

UNGASS PAKISTAN REPORT

Progress report on the
Declaration of Commitment on HIV/AIDS
for the
United Nations General Assembly Special Session on
HIV/AIDS

Prepared by
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GLOSSARY

AIDS	Acquired Immuno Deficiency Syndrome
APCP	AIDS Prevention and Control Program
ART	Antiretroviral Therapy
BCC	Behavior Change Communication
CCM	Country Coordination Mechanism
CDWP	Central Development Working Party
CDC	Center of Disease Control
CIDA	Canadian International Development Agency
CRIS	Country Response Information System
CSO	Civil Society Organization
DHS	Demographic Health Survey
DFID	Department of International Development
DoC	Declaration of Commitment
ECNEC	Executive Committee of National Economic Council
EHACP	Enhanced Program on HIV/AIDS Control Program
EQAS	External Quality Assessment Scheme
EU	European Union
FATA	Federally Administered Tribal Areas
FCA	Federal Committee on AIDS
FELTP	Field Epidemiology Laboratory Training Program
FHI	Family Health International
FSW	Female Sex Worker
GAMCA	Gulf Accredited Medical Center Association
GIPA	Greater Involvement of People living with AIDS
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GoP	Government of Pakistan
GTZ	German Technical Corporation
HASP	HIV/AIDS Surveillance Project
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRG	High Risk Group
HSW	Hijra Sex Worker
JS	Joint Secretary
IBBS	Integrated Biological and Behavioral Surveillance
IDP	Internally Displaced Person
IDU	Injecting Drug User
LSTHM	London School of Tropical Health Medicine

MARA	Most At Risk Adolescent
MARP	Most At Risk Population
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MoE	Ministry of Education
MoH	Ministry of Health
MTR	Mid Term Review
MSM	Men Who Have Sex With Men
MSW	Male Sex Worker
NACP	National AIDS Control Program
NGO	Non Governmental Organization
NPM	National Program Manager
NSF	National Strategic Framework
NTP	National Tuberculosis Program
NVP	Nevirapine
NWFP	North Western Frontier Province
OST	Oral Substitution Treatment
P&D	Planning and Development
PACP	Provincial AIDS Control Program
PDWP	Provincial Development Working Party
PC-1	Planning Commission Proforma – one (Project Document)
PHC	Primary Health Care
PIMS	Pakistan Institute of Medical Sciences
PLHIV	People Living with HIV without AIDS
PPTCT	Prevention of Parent to Child Transmission of HIV/AIDS
PPM	Provincial Program Manager
RST	Regional Support Team - UNAIDS
SDP	Service Delivery Project
SGS	Second Generation Surveillance
SOP	Standard Operating Procedure
SRA	Situation Response Analysis
STI	Sexually Transmitted Infection
TWG	Technical Working Group
TACA	Technical Advisory Committee on AIDS
UN	United Nations
UNAIDS	United Nations Joint Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office for Drugs and Crime

USAID
VCT
VCCT
WHO

United States Agency for International Development
Voluntary Confidential and Testing
Voluntary Counseling and Confidential Testing
World Health Organization

FOREWORD

Pakistan pledged its commitment to combat the HIV/AIDS epidemic by adopting the Declaration of Commitment (DoC) at the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001. The DoC reflects global consensus on a comprehensive framework to achieve the 6th Millennium Development Goal of **‘halting and beginning to reverse the HIV/AIDS epidemic by 2015’**.

Follow up to the DoC calls for careful monitoring of each country’s progress through biennial reports on agreed commitments to be submitted to the UNAIDS Secretariat, Geneva, where all reports are compiled to present the global picture. In 2002, the UNAIDS Secretariat developed a series of core indicators for all countries for a consolidated depiction of specific areas of the DoC. To improve quality and bring uniformity to the reports, UNAIDS issued the ‘Guidelines on Construction of Core Indicators’ in 2005. These indicators encompass all types of epidemics across the globe and all require to be reported unless data is either unavailable or not relevant to the country. A lens for civil society response in national HIV responses is also incorporated.

Pakistan has submitted three progress reports in 2003, 2005 and 2008 as per the period specific requirements. The Country Progress Report for the reporting period of January 2008 to December 2009 has been prepared through agglomeration and analysis of Second Generation Surveillance data, reports from VCT, treatment, care and support centers, NACP monitoring and evaluation data and interviews with key informants from the programs, government, bilateral and multilateral partners, NGOs and CSOs including PLHIV. In the present report, 14 out of 25 indicators have been validated that enunciate all facets of the epidemic in Pakistan and progress of the national response till date. The rest have not been reported due to their non-relevance and non-availability of data.

Pakistan remains a concentrated epidemic that is expanding from large urban cities to smaller towns. IDUs, the actuating force behind the epidemic, have the highest prevalence of 20.8% but also exhibit, comparatively, the largest group amongst the MARPs being accessed by the service intervention component of the country’s national HIV response. Some crucial gaps are hindering Pakistan’s progress towards achieving National Universal Access targets and need to be addressed with dynamic zeal.

STATUS AT A GLANCE

UNGASS Report writing process

Pakistan began planning for its Country UNGASS Report 2010 in late 2009. The NACP in collaboration with UNAIDS initiated the process by constituting a Technical Working Group (TWG) composed of representatives from the Planning Commission of Pakistan, NACP, UNAIDS, UNICEF, UNFPA, UNODC, WHO, CIDA (HASP unit) and CSOs.

The first meeting of the TWG took place in early January 2010 and direction of the way forward was agreed upon. The group agreed that an independent consultant will be hired for collecting information on the NCPI indicator and writing of the narrative report. The NCPI was consolidated through desk review, consultations, interviews and self-administered questionnaires. A total number of 25 key respondents for Part A and B of the NCPI were determined by the TWG and each respondent was allocated to address section/s that was most relevant to him/her. Data collection was accomplished through face to face interviews at the convenience of the respondents although some chose to complete and submit the questionnaire electronically. Validation and consensus of the results was effectuated by a vetting workshop held in February 2010 involving government officials and representatives from civil society organizations, bilateral agencies and UN organizations. Online entry of the NCPI followed this exercise which was shared with all key stakeholders and participants for their final inputs.

The second meeting of the TWG was held in early January 2010 and the contract of the consultant was extended to initiate work on the narrative report and indicators. For capacity building, the consultant attended the UNGASS Writers Workshop organized by the Technical Support Facility, South Asia in Kathmandu, Nepal in collaboration with RST UNAIDS Bangkok during 12-14th January 2010. Following frequent singular and conglomerate consultations, in person and electronically, on process methodology and information exchange between the consultant and NACP, UNAIDS, HASP and Planning Commission, the first draft of the narrative part and other indicators of the report was shared at a workshop held on 15th March 2010. Participants included representatives from all relevant organizations, who, following detailed discussion reached consensus on each indicator. The narrative part was shared electronically and inputs were systematically incorporated and edited till the final version was prepared.

A final vetting workshop was held on 30th March 2010 and the final draft of the report was shared with a wide range of national stakeholders representing the government, bilateral and multilateral organizations and the civil society organizations. Inputs given during the meeting were incorporated.

Status of the Epidemic:

Pakistan remains a country having a concentrated epidemic with prevalence levels consistently reported to be greater than 5% amongst IDUs and HSWs (Hijra sex workers). IDUs embody the core group driving the epidemic and exhibit the highest prevalence of 20.8% followed by 6.1% among HSWs and 0.9% among MSWs¹. In Pakistan, although HIV infection rates among FSWs remains low at 0.97%², there is evidence of sexual networking between FSWs and IDUs. Considering the overlap between IDUs and at-risk sexual networks, the rising HIV prevalence among IDUs increases the risk of spill-over into networks of commercial sex workers and their clients. Pakistan has an estimated 97,400 people living with HIV at the end of 2009, with 2917 patients registered in 13 treatment and 7 PPTCT centers across the country, of which 1320 are on ARV drug therapy.³ The geographic trend of the epidemic is expanding from major urban cities and provincial capitals to smaller cities and towns. Although national adult HIV prevalence in the general population remains under 0.1%, exceptions were observed as in Gujrat where 88 HIV positive cases were found out of a sample of 246 from the general population that included a large number of ex-migrant workers. Among many factors, one important factor attributing to this development is unsafe injecting practices in formal and informal healthcare settings.

Policy and Programmatic Response:

In response to the increasing prevalence amongst the MARPs, the focus of the NACP shifted to a rapid scale up of service intervention. The National Strategic Framework on HIV/AIDS was revised to its second version that focuses on this ambition. When the Enhanced HIV/AIDS Control Program [EHACP] came to its five year close in 2008-9, the PC-1 for the program was revised to further enhance and scale-up the interventions to achieve the National Universal Access targets. This approach has been abetted by a critical development in the National Health Policy 2009 which has included HIV/AIDS as a priority area and IDUs, MSWs, HSWs and FSWs are acknowledged as the most-at-risk populations.

UNGASS indicators 2010

Not all indicators of the UNGASS report are relevant to the Pakistani epidemic. Although for some indicators the subject matter is relevant however, socio-cultural barriers, gaps in surveillance and small target populations render availability of data unattainable. Therefore, out of 25, 14 country level indicators have been reported in the UNGASS report 2010 that reflect the most salient dimensions of HIV/AIDS in Pakistan and the

¹ HIV/AIDS Surveillance Program, NACP, IBBS Round III report 2008-9

² HIV/AIDS Surveillance Program, NACP, IBBS Round for FSW 2009

³ ART Center Progress Report, NACP 2009

efforts being made to curtail it. Of these, three indicators do not follow the UNGASS requirements strictly but have been reported according to the limited data available.

<i>National Commitment and Action</i>			
Indicator		Previous data	Current status
1	Domestic and International AIDS spending by categories and financing sources		
2	National Composite Policy Index	--	Annex II
<i>National Program Indicators</i>			
3	Percentage of donated blood units screened for HIV in a quality assured manner	87% (SOPs followed but no EQAS)	<i>Indicator relevant; data not available.</i> Limited data on current blood transfusion screening.
4	Percentage of adult and children with advanced HIV infection receiving ARV therapy	7.4% (550 adults and children currently on ART out of estimated 75000)	9.83% (1320 adults and children out of 13,422 estimated at an advanced stage of HIV)
5	Percentage of HIV-infected pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission	PPTCT started in 2007 and 100% of pregnant HIV positive women identified received ART (too early to make estimates)	0.44% (25 of an estimated 5,663 HIV positive pregnant mothers)
6	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	<i>Data not available</i>	<i>Indicator relevant; data not available.</i> Limited information
7	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	<i>Data not available</i>	<i>Indicator relevant; data not available due to socio-cultural barriers</i>
8	Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	<ul style="list-style-type: none"> • FSW (<25 – 5.2%; 25+ – 25.4%) • MSW (<25 – 3.5%; 25+ – 5.5%) • HSW (<25 – 8.6%; 25+ – 25.9%) • IDU (<25 – 4.6%; 25+ – 25.4%) 	<ul style="list-style-type: none"> • FSW (<25 - 15.5%; 25+ – 14.1%) • M/HSW (<25 – 1.5% 25+ – 14.3%) • IDU (<25 – 12.4%; 25+ – 11.7%)

9	Percentage of most-at-risk populations reached with HIV prevention programs	<ul style="list-style-type: none"> • FSW (<25 – 1.1%; 25+ – 2.2%) • MSW (<25 – 2.2%; 25+ – 4.3%) • HSW (<25 – 6.9%; 25+ – 8.0%) • IDU (<25 – 15.1%; 25+ – 15.8%) 	<ul style="list-style-type: none"> • FSW (<25 – 5.6%; 25+ – 6.1%) • M/HSW (<25 – 11.7%; 25+ – 15.3%) • IDU (<25 – 58.4%; 25+ – 49.2%)
10	Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	<i>Data not available</i>	<i>Subject matter not relevant</i>
11	Percentage of schools that provided life-skills based HIV education in the last academic year	<i>Data not available</i>	<i>Subject matter not relevant</i>
<i>Knowledge and Behavior Indicators</i>			
12	Current school attendance among orphans and non-orphans aged 10-14	<i>Data not available</i>	<i>Subject matter not relevant</i>
13	Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	<i>Data not available</i>	<i>Indicator relevant; Limited data available from DHS report 2007</i>
14	Percentage of MARPs 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"> • FSW (<25 – 28.2%; 25+ – 23.4%) • MSW (<25 – 24.8%; 25+ – 28.4%) • HSW (<25 – 13.1%; 25+ – 18.3%) • IDU (<25 – 16.7%; 25+ – 20.5%) 	<ul style="list-style-type: none"> • FSW (<25 – 1.8%; 25+ – 1.6%) • M/HSW (<25 – 28.6%; 25+ – 34.1%) • IDU (<25 – 22.3%; 25+ – 26.2%)
15	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	0.67% (data collected from only 13-19 yr adolescents) Male – 0.92% Female – 0.42%	<i>Indicator relevant; data not available due to socio-cultural barriers</i>
16	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	<i>Data not available</i>	<i>Indicator relevant; data not available due to socio-cultural barriers</i>
17	Percentage of women and men aged	<i>Data not available</i>	<i>Indicator relevant;</i>

	15-49 who have had more than one partner in the past 12 months who used a condom during their last sexual intercourse		<i>data not available due to socio-cultural barriers</i>
18	Percentage of female and male sex workers reporting the use of a condom with their most recent client	<ul style="list-style-type: none"> FSW (<25 – 50.5% 25+ – 42.3%) MSW (<25 – 20.0% 25+ – 23.3%) HSW (<25 – 21.4% 25+ – 21.2%) 	<ul style="list-style-type: none"> FSW (<25 – 49.5% 25+ – 39.6%) M/HSW (<25 – 32.4% 25+ – 34.0%)
19	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Data on MSW and HSW is repeated <ul style="list-style-type: none"> MSW (<25 – 20.0% 25+ – 23.3%) HSW (<25 – 21.4% 25+ – 21.2%) 	<i>Indicator relevant but data not available</i>
20	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	<ul style="list-style-type: none"> IDU (<25 – 13.0% 25+ – 22.7%) Male only IDU pop	<ul style="list-style-type: none"> IDU (<25 – 29.2% 25+ – 31.2%) Male only IDU pop
21	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	<ul style="list-style-type: none"> IDU (<25 – 29.5% 25+ – 27.5%) Male only IDU pop	<ul style="list-style-type: none"> IDU (<25 – 79.3% 25+ – 76.9%) Male only IDU pop
<i>Impact Indicators</i>			
22	Percentage of young people aged 15-24 who are HIV infected	<i>Data not available</i>	<i>Subject matter not relevant</i>
23	Percentage of most-at-risk populations who are HIV infected	<ul style="list-style-type: none"> FSW (<25 – 0.0% 25+ – 0.0%) MSW (<25 – 1.1% 25+ – 2.8%) HSW (<25 – 1.9% 25+ – 2.2%) IDU (<25 – 18.3% 25+ – 15.4%) 	<ul style="list-style-type: none"> FSW (<25 – 25+ - M/HSW (<25 – 3.1% 25+ – 4.0%) IDU (<25 – 22.5% 25+ – 20.4%)
24	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	87% data collected from one treatment center 13% have died or lost to follow up	<i>Indicator relevant; data not available</i>
25	Percentage of infants born to HIV-infected mothers who are infected	<i>Data not available</i>	28.94% (numerator of 1693 and denominator of 5663, both obtained by EPP and Spectrum modeling)

OVERVIEW OF THE HIV/AIDS EPIDEMIC IN PAKISTAN

Background:

With an estimated total population of about 168.79 million by the end of 2009 and an average annual growth rate of 1.9%, Pakistan ranks as the sixth most populous nation in the world.¹ Pakistan is divided into four provinces viz., Punjab, Sindh, North West Frontier Province (NWFP) and Balochistan; two autonomous states of Azad Jammu Kashmir and Gilgit-Baltistan; and Federal territories of Federally Administered Tribal Areas [FATA] and the Islamabad Capital Territory. With each province/territory brandishing its own lingual and socio-ethnic construct, Pakistan evinces a multicultural complexity.² Punjab and Sindh are the most populous provinces that house the largest cities and in accordance display the highest HIV prevalences. Of the total population, around 70% reside in rural areas, with relatively limited access to health services. The infant mortality rate is 64 per 100,000 live births with a life expectancy at birth of 66 years.³ Pakistan's Human Development Index and Gender Development Index are 0.562 and 0.537 respectively and literacy rate is at 54%.⁴

Following the trend of other Asian countries, the Pakistan HIV epidemic is characterized by high prevalence among IDUs with an increase among other most-at-risk populations that include FSWs, MSWs and HSWs (Hijra sex workers) and thereon into other vulnerable groups and the general population. Unsafe injecting practices and low awareness among IDUs manifested in a major outbreak in 2003 where 10% of a random sample of IDUs in Larkana city in the province of Sindh were found positive for HIV infection.⁵ Program surveillance results confirmed the consistent rise in prevalence and expanding infections among IDUs in other cities across the country during the preceding years. These findings shifted Pakistan from an initially 'low prevalence - high risk' category to a concentrated epidemic.

Current situation:

The prevalence of HIV amongst the MARPs is on a steady rise; According to Round III of the Integrated Behavioral and Biological Surveillance (IBBS) data obtained from eight major cities, it is consistently increasing amongst MARPs with an average of 20.8% among IDUs, 6.1% among HSWs and 0.9% among the MSWs.¹ Rounds I and II of the IBBS found very low HIV prevalence (0.021%) amongst female sex workers (FSWs), resulting in this group being dropped from Round III IBBS surveillance in 2008. In the

¹ Federal Bureau of Statistics, Government of Pakistan

² Federal Ministry of Information and Broadcasting, Islamabad, Govt of Pakistan

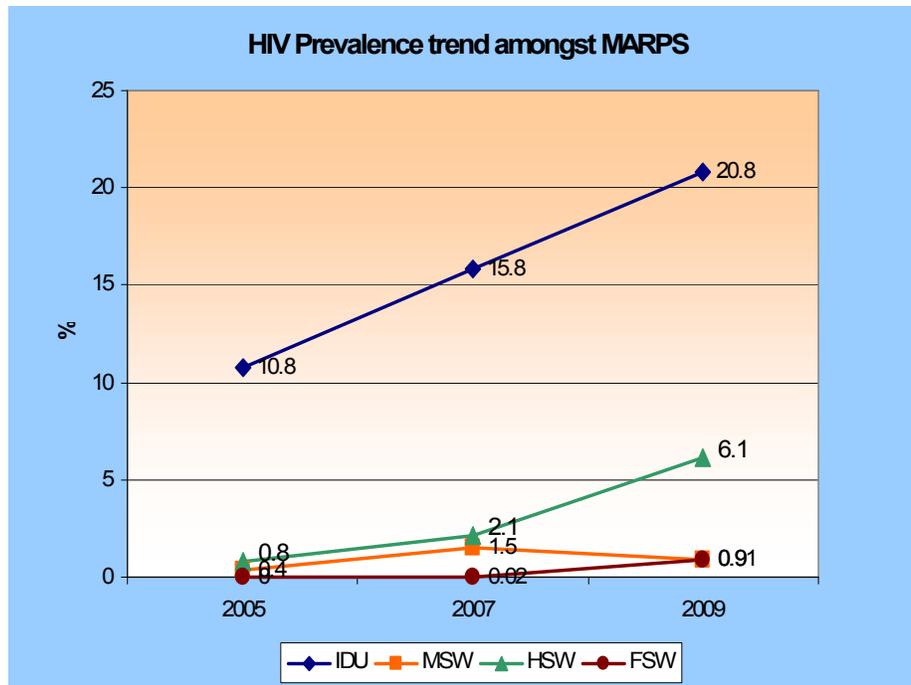
³ UN Population Division Annex 2009; 2009

⁴ Human Development Report 2009, Pakistan

⁵ Project Progress report 2003 NACP

later half of 2009 (Sept – Dec 2009) the National AIDS Control Program with UNAIDS/UNFPA support, conducted another round of IBBS among FSWs to meet the current data gap, and collected data from six cities in Punjab and Sindh provinces. HIV prevalence amongst FSWs was found to be 0.97%. The graphic representation of trend of prevalence amongst the MARPs is shown in the Figure 1. IDUs and HSWs show an unwavering rise while the MSWs and FSWs display a more level progression.

Figure 1



Mapping of MARPs from 8,728 spots in 12 major cities from the four provinces was estimated at a total population of 114,637, amongst which 31555 (27.5%) were IDUs, 49037 (42.8%) FSWs, 14725 (12.9%) HSWs and 19320 (16.9%) were MSWs.¹ Extrapolation using estimation models for national levels assay the populaces at a total of 333,000 MARPs with 91,000 IDUs, 136,000 FSWs, 43,000 HSWs and 63,000 MSWs respectively. Although one-third to half of the MARPs resides in major urban cities and provincial capitals, the geographic trend of the epidemic has shown an expansion to smaller cities and towns. Prevalence among IDUs has shown to be as high as 30% and 27% in Hyderabad and Larkana respectively. Larkana also harbours the largest population of HIV positive HSWs (27%).¹

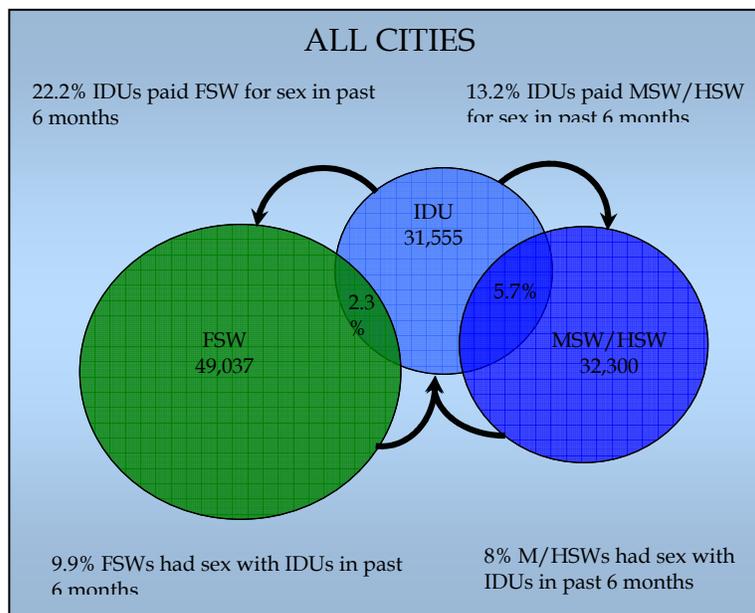
The IDUs sub-population spearheads the epidemic in Pakistan. With an average of 2.2 injections per day, 23% IDUs report using a previously used needle/syringe while 18%

¹ HIV/AIDS Surveillance Program, NACP, IBBS Round II report 2006-7

admit to passing their syringe to another IDU. Other injecting paraphernalia is used by 29% IDUs. Sharing injections/other paraphernalia is a practice common in 40% of IDUs in cities where there is no service intervention, as compared to 12% in cities where the program exists. In addition to these risky behaviours, 6.8% IDUs admit to selling blood in exchange for money.¹

Although most new infections originate from injecting drug use, sexual transmission poses a serious issue. The commercial sex industry has well established sexual networks amongst the MARPs. Figure 2 shows interactions between IDUs, FSWs, HSWs and MSWs population reported in the Round II HIV/AIDS Surveillance Report.

