COUNTRY PROGRESS REPORT

PAKISTAN

Global AIDS Response Progress Report 2012

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
APCP	AIDS Prevention and Control Program
APLHIV	Association of People Living with HIV
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavior Change Communication
CBO	Community-Based Organization
CCM	Country Coordination Mechanism
CDC	Center of Disease Control
CEO	Chief Executive Officer
CIDA	Canadian International Development Agency
CRIS	Country Response Information System
CSO	Civil Society Organization
DFID	Department of International Development
DHS	Demographic Health Survey
DoC	Declaration of Commitment
ECNEC	Executive Committee of National Economic Council
EHACP	Enhanced HIV/AIDS Control Project
EQAS	External Quality Assessment Scheme
EU	European Union
FAO	Food and Agricultural Organization
FATA	Federally Administered Tribal Areas
FELTP	Field Epidemiology Laboratory Training Program
FHI	Family Health International
FSW	Female Sex Worker
GARP	Global AIDS Response Progress
GARPR	Global AIDS Response Progress Report
GIPA	Greater Involvement of People living with AIDS
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GoP	Government of Pakistan
HASP	HIV/AIDS Surveillance Project
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRG	High Risk Group
HSW	Hijra Sex Worker
IBBS	Integrated Biological and Behavioral Surveillance
IDP	Internally Displaced Person
IDU	Injecting Drug Users
IEC	Information, Education and Communication
ILO	International Labour Organization
IOM	International Organization of Migration
IPC	Inter- Provincial Coordination

KAP	Key Affected Population
KPK	Khyber Pakhthunkhwa
M&E	Monitoring and Evaluation
MARA	Most at-Risk Adolescent
MARP	Most at-Risk Population
MDG	Millennium Development Goals
MERG	Monitoring and Reference Group
MICS	Multi Index Cluster Survey
MoE	Ministry of Education
MoH	Ministry of Health
MoIPC	Ministry of Inter-Provincial Coordination
MSM	Men who have Sex with Men
MSW	Male Sex Worker
MTR	Mid-Term Review
NACP	National AIDS Control Program
NCPI	National Commitment and Policy Instruments
NEP	Needle Exchange Program
NFC	National Finance Committee
NGO	Non-Governmental Organization
NPM	National Program Manager
NSEP	Needle Syringe Exchange Program
NSF	National Strategic Framework
NTP	National Tuberculosis Program
NVP	Nevirapine
NWFP	North West Frontier Province
OST	Opiate Substitution Therapy
P&D	Planning and Development
PACP	Provincial AIDS Control Program
PAS	Pakistan AIDS Strategy
PC	Planning Commission
PC-1	Planning Commission Proforma – one (Project Document)
PHC	Primary Health Care
PIMS	Pakistan Institute of Medical Sciences
PLHIV	People living with HIV
PPM	Provincial Program Manager
PMTCT	Prevention of Mother-to-Child Transmission
PPTCT	Prevention of Parent-to-Child Transmission
PR	Principal Recipient - GFATM
PWID	People who Inject Drugs
RST	Regional Support Team - UNAIDS
SDP	Service Delivery Package
SGS	Second Generation Surveillance
SOP	Standard Operating Procedure
SPO	Senior Program Officer
SR	Sub-Recipients - GFATM
SRA	Situation Response Analysis
STI	Sexually Transmitted Infection
TACA	Technical Advisory Committee on AIDS

TOR	Terms of Reference
TWG	Technical Working Group
UN	United Nations
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	United Nations Joint Program on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office for Drugs and Crime
USAID	United States Agency for International Development
VCCT	Voluntary Confidential Counseling and Testing
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization

FOREWORD

Pakistan pledged commitment to respond to the HIV epidemic by endorsing the Declaration of Commitment (DoC) of the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS of 2001 and to achieve the 6th Millennium Development Goal (MDG) of *'halting and beginning to reverse the HIV/AIDS epidemic by 2015'*. In 2002, the UNAIDS Secretariat and Co-sponsors developed a series of core indicators for all countries to provide consolidated depiction of progress made on specific areas of the DoC and bring uniformity to reports encompassing diverse epidemics across the globe. Pakistan has already submitted four progress reports in 2003, 2005, 2008 and 2010 as per the UNGASS requirements. This 2012 report represents the fifth such progress report.

Prior to the June 2011 Political Declaration on HIV/AIDS at the General Assembly, indicators used in the previous UNGASS reporting rounds were rigorously reviewed using an extensive evidence-informed process led by the UNAIDS Monitoring and Evaluation Reference Group (MERG) at global level. Three new indicators were added and five more were modified to be presented in the Global AIDS Response Progress Report (GARPR) 2012.

