**IF YES, given resource constraints, briefly describe what steps are in place to implement these policies:**

1. ARV treatment centers are providing treatment free of cost. 2. HIV prevention services are provided by local NGOs with the financial support from NACP in selected cities 3. Community and home based care programs are solely implemented by NGOs.

**8. Does the country have a policy to ensure equal access for women and men, to prevention, treatment, care and support? In particular, to ensure access for women outside the context of pregnancy and childbirth?**

Yes

**9. Does the country have a policy to ensure equal access for most-at-risk populations to prevention, treatment, care and support?**

Yes

**9.1 Are there differences in approaches for different most-at-risk populations?**

Yes

**IF YES, briefly explain the differences:**

SDPs

**Part B. Section I. Human rights**

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

No

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

Yes

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

Yes

**IF YES, describe the effectiveness of this review committee**

The National Ethical Review Committee was identified as part of the process to develop national ethical guidelines for HIV/AIDS service delivery and research. Although the civil societies and PLHIV are identified as members of the committee, this is a non-functional committee which exists on paper only and has never formally met to either review any research protocols or service delivery projects, hence there is overall lack of effectiveness of the committee

**12. Does the country have the following human rights monitoring and enforcement mechanisms?**

- |   |     |
|---|-----|
| - 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 |
| - 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  |
| - Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts   | No  |
| - Performance indicators or benchmarks for reduction of HIV-related stigma and discrimination   | No  |

**IF YES, on any of the above questions, describe some examples:**

An independent human rights commission exist in the country but they are not completely functional.

**Part B. Section I. Human rights**

**13. Have members of the judiciary (including labour courts/employment tribunals) been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?**

No

**14. Are the following legal support services available in the country?**

- |   |     |
|---|-----|
| Legal aid systems for HIV and AIDS casework   | No  |
| Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV | No  |
| Programmes to educate, raise awareness among people living with HIV concerning their rights                                   | Yes |

**15. Are there programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance?**

Yes

**IF YES, what types of programmes?**

Media	Yes
School education	Yes
Personalities regularly speaking out	Yes
Other::religious leaders	Yes

**Part B. Section I. Human rights**

**Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005?**

2007	1
2005	0

**Comments on progress made in promoting and protecting human rights in relation to HIV and AIDS since 2005:**

No significant progress in 2007 compared to 2005.

**Overall, how would you rate the effort to enforce the existing policies, laws and regulations in relation to human rights and HIV and AIDS in 2007 and in 2005?**

**Comments on progress made in enforcing existing policies, laws and regulations in relation to human rights and HIV and AIDS since 2005:**

No formal policy exists. One which is in the draft from titled "National HIV Policy" and the draft legislation titled " The HIV & AIDS prevention and Treatment Act, 2007" are awaiting approval by respective bodies.

**Part B. Section II. Civil society participation**

**II. CIVIL SOCIETY[5] PARTICIPATION**

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

3

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

4

**3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included**

a. in both the National Strategic plans and national reports? 4

b. in the national budget? 3

**4. Has the country included civil society in a National Review of the National Strategic Plan?**

Yes

IF YES, when was the Review conducted? Year:

2007

5. To what extent is the civil society sector representation in HIV-related efforts inclusive of its diversity?

3

List the types of organizations representing civil society in HIV and AIDS efforts:

Human Rights Commission, PLWHA

[5] Civil society includes among others: Networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; Community-based organizations; organizations of vulnerable sub-populations (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

### Part B. Section II. Civil society participation

6. To what extent is civil society able to access

a. adequate financial support to implement its HIV activities? 2

b. adequate technical support to implement its HIV activities? 1

Overall, how would you rate the efforts to increase civil society participation in 2007 and in 2005?

2007 7

2005 3

Comments on progress made in increasing civil society participation since 2005:

Efforts of civil society have increased as a result of encouragement from the government. During this two year period, the importance of civil society was felt and recognized and now civil society is considered as a partner in the efforts against HIV/AIDS

### Part B. Section III. Prevention

### III. PREVENTION

1. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV prevention programmes?