Figure 2



Source: Round 2 surveillance reports. NACP

Almost 17.7% of IDUs report buying sex from FSWs and 13.2% report paying MSW/HSWs in exchange for sex. The daily client average for sex workers is 4 for FSWs, 1.9 for MSWs and 2.6 for HSWs with 7%, 6.4% and 4.6% respectively reported having sex with an IDU in the past six months. Condom use in the last sex with a commercial client by FSWs was admitted at 43.3% and with M/HSWs, it was reported at 33.1% showing an improvement from 22.5 % in 2007. Sex workers injecting drugs themselves reported at 9.1% among FSW, 4.2% among MSW and 6.3% among the HSW.^{1,2}

¹ HIV/AIDS Surveillance Program, NACP, IBBS Round III report 2008-9

2. HIV/AIDS Surveillance Program, NACP, IBBS Round FSW report 2009-2010

Bridging populations of clients of sex workers and spouses of MARPs, estimated to be about 5 million people, have not been researched at national level although prevalence in the general population remains low, appraised at less than 0.1% among 15-49 year olds according to the NACP and UNAIDS/WHO estimations. However, a research study in Punjab found 15% prevalence in spouses/female partners of IDUs. Transmission of HIV to their wives is enhanced by 80% engaging in unprotected sex. Economic vulnerability has also driven some wives to indulging in drugs and/or selling sex too.¹

Although the epidemic is concentrated in MARPs and related mostly to risk activities, other vulnerabilities to HIV infection also exist, such as in the context of internal and external mobility. In fact, a substantial number of HIV/AIDS cases reported to the health services across provinces have been and continue to be among returning migrant workers from abroad as well as among their spouses and children. As in other countries of South Asia, a large number of these cases are among returning migrants deported from the Gulf States when found to be HIV positive.

Conditions related to the context of labor migration from Pakistan to the Gulf States and other countries in the Middle East or other regions of the world – such as periods of isolation from family and community networks, occupational conditions, lack of social and recreational alternatives, and absence of and limited access to services and social-health protection – are believed to increase HIV-related risk given limited access to information, counseling and referral to health services during the various migratory phases. Similarly, the risks of onward HIV transmission to spouses and to children have been documented upon the return of migrant workers from abroad. In the North West Frontier Province (NWFP), for example, among the registered 567 cases at the Provincial AIDS Control Program up to February 2010, over 80% is migration-related [deportees themselves amount to 53% of these cases, their spouses 23% and children 4.9%].

Migrants who are found to be HIV positive are sent back to their countries of origin mostly without proper information on prevention and without ensuring access to treatment, care and support services prior to their deportation. An example is the large number of cases in a rural locality in district Gujrat of the Punjab province where 88 HIV positive cases out of a sample of 246 from the general population were identified in mid 2008. Investigations by the Field Epidemiology and Laboratory Training Program (FELTP) teams later confirmed this and found demographics of the sample population to include a large number of ex-migrant workers.²

¹ 'The Hidden Truth' Report by Nai Zindagi and PACP, Punjab 2008

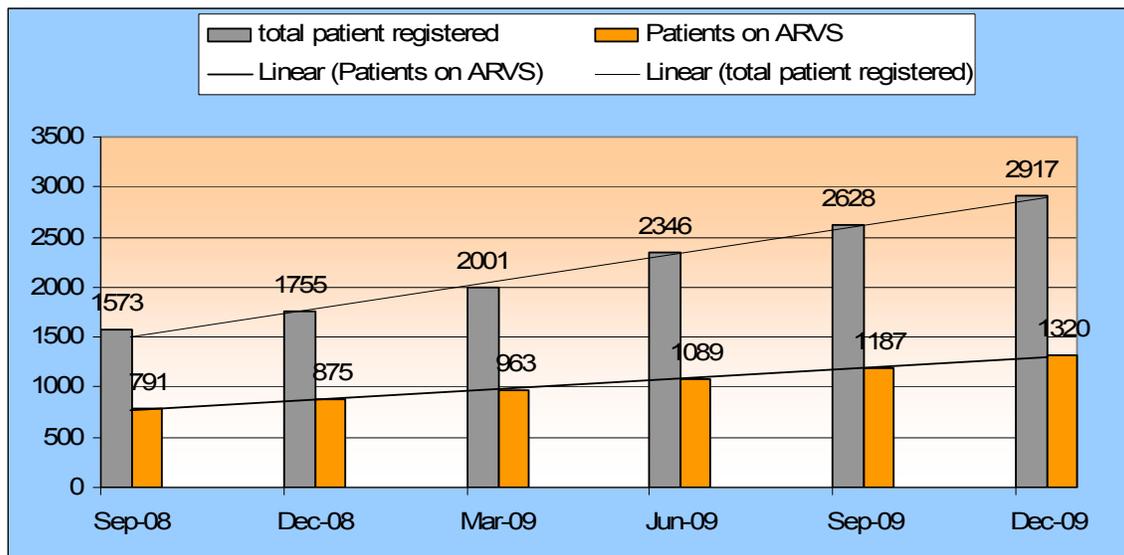
² NACP FELTP Report on HIV Outbreak in District Gujrat 2009

To obtain a work and residence visa, Gulf States and other receiving countries require prospective visitors from Pakistan to undergo mandatory testing for HIV and other health conditions, without appropriate or minimal pre and post test counseling being provided at the designated GAMCA centers. In line with the World Health Assembly (WHA) resolution on health of migrants in 2008, member states are called upon to promote migrant-inclusive health policies and equitable access to information and support for migrants. In keeping with these recommendations as well as the dialogue between Asian countries initiated by Pakistan in side meeting held during the WHA in Geneva in 2007 and 2009, as well as situation assessments and programmatic work has been started in the country in this regard and strategic priorities have been identified for 2010-11.

Pakistan is hosting around 2.5 million Afghan refugees for the past two decades. In 2009, it had the added responsibility of relocating over 2 million Internally Displaced People from Swat in NWFP due to the military operation launched by the Government against the Taliban militants and this led to disruption of preventive and treatment care and support services to certain vulnerable groups and PLHIV.

The estimated populations of PLHIV according to WHO/UNAIDS, has risen from 75,000 in 2007 to 97,400 in 2009. Pakistan is in the early phase of concentrated epidemic and the number of registered patients is low compared to the estimates. Nearly 2917 HIV/AIDS patients are registered in 13 treatment centers and 7 PPTCT centers across the country. Of these, 1320 on ARV drug therapy, of which 908 are men, 355 women and 57 are children less than 15 years. They also receive treatment for AIDS related opportunistic infections e.g. TB. The scope of the program service delivery has expanded in the past two years resulting in doubling of the number of PLHIV registering, accessing and availing ART in treatment centers, contributing to the rising trend as shown in Figure 3

Figure 3



NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

National Commitment and Action

The Government of Pakistan has been committed to the response to AIDS epidemic since the detection of first case of HIV in 1987. Today, this commitment has manifested into a close collaboration between its implementing bodies of the National AIDS Control Program, four Provincial AIDS Control Programs and AJK AIDS Control Program with the UN, bilateral and multilateral donors, and a consortium of NGOs and CSOs that operate at national, provincial and grass-root levels including representative of PLHIV organizations. The Government's response till date can be divided into three phases. The first phase was from 1987-2003, phase II from 2003-2007 and the current phase III is documented from 2007-2012.

The role of the public-private partnership with NGOs and CSOs is a crucial facet of Pakistan's AIDS response and is discussed separately.

Phase I of the Government response (1987-2003)

At the detection of the first HIV positive individual in 1987, a Federal Committee on AIDS (FCA) was constituted whose recommendations led to the establishment of the AIDS Prevention and Control Program (APCP) in the country. The APCP, funded by the WHO, was mainly a laboratory based response directed at blood safety and detection of HIV positive cases through laboratories and blood banks/screening in the public sector hospitals.

In the initial stages of the epidemic, the response was of limited scope, in view of the small numbers of visible/detected cases. In 1994, the APCP was revitalized by bringing it under the Social Action Program Project through approval of a PC-1 (project), time framed till 2003. In contrast to the previous strategy, the new activities were focused towards prevention and control interventions and were implemented within the overall health care infrastructure.

Coordinated global efforts on control of the AIDS pandemic prompted the Government of Pakistan to develop its first five-year National Strategic Framework (NSF-I) with UNAID support in 2001. This framework set priorities and outlined broad strategies for effective control of the epidemic with an emphasis on HIV prevention and information/service provision for the most-at-risk and vulnerable populations which included Injecting Drug Users, Male/Female and Hijra Sex Workers, Prison Inmates and Long Distance Truckers.

Phase II of the Government response (2003-2007)

At the culmination of the APCP and based on the NSF-I as well as the DoC of the 2001 UNGASS session, the Government of Pakistan approved the 'Enhanced Program on HIV/AIDS Control Program' (EHACP) for five years period from 2003-8 with the support of World Bank, DFID and government counterpart financing.

The overall strategy of the EHACP was a shift away from the previous approach. It commenced with the decentralization of the program from its previous umbrella set-up to one national (NACP) and five provincial (PACP) bodies. The four principal components of the EHACP were addressed as following:

1. ***Interventions for most-at-risk populations:*** Identification and mapping of core MARPs across Pakistan was accompanied by provision of services under the aegis of a capacious public-private partnership with a consortium of NGOs and CSOs. The service packages included information provision, skill development, condom distribution, syringe exchange, drug harm reduction inclusive of detoxification and preventive/ curative care in a setting that could also cater to the VCT needs. To enhance intervention for the MARPs, funding received from the Global Fund to fight AIDS, TB and Malaria (GFATM) was secured to strengthen centers for treatment, care and support for PLHIV in national and provincial capitals. The centers provided 1st and 2nd generation ARV therapy, treatment for opportunistic infections and hospitalization. They were augmented with training of healthcare professionals on HIV management. Networks of PLHIV took root during this period and an endeavor on legislations dealing with their rights was embarked upon.
2. ***Establishment of a Second Generation Surveillance System (SGSS):*** Funded by the Canadian Government, SGSS for both biological and behavioral surveillance amongst MARPs was implemented to track the HIV epidemic in Pakistan. The surveillance methodology was adapted specifically for Pakistan and constituted mapping of MARPs in the first phase and collection of behavioral and biological data in the second phase. Up-to-date estimates were used to guide the national program to scale up its service delivery response for effective outcomes.
3. ***Prevention of HIV transmission to the general public through blood and blood products:*** An extensive mass media BCC campaign for the general population, key policy/decision makers, political leaders, faith-based organizations, line Ministries e.g. Ministry of Education, Ministry of Narcotics, Ministry of Religious Affairs etc was carried out on a national scale. Consequently the National Blood transfusion Safety Ordinance was developed and promulgated to

protect the general public from HIV transmission through blood and blood products.

4. ***Provision of Treatment, Care and Support services and Capacity building:***
Eleven ART centers were established across the country for provision of free ARV, diagnostics and other treatment, care and support services to PLHIV. Capacity building was a cross cutting component of the program and included capacity building of public as well as NGO sectors involved in the implementation of interventions.

In Phase II, two significant developments took the limelight. The '*National HIV/AIDS Policy Document*' was developed in 2005 with the key aim to provide and maintain an enabling environment for HIV/AIDS prevention and care programs and services through a consistent multi-sectoral approach at all levels of government and community.

The second development was the genesis of the '*HIV/AIDS Prevention and Treatment Act, 2007*' which was designed to establish National and Provincial AIDS Coordination Committees to provide a multisectoral forum for coordination of the national and provincial response. This act also supports the government in providing HIV-specific information, care, support, equitable access to treatment and stigma/ discrimination reduction for PLHIV, vulnerable populations that have quasi-legal status and the bridging populations of families and clients.

Currently, both the documents await approval from the government.

Phase III of the Government Response (2007-2012)

In 2006, the NACP and MoH engaged a team of independent experts to undertake a detailed Situation and Response Analysis (SRA) followed by a Mid Term Review (MTR) of the national response to the HIV epidemic. Based on SRA and MTR findings, thorough in-depth consultations with a wide group of stakeholders from the government, private sector, UN partners, bilateral/multilateral donors, service delivery NGOs and PLHIVs led to the development and endorsement of the National Strategic Framework II (NSF-II) 2007-2012.

The overarching goal of NSF-II is "*to prevent a generalized epidemic in Pakistan by containing the spread of HIV/AIDS and elimination of stigma and discrimination against those infected and affected*". With the main purpose to "to expand and scale up effective national response to the threat of HIV and AIDS", four major strategies outline the foundation of the NSF-II. They include I. creation of an enabling environment; II: strengthening of the institutional framework; III: building up the right capacity and IV: scaling up program delivery.

These four strategic themes are captured by 12 priority areas in the NSF-II of which 3 new areas were added to the previous nine outlined in NSF-I. These twelve priority areas are:

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

The new areas added:

10. Institutional arrangements
11. Commodities and procurement
12. Management information systems

Face of the HIV response period 2008-2009:

The EHACP completed its five years of implementation in June 2008 however; it was extended till December 2009. Although the HIV response in Pakistan has evolved to a coordinated and multisectoral level, in order to meet the MDG Goal 6 of “*Halting and begin to reverse the spread of HIV/AIDS*” by the year 2015, the call of the day was an urgent need to scale-up the program interventions. Therefore the PC-1 of the EHACP was revised. Reasons dictating this revision included:

- Rapid geographical expansion of the HIV epidemic from large cities to smaller towns/cities demanded immediate scaling-up of prevention and control services to various new locations. Although the overall total of MARP groups showed a nearly 2-3 fold increase over the original estimates, only about 40% of the IDUs and less than 15% of the M/F/HSWs are being currently accessed. The remaining would have to be targeted to achieve the National Universal Access target of 60% coverage for F/MSWs and 80% for IDUs.
- ARV treatment till 2008 had been provided by the GFATM grant R-2. Currently, the provision is being facilitated through Continuation of Services (CoS) proposal of Global Fund R-2 grant, which is available till 31st May, 2010. In order to ensure uninterrupted supply and strengthening of this vital service, a complete HIV/AIDS care component needs to be incorporated in the revised PC-I.
- Increasing prevalence of HIV among spouse/female partners and families of IDUs prompted the need for comprehensive services provision to all MARPs including provision of primary health care, STI medicines, behavior change

communication services as well as voluntary Counseling and Confidential Testing (VCCT) and Prevention of Parent to Child Transmission (PPTCT).

- Safe blood transfusion needed an enhanced scope to cover Hepatitis B and C screening in all public sector blood banks.
- Program Management of the all AIDS programs needed capacity building, especially in the fields of research, surveillance, monitoring and evaluation and procurements.

The revised PC-1 of the Enhanced HIV/AIDS Project with a total budget of US\$ 99.4 million was approved in 2008 by Provincial Development Working Parties (PDWP), Central Development Working Party (CDWP) and Executive Committee of the National Economic Council (ECNEC). Process for the implementation of the second phase of the EHACP has been initiated in early 2010. The revised PC-I has modifications in three major components

I: HIV Prevention and Treatment Services: This component is based on community and facility activities and can be divided into:

1. Scaling up of targeted interventions for MARPs (IDUs, FSWs, M/HSWs) and bridge groups of clients and spouses of MARPs, long distance truckers, jail inmates and coal miners. Up-gradation of intervention packages will include OST under the Harm Reduction Program for IDUs.
2. HIV Treatment, Care and Support for PLHIV under qualified HIV specialists providing 1st and 2nd generation ARVs, drugs for opportunistic infections, diagnostic facilities like tests for viral load and CD4 Count, Hepatitis B vaccination and condom provision. An additional facet is the concept of cash transfer for transportation to ensure maximized access to centers in order to avoid development of resistance that can develop if follow-up to ARV regimens is sporadic.
3. Blood Transfusion Services Safety including provision of HIV, Hepatitis B and C Screening kits and Consumables in Public Sector Blood Banks
4. Control of Sexually transmitted Infection (STIs) through provision of drugs and trainings for knowledge in public sector hospitals.
5. Prevention of Parent-to-child Transmission (PPTCT) based in tertiary care hospitals in collaboration with participating gynecology departments.

II: Advocacy and Communication: This component includes:

1. Advocacy based on a coordinated strategy to address evidence-informed key areas and targeted for parliamentarians, media, educationists, religious leaders, uniformed personnel as well as the general population.

2. Communication and Stigma Reduction Campaign based on a comprehensive and realistic communication strategy that is guided by country specific research, grounded in local cultural realities and is executable.

III: Governance and the Institutional Framework of the Response: This component is divided into:

1. Governance to ensure an effective multisectoral HIV response based on operationalization and coordination of five main committees including the National Advisory Committee on AIDS, the National Technical Steering Committee on AIDS, the Multisectoral Committee, Provincial Advisory Committees and Provincial Technical Steering Committees on AIDS.
2. Capacity Building to be addressed with the support of multi-lateral partners and implemented by NACP who will take a leadership role in training of public sector and civil society managers.
3. Program Management guiding the HIV response will be shouldered by the NACP's National Program Manager who will oversee the workings of an Administration Section and a Technical Wing, along with the HIV Care and Support Section and the Monitoring, Evaluation, Surveillance and Research Unit, all of which will house appropriate specialists.
4. Monitoring and Evaluation of the HIV Response to be addressed by M&E, Surveillance and Research Units based at both Federal and Provincial levels. The reporting function of these units includes collation of all surveillance, research and program M&E information about HIV SDPs and to report it via specific reports. Additionally, independent third party evaluations will expand to include all services nationwide

For the reporting period, Pakistan's HIV response performance brandishes several achievements at different levels.

At a policy level, the national HIV/AIDS response was strengthened by two salient accomplishments in 2008-9. The first was the inclusion of HIV/AIDS as a priority area in the National Health Policy 2009 with IDUs, MSWs, FSW and HSWs mentioned as the most-at-risk populations.

The second was the genesis of "HIV/AIDS Safety and Control Bill 2009". An event leading to this denouement was when, under the patronage of NACP and a PLHIV organization, representatives from the IDU, PLHIV and Hijra communities presented their testimonies before sub-committee of the National Assembly Steering Committee on Health in September 2009. Recognition of the HIV/AIDS issue at this level consequently culminated to the development of the bill which has been accepted by the Parliament for review. The key principles of this document are public awareness on HIV prevention for

general population augmented with blood and institutional healthcare safety measures including injection safety in formal and non-formal healthcare settings and equitable access to prevention, treatment, care and support services by PLHIV and MARPs without stigma and discrimination. A focus on human rights of PLHIV is also stressed upon.

At a legislative level, the Supreme Court of Pakistan in 2009 gave a ruling which entitled Hijras to complete citizenship rights under article four (rights of individuals to be dealt with in accordance of law) and article nine (security of person) of the Constitution. Hijras in Pakistan will now be registered with 'Third Sex' designating their gender on national identity papers which will enable them to access the services of state social welfare departments and financial support programs. Although this ruling is not HIV related or the results of program efforts, it is a key achievement for this marginalized populace who has historically been ostracized and considered undesirable elements chaffing the socio-cultural fabric of the Pakistani society.

At the program level, a 17 million-euro Safe Blood Project funded by the German government through the German Technical Cooperation (GTZ) was revived in 2008. A series of consensus meetings and workshops led to the development of the 'National Blood Policy and Strategic Framework 2008-2012 for Blood Transfusion Services in Pakistan.' The PC-1 for the Safe Blood Project was approved by the PDWP and recently by the national Planning Commission. At ground level, Blood Transfusion Authorities were established to ensure blood screening for HIV, Hepatitis B and C in all public sector blood banks, with reported 90% success.

At the service delivery level, HIV/AIDS interventions reached more than 30,000 IDUs, 25000 M/HSWs, 12000 FSWs and 50,000 Long Distance Truckers. Keeping in view that the program is currently not accessing significant proportions of the estimated target populations, national consultations with key stakeholders and implementers were conducted in 2008-09 to identify gaps, bottlenecks in the implementation and develop strategies to scale up services for IDUs, FSWs and H/MSWs.

Two new treatment centers were established in this period bringing the total to 13 treatment centers that have registered 2917 PLHIV out of which 1320 are on ART provided free by the government. Similarly two PPTCT were also established bring the total to 7 PPTCT centers countrywide. Guidelines on STI Syndromic Management were developed and training of healthcare professionals in the same was carried out to ensure availability of STI knowledge, treatment and management to MARPs frequenting the treatment centers.

Other salient achievements and initiatives of the NACP include:

- Approval of the Global Fund Proposal R9. Its initial submission was not successful and was given category 3. Following the CCM decision, an appeal was made which was successful. It is envisaged that this will bridge the gap between the current national response and achievements of the universal access targets.
- National consultation with key stakeholders led to agreement on the Oral Substitution Treatment Pilot Project (OST), the first of its kind since the inception of the HIV response. Implementation of the OST is envisaged in 2010
- One successful round of IBBS in eight major urban cities for IDUs and MSWs/HSWs was carried out in 2008. A special IBBS round for FSWs was conducted in six major cities of Punjab and Sindh in 2009.
- International and national dissemination of research work by LSTHM, Population Council and NACP
- Signing of FSW Technical Assistance contract with FHI with the aim to build the capacity of NGOs for service delivery among FSWs
- Collaboration with CDC, (Atlanta -USA) for technical assistance in Surveillance and Reference Laboratory manifested as the Field Epidemiology Laboratory Training Program (FELTP).
- Collaboration with Clinton Foundation was revitalized for technical assistance in strengthening the HIV Treatment, Care and Support component of the National response.

Role of NGOs and CSOs in Pakistan's HIV/AIDS response:

The Public-private partnerships developed by the GoP with a consortium of NGOs and CSOs is a crucial facet that spearheads the implementation of the service delivery component of country's response to the HIV/AIDS epidemic. NGOs and CSOs have the comparative advantage of accessing and providing services to the marginalized MARPs, most of whom have a quasi-legal status, in a focused, aegis and relatively cost effective manner.

These NGOs and CSOs operate at national, provincial and community levels with very close contact with their concerned community. A National Association of PLHIV formed in 2007 functions as the bridge between the PLHIV community and their support organizations. The key role of the association includes advocacy for access to preventive, treatment, care and support services for all vulnerable populations, particularly for PLHIV, and ensuring Greater Involvement of PLHIV (GIPA) in all policy and decision making processes.

Organizations of PLHIV have taken root and evolved rapidly and today play a significant role in the national AIDS response. Majority of the CSOs providing care and support

services in collaboration with NACP are PLHIV organizations, most of which are founded and headed by PLHIV themselves. The National Association of PLHIV has not limited its activities to only PLHIV care and support but has branched out to other areas of advocacy and prevention to high risk communities and the general population.