The GARPR reporting period from January 2010 to December 2011 has been prepared through consolidation and analysis of recent Second Generation Surveillance (SGS) data, service utilization reports – from Voluntary Confidential Counseling and Treatment (VCCT), treatment, prevention, care and support centers; Monitoring and Evaluation (M&E) data of the National AIDS Control Program (NACP) and interviews with key informants from Government, multilateral, civil society and community-based organizations (CBOs), including the Association of People living with HIV (APLHIV). In the present report, 17 out of 30 indicators have been validated that comprehensively describe various facets of the epidemic in Pakistan as well as progress of the national response to date. The remaining indicators have not been reported on either due to non-relevance or non-availability of data.

Pakistan continues to face an expanding concentrated epidemic with people who inject drugs (PWID) as the driving force exhibiting an HIV prevalence of 27.2% across urban centers. Prevention remains the most funded programmatic area of the country's response. In 2010-2011, implementation of the 18th Amendment of the Constitution of Pakistan dictated the 'devolution' of the Ministry of Health (MoH) to the autonomous provincial level. The NACP now comes under the Ministry of Inter-Provincial Coordination (MoIPC).

STATUS AT A GLANCE

Description of report-writing process

Pakistan initiated the report-writing process for the Global AIDS Response Country Progress Report (GARPR) in early 2012. The NACP, in collaboration with UNAIDS and other members of the Joint UN Team on AIDS, started the process by constituting a Technical Working Group (TWG) which includes representatives from the Planning Commission, NACP, UN agencies (UNFPA, UNICEF, UNODC, and WHO), and civil society organizations (CSOs).

The first meeting of the TWG took place in February 2012 in which all partners agreed upon the relevant indicators to report on, the timeline and process of data collection, analysis, validation and report-writing. A consultant was hired for collecting information on the National Commitment and Policy Index (NCPI) indicator and the writing of the narrative report receiving assistance from the NACP and UNAIDS when needed. The task of NCPI was taken-up first and prepared through a process of desk review, consultations, key informant interviews, and self-administered questionnaires. A total of 13 key respondents were identified by the TWG and each respondent was requested to address sections relevant to them. Data collection was accomplished through face-to-face interviews conducted at the convenience of the respondents and electronic submission of self-administered questionnaires. Validation and consensus of the results was ensured through a validation workshop held in March 2012 involving Government officials and representatives from CSOs and UN Agencies. Online entry of the NCPI followed this exercise which was shared with key stakeholders for their inputs.

The second meeting of the TWG was held in late February 2012. Following consultations, in person and electronically, on the process, methodology and information-exchange between the consultant and the TWG, the first draft of the narrative and other indicators of the report were shared electronically and inputs incorporated till a final version was prepared.

The validation and consensus workshop was held on 26 March 2012 and the final draft of the complete report, inclusive of the NCPI, was shared with national and provincial stakeholders representing the Government, UN agencies, CSOs and Non-Governmental Organizations (NGOs). Inputs received during the meeting were incorporated before final submission.

Status of the HIV Epidemic

The trend of a concentrated HIV epidemic among Key Affected Populations in Pakistan continues to be driven by PWID exhibiting the highest HIV prevalence at 27.2% in 2011. This is followed by 'Hijra' (HSWs) or transgender and male sex workers (MSWs) at 5.2% and 1.6%, respectively. Among the Key Affected Populations identified in the country, female sex workers (FSWs) exhibit the lowest prevalence of 0.6%.

The geographic trend of the epidemic over time is one beginning with major urban cities and provincial capitals expanding over time to smaller cities and towns.

The high prevalence of HIV infection amongst PWID is consistent with their frequent and risky injection practices: 71.5% report having 2-3 injections per day with 39% always using a new syringe in 2011. Linkages with sex workers exist with around 14% and 7.1% reporting paying for sex with FSWs and M/HSW respectively in the past six months, but only around 16% used a condom in their last sexual act. In Pakistan, as elsewhere, contextual and structural changes are occurring in sex work. Recent improvements in communication technology, especially the easy and wide availability of cell phones, has diminished street-based sex work as sex workers and clients can now directly interact without the need of going through a third person. This has made female sex work diffuse and more difficult to access.

Other than the Key Affected Populations, evidence also exists of either HIV-related risk factors or infection among certain vulnerable populations, such as the spouses of at-risk persons, imprisoned populations, most at-risk adolescents and in certain occupational settings, including in some cases through nosocomial infection. While the evidence overwhelmingly calls for a focus on the Key Affected Populations, it is essential that prevention strategies and 'low-threshold' programs also be sustained for these larger segments of the population.

Pakistan had an estimated 98,000 people living with HIV by the end of 2009, with 5,256 PLHIV registered in 17 ART centers by end of 2011, including 189 children, 1,018 and 4,049 adult females and males, respectively. Out of these, 2,491 PLHIV are on ART of which 105 are children, 646 adult females and 1,740 adult males. Looking at recent trends there has been a gradual increase in the number of PLHIV registered at ART centers and on ART. On average, in 2011 there were around 40-45 new PLHIV starting on ART per month.