Yes

IF NO, how are HIV prevention programmes being scaled-up?:

**IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts in need?**

Blood safety	The service is available in	most districts* in need
Universal precautions in health care settings		most districts* in need
Prevention of mother-to-child transmission of HIV		some districts* in need
IEC on risk reduction		most districts* in need
IEC on stigma and discrimination reduction		most districts* in need
Condom promotion		some districts* in need
HIV testing & counselling		most districts* in need
Harm reduction for injecting drug users		some districts* in need
Risk reduction for men who have sex with men		N/A
Risk reduction for sex workers		some districts* in need
Programmes for other vulnerable sub-populations		some districts* in need
Reproductive health services including STI prevention & treatment		most districts* in need
School-based AIDS education for young people		some districts* in need
Programmes for out-of-school young people		some districts* in need
HIV prevention in the workplace		some districts* in need
Other programmes::Training for health care provider		some districts* in need
Other programmes::Behavior change communication program		some districts* in need
Other programmes::Vocational training for MARP		some districts* in need

**\*Districts or equivalent geographical/de-centralized levels in urban and rural areas**

**Part B. Section III. Prevention**

**Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?**

2007	6
2005	3

**Comments on progress made in the implementation of HIV prevention programmes since 2005:**

Prevention efforts have been increased by involvement of media. Many programs have been scaled up by increase in funds for HIV/AIDS. the most positive thing is the change in the attitude of government and as a result different organizations are working together for the common goal of prevention of HIV/AIDS. But still there are areas which needs improvement such as monitoring and evaluation system. Also there is a need to develop strategies to reach general public with prevention steps for HIV.

#### IV. TREATMENT, CARE AND SUPPORT

**1. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?**

Yes

**IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?:**

**IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts\* in need?**

Antiretroviral therapy	The service is available in	most districts* in need
Nutritional care		some districts* in need
Paediatric AIDS treatment		some districts* in need
Sexually transmitted infection management		most districts* in need
Psychosocial support for people living with HIV and their families		some districts* in need
Home-based care		some districts* in need
Palliative care and treatment of common HIV-related infections		some districts* in need
HIV testing and counselling for TB patients		N/A
TB screening for HIV-infected people		some districts* in need
TB preventive therapy for HIV-infected people		N/A
TB infection control in HIV treatment and care facilities		some districts* in need
Cotrimoxazole prophylaxis in HIV-infected people		some districts* in need
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)		some districts* in need
HIV treatment services in the workplace or treatment referral systems through the workplace		N/A
HIV care and support in the workplace (including alternative working arrangements)		some districts* in need

**\*Districts or equivalent geographical de-centralized governmental levels in urban and rural areas**

**Part B. Section IV. Treatment, care and support**



**Overall, how would you rate the efforts in the implementation of HIV treatment, care and support services in 2007 and in 2005?**

2007	3
2005	1

**Comments on progress made in the implementation of HIV treatment, care and support services since 2005:**

There is a clear upswing in the progress related to HIV treatment in the country, ARV is available for free for life long for those who make it to these treatment centers, health care providers are specifically trained for HIV treatment and care. But this is not enough and much needs to be done. Treatment centers are located at provincial level rather than need oriented geographical areas and thus accessibility of patients to these centers becomes challenging.

**2. What percentage of the following HIV programmes or services is estimated to be provided by civil society?**

Prevention for youth	>75%
Prevention for IDU	>75%
Prevention for sex workers	>75%
Counselling and Testing	>75%
Clinical services (OI/ART)*	<25%
Home-based care	>75%
Programmes for OVC**	>75%

\*OI Opportunistic infections; ART Antiretroviral therapy

\*\*OVC Orphans and other vulnerable children

**Part B. Section IV. Treatment, care and support**

**3. Does the country have a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)?**

No

**3.1 IF YES, is there an operational definition for OVC in the country?**

**3.2 IF YES, does the country have a national action plan specifically for OVC?**

**3.3 IF YES, does the country have an estimate of OVC being reached by existing interventions?**

**IF YES, what percentage of OVC is being reached?**

**Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?**

2007	2
2005	1

**Comments on progress made since 2005:**

\* N/A in Question 1 of the treatment care and support section means "NOT AVAILABLE" \*\* As far as TB screening for HIV infected people is concerned, it is not a mandatory test for all HIV/AIDS patients and is only considered for patients who present with relevant signs and symptoms or relevant history. \*\*\* Because of the illegal status of IDUs and sex workers, most of the prevention activities for these subgroups are provided through Civil society.

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