UNGASS INDICATORS

INDICATOR 1:

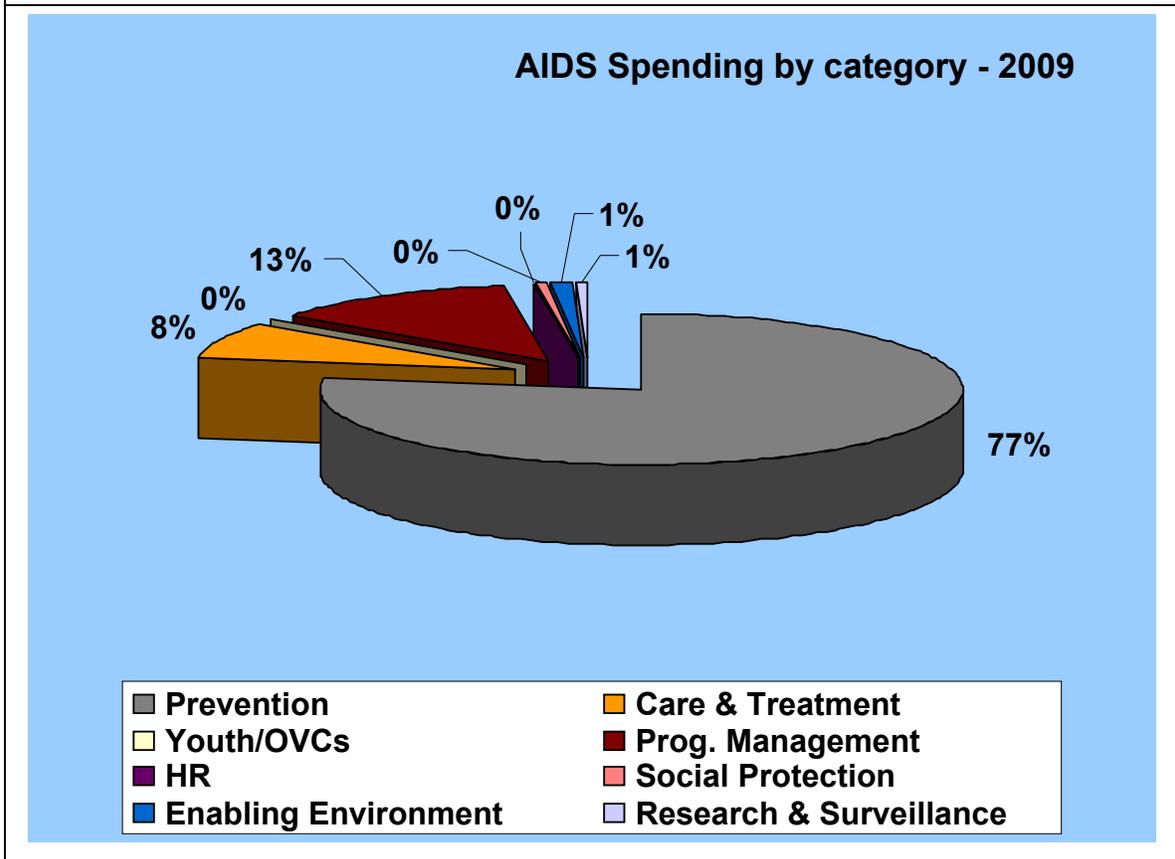
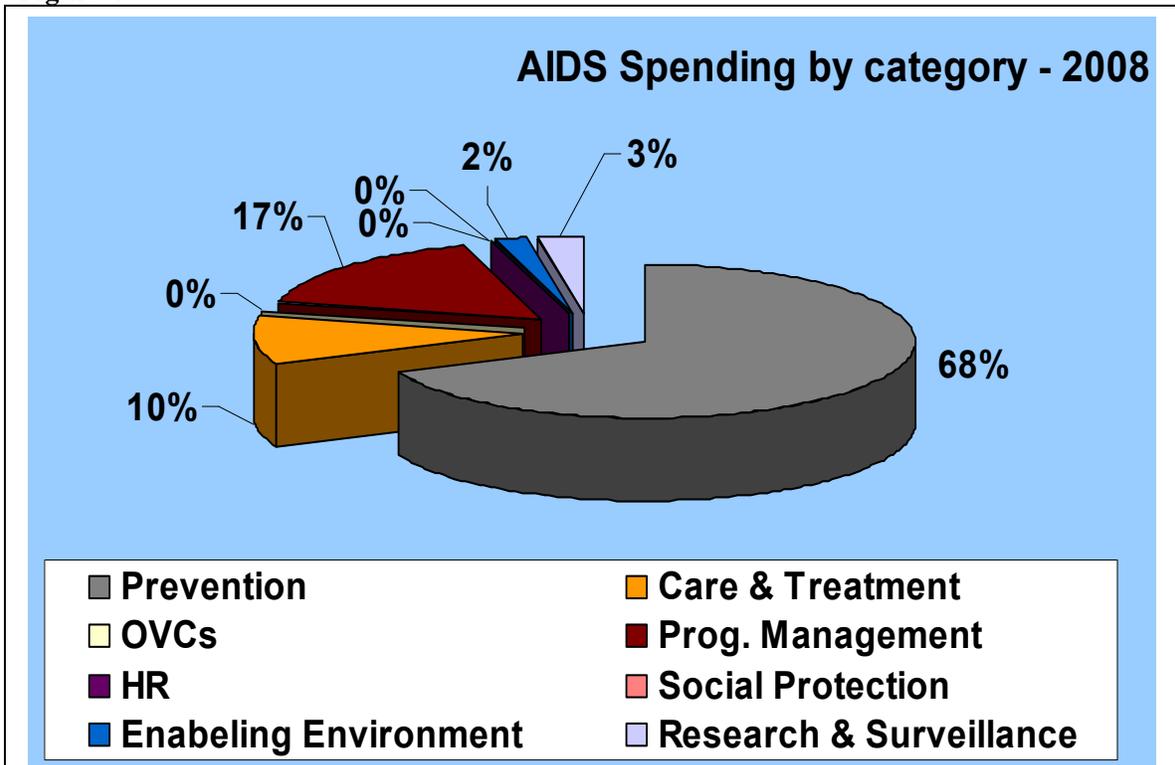
Domestic and international AIDS spending by categories and financing sources

The HIV/AIDS issue was recognized as an important development in 2002 i.e. after the development of first National HIV/AIDS Strategic framework. The Government of Pakistan (GoP) along-with other development partners including World Bank, CIDA, USAID, DFID, EU, and UN agencies, mainly UNAIDS started implementing HIV prevention and control response in 2003. The GoP with support from World Bank is the major financier of the response since 2003. The domestic and international spending on HIV/AIDS country has increased with every passing year. However, the country is yet to conduct its first National AIDS Spending Assessment (NASA).

For data collection on this indicator, the NASA matrix was circulated among all stakeholders including National and Provincial AIDS Control Programs, USAID, CIDA, GFATM, UN agencies, EU, and CSOs. Information was obtained for years 2008 and 2009 on all eight intervention areas identified in NASA matrix.

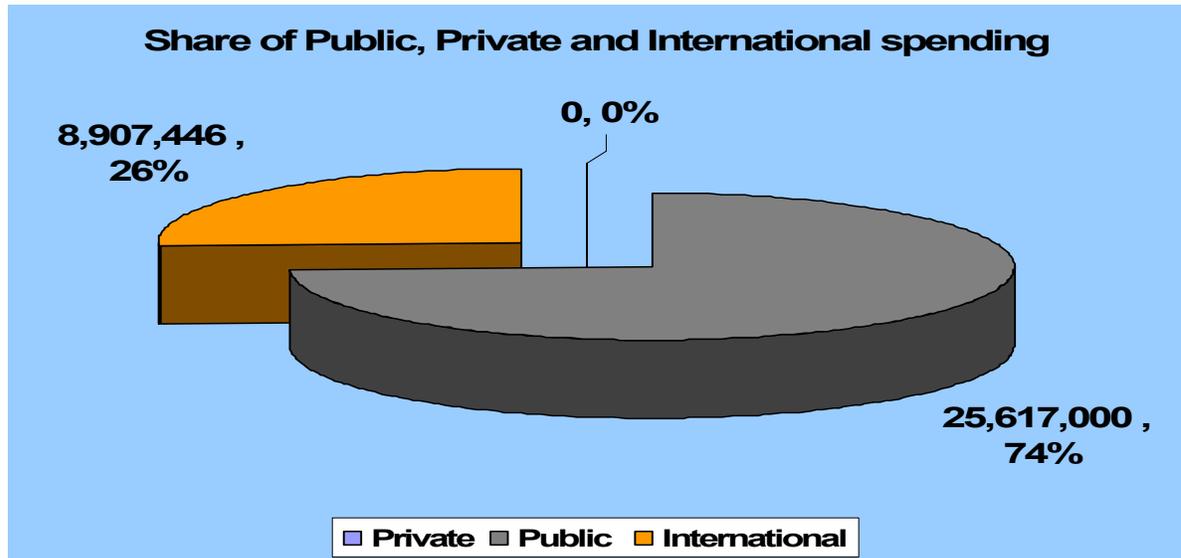
The analysis of the NASA matrix shows that a total of US\$ 34.19 million were spent in year 2008 and 2009. The AIDS spending was about 30% higher in 2009 i.e. US\$ 20 million compared to 2008 i.e. US\$ 14.2 million. The detailed spending by category for these two years is shown in the following figure.

Figure 4



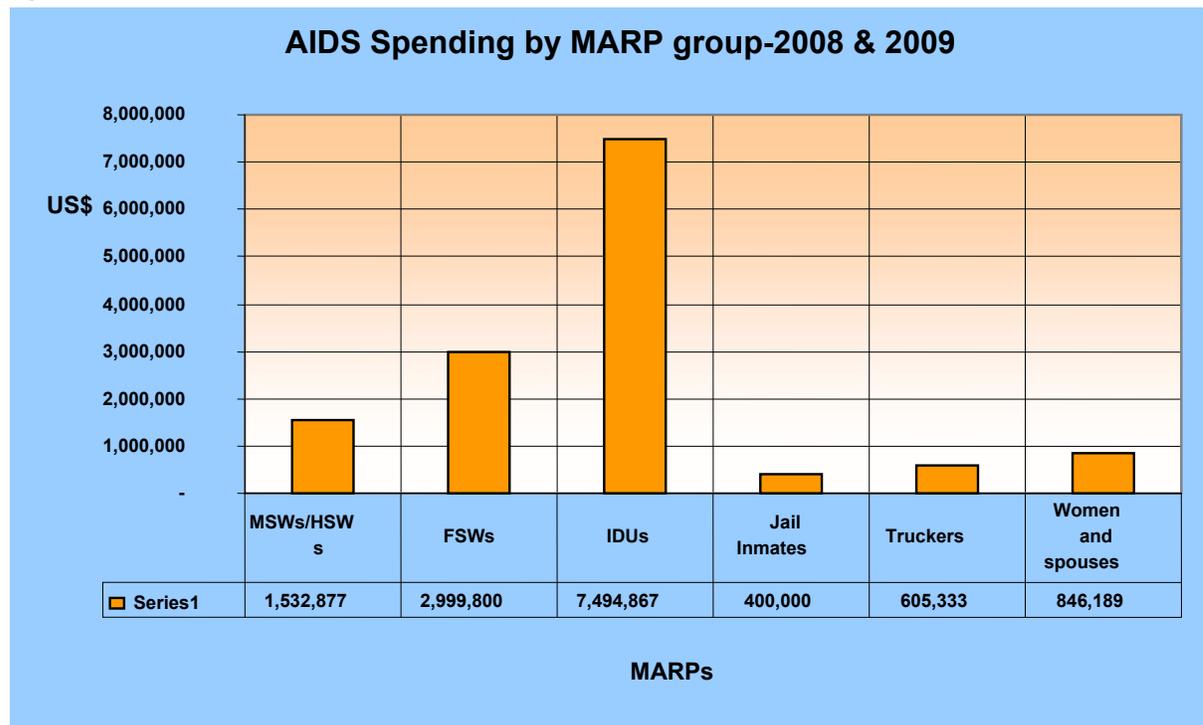
As already mentioned, assessment of spending within the public and private sectors and International agencies (including UN, bilateral and multilateral donors) indicates that public sector is the major financier of response with a total of 74% financing by public sector, 26% by international sources and 0% by private sector resources.

Figure 5



The spending on provision of services to MARPs was highest among all eight intervention categories and its distribution for various MARP groups for years 2008 and 2009 is shown in the following figure.

Figure 6



INDICATOR 2:

National Composite Policy Index

Since its inception, the national programmatic response has undergone many policy changes that reflect the shift of Pakistan from a 'low prevalence - high risk' phase to a concentrated epidemic in 2003. To effectively address the evolving HIV/AIDS epidemic, a multisectoral approach was adopted seven years ago. In an effort to capture the impact of this approach, this report identified 25 key respondents that encompassed a wide range of stakeholders with a special focus on CSOs and PLHIV. The NCPI in this report is hence the most comprehensive. Figure 7 and 8 graphically represent the trend analysis of the NCPI Part A and B respectively from 2006 to date.

Figure 7

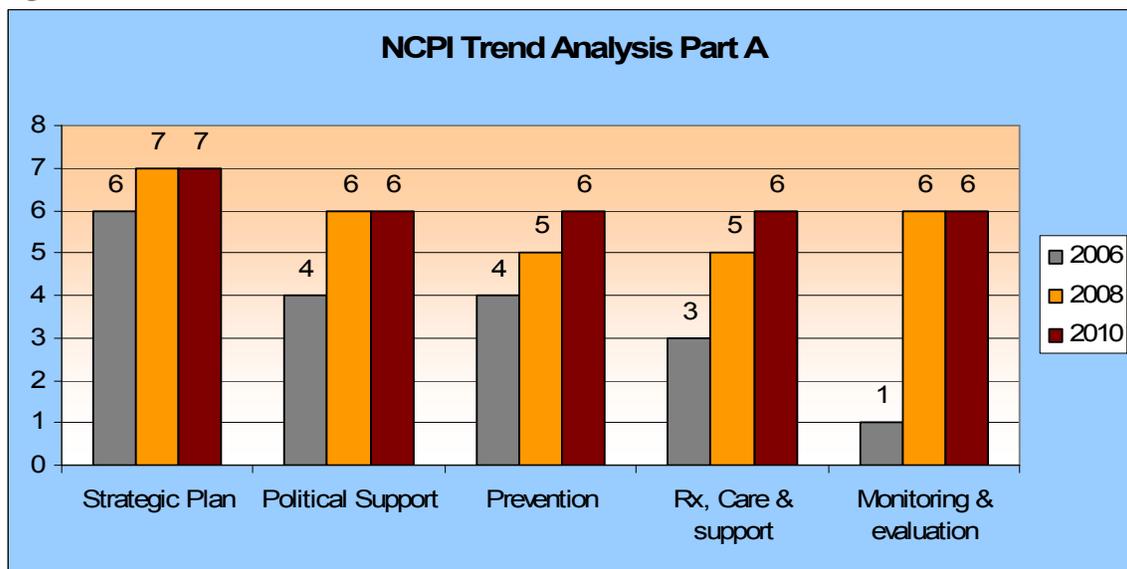
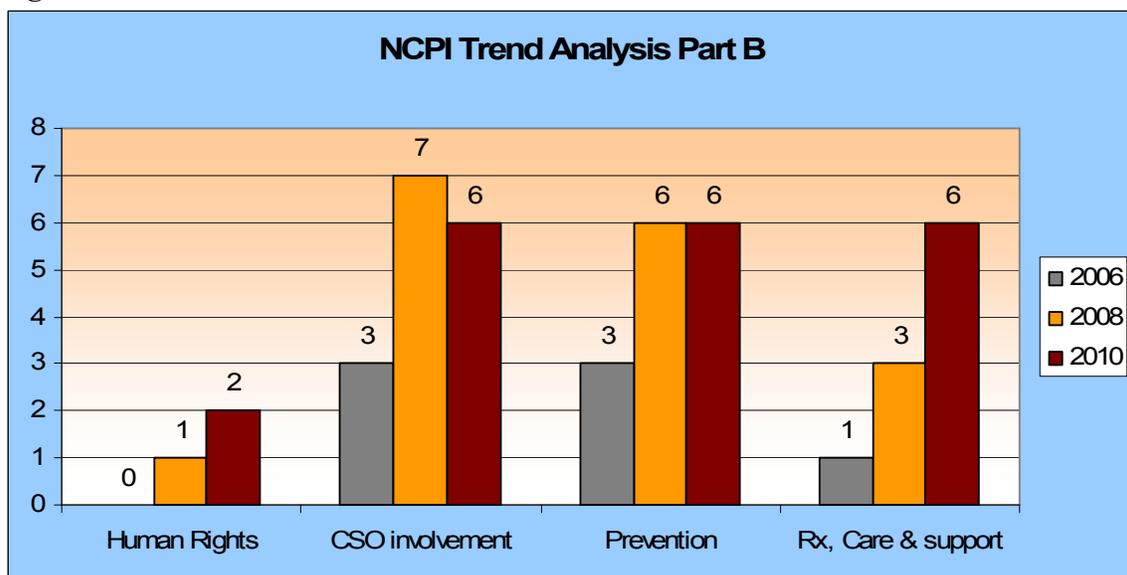


Figure 8



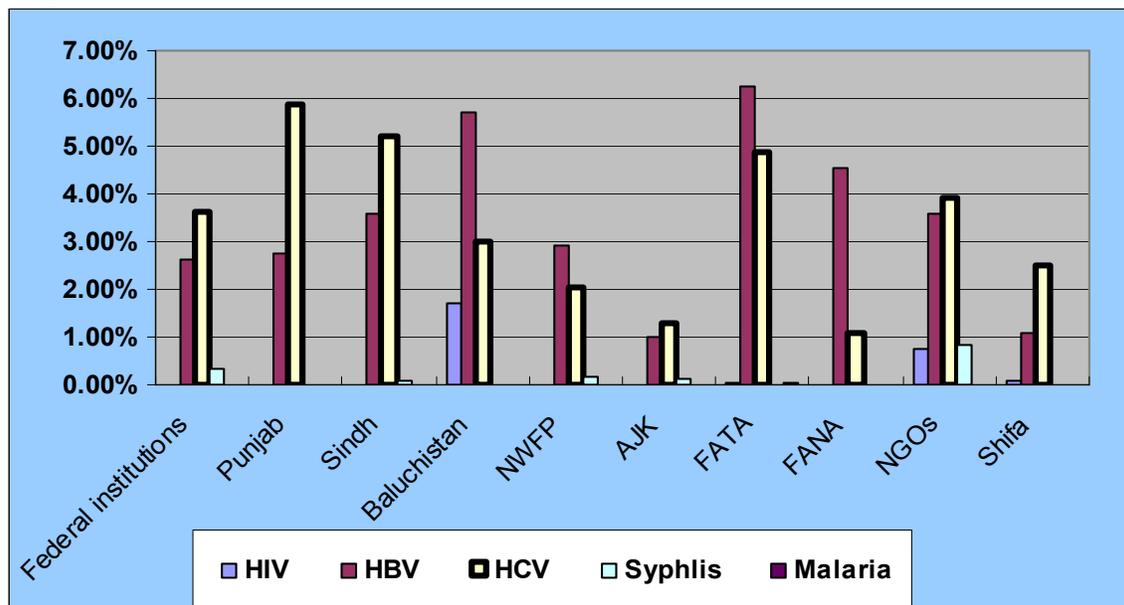
INDICATOR 3:

Percentage of donated blood units screened for HIV in a quality assured manner

Pakistan has a fragmented blood transfusion system which is poorly regulated. According to a national study, only 50% of the 1.5 million blood bags annually transfused are screened for HIV, HBV and HCV.¹ The large and medium size hospitals have more than 170 blood banks which mostly cater to hospital needs. There are about 450 blood banks in the private sector that contribute more than 50% to the annual blood transfusions. A number of studies conducted in recent past to determine HIV, HBV and HCV seroprevalence indicate a very low HIV prevalence with HBV prevalence of 3%-7% and HCV 2%-6% in these transfusions²

The National and Provisional AIDS Control Programs are the major suppliers of screening kits to all public sector blood banks. Screening reports from these blood banks are first shared with Provincial AIDS Control Programs and all data is aggregated on quarterly basis at the National AIDS Control Program. According to this data, in 2008, about 963496 donations were made in public sector blood banks with a feedback of more than 95% reported HIV, HBV and HCV screening conducted in line with the National Guidelines. Province and institution wise distribution of various Transfusion Transmissible Infections (TTIs) in these donations is shown in following figure.

Figure 9



¹ Final Report for the IMPACT Project in Pakistan, Sep 2007

² Mujeeb & Pearce 2008; Mumtaz et al. 2002; Asif, Khokhar & Ilahi 2004

Private sector blood banking is not well regulated in Pakistan and there is no monitoring mechanism to confirm screening status of blood donations in these blood banks. However, an end-project evaluation of the Global Fund Round 2 support that included an objective to strengthen private sector blood transfusion services was conducted in 2008. The evaluation reported that about 98% of the sampled blood banks i.e. 45 out of 48 were conducting HIV, HBV and HCV screening but there were serious issues in terms of following SOPs and meeting quality assurance standards. The overall quality of services was found satisfactory in only 9.3% of the blood banks i.e. 4 out of 48 blood banks. However, in terms of an External Quality Assurance Scheme for HIV screening, neither private nor public blood banks/screening laboratories in Pakistan have any record of participation.

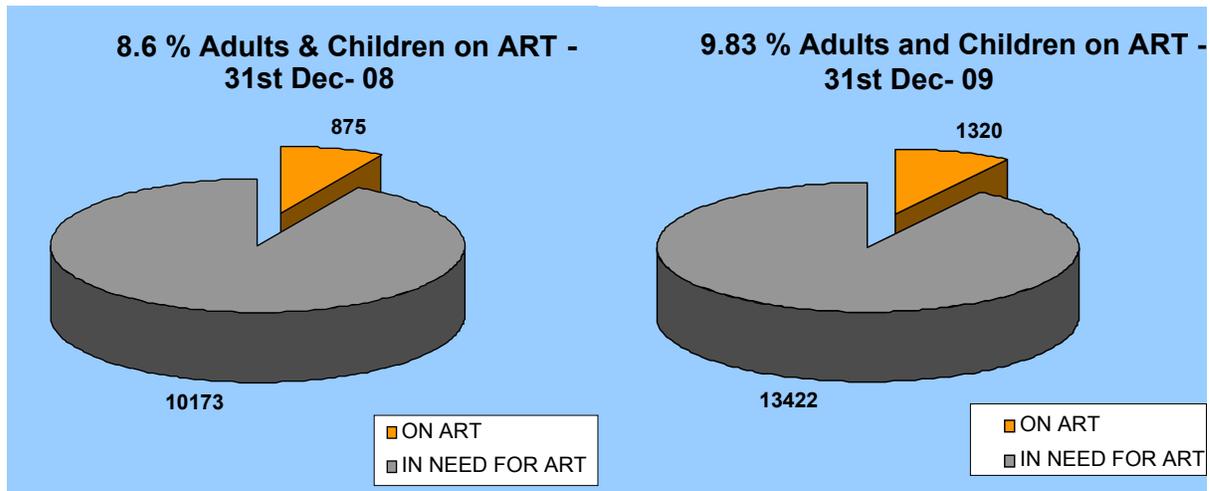
INDICATOR 4:

Percentage of adult and children with advanced HIV infection receiving antiretroviral therapy

The provision of Highly Active Retro-viral Therapy to HIV positive individual in Pakistan started in 2005. The first Enhanced HIV/AIDS Control Program envisaged establishing five ARV treatment centers in federal and provincial capitals; however over the last few years it expanded to thirteen centers across the country in both public and private sector hospitals. At present all thirteen centers are fully functional and providing free ARVs and other treatment and care related services to PLHIVs. Till 31st December 2009, there were 2917 PLHIVs (adults and children) registered with these centers and of these, 1302 were receiving free Antiretroviral therapy based on criteria set by National ART Guidelines. Currently, ARVs to these patients are being provided through Continuation of Services (CoS) proposal of Global Fund R 2 grant, which is available till 31st May, 2010.

For reporting on this indicator the data for numerator was obtained from HIV treatment and care coordination unit of the National AIDS Control Program and denominator was estimated using UNAIDS/WHO estimation models i.e. EPP and Spectrum. To analyze the trend, data for both 2008 and 2009 is being reported on this indicator. By the end of December 2008 there were 875 PLHIVs, both adults and children receiving ART from an estimated 10173 in need of ART i.e. 8.6 % and this number increased to 1320 PLHIVs on ART from estimated 13422 in need i.e. 9.83% by 31st December, 2009.