Policy and Programmatic Response

The 18th Amendment to the Constitution of Pakistan was passed by the Parliament in 2010, and, as part of its implementation, the MoH was fully devolved by June 2011 with the NACP and other programs subsequently placed under the MoIPC. In the post-devolution scenario, NACP has been assigned a more confined role around management of the GFATM grant on HIV as the Round 9 (R9) public sector Principal Recipient (PR), coordination, global reporting, and surveillance.

The National Strategic Framework-II (NSF-II) completed its five year time-frame in December 2011. The third NSF is currently being developed, the process for which started in fall 2011. Due to devolution, each Province is developing its own AIDS strategy tailored to its specific context with costed action plans. The final document will include a consolidation of the four provincial strategies within one overarching framework entitled the 'Pakistan AIDS Strategy' or PAS-III. The PAS-III will be in line with the

overall national health and development strategies as well as the 2011 Political Declaration on HIV/AIDS, MDG targets and other international commitments on AIDS.

The programmatic response in Pakistan encompasses HIV prevention, treatment, care and support, with a priority focus on reaching Key Affected Populations. The Global Fund R9 grant is focused on 'Continuum of Prevention and Care' (CoPC) for PWID, spouses and children as well as 'Community and Home-Based Care' (CHBC) for people with and affected by HIV. A regional Global Fund R9 grant implemented by a new community-based NGO is focused on HIV prevention among men who have sex with men (MSM) and Transgender. Funding and implementation gaps in specific areas of HIV prevention, treatment and care in the context of drug use, sex work, Antiretroviral Therapy (ART), continuum of care, prevention of mother- to-child transmission, and humanitarian responses have been being supported by the Joint UN Programme on AIDS in 2010-2011.

Summary Table of Core Indicators

Of the total 30 indicators under the seven targets in the 2012 report, Pakistan is reporting on 17 indicators that reflect key features of the HIV epidemic and response in Pakistan. The ones not reported on include indicators that were either not relevant to the country context or those for which data was not available.

	No.	Indicator	UNGASS Reporting 2010	Global AIDS Progress Response Reporting 2012
Target 1. : Reduce sexual transmission of HIV by 50 per cent by 2015				
General population	1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Indicator is relevant, but there is limited data from DHS on *Married women 15-24 yrs:* 28% knew about sexual mode of transmission and 17% knew about condom protection against HIV	Indicator is relevant, but data not available No updated DHS
	1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Indicator relevant, but data is not available	Indicator is relevant, but data not

				available
	1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	Indicator is relevant, but data is not available	Indicator is relevant, but data is not available
	1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	Indicator is relevant, but data is not available	Indicator is relevant, but data not available
	1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	Indicator is relevant, but data not available	Indicator is relevant, but data not available
	1.6	Percentage of young people aged 15-24 who are living with HIV	Indicator relevant, but data not available	All young people= 0.04% (15-19= 0%; 20-24= 0.05%)
Sex Workers	1.7	Percentage of sex workers reached with HIV prevention programs	FSW (<25 = 5.6%; 25+ = 6.1%) M/HSW (<25= 11.7%; 25+= 15.3%)	All sex workers= 8.7% (<25= 7.5%, +25 = 9.9%) FSW= 8.1% M/HSW= 9.1%
	1.8	Percentage of sex workers reporting the use of a condom with their most recent client	FSW (<25 = 49.5%; 25+ = 39.6%) M/HSW(<25= 32.4%, 25+= 34.0%)	All sex workers= 35.4% (<25= 33.3%; +25= 37.2%) FSW= 41.5% M/HSW= 32%
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	FSW (<25 = 15.5%; 25+= 14.1%) M/HSW(<25= 1.5%, 25+= 14.3%)	All sex workers 8.1% (<25= 6.2%, +25= 7.4%) FSWs= 5.7% M/HSWs= 9.4%
	1.10	Percentage of sex workers who are living with HIV	FSW= 0.91% M/HSW(<25= 3.1% 25+= 4.0%)	All sex workers= 2.4% (<25= 2.2%, +25= 2.6%) FSWs= 0.6%

				M/HSWs=3.44%
Men who have sex with men	1.11	Percentage of men who have sex with men reached with HIV prevention programs	New Indicator	Indicator is relevant, but data not available
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Indicator relevant, but data not available	Indicator is relevant, but data not available
	1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	Indicator relevant, but data not available	Indicator is relevant, but data not available
	1.14	Percentage of men who have sex with men who are living with HIV	Indicator relevant, but data not available	Indicator is relevant, but data not available
Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015				
	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programs	New Indicator	42 syringes per PWID per year
	2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	PWID (<25= 29.2% 25+= 31.2%) Male only PWID	All PWID= 22.6% (<25= 21.9%, +25= 22.7%) Male PWID= 22.3% Female PWID= 45%
	2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	PWID (<25= 79.3%, 25+= 76.9%) Male only PWID	All PWID= 66% (<25= 63.5%, +25= 66.8%) Male PWID= 65.9% Female PWID= 84.6%
	2.4	Percentage of people who inject drugs	PWID (<25=	All PWID= 9.1%