Figure 10



INDICATOR 5:

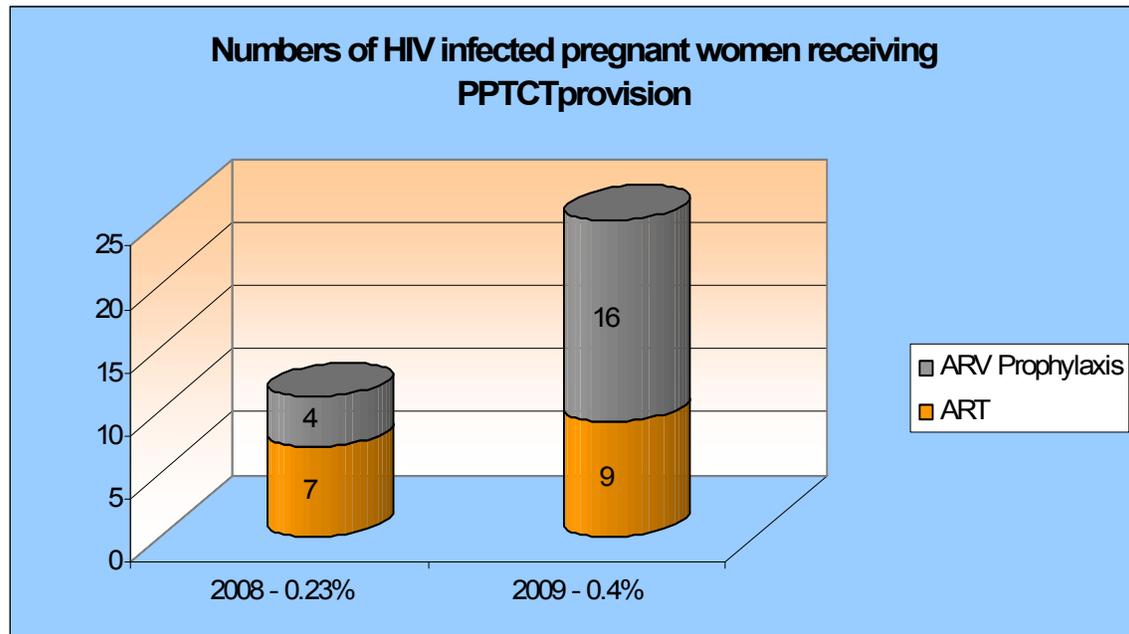
Percentage of HIV-infected pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission

The PPTCT program for HIV positive pregnant women was initiated in early 2007 and has a total of 7 PPTCT centers in major cities across the country. So far a cumulative of 84 HIV infected pregnant mothers have been registered, availed treatment and delivered babies all of whom were HIV negative. Pakistan is in the infancy of this service provision, therefore the total number of registered mothers is low as compared to the estimates

In 2008 (January-December), 11 women availed PPTCT services across 5 centers of which 4 and 7 received ARV prophylaxis and ARV therapy respectively. In the last 12 months from January 2009 to December 2009, a total of 25 pregnant women registered in 7 PPTCT centers, of which 16 received ARV prophylaxis regimens and 9 were on ARV therapy. Prophylactic regimens in Pakistan are limited to a combination of three ARV drugs.

For reporting on this indicator the denominator for each year was estimated using EPP and Spectrum models and according to these there were 4783 and 5663 HIV infected women in the country in the years 2008 and 2009 respectively. Accordingly the value for this indicator is 0.44% in the last 12 months as compared to 0.23% in the previous year. The annual trend shows an increase and is depicted in figure 11 which, in lieu of very small percentages, is presented in numbers.

Figure11



INDICATOR 6:

Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV

The TB detection rate in Pakistan is 67% and treatment regimens are provided in line with the National Guidelines on TB-DOTS. The success rate of TB treatment in Pakistan is 88%. There is a close collaboration between the NACP and the National Tuberculosis Program (NTP) that started in 2003 after the launch of Enhanced HIV/AIDS Control Program. All PLHIVs registered in ART centers are regularly screened for TB and referred to TB-DOTS centers for TB treatment. The ART centers in Pakistan still lack a proper monitoring information system and it was difficult to obtain data on this indicator from these centers. Although NTP monitors and disseminates progress information in their Quarterly Progress Reports, the data available is limited and does not fulfill the UNGASS requirements. Since the inception of this collaboration till end of December 2009, the cumulative number of PLHIV receiving testing, counseling and treatment for HIV and have screened positive for TB symptoms from 16 sentinel sites established under GFTAM TB Grant Round 6, were 234. However, data for incident cases of PLHIV tested positive for TB and who are receiving treatment for both during 2009 and disaggregation by age and sex was not available. Although the denominator is the WHO estimate of number of incident TB cases in PLHIV determined at 6200, lack of data for the numerator renders percentage for this indicator unattainable.

INDICATOR 8:**Percentage of most-at-risk-populations (MARPs) who have received an HIV test in the last 12 months and who know their results**

At present, Pakistan is in a concentrated phase of HIV epidemic. The provision of HIV prevention and control services to MARPs is the mainstay of national HIV response. These services are being provided to MARPs in all major cities of the country as standardized service delivery packages (SDPs) through public-private partnerships. The provision of VCT services is an important component of the service delivery packages. All MARPs accessing SDPs are offered VCT services. In addition, these services are also available in all thirteen HIV treatment and care centers across the country.

The data for this indicator is regularly collected through annual IBBS rounds in the country. In all previous IBBS rounds except the most recent round that was conducted among FSWs in six major cities, the data for this indicator is collected on being 'ever tested' rather than 'tested in last 12 months'. However, for IBBS round among FSWs, the questionnaire was modified to include a question on testing status in last 12 months. Reliability and quality of IBBS data is validated by a number of quality control mechanisms. Field work is monitored by an independent monitoring team, which operates separately from the data collection team. The monitoring team assures that the data is collected as per the protocol guidelines and all subjects who participate in the study are actual members of the HRG. The team also cross-checks the validity of information by re-confirming some of the key information obtained. The HASP technical team continuously monitors the data collection process and provides on-ground support to field teams at all points in time. The PACPs and NACP being part of the research team, also pay monitoring visits to the field sites under the coordination of HASP. A CIDA monitoring mission validates the data collection process during surveillance rounds. The biological component (HIV blood testing) follows an international quality assurance protocol, in which 10% of the samples are cross tested by Pakistani labs and positive samples are re-confirmed in the HIV retrovirological labs in Canada.

Sex workers in Pakistan include FSWs, MSWs and HSWs. Hijra Sex workers are a characteristic South Asian sub-group that fall in an independent category of a third gender. However for the purpose of the UNGASS indicators, they are grouped under the category of MSWs for their similarity of modus operandi in terms of vulnerability for HIV/AIDS transmission. The IDUs in Pakistan are predominantly male, therefore disaggregation by sex is not applicable to this sub-group.

The analysis of the indicator shows that VCT uptake in all four groups is still very low (Figure12). It is highest among FSWs compared to IDUs and M/HSWs. However,

compared to UNGASS 2008 reporting, there is a considerable improvement in this indicator for all three MARPs (Figure 13).

Figure 12

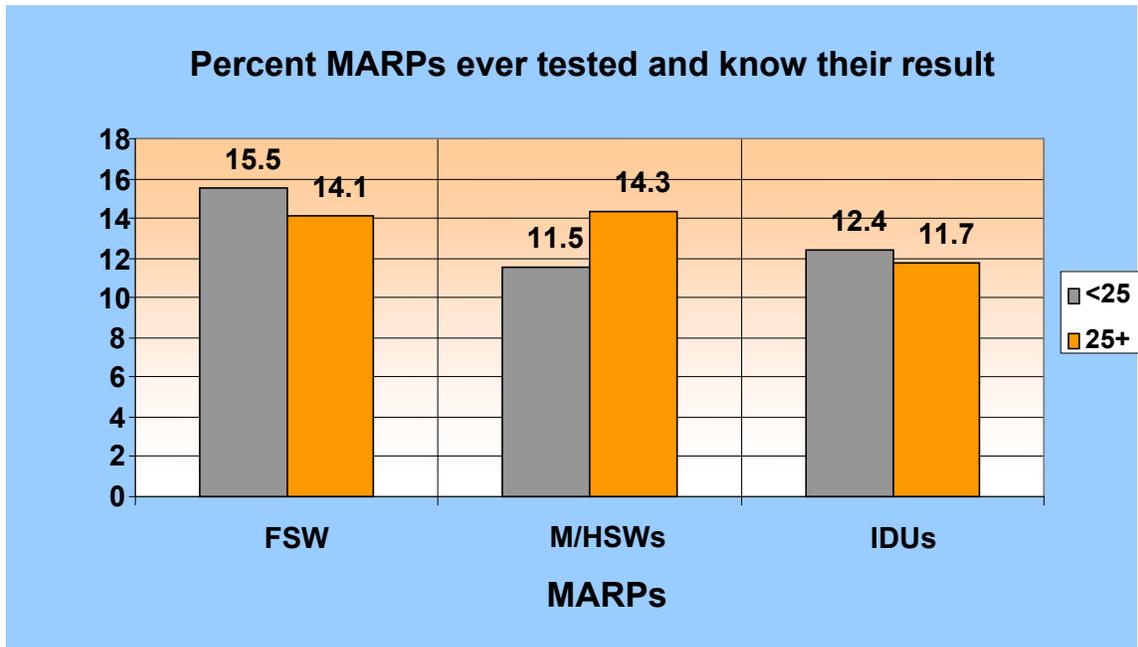
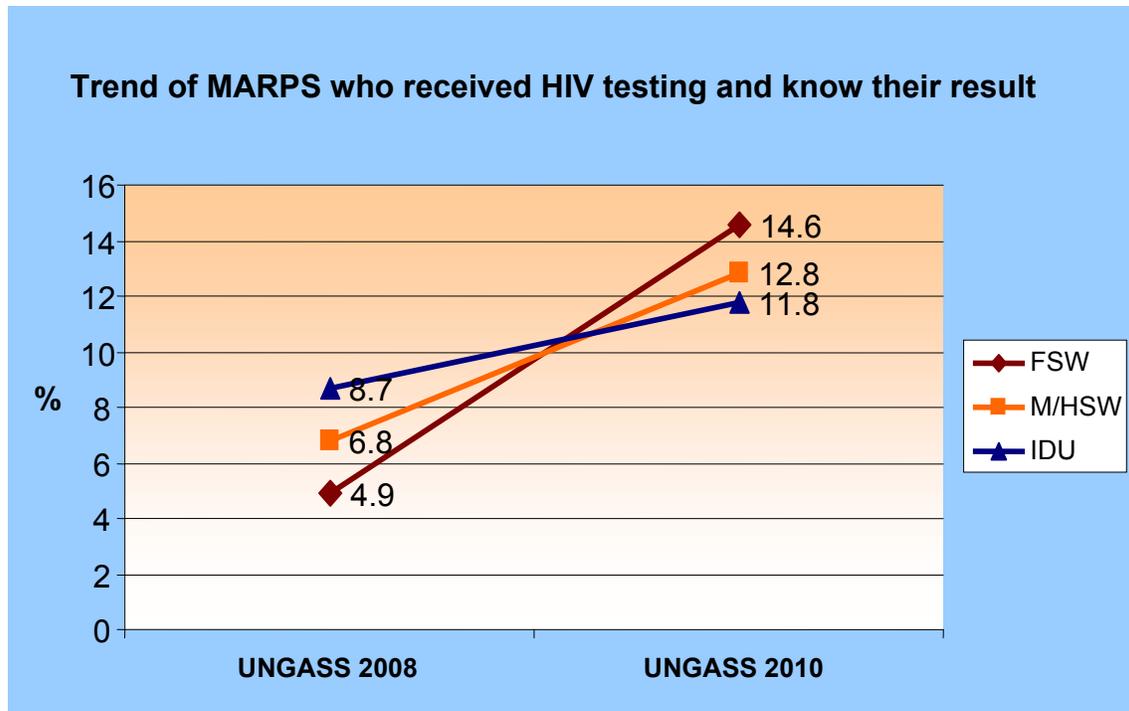


Figure 13



INDICATOR 9:

Percentage of most-at-risk populations reached with HIV prevention programs

This indicator requires specific questions to be asked in surveys to get data on the numerator. The IBBS surveys in Pakistan collect data on coverage in a different way. First, the data is collected for being ever in contact with a service delivery program rather than for contact in the last twelve months. Second, there is no specific question on accessing services for HIV test and third, the question is specifically asked about contact with government run programs. However, in the last IBBS round for IDUs and M/HSWs the question on ever contact with a government run program was replaced with ever contact to any program in the area. Similarly, in the recent FSW IBBS round, the question on ever contact was replaced with contact in the last twelve months. The question of provision of condoms in the last twelve months was not asked of the IDUs. The data on the other two questions mentioned in the UNGASS 2010 guidelines for determining the numerator is routinely collected for FSWs and M/HSWs.

The data on this indicator clearly indicates that coverage of HIV prevention programs is highest for IDUs, i.e. 58.4% for IDUs <25 years old and 49.2% for IDUs 25+ years old (Figure 14). In Pakistan, this data is collected from major cities where government run interventions are available and only reflects the male IDU population. Considering the HIV epidemiological situation, provision of harm reduction services to IDUs has always remained a top priority in the national HIV prevention and control response, the coverage among the other two MARPs is relatively low. However, in comparison to UNGASS 2008 data, there is a considerable improvement in the reach of HIV prevention programs in the country (Figure 15).

Figure 14

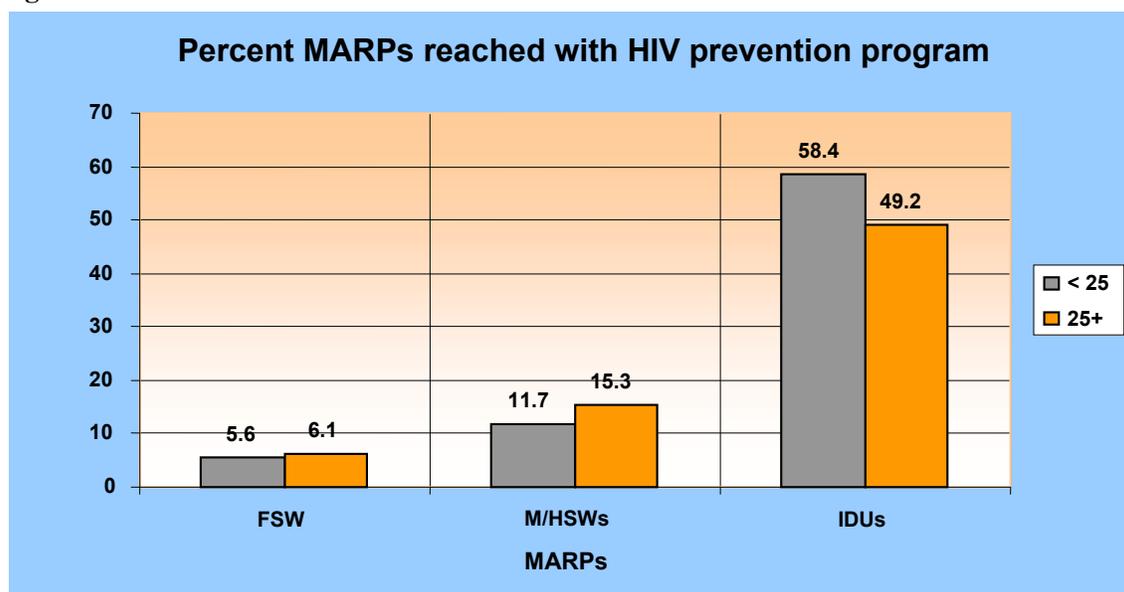
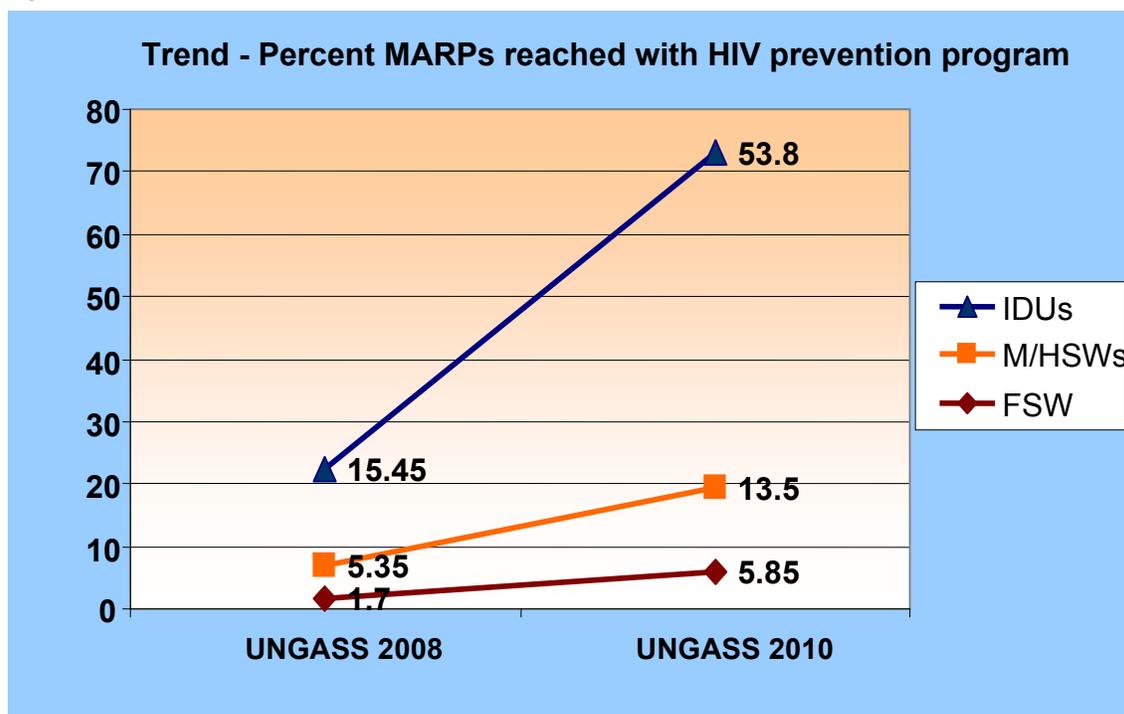


Figure 15



INDICATOR 13:

Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

This indicator is relevant to Pakistan but data is difficult to obtain due to socio-cultural barriers. The DHS report 2007 made an attempt to gather data on this indicator but the study population in the survey was limited to only ‘ever married women’. Men and unmarried women were excluded. Data was obtained from a sample size of 2064 ever married women within the age range of 15-24. Results were reported as per questions asked in the survey. Accordingly, it was not possible to report on this indicator as per UNGASS 2010 guidelines. However, the most relevant available information is presented in the table below.

Table 1

Question	% who gave correct answers
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner?	28.6%
Can a person reduce the risk of getting HIV by using a condom every time they have sex	17.0%

Can a health-looking person have HIV	25.8%
Can person get HIV from mosquito bite	17.2%
Can a person get HIV by sharing food with someone who is infected	18.6%

INDICATOR 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

Correct knowledge of modes of transmission of HIV/AIDS among MARPs is a cornerstone for concentrated epidemics. Pakistan recognizes this fact and has maintained this as a crucial facet of the SDP for MARPs that is regularly evaluated in surveillance rounds. Data on this indicator is routinely collected through IBBS rounds with minor differences e.g. in the question “can a person get HIV from a mosquito bite?” the mosquito bite is replaced with “insect bite”. The first question ‘Can having sex with only one faithful uninfected partner reduce HIV transmission risk’ was not asked from M/HSWs for whom the numerator has answers to 4 out of 5 questions. However, for recent FSW IBBS round all five questions on knowledge, inclusive of this first question, were asked as per UNGASS 2010 guidelines.

Commensurate levels of pertinent HIV related knowledge was found amongst the M/HSW at 23.1% and IDUs at 22.5%, both displaying a steady increase from previous reports. The FSW sub-population exhibited very low levels of knowledge at 1.07% presenting a substantial dip from the previous level of 25.8%. This can be attributed to the fact that in the IBBS round for FSW 2009, all five questions were asked as compared to 4 out 5 asked of the other MARPs in IBBS round III. The low response reported specific to question one (6.28%) can be assumed to have contributed to very low cumulative indicator of percentage who answered all five questions correctly. Similarly, the IBBS round II used for the UNGASS 2008 report did not ask FSWs all five questions, therefore the trend analysis should not be interpreted in a simplistic manner. Disaggregation by age and sex is depicted in the Figure 16 and the trend since the last reporting period information can be seen in Figure 17.

Figure 16

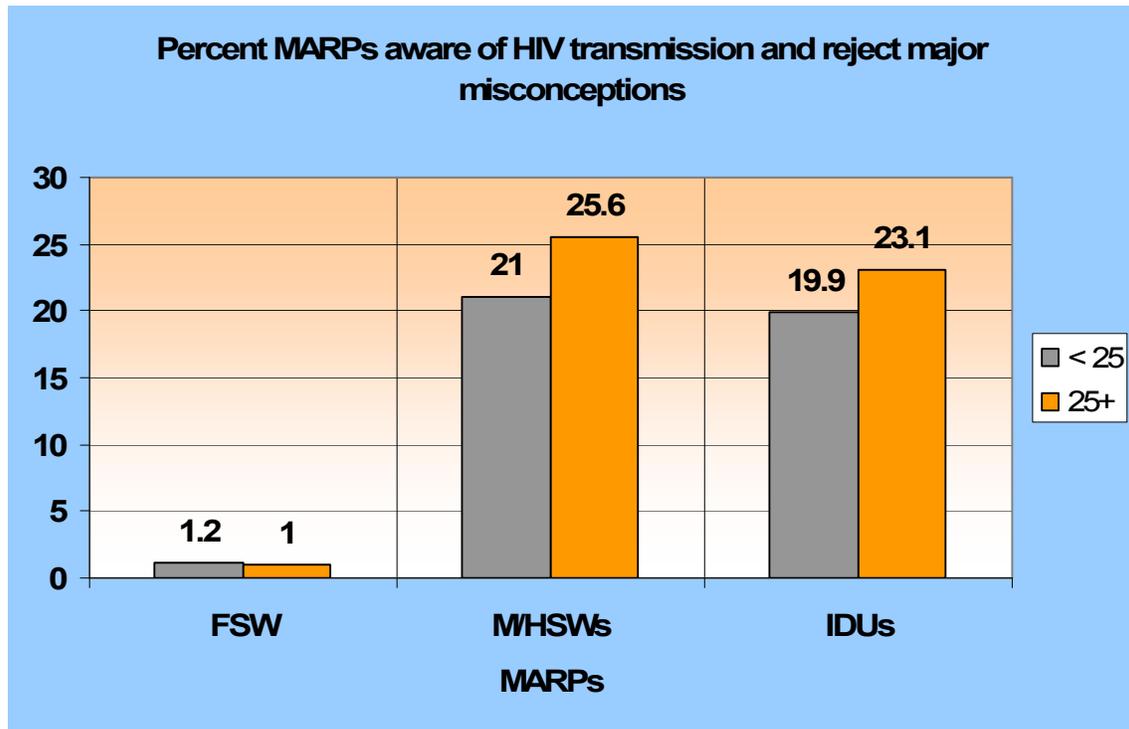


Figure 17

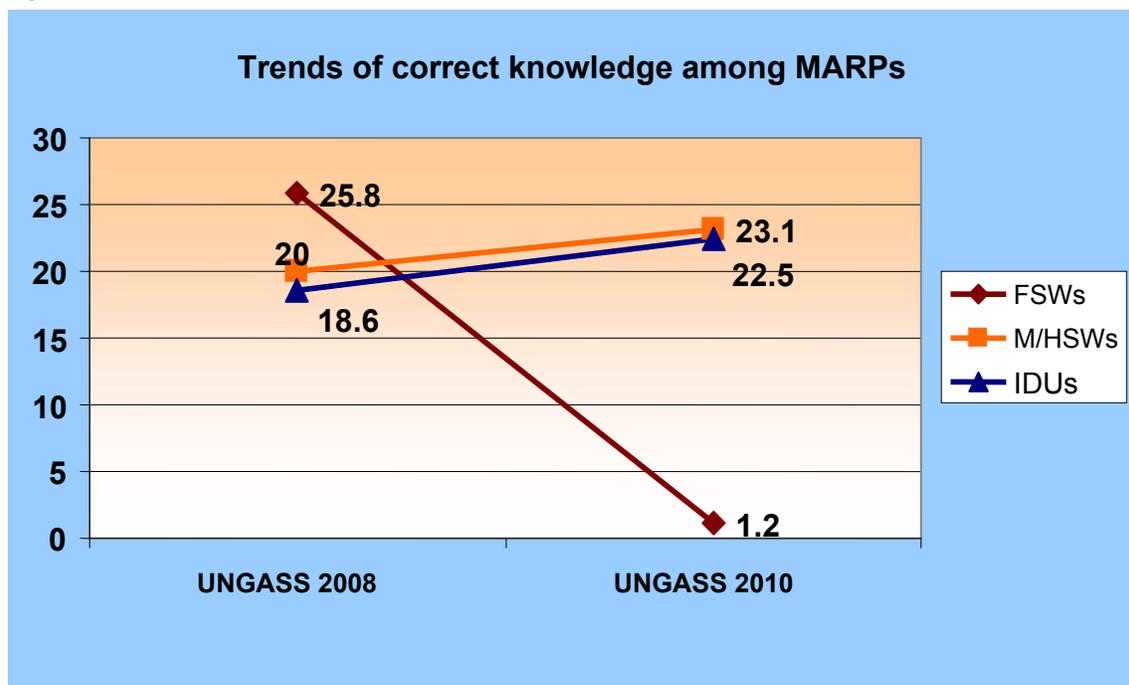
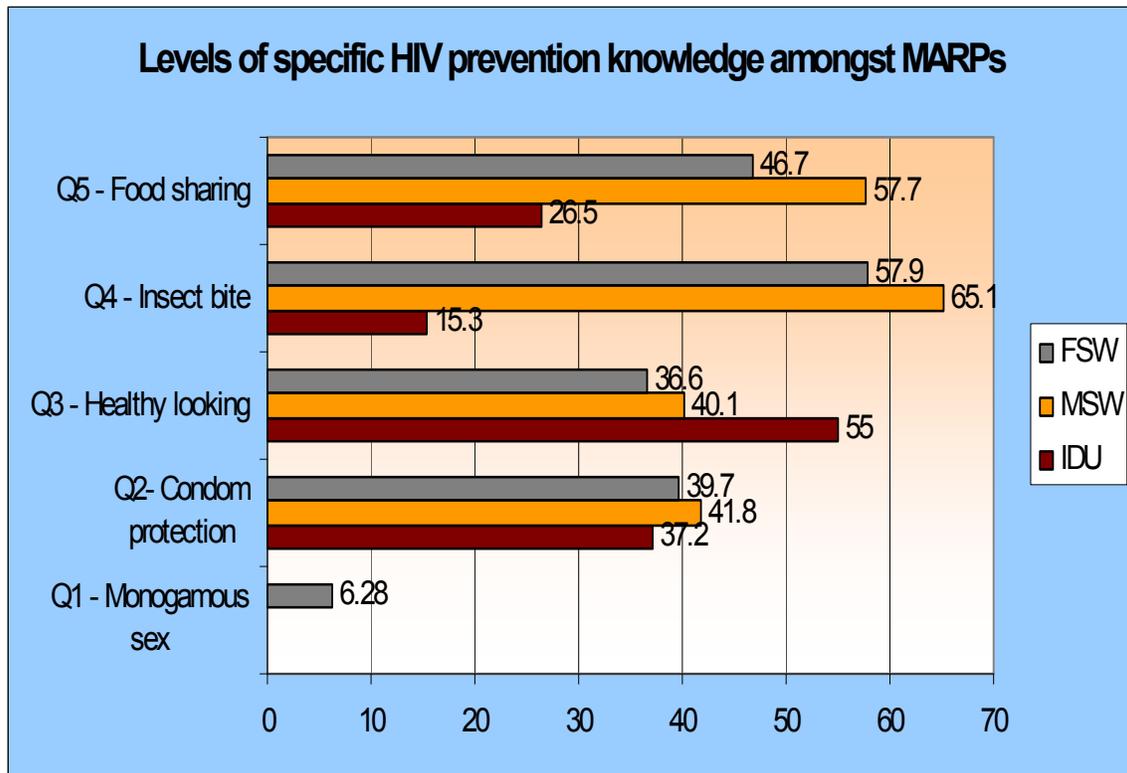


Figure 18



INDICATOR 18

Percentage of female and male sex workers reporting the use of a condom with their most recent clients

There are about 136,000 FSWs in the country as per national MARP size estimates, making them the largest among all MARP groups. The recent FSW IBBS round in six major cities of the country identified 23.8% street based, 23.9% brothel, 24.7% home-based and 22.4% *Kothikhana* (based in houses in suburban residential areas) FSWs from a sample of 2055. The daily numbers of commercial clients were reported to be 4 averaging to 43 clients per month with an average of 3 non-commercial sex partners in one month. *Kothikhana* FSWs reported the highest daily commercial clientage of 6 per day averaging 45 per month with 4 per month non-commercial partners. Sex with an IDU in the past six months was reported by 7% FSWs while 6% admitted to indulging in injecting drugs themselves. These high risk activities were more common in *Kothikhana* FSWs where 8.2% reported sex with an IDU and 9.1% injecting drugs.

Condom use in the last vaginal intercourse was reported by 43.3% FSWs with brothel based workers exhibiting the highest use at 82% and *Kothikhana* workers showing lowest

use at 30.7%. Condom use in last episode of anal sex and oral sex was reported at 5.2% and 3.1% respectively, with brothel based and *Kothikhana* FSW exhibiting the highest (9.8%) and lowest use (2.7%) respectively.

For UNGASS reporting, the MSW category includes data from both MSW and HSW. However, individual behavioral variations demand their separate reporting. MSW estimated at a total population of 63,000 in the country, report a daily clientage of 1.9 ± 0.98 averaging to 20 per month out of which 24% used a condom with a paying client in the last month. However, 41.8% report having sex with at least one non-paying client in the last one month. In the past six months, 6.4% MSW reported having sex with an IDU and 4.2% admitted to injecting drugs themselves.

HSWs, estimated at 43,000, have an average daily commercial clientage of 2.6 ± 1.9 (49 per month) with 19.7% always using a condom in the last one month. An additional 44% reported at least one non-paying client in the past month. In the past six months, 6.3% HSWs injected drugs and 4.6% reported having sex with an IDU.

For this indicator, an overall 37.8% of both female and male sex workers reported using the condom with their most recent clients. Condom use with most recent client by M/HSWs increased from 21.5% in the last reporting period to a current 33.1% with a somewhat equitable use for both younger and older M/HSWs. Younger FSWs exhibited a higher level of condom use (49.5%) as compared to older workers at 39.6% but with a stable trend when compared to previous reports. The high levels of condom use amongst FSWs can be attributed to its use as a contraceptive measure rather than a protection against HIV transmission. This fact is further reinforced by the higher level of condom use in vaginal sex as compared to anal sex. Disaggregation by age and sex and trend analysis is depicted in figure 19 and 20 respectively.

Figure 19

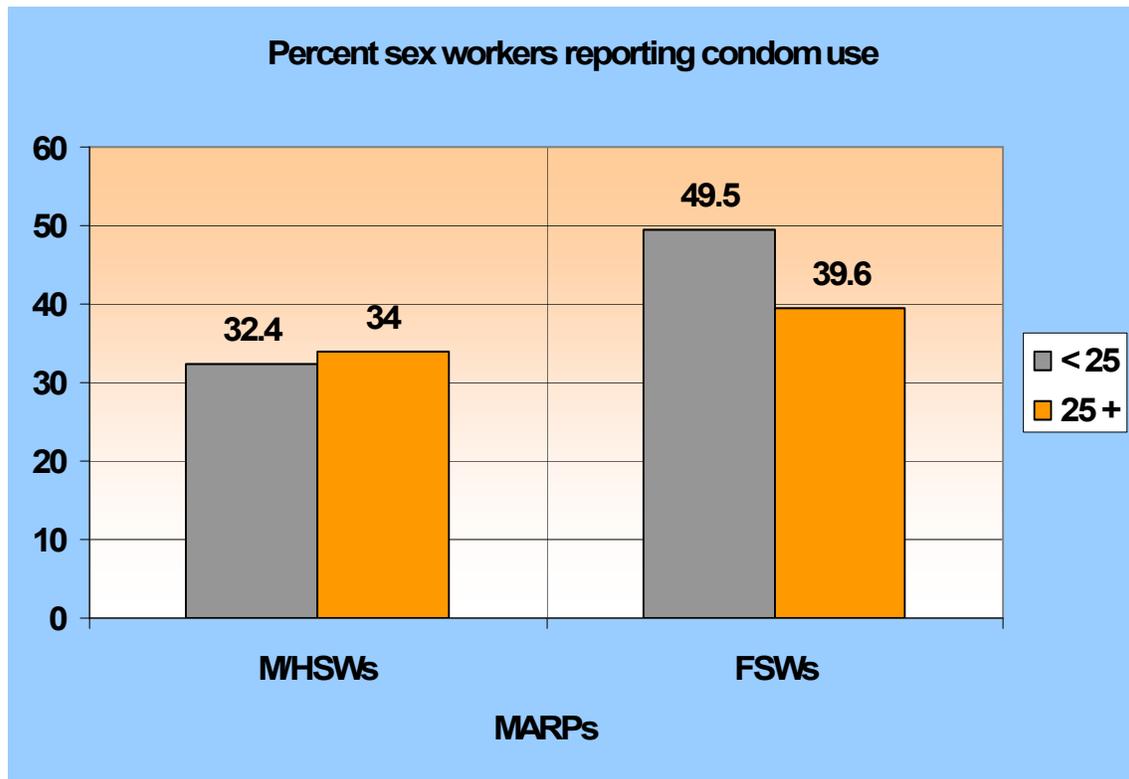
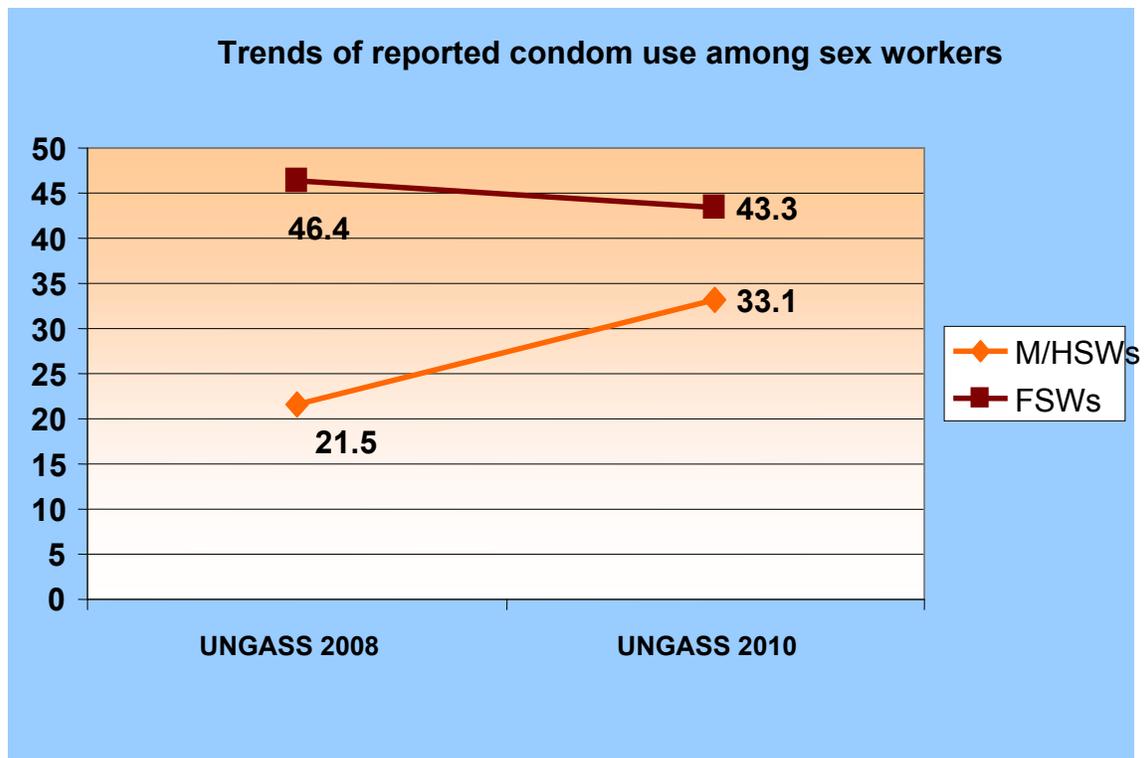


Figure: 20



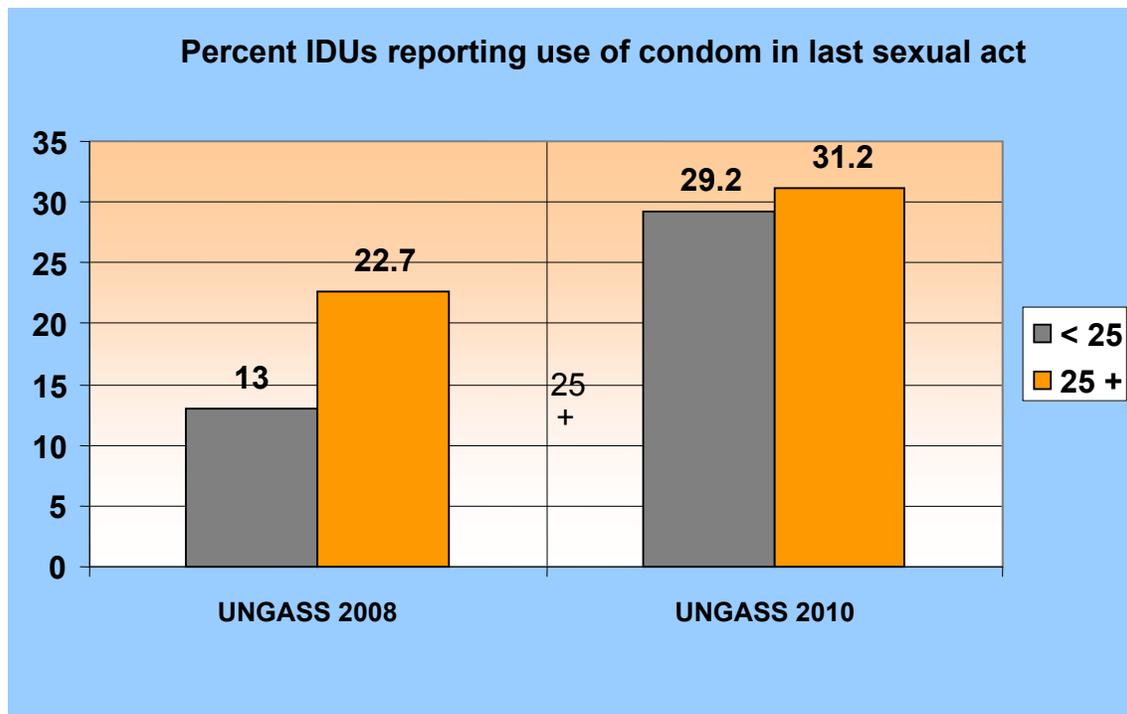
INDICATOR 20:

Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse

Although, national MARP size estimation based on HIV/AIDS Surveillance Project (HASP) mapping in 12 major cities estimates IDUs at 91,000 making them the second largest MARP group, they are nonetheless the core group driving HIV epidemic in the country. Drug users in Pakistan often switch from injecting to non-injecting drug use and vice versa depending on quality and availability of drug of choice. In order to get an indubitable representation, the inclusion criterion for IBBS is defined as ‘injecting drugs for non-therapeutic purpose in past six months’ rather than in past one month.

Of the IDUs surveyed in eight major cities in IBBS round III, 41% were currently married with 17.7% reporting sex with FSW in the past six months. Sex with M/HSW in the past six months was reported by 13.9% with 13.8% reporting use of a condom in these encounters. About 16.8% IDUs reported selling sex for drugs or money in past six months. Data for this indicator reported 30.8% of IDUs using a condom in their last sexual intercourse with a somewhat equal use in both the older and younger IDUs. This is approximately double the frequency reported in the last UNGASS report. Keeping in mind that IDUs in Pakistan are predominantly male, age-wise distribution and trends of condom use is shown in Figure 21.

Figure 21



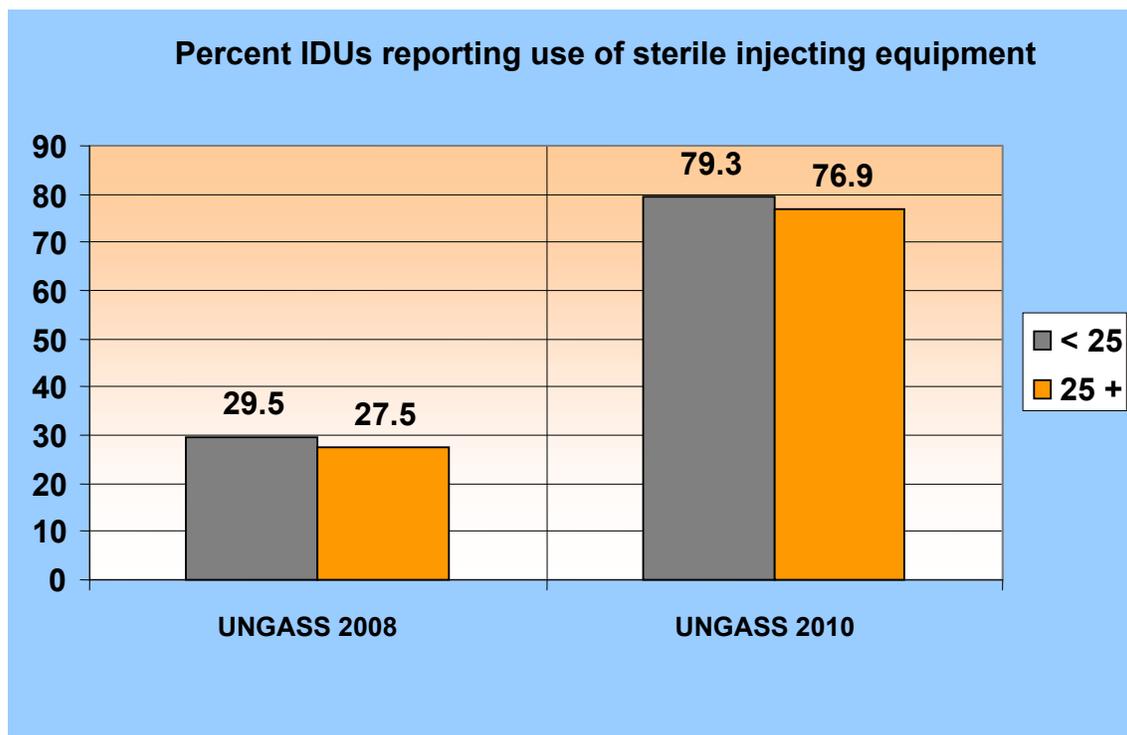
INDICATOR 21:

Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected

From a sample size of 2979 street based IDUs in eight major cities, 77.3% reported using sterile needle in the last injecting episode. There was very little age-related variation in adoption of this practice with both younger and older IDUs. Although there is a significant improvement in this harm reduction component, it must be noted that the IBBS round III was conducted only in cities with major program interventions and the results may be an overestimate. Smaller towns and cities with no program intervention fall off our radar but their IDU populations may equally contribute to the HIV epidemic.

The average age of initiation of injecting was 28.5 years with an average 4.6 years of injecting drugs. The average number of injections used was 2.2 ± 1.4 (median 2) per day. Help for injecting by ‘professional injectors/street doctor’ within the past one month was taken by 60.6% IDUs. Out of these, 12.2% always got their injections from these professional injectors. Of the IDUs surveyed 23% reported injection with a used needle/syringe at the last injection and 18% passed their needle to another IDU. In addition, approximately 29.1% reported using other injecting paraphernalia including cooker, water, cotton caps etc.

Figure 22



INDICATOR 23:

Percentage of most-at-risk populations who are HIV infected

The HIV prevalence among IDUs in the country is consistently greater than 5% and steadily rising. As per the Asian Epidemic Model, the IDUs embody the core group driving the epidemic in the country and consequently exhibit the highest prevalence of 20.8% with both younger (<25) and older (25+) users having similar prevalences of 22.5% and 20.4% respectively

M/HSW collectively tested 3.5% positive for HIV with little age variation showing prevalence of 4.0% amongst the older workers as compared to 3.1% in the younger workers. As mentioned earlier, the HSW category of MARPs has been grouped with MSWs for UNGASS 2010 reporting. Independently, the average HIV prevalence among MSWs was 0.9% and among HSWs 6.1% while the IBBS rounds for FSWs revealed a prevalence of 0.97%. The prevalences and trend is depicted in figure 23 and 24 respectively. The geographic trend of the epidemic has shown an expansion to smaller cities and towns. Prevalence among IDUs has shown to be as high as 30% and 27% in Hyderabad and Larkana respectively. Larkana also harbours the highest HIV positive HSWs (27%). Prevalence according to city/town and HRG is shown in table 2

Figure 23

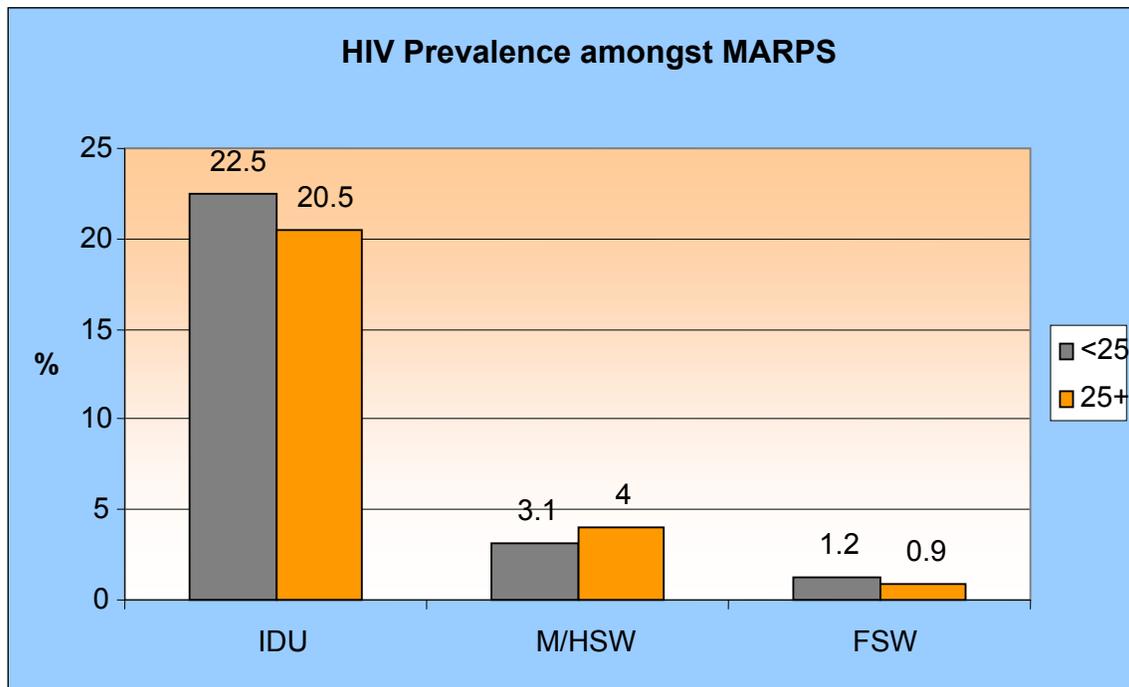


Figure 24

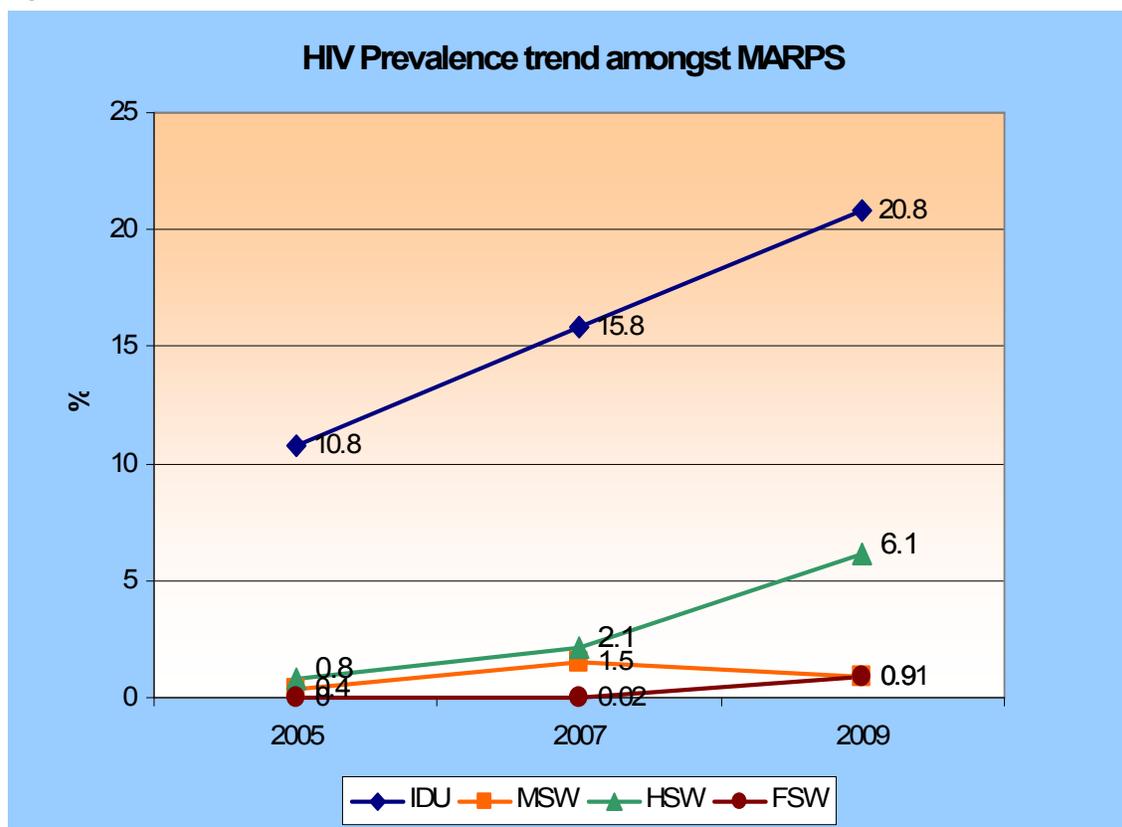


Table 2: HIV Prevalence by city and HRG

CITY/PROVINCE	IDU	MSW	HSW	FSW
Karachi – provincial capital Sindh	23%	3.1%	3.5%	2.0%
Hyderabad – Sindh	30%	0.0%	0.0%	0.0%
Larkana – Sindh	28%	0.5%	27%	0.61%
Lahore – provincial capital Punjab	15%	0.1%	2.5%	0.98%
Faisalabad – Punjab	12%	--	2.5%	0.75%
Sargodha – Punjab	23%	--	--	1.2%
Peshawar – provincial capital NWFP	13%	--	1.2%	--
DG Khan – Punjab	19%	--	--	--
Total	20.8% N=2971	0.9% N=1205	6.1% N=1186	0.91% N=2197

Source: HASP IBBS round III and IBBS FSW round

INDICATOR 25**Percentage of infants born to HIV-infected mothers who are infected**

Data for this indicator was obtained by EPP and Spectrum modeling. The numerator was estimated at 1693 children aged 0-4 years who are HIV infected during the period of January to December 2009. The denominator was estimated at 5663 HIV-infected pregnant mothers at the same period. Accordingly, the percentage for this indicator was calculated at 28.94%

BEST PRACTICES

HIV/AIDS in Pakistan evolved to a concentrated epidemic seven years ago and during this brief period, two best practices have come to the fore.