		that have received an HIV test in the past 12 months and know their results	12.4%, 25+= 11.7%)	(<25= 7.8%, +25= 9.4%) Male PWID= 8.8% Female PWID= 48.8%
	2.5	Percentage of people who inject drugs who are living with HIV	PWID (<25= 22.5%, 25+= 20.4%)	All PWID= 27.2% (<25= 33.9%, +25= 25.3%) Male PWID= 27.3% Female PWID= 17.9%
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal death				
	3.1	Percentage of HIV-positive pregnant women who receive Antiretroviral drugs to reduce the risk of mother-to-child transmission	0.44% (25 of an estimated 5,663 HIV positive pregnant mothers)	1.66% (57 of an estimated 3,418 HIV positive pregnant mothers)
	3.2	Percentage of infants born to HIV positive women receiving a virological test for HIV within 2 months of birth	New Indicator	19.5% (8/41)
	3.3	Mother-to-child transmission of HIV (modeled)	New Indicator	36.2% (1,239/3,418)
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2011				
	4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	9.83% (1,320 adults and children out of 13,422 estimated at an advanced stage of HIV)	8.7% (2,491 adults and children out of 28,554 estimated eligible adults and children)
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Indicator is relevant, but data not available	Indicator is relevant, but data not

				available
Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2011				
	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Indicator relevant, but data not available. Limited information	Indicator is relevant, but data not available
Target 6: Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries				
	6.1	Domestic and international AIDS spending by categories and financing sources	Complete Matrix submitted	Complete Matrix submitted
Target 7: Critical Enablers and Synergies with Development Sector				
	7.1	National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination and monitoring and evaluation)	Complete submitted	Annex II
	7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	New Indicator	Indicator is relevant, but data not available
	7.3	Current school attendance among orphans and non-orphans aged 10–14	Subject matter not relevant	Data not available
	7.4	Proportion of the poorest households who received external economic support in the last 3 months	New Indicator	58.33% (3.5/6 million)

OVERVIEW OF THE HIV EPIDEMIC

Background

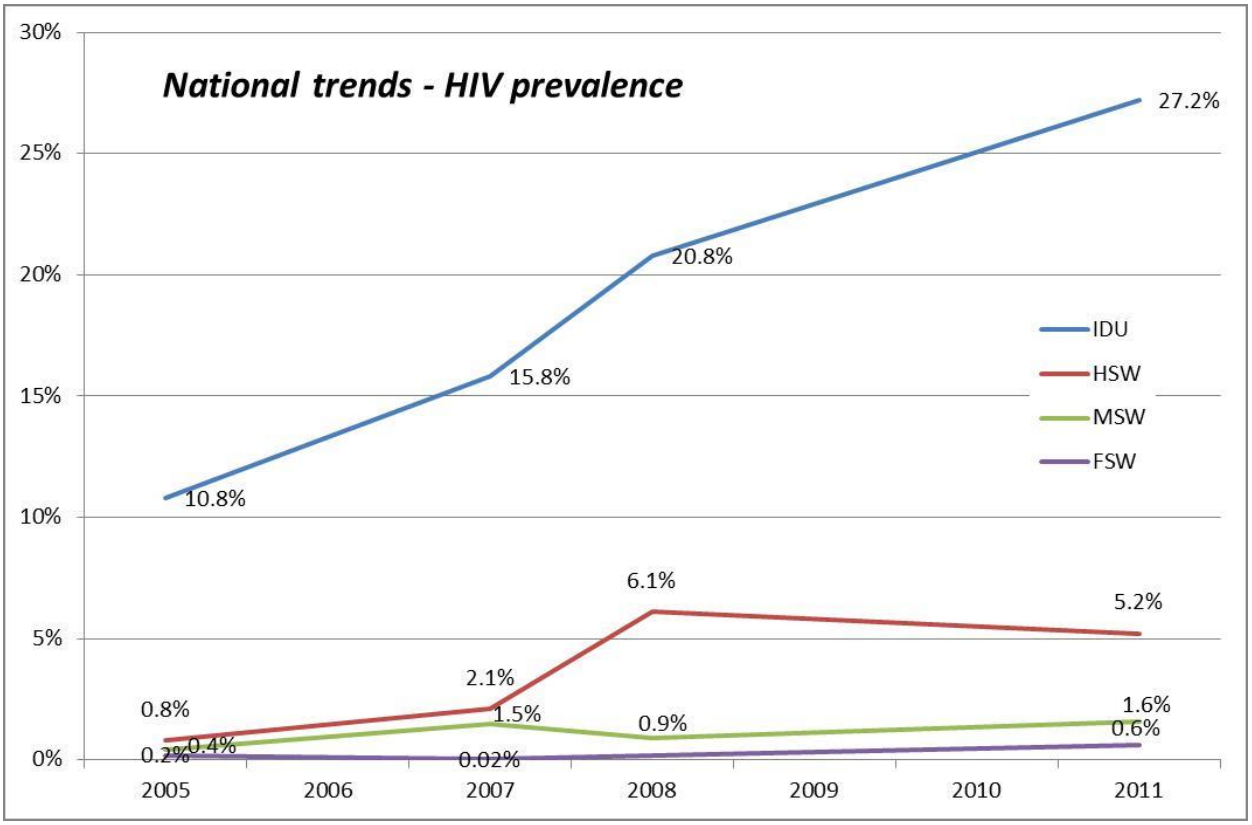
The population of Pakistan is estimated at around 187 million in 2011 making it the sixth most populous nation in the world with an average annual growth rate of 1.8%[1]. The country consists of four main Provinces: Punjab, Sindh, Baluchistan, and Khyber Pakhtunkhwa (KPK) formally known as the North West Frontier Province (NWFP); two autonomous states, including Azad Jammu Kashmir (AJK) and Gilgit-Baltistan; as well as federal territories of the 'Federally Administered Tribal Areas' (FATA) and the Islamabad Capital Territory (ICT). Pakistan presents a multi-cultural environment with each Province or Region featuring its own socio-demographic characteristics. Punjab and Sindh are the most populous Provinces that house the largest cities and also report the highest HIV prevalence among Key Affected Populations. Of the total population of the country, around 63% reside in rural areas although with rapid urbanization this trend is evolving considerably. The infant mortality rate is 70 per 1000 live births with a life expectancy at birth of 65 years. Pakistan's Human Development Index and Gender Inequality Index are 0.504 and 0.537 respectively, and literacy rate is at 55.5%[2]. Like other Asian countries, Pakistan is following a comparable HIV epidemic trend having moved from 'low prevalence, high risk' to 'concentrated' epidemic in the early to mid-2000s among Key Affected Populations, namely among PWID and sex workers. It is also important to note that in some locations, clusters of HIV positive cases were identified in semi-urban communities due to a mix of unsafe injecting practices in informal health care settings as well as other risks. Results from the recently completed Integrated Bio-Behavioral Surveillance (IBBS) Round IV conducted in 2011 have confirmed rising prevalence among PWID in numerous cities across the country.

Current Situation

The 2011 IBBS conducted by the Government of Pakistan's HIV/AIDS Surveillance Project (HASP) supported through the Canadian International Development Agency (CIDA) through technical partners, such as the University of Manitoba, in 19 cities confirms that HIV prevalence among Key Affected Populations continues to rise, with an average prevalence of 27.2% among PWID as compared to 20.8% in 2008; 1.6% among Male sex workers (MSWs) as compared to 0.9% in 2008; and 0.6% among Female sex workers (FSWs) as compared to 0.2% in 2007. Notably, however, an additional round of IBBS on FSW was conducted in 2009 finding the prevalence to be 0.97%. Amongst 'Hijra' or Transgender sex workers prevalence was at 5.2% in 2011 lower than 6.1% in 2008. Figure 1 below shows these trends in graphical form suggesting a clear rise in prevalence among PWID, a moderate rise in MSW and FSW with a mild drop in HSW.

[1] *Federal Bureau of Statistics, Government of Pakistan*

[2] *http://hdrstats.undp.org/en/countries/profiles/PAK.html)*

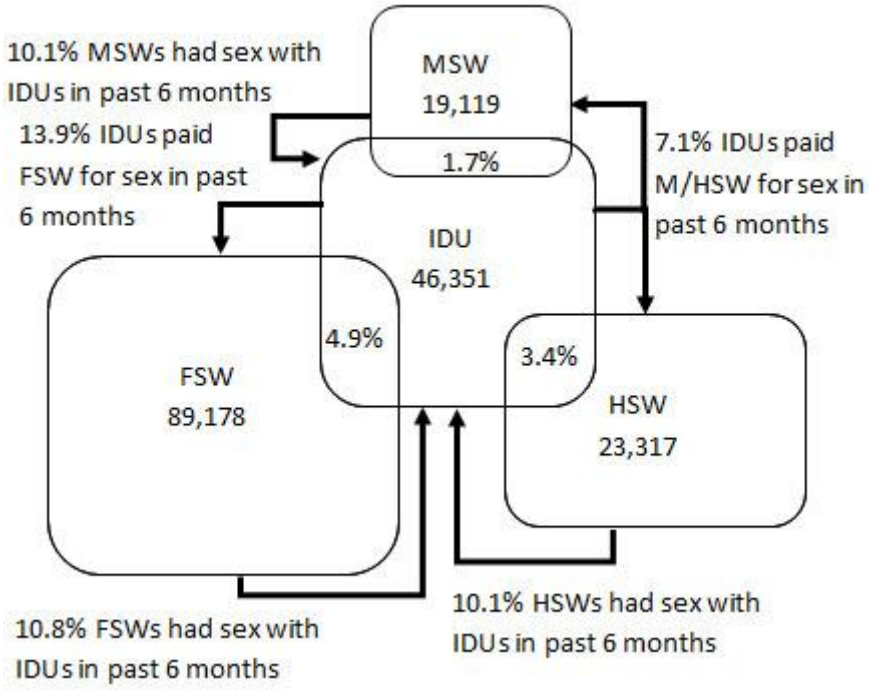


Characteristics of Drug Injecting

Estimated to number 91,000 in 2007, injecting drug users are now found across the country with large concentrations in key cities, such as Karachi, Faisalabad and Lahore, the largest metropolitan areas. Based on the 2011 data, PWID are overwhelmingly male (98.4%) with an average age between 25-40 years old, 57.1% have no formal education, 81.2% live with their families or friends, and 33.8% are married.

The high HIV prevalence among PWID is consistent with their frequent and risky injection practices: 71.5% report 2-3 injections per day and another 21% report more than 3 injections a day. Only 39% report always using a new syringe. An additional important aspect of transmission dynamics is the linkage between injecting practices and unprotected sexual contacts. For example, around 14% of PWID report having sex with FSWs in the past six months. Topping this fact, the reported condom use is also low: 28% with FSW and 16.3% with MSW/HSW. Figure 1 below shows the interactions between different Key Affected Populations as reported in Round IV.

Figure 1: Interactions between PWID, MSW, HSW and FSW populations (Source: HASP 2012)



Adding to the above factors are gaps in knowledge and access to preventive measures. Although 86% of PWID knew HIV can be sexually transmitted, only half of them knew that condoms can prevent HIV transmission and 32.8% were aware of where they could undergo testing for HIV. The knowledge of HIV prevention programs amongst PWID is still insufficient: 44% are aware of the existence of specific service delivery programs in their cities. However, encouragingly, of those who knew of these services, 76% visit them frequently and 92% accessed them to obtain new syringes.

Characteristics of sex work