The driving force behind Pakistan's HIV epidemic is the core group of IDUs and provision of comprehensive HIV prevention services inclusive of harm reduction for this population has been one of our best practices in the recent past. The Harm Reduction Program was initially funded by UNAIDS and DFID in five cities in 2000-2003 and was further expanded by GoP with the support from the World Bank in 2005. By the end of 2009, the harm reduction services were being provided to IDUs reaching around 30,000 IDUs according to estimates. Consecutive rounds of IBBS findings indicate a decrease in sharing of needles and syringes particularly in cities where interventions for IDUs exist. According to the most recent surveillance round, the practice of sharing syringes is common in 40% of IDUs in cities where there is no service intervention, as compared to 12% in cities where the program exists and even lower in cities where the criteria of adequate coverage is being met. This has been accompanied by an increase in condom use, knowledge and risk perception of HIV/AIDS amongst the IDUs. Keeping in view the success so far achieved by the harm reduction initiatives in the country, the government has decided to enhance these services to reach a significant number of IDUs in the country in order to have an impact on the HIV epidemic. The number of IDUs accessing harm reduction services is likely to increase up to 39,500, as per the revised PC-1, during the next five years and an additional 28,000 IDUs are proposed to be accessed under the Global Fund Round-9 grant which has been approved recently. The Harm Reduction Program has now matured to the point where Pakistan is set to implement the 'Oral Substitution Treatment Pilot Project' in 2010 as part of overall interventions for IDUs.

The second best practice that has emerged in the past few years is the Second Generation Surveillance System that has guided the HIV national response based on evidence based planning. As part of the EHACP, CIDA provided financial and technical assistance for the establishment of SGC through the Canada-Pakistan HASP. The project developed country specific methodology for surveillance that is conducted in two phases; Phase I involves mapping of risk groups in all major cities to estimate size, location and operational typologies of MARPs followed by collection of behavioral and biological data in Phase II. Since its implementation in 2004, HASP has successfully conducted three IBBS rounds and interviewed a total of 9450 IDUs, 5275 MSWs and 4898 HSWs from eight cities in 2005-6, twelve in 2006-7 and eight in 2008. IBBS rounds accessing a total of 9970 FSW were conducted in eight cities in 2005-6, twelve in 2006-7 as part of rounds I and II and in six cities in 2009 in a special round for FSWs only. In addition to

understanding the magnitude of the epidemic and highlighting its changing patterns, this SGS data has been used extensively by National and Provincial programs at different levels of:

1. **Policy development and Advocacy:** For a long time, the existence of a sizeable commercial sex industry in Pakistan was denied by the authorities. The mapping data was used as an advocacy tool to sensitize state and non-state actors especially policy makers and community leaders about the consequences of an unfolding epidemic. This led to the first National HIV/AIDS policy document development.
2. **Development of an integrated national response and resource allocation:** SGS data provided valuable information for the development of the NSF-II as well as the Global Fund proposal Round 9. At a national level, size estimations of risk groups has helped determine the National Universal Access targets as well as set targets in line with the MDGs
3. **Designing and Scaling up of services for MARPs:** The behavioral component of the SGS data was used to develop and refine the SDPs to at-risk groups. Biological data was used to channel resources to groups and areas most affected by the epidemic. Data collected on geographical distribution helped in planning service delivery sites while population estimates helped determine the number and extent of services required for appropriate coverage, program staffing needs, service infrastructure, and commodities.
4. **Evaluation of program success:** Use of SGS data to significance levels has helped in determining whether or not prevention and care interventions have been successful. The combined analysis of SGS datasets with data collected from SDPs provides a valid assessment of program effects on the course of the epidemic.

As part of the revised PC-1, collaboration with CIDA has been renewed for another 18 months and the project is being scaled up to develop capacity at national and provincial levels in the arena of surveillance as well as to institutionalize the surveillance activities of HASP

MAJOR CHALLENGES AND REMEDIAL ACTIONS

Progress on key challenges reported in UNGASS 2008 report:

Based on the constraints and gaps identified in the 2006 Situation and Response Analysis (SRA) and the Mid-Term Review (MTR), several remedial strategies to expand the scope of service and scaling up of the HIV/AIDS interventions were proposed in the 2008 UNGASS report. Realizations of these proposed angles achieved in the last two years include:

1. Scaling up of program delivery in terms of geographical and numerical expansion of existing services to provide greater coverage was achieved by HIV/AIDS interventions accessing more than 30,000 IDUs, 25000 M/HSWs, 12000 FSWs and 50,000 Long Distance Truckers. In addition, a Global Fund regional proposal for MSW and HSW include a grant of US\$9 million for Pakistan. This proposal mainly includes technical assistance for the provision of services to this group.
2. Scaling up of program delivery in terms of expansion in the range of services based on the needs of the target groups was addressed by a national agreement on the ‘Oral Substitution Treatment Pilot Project’, the first of its kind set for implementation in 2010. High HIV prevalence amongst spouses of IDU has been addressed in the approved revised PC-1 where a separate component of BCC specifically for spouses and families of IDUs has been budgeted. In addition to BCC, this component includes primary health care, STI medicines, voluntary Counseling and Confidential Testing (VCCT) and Prevention of Parent to Child Transmission (PPTCT).
3. In order to achieve an enabling environment, the “HIV/AIDS Safety and Control Bill 2009” was developed and is submitted to the Parliament for review. This legislation document provides a framework protecting the rights of the MARPs, PLHIV and their families with equitable access to prevention, treatment, care and support without stigma and discrimination. It also dictates safety measures in the healthcare institutional arena and blood transfusion services.
4. Stigma and discrimination reduction was addressed at policy and programmatic levels. In observance to the GIPA policy, PLHIV were involved in the various levels during the development of the Global Fund Proposal and the revision of the PC-1 for the EHACP. Funding has been budgeted for activities specific to stigma and discrimination reduction and improving opportunities for employment and career growth for PLHIV.

Major challenges faced during 2008-9

Although Pakistan successfully addressed several of the previous challenges, some emic components remain persistent. In the reporting period, the program faced additional challenges. Comprehensively they include:

1. **Funding issues:** Sources of funding for the program are limited to a few channels and over-reliance on these exiguous funders leads to impediments in sustainability of service delivery. This is further aggravated by delayed mobilization of committed funds due to bureaucratic and technical hurdles.
2. **Capacity issues:** Impediments in this arena remain the same. They are:
 - (i) Shortage of technically qualified persons exaggerated by constrains in travel to Pakistan dictated by the unstable security situation.
 - (ii) Capacity gaps in the technical stratum in NACP and PACPs
 - (iii) Lack of HIV/STI knowledge and management capabilities amongst healthcare professionals in both public and private sectors
 - (iv) Capacity deficiency in NGOs especially in view of the anticipated up-scaling of the HIV response. Although NGO and CSO involvement in the HIV response is substantial, the public-private partnerships in Pakistan are in the infancy stage. They need to evolve to a stage where they are not singularly dependent on public sector and donor support.
3. **Quality of care:** Reach and ease of access to comprehensive treatment, care and support for PLHIV is limited. Even where ART, VCT and other services are available, there is a lack of holistic approach that includes treatment adherence, referrals and continuum of care.
4. **Limitations in the multisectoral approach:** Involvement of non-health sectors in the HIV response is lukewarm. This limited approach will adversely affect the integration of the HIV response especially in arenas of uniformed personnel, migrants, coal-miners, women and youth. Except for long distance truckers and jail inmates, there are little or no services for the bridging populations of migrants, coal miners and clients and spouses/partners of MARPs.
5. **Rising terrorism and insecurity:** Pakistan has faced two terrible years of an unprecedented spate of indiscriminate suicide bombings that killed thousands and created terror and mayhem. The worst hit areas were Balochistan and NWFP. In the latter, government action against the Taliban militants led to the internal displacement of 2 million people in 2009. In terms of the HIV response, service delivery was rendered unstable and interrupted, exaggerated by capacity issues in the hard-hit areas.
6. **Emic barriers:** Despite the fact that Pakistan is in a concentrated epidemic, the reluctance to acknowledge the extent of this danger is still high, exaggerated by socio-cultural barriers that inhibit open discussion of sexual behaviors in the general populations. Stigma and discrimination is an inherent barrier that hinders the sustainability of an enabling environment to implement HIV prevention, treatment, care and support efforts.

7. **Unsafe injecting practices:** Reuse of injecting equipment in the absence of Universal Precaution is very common, particularly in the healthcare facilities catering to low income populations in urban and rural areas. A number of studies indicate unsafe injecting practices as a major route of transmission of HBV and HCV in the country. Currently, the HIV prevalence among the general population is very low. However, the highly prevalent unsafe injecting practices can quickly fuel the HIV epidemic if the virus enters the general population. An example of this is the identification of large numbers of HIV positive cases in 2008-9 in a rural setting in Gujrat District of Punjab province where unsafe injecting practices might have played a significant role.

Proposed remedial strategies:

The Ministry of Health and Economic Affairs Division are in dialogue with DFID and World Bank for finalization of the next phase of the EHACP and early release of committed funds which is expected to materialize in the second half of 2010. The Global Fund in Round 9 has approved a grant in March 2010 and it is envisaged that both of these funding will address the major budgetary constrains for the next five years.

The anticipated implementation of the revised PC-1 will address several of the above mentioned challenges. A component of small grants scheme has been subsumed to enhance public – private partnerships. These small grants are envisaged to carry out research, test service delivery mechanisms and innovative approaches that could assist and/or compliment current and planned program activities. The scheme will also have a specific focus on human rights, including gender inequalities, addressing vulnerability factors that fuel the spread of infection, reducing stigma and discrimination against PLHIV and social services, needs of adolescents, youth and orphans and seek to address gaps in the national strategic plan or emergent situations that have not been accounted for previously. A few suggested innovations under this scheme include:

- Behaviour change communication activities guided by evidence based communication strategies for special population(s)/vulnerable groups.
- Piloting innovative HIV prevention ideas adapted to religious and socio-cultural realities while retaining focus on core program components and values.
- Capacity building of health and social sector NGOs in relevant technical and quality management aspects
- Addressing risk in areas not already covered i.e. hard to reach populations/rural areas or to pilot programmes in cities with small numbers of MARPs which may be cost-ineffective to cover with a conventional SDP particularly with reference to Balochistan and NWFP provinces.

The proposed HIV Care Model in the revised PC-1 and Global Fund Round 9 grant envisages a comprehensive treatment, care and support services package implemented with the involvement of community health centres, to be established across the country. In addition to the current provisions, it has the added facet of ‘conditional cash transfer’ to maximize access to treatment centers. It operates on a simple concept of a cash payment to the patient on arrival at the clinic. This is of dire importance in order to avoid development of resistance that occurs if follow-up to ARV regimens is sporadic. Quality of care is ensured by capacity training in adult and paediatric HIV care of hospital staff who will also be encouraged for referrals if and when required. Since, hospital consultants will be assigned to HIV related duties in addition to other responsibilities, a consultancy fee will be paid to encourage dedication, maintain quality and ensure continuum of care.

The issue of unsafe injecting practices in Pakistan needs to be addressed at various levels ranging from policy development to its translations into actual practices. One of the key areas that require immediate strengthening is the present healthcare delivery system, especially in low income urban and rural settings. The envisaged National Health Policy recognizes this area as an important priority and plans to mobilize local and foreign resources to strengthen the healthcare delivery system to address this issue.

The Second Generation Surveillance (SGS) project of the program, funded by CIDA has been extended for another eighteen months. It is anticipated that bridging populations will also be addressed in the extended program. In addition, NACP in collaboration with UNAIDS and other UN agencies will be embarking on operational research to understand the gravity of the migrant issue and its impact on the changing face of the HIV epidemic and designing of appropriate interventions.

SUPPORT FROM COUNTRY'S DEVELOPMENT PARTNERS

Development partners are envisaged to work in close collaboration with a government's national response to achieve the goal, objectives and ultimately success in combating the HIV/AIDS epidemic. The roles for development partners defined in the National Strategic Framework are to:

1. Provide strategic technical guidance and financial assistance that directs the government in attaining the national goals and MDG targets pertaining to epidemic.
2. Seek out and make available innovations that assist in implementation of the national HIV response.
3. Forge partnerships to address emerging and unattended priorities as well as ensure adaptability, within the context of their existing agreements, to respond effectively.
4. Support modalities of the national response viewed as core challenges but that fall off the radar of the program
5. Provide assistance through standardized, regulated channels to avoid duplication and ensure sustainability of services.

Since the beginning of the epidemic in Pakistan, bilateral and multilateral donors have been key collaborators in the national response to HIV/AIDS. The major partners include UNAIDS, UNFPA, UNICEF, UNODC, WHO, UNIFEM, GTZ, USAID, World Bank, DFID, and CIDA. The UN agencies function within the framework of a Joint UN Team on AIDS.

They played a pivotal role in the revision of the NSF to update it to its present NSF-II version. They have also aided in developing annual work plans in line with this version. In recent years, they have boosted the HIV efforts by facilitating technical and financial assistance as well as preventive services. The support of these development partners in the policy and legislative environment for PLHIV has culminated into several accomplishments that today have highlighted the PLHIV community. They are also essential in supporting enabling initiatives with parliamentarians, media and religious leaders and women groups.

MONITORING AND EVALUATION ENVIRONMENT

Overview of the Current M&E system

The National HIV/AIDS M&E system in Pakistan is guided by four key principles; a multi-sectoral approach; developed based on national priorities; built on existing systems and practices; and government owned and led. The goal of the M&E system is to ensure effective use of available M&E data for evidence-based decision making for policy and program development, advocacy, and resource mobilization and allocation. To achieve this goal, a set of core national indicators have been outlined in the national M&E framework.

Program outputs/activities are monitored by implementation units at provincial and national level. These M&E activities are also coordinated by M&E sub-committees of TACA/TWG at a national level which is composed of representatives from public and private sectors, PLHIV and development partners. The sub-committee provides technical inputs and uses the M&E efforts to track the HIV epidemic and steers program interventions accordingly. In addition, the NACP contracts independent firms/organizations to conduct third party evaluation for Blood Safety, VCT and STI services. Data for all national core indicators is obtained from the following channels:

- Integrated Biological and Behavioral Surveys (IBBS)
- M&E of programs and projects
- Special studies and research
- Financial monitoring of national response
- Other sources e.g. AIDS Case reporting System, DHS, HMIS, Statistical Bureau

Data is gathered by provincial level units and analyzed to generate and disseminate quarterly provincial level information. Subsequently the data is forwarded to the federal implementation unit that manages the central national HIV and AIDS database/repository established in the NACP. The principal role of the NACP M&E Unit is to coordinate surveillance and M&E activities all over the country and between provinces with three primary functions:

- M&E of the interventions that are implemented by the NACP.
- Coordination of HIV national surveillance that currently is being conducted by HASP.
- Collate and assimilate all epidemiological and program information available in the country in order to analyze on the current stage and future epidemic directions of the country and to inform about the effectiveness of the response.

The National M&E Framework which was developed in consultation with all the stakeholders envisages a robust system which focus on program monitoring, evaluation,

surveillance (sentinel and SGS), and research information gathering. The national M&E plan has an inbuilt system for achieving and maintaining quality standards for program areas and forms the basis for measuring performance, analyzing variances, identifying bottlenecks and serves as an early warning mechanism for facilitating corrective action.

For effective use of all available information and evidence based planning, the national M&E Framework includes National and Provincial M&E units (to be strengthened through additional resources available through Enhanced program and Global fund R-9 grant towards the end of 2010) to facilitate strategic planning, monitoring, evaluation, surveillance and research. This national M&E system has been built on existing data-collection mechanisms by different stakeholders in the national response to HIV and AIDS, rather than establishing new ones.

Third Party Evaluation

As part of the M&E plan during the implementation of the EHACP, NACP also engaged a firm/organization for third party evaluation of the progress on the project activities [process evaluation] for all the major interventions [IDUs, MSWs/HSWs, FSWs and long distance truck drivers] in addition to VCT and STI services. NSF-II implementation also includes biennial third party evaluation for which resources have been identified.

Challenges faced in M&E of the national response and remedial actions.

The main challenge in the overall M&E system is the limited capacity at the implementation level for data collection and its usage. Non-existence of standardized tools for data collection, compilation and use of electronic database are additional challenges.

To address the capacity issue, NACP and PACPs in collaboration with UNAIDS and other partners conducted a series of trainings for the implementing partners at provincial level over the last two years. As part of the review of the M&E plan 2010, a comprehensive action plan for the next two years will be developed to address the capacity, data collection tools and database gaps that exist at various levels.

ANNEX I: CONSULTATION PROCESS

The NACP in collaboration with UNAIDS initiated the process for development of the UNGASS report 2010 by creating a Technical Working Group (TWG) composed of representatives from the Planning Commission, NACP, UNAIDS, UNICEF, UNFPA, UNODC, WHO, CIDA (HASP unit) and Civil Society Organizations. The first meeting of the TWG took place in early January 2010 and road map of the UNGASS report preparation was carved out. During this meeting, sources of data were identified and process methodology was agreed upon.

Meeting of TWG on UNGASS Report 2010 Preparation

Date: 2nd January 2010
Venue: Committee Room of the NACP

Attendance:

1. Dr Hassan Abbas Zaheer, Program Manager, NACP
2. Dr Muhammed Saleem, M&E Officer UNAIDS
3. Dr Qaid Saeed, HIV/AIDS Officer, WHO
4. Dr Safdar Kamal Pasha, UNFPA
5. Dr Faran Emanuel, HASP
6. Dr Muhammed Imran, Epidemiologist, NACP
7. Dr Rehman Shah, NACP
8. Dr Arshad Mehmood, NACP
9. Dr Shafiq-ur-Rehman, PLHIV
10. Dr Salman Qureshi, NGO (Nai Zindagi)

Proceedings:

The following proceeding took place:

1. Introduction of the participants
2. Presentation by Dr Muhammed Saleem on the process involved in the preparation of the UN GASS report of 2010. He highlighted the new developments in the core indicator guidelines and the UNAIDS online tool for submission of this report.
3. Presentation by Dr Muhammed Imran on the shortcomings of the previous report. Each point was highlighted and discussed on how to avoid the same in the current report.

Decisions reached:

1. A group discussion took place to carve out the road map to be followed for the preparation for the current report. It was decided that independent consultant/s would be hired. One, to be hired initially, would work on the NCP only and

- another would be taken on board at a later stage to complete the remaining indicators as well as the narrative part.
2. Documents relevant to the desk review of the NCPI were listed out and agreed that they shall be made available by one key person who will also take the responsibility of the coordinating with the consultant in terms of documentation, introduction and arrangements of one-to-one or conglomerate consultations with the relevant stakeholders. The person nominated was Dr Muhammed Imran.
 3. The meeting concluded with the selection of participants for Part A and B of the NCPI questionnaires. In order to capture the impact of the multisectoral approach, a wide range of respondents were listed with a special focus on CSOs and PLHIV. Alternates for as many participants as possible were also agreed upon in case of the issues of non-availability within the time frame of the consultancy.

Follow up action:

1. All relevant documents were to be send to Dr Imran for collection and consolidation
2. UNAIDS, in collaboration with NACP was to advertise for the consultancy and carry the necessary protocols for hiring.

The NCPI consultant was hired and an informal meeting with the TWG took place. The process methodology for the preparation of the NCPI was explained and the selected respondents for Part A and B were then allocated section/s of each part most relevant to them. Relevant documents for the desk review were shared with the consultant and mode of coordination with the NACP representative was agreed upon. Following data collection and analysis of the NCPI, the first draft was shared in a consensus meeting.

Consensus meeting of key stakeholder on NCPI

Date: 4th February 2010
Venue: Committee room of the NACP

Attendance:

1. Dr Hassan Abbas Zaheer, National Program Manager, NACP
2. Dr Muhammed Saleem, M&E Officer UNAIDS
3. Dr Qaid Saeed, HIV/AIDS Officer, WHO
4. Dr Safdar Kamal Pasha, UNFPA
5. Dr Faran Emanuel, HASP
6. Dr Muhammed Imran, Epidemiologist, NACP
7. Dr Rehman Shah, NACP
8. Dr Arshad Mehmood, NACP

9. Dr Shazra Abbas, UNICEF
10. Dr Naveeda, HIV/AIDS Treatment specialist, NACP
11. Dr Salman Qureshi, NGO (Nai Zindagi)
12. Dr Rubina Mumtaz, Consultant

Proceedings and decisions reached

1. Introduction of participants
2. Presentation by Dr Muhammed Saleem and Dr Imran giving the background of the process involved in the NCPI preparation to the present stage.
3. Presentation by Dr Rubina Mumtaz describing the methods of data collection, participation rate, compilation and analysis of results. Answers to questions in Part A and B of the entire questionnaire were presented and conflicting views highlighted. In lieu of the lengthy process, working tea and lunch was served
4. Each question for Part A and B was presented, irrespective of any conflict or not. Each answer was agreed upon before proceeding to the next. Questions with conflicting responses were resolved following lengthy discussions. Unanimous consensus for all answers was achieved by all participants

Follow-up actions:

Dr Muhammed Imran in coordination with the consultant was to carry out online entry of the NCPI and the password for viewing was shared with all participants for any further input. Any additional changes were requested to be forwarded electronically so all participants could view them before they were entered online.

The TWG held its second meeting to determine the process for the development of the rest of the UNGASS reports. It was decided to extend the contract of the consultant and preparation method for the remaining indicators and narrative was agreed upon. For capacity building, the consultant attended UNGASS Writers Workshop organized by the Technical Support Facility, South Asia in Kathmandu, Nepal. Following frequent singular and conglomerate consultations, in person and electronically, on process methodology and information exchange between the consultant and NACP, UNAIDS, HASP and Planning Commission, the first draft of the narrative part and other indicators of the report was shared at a workshop held on 15th March 2010.

Consultative meeting of Key Stakeholder on UNGASS Report 2010

Date: 15th March 25, 2010

Venue: Committee room of the NACP

Attendance:

1. Dr Hassan Abbas Zaheer, National Program Manager, NACP

2. Dr Muhammed Saleem, M&E Officer UNAIDS
3. Dr Safdar Kamal Pasha, UNFPA
4. Dr Faran Emanuel, HASP
5. Dr Muhammed Imran, Epidemiologist, NACP
6. Dr Naveeda, HIV/AIDS Treatment specialist, NACP
7. Dr Tahira Reza, HASP
8. Dr Salman Qureshi, NGO (Nai Zindagi)
9. Dr Rubina Mumtaz, Consultant

Proceedings

1. Introduction of participants
2. Presentation by Dr Imran on the background of events and activities leading to the present meeting
3. Presentation by Dr Rubina Mumtaz highlighting the issues concerning the indicators in terms of their relevance and data availability as per the UNGASS 2010 requirements. Indicators were discussed individually.

Decisions reached and follow up actions:

1. Since Pakistan has not begun to use the NASA, Indicator 1 was to be presented as per the funding matrix sheet filling only the relevant categories
2. Data was Indicator 3 as per the UNGASS guidelines was not available. It was therefore decided to highlight the work done so far in the narrative
3. Indicator 4 and 5 needed data for 2008 and 2009 separately to report on the annual trend. Denominators by spectrum modeling for both years were needed. Dr Naveeda and Dr Tahira were given the tasks for the numerator and denominator respectively.
4. Indicator 6 was not reported in the last report. It was decided that data for this report must be extracted from the NTP and the treatment centers. However, information from the NTP would have the limitation of no disaggregation by age and sex
5. For Indicators 8,9,14 and 18, it was decided that for the sake of the UNGASS indicators, the HSW would be placed in the category of MSW and presented as 'M/HSW'. Indicators on MSM would not be reported for lack of available data. Disaggregation of the data for these four indicators by age, sex and specific responses to individual questions was needed and Dr Tahira was instructed to give these details.
6. Data for Indicator 13 as per requirement was not available. However the DHS 2007 had some limited information on this indicator and it was decided to share that in the narrative

7. Indicator 15, although reported in the last report, would not be reported this time due to lack of data.
8. Impact indicator 24 was thought to be important and information could be extracted from the treatment centers. Dr Naveeda was given the task to make this attempt.
9. Best practices was agreed upon as the Harm reduction program and evidence based dissemination of information
10. The narrative was to be shared electronically with all participants and feedback welcomed as track changes to the document. Additional inputs were also requested.
11. Online entry of the indicators was carried out simultaneously wherever possible. On Indictors not being reported, indicator and subject matter relevance was agreed upon and entered with comments if applicable.

The final draft of the UNGASS report 2010 was shared with a wide range of national key stakeholders representing the government, bilateral and multilateral organizations and the civil society organizations in a vetting workshop held on 30th March 2010. During this workshop, data on NCPI and all other relevant indicators for which data was available was shared with the participants. Comments and observations made in the meeting were incorporated accordingly in the online tool and narrative part of the report. There was complete consensus and all the stakeholders appreciated the efforts which went into the collection and compilation of data for UNGASS 2010 Country Report.

ANNEX II: NATIONAL COMPOSITE POLICY INDEX

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

Dr Muhammed Imran,
Epidemiologist/M&E focal point

Postal address: NACP, NIH, Chakshahzad, Islamabad 44000, Pakistan
Tel: +92-51-925560392 ; 51-9255096; 51-9255367-8
Fax: +92-51-9255214
E-mail: drimrannacp@gmail.com
Date of submission: 31st March 2010

Describe the process used for NCPI data gathering and validation:

A list of 11 respondents for Part A and 14 respondents for Part B was identified by the UNGASS 2010 Technical Core Working Group (TWG). Each respondent was interviewed according to the parts most relevant to them, giving an average of 6-8 respondents for each section. Face to face interviews were conducted at the convenience of 21 respondents while 4 chose to complete and submit the questionnaire electronically. Results were tabulated and analyzed according to the following categories:

- a. For the standardized responses, the yes/no response were presented according to the majority and the scale-response was presented by stating the mode. If a question had somewhat equal "yes" and "no" responses and the scale responses had more than one mode, then those specific question were left pending for consensus at the TWG meeting.
- b. For the open text questions, the comments in common by most of the respondents were presented. Additional comments were listed but all comment were comprehensively subjected to consensus on their relevance.

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

Consensus for disagreements was carried out by conducting a Technical Working Committee meeting. Participants for this meeting were representatives of the NACP, UN agencies, bi-lateral agencies and civil society organizations. Questions that had disparate answers were discussed till consensus of a single answer was achieved.

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

None

Respondents to PART A [administered to government officials]

	Organization	Names/ Position	Respondents to Part A				
			A: I	A: II	A: III	A: IV	A: V
1	NACP, Islamabad	Dr Hassan Zaheer Abbass, NPM	√	√	√	√	√
2	PACP, Lahore	Dr Ali Razzak, PPM Punjab	√	√	√	√	√
3	PACP, Karachi	Dr Qamar Abbas, Dep. PPM	√	√	√	√	√
4	PACP, Peshawar	Dr Rajwal, Deputy PPM, NWFP	√	√	√	√	√
5	Planing Commission Islamabad	Dr Fazal-e-Hakim Chief Health	√	√			
6	MoH, Islamabad	Dr Azam Saleem, JS (P&D)	√	√			
7	NACP, Islamabad	Dr Amir Maqbool, Deputy NPM			√		√
8	NACP, Islamabad	Dr Mohammed Imran Epidemiologist/M&E Consultant			√		√
9	NACP, Islamabad	Mr Naeem Akhtar, BCC Specialist			√		
10	PIMS, Islamabad	Dr Rizwan Kazi, HIV Treatment Specialist				√	
11	NACP, Islamabad	Dr Naveeda, HIV Treatment Specialist				√	

Respondents to PART B [administered to civil society organizations, bilateral agencies, and UN organizations]

	Organization	Names/ Position	Respondents to Part B			
			B: I	B:II	B:III	B:IV
1	UNAIDS	Mr Oussama Tawil	√	√	√	√
2	World Bank	Shahnaz Kazi		√	√	
3	UNODC	Dr Nadeem-ur-Rehman	√	√	√	√
4	UNFPA	Dr Safdar Kamal Pasha	√	√	√	
5	WHO	Dr Qaid Saeed			√	√
6	UNICEF	Bettina Schunter			√	√
7	FHI	Dr Naseer Nizamani		√	√	
8	Nai Zindagi	Dr Tariq Zafar	√	√		
9	Infection. Control Society	Dr Rafiq Khanani		√	√	√
10	Gender & RH Rights	Aleem Baig		√	√	√
11	Pak Society	Dr Saleem Azam		√	√	√
12	PLHIV	Shukria Gul		√	√	√
13	PLHIV	Imran Zali		√	√	√
14	PLHIV	Qasim Iqbal	√	√		

PART A-I: STRATEGIC PLAN

Q1: Has the country developed a national multisectoral strategy to respond to HIV? Yes, for a period of five years from 2008-13

1.1 How long has the country had a multisectoral strategy? Seven years since 2002

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

Sectors	Included in strategy	Earmarked budget
Health	Yes	Yes
Education	Yes	Yes
Labor	Yes	Yes
Transportation	Yes	No
Military/police	Yes	Yes
Women	Yes	Yes
Young people	Yes	Yes
Others	No	No

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

The transportation sector, although included in the strategy, does not have an earmarked budget due to funding constraints and low priority.

1.3: Does the multisectoral strategy address the following target populations, settings and cross-cutting issues?

	<i>Target population</i>	
a.	Women and girls	Yes
b.	Young women/men	Yes
c.	IDU	Yes
d.	MSM	Yes
e.	Sex workers	Yes
f.	Orphans & vulnerable children	Yes
g.	Other specific vulnerable subpopulations	Yes
	<i>Settings</i>	
h.	Workplace	No
i.	Schools	Yes
j.	Prisons	Yes

	<i>Cross-cutting issues</i>	
k	HIV & Poverty	No
L	Human rights protection	Yes
m	Involvement of PLHIV	Yes
N	Addressing stigma and discrimination	Yes
0	Gender empowerment and/or gender equality	Yes

Q1.4: Were target populations identified through a needs assessment? Yes, in 2002

Q1.5: What are identified target populations for HIV programs in the country?

- MARPs i.e. IDU, MSW, FSW and HSW
- Prison inmates
- Truckers
- Migrants
- IDP
- Bridging population of spouses of MARPS, PLHIV and truckers

Q1.6: Does the multisectoral strategy include an operational plan? Yes

Q1.7: Does the multisectoral strategy or operational plan include:

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

Q1.8: Has the country ensured ‘full involvement and participation’ of civil society in the development of the multisectoral strategy? Moderate involvement

IF moderate involvement, briefly explain how this was organized:

Q1.9: Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)? Yes

Q1.10: Have external development partners aligned and harmonized their HIV-related programs to the national multisectoral strategy? Yes, all partners

Q2: Has the country integrated HIV into its general development plans such as in (a) national Development Plan (b) Common Country Assessment/ UN Development Assistance Framework © Poverty reduction Strategy and (d) sector-wide approach
Yes

Q2.1: If YES, in which specific development plan(s) is support for HIV integrated

a. National Development Plan	Yes
b. Common Country Assessment/ UN Development Assistance Framework	Yes
c. Poverty Reduction Strategy	Yes
d. Sector-wide approach	Yes
e. Other –Vision 2030	Yes

Q2.2: If YES, which specific HIV-related areas are included in one or more of the development plans?

HIV treatment	Yes
Treatment for opportunistic infections	Yes
Antiretroviral treatment	Yes
Care and support (including social security or other schemes)	Yes
HIV Impact alleviation	No
Reduction of gender inequalities as they relate to HIV treatment, care and support	Yes
Reduction of stigma and discrimination	Yes
Women empowerment (e.g. access to credit card, land, trainings etc)	Yes
Other	No

Q3: Has the country evaluated the impact of HIV on its socio-economic development for planning purposes? No

Q4: Does the country have a strategy for addressing HIV issues among its national uniformed services (military, police, peacekeepers, prison staff etc) Yes

Q4.1: If YES, which of the following programs have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

Behavioral change communication	No
Condom provision	No
HIV testing and counseling	Yes
Sexually transmitted infections services	No
Antiretroviral treatment	No
Care and support	No
Other	No

If HIV testing and counseling is provided, briefly describe the approach taken:

Normally HIV testing in Pakistan follows the National Guidelines of 'Voluntary Counseling and Testing Approach' where confidentiality of the patient is maintained. For

uniformed personnel opting for peacekeeping duties out of Pakistan, testing is mandatory on departure and on arrival. For migrant workers going to the Middle Eastern countries, HIV testing is mandatory as per visa requirements of host countries.

Q5: Does the country have non-discrimination laws which specify protection for MARPs and other vulnerable subpopulations? No

Q6: Does the country have laws, regulations policies that present obstacles to effective HIV prevention, treatment, care and support for MARPs and other vulnerable subpopulations? Yes

Q6.1: If yes, for which populations?

Women	No
Young people	No
IDU	Yes
MSM	Yes
Sex Workers	Yes
Prison inmates	Yes
Migrants	No
Other – Long Distance Truckers	No

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

1. The Control of Narcotic Substances Act, 1997 criminalizes drug use and possession;
2. The Hudood Ordinance of 1979; The (Punjab and West Pakistan) Suppression of Prostitution Ordinances 1961, and the Pakistan Penal Code 1860 criminalize activities of MSM & FSW.

Briefly comment on how they pose barriers

1. Police raids on IDUs disperse them underground, out of our reach and into the general population, thereby increasing the risk of spread.
2. The Hudood ordinance categorizes FSWs and MSMs a quasi-legal population making service delivery difficult

Q7: Has the country followed up on the commitments towards universal access made during the High-Level AIDS review in June 2006: Yes

Q7.1: Have the national strategy and national HIV budget been revised accordingly? Yes

Q7.2: Have the estimates of the size of the main target populations been updated? Yes

Q7.3: Are there reliable estimates of current needs and of future needs of the number of adults and children requiring ARV therapy? Estimates of current and future needs

Q7.4: Is HIV program being monitored : Yes

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

b) **IF YES, is coverage monitored by population groups** Yes

IF YES, for which population groups? The MARPS including Female Sex Workers, Male Sex Workers, Hijra Sex Workers, Intravenous Drug Users, Long distance Truckers, Prison Inmates and to a lesser extent, the bridging populations

Briefly explain how this information is used:

This information is used to

- Identify gaps and improve quality of services and design of packages
- Modify capacity building needs
- Assess the impact of terrorism on the HIV response, especially in NWFP

(c) Is coverage monitored by geographical area? Yes

IF YES, at which levels: At Provincial levels and mainly in large cities because they harbor concentrated pockets of MARPS; to a lesser extent, small towns are also monitored

Briefly explain how this information is used:

This information is used to

- Identify gaps and improve quality of services and design of packages
- Modify capacity building needs
- Assess the impact of terrorism on the HIV response, especially in NWFP

Q7.5: Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities and logistical systems to deliver drugs? Yes

Overall, how would you rate strategy/planning efforts in the HIV program in 2009 (scale 0-10) 7

Since 2007, what have been the key achievements in this area?

1. Approval of revised enhanced project plans for 2009-14 which will lead to significant upscaling of HIV prevention and control interventions.

2. Delivery of HIV prevention and control services to more than 30,000 IDUs, 25,000 MSWs/HSWs, 12,000 FSWs and 50,000 truckers all across the country.
3. Scaling-up of treatment, care and support services through establishment of 13 treatment and 7 PPTCT centers with more than 1300 PLHIV accessing free ART
4. Establishment of blood transfusion authorities to ensure safe blood transfusion in the public health sector.
5. Revival of GTZ & KFW funded Safe Blood Transfusion project
6. Two successful annual rounds of HIV surveillance in 8 major cities of the country.
7. Agreement on Oral Substitution Treatment Pilot Project
8. Development/adaptation of guidelines for syndromic management of STIs and capacity building of public sector clinicians to manage STIs

What the remaining challenges in this area?

1. The actual implementation of revised PC-1 in terms of capacity particularly in the envisaged plan of up-scaling of services provision.
2. Geographic coverage for the expanding epidemic and access to certain high risk groups in terms of policy and infrastructure.
3. Funding constrains and sustainability in achieving universal targets
4. Establishment and implementation of Blood Safety Transfusion in the country
5. Terrorism related deteriorating security as an obstacle to service delivery

PART A-II: POLITICAL SUPPORT

Q1: Do high officials speak publicly and favorably about HIV efforts in major domestic forums at least twice a year?

President/ Head of Government	No
Other High Officials	Yes
Other officials in regions and/or districts	Yes

Q2: Does the country have an officially recognized national multisectoral AIDS coordination body (i.e. a National AIDS council or equivalent)

Yes

Q2.1: IF YES, when was it created: 2003

Q2.2: IF YES, who is the Chair? Secretary Health as Chairman

Q2.3: IF YES, does the national multisectoral AIDS coordination body

Have terms of reference	Yes
Have active Govt leadership/participation	Yes
Have a defined membership	Yes

How many members?	25
Include civil society representatives How many?	Yes 10
Include PLHIVs How many?	Yes 2
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?	Yes
Provide opportunity for CSO to influence decision making?	Yes
Strengthen donor coordination to avoid parallel funding and duplication of efforts?	Yes

Q3: Does the country have a mechanism to promote interaction between Govt, CSOs and the private sector for implementing HIV strategies/programs? : Yes

IF YES, briefly describe the main achievements:

1. Continuous provision of care and support funded by Global Fund R-2 grant and Enhanced program through public-private partnerships of NGOs and CSOs as major implementers.
2. Active representation and participation of CSOs in a wide range National consultative meetings; several CSOs are members of the CCM
3. All surveillance rounds have been conducted in partnership with CSOs and private sector

Briefly describe the main challenges

1. Funding constrains and continuous flow of funds for sustainability
2. Capacity issues in CSOs especially in geographic expansion of service delivery
3. Deteriorating security situation is a key challenge.

Q4: What percentage of the national HIV budget was spent on activities implemented by civil society in the past year? 60%

Q5: What kind of support does the NACP provide to CSOs for the implementation of HIV related activities?

Information on priority needs	Yes
Technical guidance	Yes
Procurement and distribution of drugs or other supplies?	No
Coordination with other implementing partners?	Yes
Capacity building	Yes

Other	No
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Q6: Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control Policies? Yes

Q6.1: If YES, were the policies and laws amended to be consistent with the National AIDS Control Policies? No

Overall, how would you rate the political support for the HIV program in 2009? (scale 0-10) 6

Since 2007, what have been key achievements in this area

1. The development and revision of new project plans (PC-1) passed in August 2009 due to personal efforts of the Federal Minister of Health
2. Sensitization of policy makers to the HIV issue and active participation of parliamentarians in HIV related activities

What are the remaining challenges?

1. Further advocacy and BCC is needed
2. Unstable political environment
3. Rising insecurity is a key challenge
4. Lack of coordination between line departments
5. Cumbersome administrative & financial procedures

PART A-III: PREVENTION

Q1: Does the country have a policy or strategy that promotes information education and communication (IEC) on HIV to the general population? Yes

Q1.1: IF YES, what key messages are explicitly promoted?

a. Be sexually abstinent	Yes
b. Delay sexual debut	No
c. Be faithful	Yes
d. Reduce the number of sexual partners	Yes
e. Use Condoms consistently	Yes
f. Engage in safe/r sex	Yes
g. Avoid commercial sex	No
h. Abstain from injecting drugs	Yes
i. Use clean needles and syringes	Yes
j. Fight against violence against women	Yes
k. Greater acceptance and involvement of people living with HIV	Yes
l. Greater involvement of men in reproductive health programs	Yes

m. Males to get circumcised under medical supervision	N/A
n. Know your HIV status	No
o. Prevent mother-to-child transmission of HIV	Yes
P. Other	

Q1.2: In the last year, did the country implement an activity or program to promote accurate reporting on HIV by the media? Yes

Q2: Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people? No

Q2.1: Is HIV education part of the curriculum in:

- Primary schools No
- Secondary schools No
- Teacher training No

Q2.2: Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women? No

Q2.3: Does the country have an HIV education strategy for out-of-school young people? No

Q3: Does the country have a policy or strategy to promote IEC and other preventive health interventions for MARPS or other vulnerable sub-pops? Yes

Q3.1: If YES, which population and what elements of HIV prevention do the policy/strategy address?

	IDU	MSM	Sex Workers	Clients of sex workers	Prison inmate	Other Long distance trucker
Targeted information on risk reduction & HIV education	√	√	√	X	√	√
Stigma & discrimination reduction	√	√	√	X	√	√
Condom provision	√	√	√	X	√	√
HIV testing and counseling	√	√	√	X	√	√
Reproductive health,	√	√	√	X	√	X

including STI prevention and treatment						
Vulnerability reduction (e.g. income generation)	N/A	N/A	X	N/A	N/A	N/A
Drug substitution therapy	√	N/A	N/A	N/A	N/A	N/A
Needle & syringe exchange	√	N/A	N/A	N/A	N/A	N/A

Overall, how would you rate policy efforts in support of HIV prevention in 2009? (scale 0-10)

8

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

1. Consensus of HIV/AIDS policy after in-depth consultations with multiple bilateral and multilateral stakeholders. Currently it is pending approval with the MOH.
2. For the first time, inclusion of HIV/AIDS in the National health policy with high risk groups mentioned as a priority category.
3. Greater involvement of media in the HIV response.
4. Religious leaders have gotten a greater understanding of the HIV/AIDS issue and shown a willingness to speak publicly
5. NACP and CSO interventions have improved implementations
6. Greater availability of ARV.

What are the remaining challenges?

1. Major challenge is that HIV/AIDS is still not recognized as a primary health issue since our focus is still on curative rather than preventive.
2. The bridging population btw the MARPS and the general population is neglected in terms of both policy and intervention.
3. A key challenge to addressing and accessing migrant populations again in terms of policy and intervention

Q4: Has the country identified specific needs for HIV prevention programs? Yes

If YES, how were these specific needs determined?

1. Based on evidence based data obtained via surveys e.g. KAP surveys and different rounds of IBBS.
2. Via Situation and Response analysis and the Midterm Review of the national response by the government, donors and other partners
3. Via dialogues with MARPs and Civil Society
4. Via research studies and import of best practices that were successful in similar epidemics.

Q4.1: To what extent has HIV prevention been implemented?

HIV Prevention Component	Majority people in need have access to
Blood Safety	Disagree
Universal precaution in healthcare settings	Disagree
Prevention of mother-to-child transmission of HIV	Disagree
IEC on risk reduction	Disagree
IEC on stigma and discrimination reduction	Disagree
Condom promotion	Agree
HIV counseling and testing	Disagree
Harm reduction for injecting drug user	Agree
Risk reduction for men who have sex with men	Agree
Risk reduction for sex workers	Agree
Reproduction health services including sexually transmitted infections prevention and treatment	Agree
School based HIV education for young people	Disagree
HIV prevention for out of school young people	Disagree
HIV prevention in the workplace	Disagree
Other	N/A

Overall, how would you rate the efforts in the implementation of HIV prevention programs in 2009? (scale 0-10)

6

Since 2007, what have been the key achievements?

1. The key achievement has been the improvement of provision of services to IDU, FSW, MSW, HSW and prison inmates.
2. Successful harm reduction programs with IDUs; Successful launch of a Pilot HIV prevention services intervention for families of IDUs. Both can be attributed to improved NGO mobilization
3. Another successful round of surveillance; A study of STI prevalence amongst urban young men in Pakistan was conducted.
4. Increase in PLHIV registration in centers;. additional achievement of increased employment opportunities for PLHIVs
5. Stigma & discrimination Assessment Tools developed for the first time in Pakistan; successful implementation of Disclosure Strategy
6. Development of a Service Delivery Model , Specific Life Skills Manual, Peer Educator Toolkits and VCT training for Most at Risk Adolescents

What are the remaining challenges in this area?

1. The current scale of these services is too low to have a significant impact on the epidemic. To avert expansion of the epidemic to a generalized level, these services should be scaled up to 60-70%, the universal access target
2. Provision of funds for sustainability of prevention services delivery amongst MARPs remains a challenge in 2008-9.
3. Better access to HSW and FSW still remains a challenge
4. Rising terrorism -related security issues present an obstacle to service delivery and capacity building; Stigma and discrimination is still a huge challenge

PART A-IV: TREATMENT, CARE AND SUPPORT .

Q1: Does the country have a policy or strategy t promote HIV treatment, care and support? Yes

Q1.1: If YES, does it address barriers for women? Yes

Q1.2: IF YES, does it address barriers for MARPs Yes

Q2: Has the country identified the specific needs for HIV treatment, care and support? Yes

If yes, how were these determined?

1. Based on evidence based data obtained via surveys e.g. KAP surveys and different rounds of IBBS.
2. Via Situation and Response analysis and the Midterm Review of the national response by the government, donors and other partners
3. Via dialogues with MARPs and Civil Society
4. Via research studies and import of best practices that were successful in similar epidemics.

Q2.1: To what extent have the following HIV treatment, care and support services been implemented?