Although sex workers are defined under three distinct categories of male, female and Hijra sex work in Pakistan, the current and previous UNGASS reports groups male and Hijra sex work together. Findings are, therefore, presented below in accordance with existing in-country definitions of these populations.

***Female Sex Work*:** With an estimated population of 136,000 in 2007, the majority of FSWs are located in large cities. Their average age in 2011 was 26.9 years with 64.3% of them reporting being married. Their 'modus operandi' in sex work was for 43.1% brothel, 'KotiKhana'[3] or home-based mostly operating through a 'Madam', while 22.3% were street-based and 24.7% used cell phones for accessing clients.

[3]*Refers to a rented house in a residential neighborhood proving sex work services. Reference: Mapping Networks of Female Sex Workers in KothiKanas and Private Homes, NACP, Canada-Pakistan HIV/AIDS Surveillance Project, 2007.*

FSWs had an average of three clients a day. Condom use with clients was generally low as only 33.2% reported that they always used a condom with their non-paying client in the last month, and 50% reported using a condom during their last vaginal intercourse with paying or non-paying partners. Brothel-based FSW reported substantially more condom use than the other types of sex workers. Overall, condom use during anal sex was lower than that reported during vaginal sex.

Use of alcohol and drugs during sexual encounters was reported by 39% of FSWs. The highest proportion of FSWs' injecting drug use was reported at 16.8% in one city. Both injecting drugs and having sex with a PWID were highest among brothel-based FSWs at 7.2% and 15.8%, respectively.

Assessment of HIV-related knowledge revealed that approximately 80.4% had ever heard of HIV/AIDS, with brothel-based sex workers reporting the highest level of awareness (91.2%). Of the total number who had heard about HIV, 94.3% knew that HIV can be transmitted by sexual intercourse, but less than one-third (32.6%) knew that HIV can be transmitted through needles/syringes and only 13.4% knew about mother-to-child transmission.

An estimated 18.9% of FSWs were aware of HIV prevention programs in their city. Among those, 36.6% used the services once a month. Knowledge of and participation in programs was much higher among brothel-based FSW than any other category: approximately 89.1% of the former had received a free condom in the past month. Of the total population of FSW, 22.5% knew where to get tested and 15.7% had an HIV test at least once.

Male Sex Workers: The estimated total number of MSW in 2007 was 63,000 with the majority also found in larger cities. The average age of MSWs was less than 30 years, the majority was unmarried, approximately 40.2% had received no formal education, and more than 80% lived at home with their families. More than one half (57.6%) solicited clients by roaming around in public places; however, an important proportion (30.4%) used cell phones to access clients.