HIV Treatment, care and support service	Majority people have access to
Antiretroviral therapy	Agree
Nutritional care	Disagree
Pediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree

Psychosocial support for people living with HIV and their families	Disagree
Home based care	Disagree
Palliative care and treatment of common HIV-related infections	Agree
HIV testing and counseling for TB patients	Agree
TB screening for HIV infected people	Agree
TB preventive therapy for HIV-infected people	Disagree
TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in HIV infected people	Agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Disagree
HIV treatment services in the workplace or treatment referral systems through the workplace	Disagree
HIV care and support in the workplace (including alternative working arrangements)	Disagree
other	N/A

Q3: Does the country have a policy for developing/using generic drugs or parallel importing of drugs in HIV? Yes

Q4: Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as ARVs, condoms and substitution drugs? Yes

If yes, for which commodities?

- ARV therapy
- Condoms

Overall how would you rate the efforts in the implementation of HIV treatment, care and support programs in 2009? (scale 0-10) 6

Since 2007, what have been the key achievements?

1. Availability of ARV (1st & 2nd generation); pediatric drugs and co-infection drugs
2. Availability of free diagnostics testing that including CD4, VL, rapid tests & confirmation ELISA tests
3. Establishment of PPTCT and pediatric centers
4. Development of the National HIV treatment guidelines and tools; Training of healthcare providers in on the same

What are the remaining challenges in this area?

1. To provide facilities, diagnosis and treatment of other co-infections, especially HBV and HCV in HIV infected people
2. To improve linkages and access between MARPS, PLHIVs and the treatment centers
3. Standardization of services in treatment centers in terms of HMIS, quality and adherence
4. Dissemination of the National HIV Treatment Guidelines and Tools to a larger audience inclusive of private practitioners.
5. To address the financial and mobility constraints of PLHIV for regular and timely visits to the treatment centers; additional focus needed to improve accessibility of treatment centers for far-flung areas
6. We need to address stigma and discrimination reduction on a larger scale with a focus on health care providers within the healthcare system.

Q5: Does the country have a policy and strategy to address the additional HIV-related needs of orphans and other vulnerable children? Yes

Q5.1: If YES, is there an operational definition for OVC in the country?

Yes- SAARC definition

Q5.2: If YES, does the country have a national action plan specifically for OVCs

No

O5.3: If YES, does the country have an estimate of OVC being reached by existing interventions?

No

Overall how would you rate the efforts to meet the HIV related needs of orphans and other vulnerable children in 2009? (Scale 0-10) 4

Since 2007, what have been the key achievements?

1. There are 135 children registered in thirteen HIV Treatment and Care Centers. Those registered receive all required services inclusive of ARV in pediatric suspension
2. Development of Pediatric ART adherence tools – The National Guidelines for the Care and Support of Children
3. Establishment of drop-in centers for street children that offer social support, nutritional care, hygiene awareness and education
4. The first ever clinical National Pediatric HIV management workshop conducted for pediatrician training.

What are the key challenges?

1. Identification and accessibility to orphans/vulnerable children within our estimated HIV population is a key challenge
2. Identification of HIV pregnant mothers who give birth out of PPTCT centers fall off our radar. We need to address this gap
3. Capacity building for pediatric HIV management

PART A-VI: MONITORING AND EVALUATION

Q1: Does the country have one national M&E plan? Yes

Q1.1: If yes, years covered: from 2008-13

Q1.2: If YES, was the M&E plan endorsed by key partners in M&E? Yes

Q1.3: If YES, was the M&E plan developed in consultation with CSO including PLHIV? Yes

Q1.4: If YES, have key partner aligned and harmonized their M&E requirements with the national M&E plan? Yes, most partners

Q2: Does the national monitoring and evaluation plan include

A data collection strategy	Yes
If yes, does it address	
Routine program monitoring	Yes
Behavioral surveys	Yes
HIV surveillance	Yes
Evaluation/research studies	Yes
A well defined standardized set of indicators	Yes
Guidelines on tools for data collection	No
A strategy for assessing data quality	No
A data analysis strategy	No
A data dissemination & use strategy	No

Q3: Is there a budget for implementation of the M&E plan? Yes

Q3.1: If YES, what percentage of the total HIV program funding is budgeted for M& E activities 10 %

Q3.2: If YES, has full funding been secured? No

If No, briefly describe the challenges

Most of the funding for M&E in national response is from international donors, which is committed but not yet released

Q3.3: If YES, are M&E expenditures being monitored? No

Q4: Are M&E priorities determined through a national M&E system assessment?

Yes

If YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves?

Feedback from stakeholders and key partners plus HASP data is used to modify the general M&E framework. Usually, it is an ongoing process and amendments are made as and when required.

Q5: Is there a functional national M&E unit? Yes

Q5.1: If YES, is the national M&E unit based

In the National Aids Commission (or equivalent)	Yes
In the Ministry of Health	No
Elsewhere	Provincial level

Q5.2: If YES, how many and what type of professional staff are working in the national M&E unit

Temporary staff 3

M&E specialist	full time	since 2007
Data entry operator	full time	since 2006
IT support officer	full time	since 2006

Permanent staff 1

Epidemiologist	full time	since 2006
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Q5.3: If YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system? Yes

If YES, briefly describe the data sharing mechanisms:

1. The routine monitoring data from NGOs is reported to Provincial AIDS Programs and is shared regularly with National Program for consolidation and review.

2. The evaluation studies are conducted as annual evaluation rounds by a third party firm and shared with all stakeholders.
3. The outcome indicators are captured through annual bio-behavioral surveillance conducted by HIV Surveillance Project team, which has its presence at both national and provincial levels.

What are major challenges?

1. The current M&E system has a weak organizational structure, especially at the provincial levels.
2. The human resource availability, especially M&E related technical staff is scarce at the provincial and grass-root levels.
3. The M&E plan has not yet been costed. The present activities are reflected in the budget of Enhanced program, the finances against which are not yet available
4. Considerable effort will be needed to establish ONE HIV M&E system.
5. The data collection tools and protocols are not yet fully developed and need revision and standardization.
6. There is no computerized MIS system at the national and provincial levels. Some NGOs do have their own MIS systems, but need up-gradation and standardization as per the requirement of national M&E system.

Q6: Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

Yes but meets irregularly

Q6.1: Does it include representation from civil society?

Yes

Q6.2: If YES, briefly describe who the representatives from civil society are and what their role is:

1. NGOs working with MARPs
2. PLHIV
3. Academic and research institutions.

All play the same role of reviewing overall implementation of M&E related activities and provide guidelines towards progressing to one M&E system.

Q7: Is there a central national database with HIV related data?

Yes

Q7.1: If YES, briefly describe the national database and who manages it

It is based in the NACP and data is mainly from the annual bio-behavioral services. It is jointly managed by NACP and HASP

Q7.2: If YES, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes but only some of the above

Q7.3: Is there a functional Health Information System?

At national level and provincial levels but both are not HIV specific

Q8: Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data?

Yes

Q9.1: To what extent are M&E data used in developing/ revising the national AIDS strategy (Scale 0-5)

4

Provide a specific example:

Programmatic data as well as data from 3 previous rounds was used to develop the enhanced HACP?? and the global fund rounds 7, 8, 9 proposals

What are the main challenges, if any?

1. Data usage at implementation level for program improvement needs more focus
2. Data is not of high quality
3. Capacity issues in terms of doing research and translating it in a meaningful manner

Q9.2: To what extent are M&E data used for resource allocation? (Scale 0-5)

4

Provide a specific example

Costing of the Enhanced HACP, the national strategic framework and the Global rounds 8 & 9 proposals

What are the main challenges, if any?

Utilization of M&E data at implementation level for improvement of the program is lacking

Q9.3: To what extent are M &E data used for program improvement? (scale 0-5)

3

Provide a specific example:

1. M&E data is used by NGOs for improvement of their service delivery
2. M&E data is used at national and sub-national levels to prioritize services to high risk groups in terms of their geographic location

What are the main challenges, if any?

Main challenge is technical capacity issue at service delivery level. NGOs need to strengthen evidence based programming

Q10: Is there a plan for increasing human capacity in M&E at national, sub-national and service delivery level? Yes but addressing some levels

Q10.1: In the last year, was training in M&E conducted

At National level	Yes
Number trained	50
At Provincial level	Yes
Number trained	100
At service delivery level (Including civil society)	Yes
Number trained	250

Q10.2: Were other M&E capacity building activities conducted other than training? Yes

If YES, describe what types of activities

1. Participation in international conferences and workshops
2. Exposure visits to various countries with M&E systems in place

Overall, how would you rate the M&E efforts of the HIV program in 2009? (Scale 0-10) 6

Since 2007, what have the key achievements been?

1. Development of National M&E framework plan.
2. Establishment of a M&E Working Committee Group
3. Minimal resource allocation for operations of M&E
4. Agreement on national level core indicators

What are remaining challenges in this area?

1. Operationalization of the M&E Plan
2. We need to strengthen the existing M&E units at national and provincial level
3. Capacity building at all levels of M&E

PART B-I: HUMAN RIGHTS

Q1: Does the country have laws and regulations that protect PLHIVs against discrimination? No

Q2: Does the country have non-discrimination laws or regulations which specify protections for MARPs and other vulnerable subpopulations? No

Q3: Does the country have laws, regulations or policies that present obstacles to effective HIV Prevention, Rx, care & support for MARPs and other vulnerable pops? Yes

Q3.1: If yes, for which subpopulations?

Women	No
Young people	No
IDU	Yes
MSM	Yes
Sex Workers	Yes
Prison inmates	Yes
Migrants	No

If YES, briefly describe the content of these laws, regulations and policies?

1. The Control of Narcotic Substances Act, 1997 criminalizes drug use and possession;
2. The Hudood Ordinance of 1979 declares non-marital sex and homosexuality as offences punishable under this law.
3. The(Punjab and West Pakistan) Suppression of Prostitution Ordinances 1961 and the Pakistan Penal Code 1860 criminalize activities of all sex workers including FSW, MSW and HSW.

Briefly comment on how they pose barriers

1. Police raids on IDUs pushes them underground, out of our reach and into the general population, thereby increasing the risk of HIV spread
2. All sex workers and MSM fall into the category of a quasi-legal population which naturally makes steady, consistent service delivery a difficult task, thereby diluting the impact of our activities

Q4: Is the promotion and protection of human rights explicitly mentioned any HIV policy or strategy

Yes, but the policy is in draft shape and awaiting approval

Q5: Is there a mechanism to record, document and address cases of discrimination experienced by PLHIV, MARPs and/or other vulnerable pops? No

Q6: Has the Govt., through political and financial support, involved PLHIV, MARPs and/or OVP in Govt HIV policy, design and program implementation?

Yes

If YES, describe some examples

1. There was some involvement in policy/design of the Enhanced framework
2. During grant proposal development for round 8 & 9, PLHIVs played a role
3. PLHIVs participated in several global fund meetings
4. Several CSOs are members of the CCM

Q7: Does the country have a policy of free service for the following

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

If YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions and barriers to access different populations

Steps in place are as follows”

1. ARV(1st & 2nd generation), CD4, Viral Load and Elisa tests are available free at treatment centers
2. Harm Reduction Program, inclusive of Needle exchange program for the IDUs
3. Condom promotion and provision to all MARPs
4. HIV testing and counseling to MARPs

Barriers are:

1. HIV related co-infections (except TB) and routine tests are not supported and patients have to either pay out of pocket or access the various organizations of PLHIV who have grants from different funding agencies for provision of these facets of treatment. Access to these organizations is a barrier due to lack of communication and knowledge of their existence.
2. Financial constrains and inadequate skill power
3. Stigma, especially against the Hijra community is high, inhibiting entry into treatment centers without fear of discrimination. Hijras, as a lifestyle, opt for voluntary castration which is not supported by our centers forcing them to opt for traditional methods that are unhygienic and dangerous.

Q8: Does the country have a policy to ensure equal access for women and men to HIV prevention, care & support? Yes

Q8.1: In particular, does the country have a policy to ensure access to HIV PTCS for women outside the context of pregnancy and childbirth? No

Q9: Does the country have a policy to ensure equal access for MARPs and OVP to HIV Prevention, treatment, care and support? Yes

If YES, briefly describe the content of this policy

Pakistan has a concentrated epidemic, hence all service centers providing PTCS are targeted for the MARPs and OVPs.

Q9.1: If YES, does this policy include different types of approaches to ensure equal access for different MARPs and OVP? Yes

If YES, briefly explain the different types of approaches to ensure equal access for different populations

1. Treatment centers are located in government hospitals that are easily accessible to all citizens; Barriers to IDU and HSW are addressed by facilitating their access to treatment, care and support via CSOs.
2. Preventive services are available via the CSOs who establish centers in specific localities commonly frequented by MARPs

Q10: Does the country have a policy prohibiting HIV screening for general employment purposes? No

Q11: Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review body?

Yes

Q11.1: If YES, does the ethical review committee include representatives of civil society including PLHIV?

Yes, except PLHIV since they have recently organized themselves.

If YES, describe the approach and effectiveness of this review committee?

It ensures

1. No human rights violation
2. Confidentiality and compensation
3. Data is not disseminated without designated approval
4. Subjects' health is not adversely affected

Q12: 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 which consider HIV-related issues within their work

Yes

-- Focal points within government 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

If Yes to any of the above questions, give examples

Human Rights Commission exists but it is not focused on HIV rights. However, Association of PLHIV, protects and advocates for HIV human rights

Q13: In the last two years, have members of the judiciary been trained/sensitized to HIV and human rights issues that may come in the context of their work?

No

Q14: Are the following legal support services available in the country?

- Legal aid system for HIV casework No
- Private sector law firms or university base centers to provide free/low cost legal services to PLHIV No
- Programs to educate, raise awareness in PLHIV concerning their rights

Yes

Q15: Are there programs in place to reduce HIV related stigma and discrimination?

Yes

If YES, what types of programs?

- Media Yes
 - School education No
 - Personalities regularly speaking out Yes
 - Other – Yes
- The Pakistan chapter of a regional study “PLHIV Stigma Index” is currently under process.

Overall how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009? (Scale 0-10) 2

Since 2007, what have been the key achievements?

The Supreme Court decision to give inclusive rights to Hijras; although this ruling is not HIV related, it is a key achievement for the transgender community in Pakistan

What are the remaining challenges in this area?

Human Rights issues in general are itself an enormous challenge in Pakistan. As Pakistan has a concentrated epidemic and HIV related human rights violations are not that common or obvious because of the less number of known/visible cases. However, Human rights related to HIV status is an area addressed in the HIV policy and HIV and AIDS law and its approval from the Government and parliament respectively is a challenge for the HIV response.

Overall how would you rate the efforts to enforce the existing policies, laws and regulations in 2009? (Scale 0-10) 2

Since 2007, what have been the key achievements?

1. HIV/AIDS policy development
2. HIV and AIDS law and act development

What are remaining challenges in this area?

Approval of the HIV policy and Law from Government and Parliament respectively

PART B-II: CIVIL SOCIETY PARTICIPATION

Q1: To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations? (Scale 0-5)

3

Comments and examples:

1. For the first time, an HIV sub-committee of the parliament was constituted and the committee held sessions to discuss the national response. This session was participated by CSO, PLHIV and MARP representatives.
2. Representation of parliamentarians in HIV activities at national and international levels.
3. Parliamentarians entered into dialogue with CSO on a range of HIV issues.

Q2: To what extent have civil society representatives been involved in the planning and budgeting process for the national strategic plan on HIV or for the most current activity plan (e.g. attending meetings and reviewing drafts)? (Scale 0-5) 3

Comments and examples

1. They participated in the consultative meetings for the development of Enhanced HIV and AIDS Programme and National Strategic Framework
2. They participated in the development of the Global Fund Proposals
3. Involvement in budgeting and planning of activities

Q3: To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in (scale 0-5)

- The national AIDS strategy 4
- The national AIDS budget 4
- National AIDS reports 3

Comments and examples:

Civil society organizations are the key actors in the provision of prevention and care and support services. Strong linkages exist between the government and PLHIV networks and association of PLHIV in the provision of treatment services as well.

Q4: To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response? (Scale 0-5)

- Developing the national M&E plan 3
- Participating in the national M&E committee/
working group responsible for coordination of
M&E activities 3
- M&E efforts at local level 3

Comments and examples:

Civil society is an active participant in the M&E activities and is a proactive member of the M&E working group.

Q5: To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations? (Scale 0-5) 3

Comments and examples:

1. Depends on the level; there is more participation on ground level and less on policy levels
2. Depends on the MARP group. Sex workers have no organizations; the Hijra organizations are minimally involved; APLHIV and faith-based are involved to a greater extent because of their capacity and proactive role

Q6: To what extent is civil society able to access (Scale 0-5)

- Adequate financial support to implement its HIV activities 3
- Adequate technical support to implement its HIV activities 3

Comments and examples:

1. Funding opportunities in 2009 have been scarce; sustainability of the few available grants has been precarious.
2. There are very few technical organizations and lack of funding makes them further inaccessible
3. NGOs dealing with FSW and IDU received funding and technical support and have yielded satisfactory results. However, NGOs dealing with other vulnerable groups have received no technical support.
4. In general civil society organizations and PLHIV have equal opportunities for technical assistance from UN system and other development partners

Q7: What percentage of the following HIV services is estimated to be provided by civil society?

- Prevention for youth >75%
- Prevention for IDU >75%
- Prevention for MSM >75%
- Prevention for sex workers >75%
- Testing and counseling 51-75%
- Reduction of stigma & discrimination 51-75%
- Clinical services (ART/OI) <25%
- Home based care >75%
- Programs for OVCs <25%

Overall how would you rate the efforts of increase civil society participation in 2009 (Scale 0-10)

6

Since 2007, what have been the key achievements?

1. The participation of CSOs has gone up considerably in an institutionalized manner.
2. Overall capacity building for service delivery
3. The Association for PLHIV has expanded and is involved in several activities.
4. The Government has acknowledged and accepted the critical role of CSO participation especially in Balochistan and NWFP where the MARPS are spread out over huge geographic areas and this itself is a huge achievement

What are remaining challenges in this area?

1. Availability and sustainability of funding
2. Availability of technical capacity even with government organizations particularly in NWFP and Balochistan
3. Availability of services in far flung areas needs to improve. Here community based mobilization groups need to play a greater role
4. The need for more focus on stigma and discrimination reduction

PART B-III: PREVENTION

Q1: Has the country identified the specific needs for HIV prevention programs?

Yes

If YES, how were these needs determined?

1. Based on evidence obtained via surveys e.g. KAP, Three rounds of IBBS conducted on annual basis by NACP
2. Through Situation and Response Analysis and the Mid-term Review by the government and supported by development partners
3. Dialogues with high risk groups and CSOs
4. Via research studies and import of best practices that were successful in similar epidemics

Q1.1: To what extent has HIV prevention been implemented?

HIV Prevention Component	Majority people in need have access to
Blood Safety	Disagree
Universal precaution in healthcare settings	Disagree
Prevention of mother-to-child transmission of HIV	Disagree
IEC on risk reduction	Disagree
IEC on stigma and discrimination reduction	Disagree
Condom promotion	Agree
HIV counseling and testing	Disagree
Harm reduction for injecting drug user	Agree
Risk reduction for men who have sex with men	Agree
Risk reduction for sex workers	Agree
Reproduction health services including sexually transmitted infections prevention and treatment	Agree
School based HIV education for young people	Disagree
HIV prevention for out of school young people	Disagree
HIV prevention in the workplace	Disagree
Other	N/A

Overall how would you rate the efforts in the implementation of HIV prevention program in 2009? (scale 0-10)

6

Since 2007, what have been the key achievements?

1. Up-scaling of provision of prevention services to MSW, HSW, FSW and prison inmates; raised awareness of HIV related issues amongst the same
2. Successful harm reduction programs with IDUs; Successful launch of a Pilot HIV prevention services intervention for families of IDUs. Both can be attributed to improved NGO mobilization
3. Another successful round of surveillance; A study of STI prevalence amongst urban young men in Pakistan was conducted.
4. Increase in PLHIV registration in centers; additional achievement of increased employment opportunities for PLHIVs
5. Stigma & Discrimination Assessment Tools developed for the first time in Pakistan; successful implementation of Disclosure Strategy
6. Development of a Service Delivery Model , Specific Life Skills Manual, Peer Educator Toolkits and VCT training for Most at Risk Adolescents

What are the remaining challenges in this area?

1. The current scale of these services is too low to have a significant impact on the epidemic. To avert expansion of the epidemic to a generalized level, these services should be scaled up to 60-70%, the universal access target
2. Sustainability of funding for prevention services delivery has been a challenge in 2009.
3. Better access to HSW and FSW still remains a challenge
4. Rising terrorism -related security issues present an obstacle to service delivery and capacity building; Stigma and discrimination is still a huge challenge

PART B-IV: TREATMENT, CARE AND SUPPORT

Q1: Has the country identified the specific needs for HIV treatment, care and support services?

Yes

If YES, how were these specific needs determined?

1. Based on evidence obtained via surveys e.g. KAP, Three rounds of IBBS conducted on annual basis by NACP
2. Through Situation and Response Analysis and the Mid-term Review by the government and supported by development partners
3. Dialogues with high risk groups and CSOs

4. Via research studies and import of best practices that were successful in similar epidemics

Q1.1: To what extent have HIV treatment, care & support services been implemented?

HIV Treatment, care and support service	Majority people have access to
Antiretroviral therapy	Agree
Nutritional care	Disagree
Pediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree
Psychosocial support for people living with HIV and their families	Disagree
Home based care	Disagree
Palliative care and treatment of common HIV-related infections	Agree
HIV testing and counseling for TB patients	Agree
TB screening for HIV infected people	Agree
TB preventive therapy for HIV-infected people	Disagree
TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in HIV infected people	Agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Disagree
HIV treatment services in the workplace or treatment referral systems through the workplace	Disagree
HIV care and support in the workplace (including alternative working arrangements)	Disagree
other	N/A

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support program in 2009? (Scale 0-10) 6

Since 2007, what have been the key achievements?

1. Availability of ARV (1st & 2nd generations); pediatric drugs and co-infection drugs
2. Availability of free diagnostics testing that including CD4, VL, rapid tests & confirmation ELISA tests.
3. Establishment of PPTCT and pediatric centers
4. Development of the National HIV treatment guidelines and tools; Training of healthcare providers in on the same

What are the remaining challenges in this area?

1. To provide facilities, diagnosis and treatment of other co-infections, especially HBV and HCV in HIV infected people
2. To improve linkages and access between MARPS, PLHIVs and the treatment centers
3. Standardization of services in treatment centers in terms of HMIS, quality and adherence
4. Dissemination of the National HIV Treatment Guidelines and Tools to a larger audience inclusive of private practitioners.
5. To address the financial and mobility constraints of PLHIV for regular and timely visits to the treatment centers; additional focus needed to improve accessibility of treatment centers for far-flung areas
6. We need to address stigma and discrimination reduction on a larger scale with a focus on health care providers within the healthcare system.

Q2: Does the country have a policy or strategy to address the additional HIV related needs of orphans and other vulnerable children? Yes

Q2.1: If YES, is there an operational definition for orphans and vulnerable children in the country? Yes –SAARC definition

Q2.2: If YES, does the country have a national action plan specifically for OVC? No

Q2.3: If YES, does the country have an estimate of OVC being reached by existing interventions? No

Overall how would you rate the efforts to meet the HIV related needs of orphans and other vulnerable children in 2009? (Scale 0-10) 4

Since 2007, what have been the key achievements?

1. There are 135 children registered in thirteen HIV Treatment and Care Centers. Those registered receive all required services inclusive of ARV in pediatric suspension
2. Development of Pediatric ART adherence tools – The National Guidelines for the Care and Support of Children
3. Establishment of drop-in centers for street children that offer social support, nutritional care, hygiene awareness and education
4. The first ever clinical National Pediatric HIV management workshop conducted for pediatrician training.

What are the key challenges?

1. Identification and accessibility to orphans/vulnerable children within our estimated HIV population is a key challenge
2. Identification of HIV pregnant mothers who give birth out of PPTCT centers fall off our radar. We need to address this gap
3. Capacity building for pediatric HIV management