On average, MSWs entertained 2 clients per day, averaging a number of clients per month of 40.4 ± 32. Bisexual behavior was reported by approximately 39.5%. Consistent condom use was generally very low: overall, only 13% reported regular condom use with paying partners. The proportion was lower (10.9%) with non-paying sex partners. Consistent condom use during the past month varied significantly by age with younger less likely to use condoms when compared to older age groups. Consistent condom use increased as education level increased.

Overall, only 1.7% of MSWs reported injecting drugs in the six months, but 52.5% reported using alcohol or drugs while having sex in the past six months. Approximately 10.1% reported having had sex with a PWID in the past six months. Knowledge of sexual transmission as a mode of HIV transmission was reported by 94.5%, whereas only 46.2% knew that HIV can be transmitted through syringes. Approximately 69.8% of those who had heard of HIV knew that transmission can be prevented by using a condom during sex.

Only 22% of MSWs interviewed had ever been tested for HIV and 12.7% were aware of an HIV prevention program in their city. Among those who utilized these services, over one-half (57.8%) used them less than once a month. Service utilization varied considerably across cities.

Hijra Sex Workers: It was estimated that there are a total of 43,000 HSWs in 2007. In 2011, approximately 22.7% of HSWs had moved from other cities: Rawalpindi, followed by Karachi, Quetta, and Peshawar were the most commonly reported destination points. A little over one-third (34.7%) were between 25-29 years old, more than two-thirds (85.1%) were unmarried, almost one-half were illiterate (42.4%), and 70.6% lived in 'Deras' [Note: Hijra communal residence]. The most commonly used means to solicit clients were public places (38%) and/or cell phones (44.4%), with only 10.7% of HSWs relying on 'Gurus' [Note: They have a comparable role to 'Madams' among FSW] for clients, reflecting the decreasing dependency on Gurus for sexual partnering.

On an average, HSWs entertained two clients per day or approximately 40 clients per month. Reported consistent use of condoms was low, with only 23.6% of HSWs reporting that they always used a condom with clients in the past month. This proportion was even lower with respect to regular condom use with non-paying partners at 18.1%. With respect to condom use during the last sexual act, the corresponding proportions were 36.6% and 26.8%, respectively.

More than half (55.1%) HSW reported using alcohol and/drugs during sexual intercourse in the past six months. Overall, 10.1 % of HSWs reported to have had sex with PWID in the past six months, whereas 3.4 % HSWs reported that they had been injecting drugs in the same time period. A high proportion (90.9%) had knowledge of HIV/AIDS and means of prevention. Around 32.6% had ever been tested for HIV and 35.8% knew where to go for HIV testing.

Approximately 31.6% of HSWs were aware of HIV prevention programs in their city. Among those aware of services, 7.8% said they never utilized them but almost one-half of HSWs (47.9%) used the services less than once a month. Obtaining condoms was the most utilized service (85%) followed by requests for lubricants (39%), obtaining medications (26%), and HIV testing (20%).

Vulnerable Populations

Other at-risk and vulnerable populations, such as clients of sex workers and spouses of Key Affected Populations, were estimated to number around five million in Pakistan in 2011. While these populations have not been sufficiently researched, prevalence in the general population remains low equivalent to or less than <0.1%. A national study conducted in 2011 among 26,500 women in antenatal clinics found prevalence to be at 0.04%.[4] Among several vulnerable populations that also include at-risk adolescents and prisoners, details are provided below on spouses of persons who inject drugs, specific occupational settings, migrants, and refugees and internally displaced persons (IDPs).

[4] *Antenatal Sero-surveillance for HIV/AIDS in Pakistan, NACP, HASP, 2012,*

A research study conducted in Punjab by the NGO Nai Zindagi found 15% HIV prevalence among **spouses** and female partners of male PWID[5]. Transmission of HIV from PWID to their wives is enhanced by the fact that around 80% of the former engage in unprotected sex.

Another study conducted by the Population Council of Pakistan in 2008 focused on **urban men** in an effort to further characterize vulnerability to HIV. According to this study, which sampled 2,400 men (mean age of 29 years) in six cities, almost 29% of men reported ever having non-marital sex of which 37% reported having ever used a condom. Of the 29%, 16% had premarital sex while the rest (11%) engaged in both pre and extra-marital sex. However, non-marital sex was most commonly reported with females who were not sex workers. As in the case of Key Affected Populations, this population had relatively high awareness regarding HIV [Note: 90% had heard of HIV/AIDS, but many had misconceptions about the modes of transmission]. Of the 2,396 subjects who agreed to be tested, 4.4% were found positive for at least one of the five of the sexually transmitted infections (STIs). The individual prevalence of HIV, Syphilis, HSV-2, Gonorrhea and Chlamydia was 0.1%, 1.3%, 3.4%, 0.8% and 0%, respectively[6].

A 2011 survey of **coal miners** in Baluchistan revealed that almost 90% of the sampled subjects had had sexual intercourse, with the mean number of sexual partners being 4.2 in the past one year. The mean number of paid female sex partners in this population was 6.1 in the last one year. Alarmingly, condom use was very low, with only 2% always using a condom. This population has interactions with both female and Hijra sex workers. While awareness of STI was relatively high (79%), more than half reported experiencing STI symptoms[7].

Vulnerability to HIV exists in the context of internal and external **migration** in Pakistan. A substantial number of HIV cases reported to the health care services across the four Provinces have been and continue to be among returning migrant workers from abroad as well as among their spouses and children. There has been significant migration from rural areas of all Provinces to the Gulf States. The net outward migration rate from Pakistan is estimated at 3.3 per 1000 inhabitants.

To obtain a work and residence visa, Gulf States and other receiving countries require prospective visitors from Pakistan and other countries to undergo mandatory testing for HIV and other health conditions, without appropriate pre and post test counseling being provided at the designated Gulf Cooperation Council GCC Approved Medical Center's Associations (GAMCA). In line with the World Health Assembly (WHA) resolution on health of migrants in 2008, member states were 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 pursued by

[5] *The Hidden Truth' Report by Nai Zindagi and PACP, Punjab 2008*

[6] *Study of Sexually Transmitted Infections Among Urban Men in Pakistan: Identifying the Bridging Population. Population Council, May 2008*

[7] *Bio-Behavioral Survey among Mine workers in Balochistan, Pakistan. January 2012*

Pakistan in 2007, strategizing of priorities is in place since 2011 through a Government and UN working group on migration and HIV.

Conditions related to the context of labor migration from Pakistan to the Gulf – 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 risks and vulnerabilities given limited access to information, counseling and referral to health services during the various stages of migration. As in other countries of South Asia, a number of HIV cases continue to be among returning migrants deported from the Gulf States when found to be HIV positive. Most deportees do not receive counseling, proper educational information about their status and/or ensuring access to treatment, care and support services upon return to their countries of origin.[8]

The risks of onward HIV transmission to spouses and to children have been documented upon the return of migrant workers from abroad. In KPK, for example, among the registered 567 cases at the Provincial AIDS Control Program (PACP) up to February 2010, over 80% were among migration-related [Note: Deportees themselves amount to 53% of these cases, their spouses 23% and children 4.9%]. A similar situation was identified in the district of Gujrat in the Province of Punjab where 88 HIV positive cases out of a sample of 246 from the general population were identified in mid to late 2008. Despite the fact that unsafe therapeutic injecting practices was believed to be the key factor in onwards transmission in Gujrat, and investigation by the Field Epidemiology and Laboratory Training Program (FELTP) research team found demographics of the sample population to include a significant number of ex-migrant workers.[9]

For more than two decades, Pakistan has also faced the challenge of hosting millions of Afghan refugees. In 2009-2010, it had the added responsibility of assisting the relocation of over 2 million **Internally Displaced Persons** (IDPs) within the Province of Khyber Pakthunkhwa and FATA due to the military operations launched by the Government against militants. This led to some disruption of preventive and treatment care and support services to vulnerable populations as well as to PLHIV. Almost one million remain displaced by armed conflict in FATA. The IDP situation worsened by the displacement of millions people due to the flooding of the Indus River in 2010 that ravaged large tracts of land across the length of Pakistan. In December 2011, more than half a million still remain displaced[10]. The challenge of ensuring continuity of services for PLHIV and Key Affected Populations, assessing HIV-related vulnerabilities for the displaced and otherwise **flood-affected populations** and providing HIV-related information, services and programs for those in need among the displaced was undertaken by the Government and UN agencies. A similar situation occurred with the floods of 2011, largely confined to the Province of Sindh.

[8] *Mapping of HIV Risk and Vulnerabilities of Temporary Contractual Workers from Pakistan to GCC Countries 2011, Government of Pakistan, IOM and UNAIDS*

[9] *NACP FELTP Report on HIV Outbreak in District Gujrat 2009*

[10] *Source: http://www.internal-displacement.org/countries/pakistan*

NATIONAL RESPONSE

NATIONAL COMMITMENT AND ACTION

The Government of Pakistan (GoP) has maintained a continued response to the AIDS epidemic since 1987 through a close collaboration between the National AIDS Control Program (NACP), Provincial and AJK AIDS Control Programs and UN agencies, bilateral and multilateral donors, and a consortium of NGOs and CSOs operating at national, provincial and grass-root levels. Inclusion of PLHIV representative organizations has also been a feature of this response. The Government's response till date can be divided into four phases: The first phase was from 1987-2003, phase II from 2003-2007 and phase III from 2008-2010 which was originally to be reported over a five-year time frame. Revision of the time frame of phase III, however, became necessary following the devolution of the Federal MoH in 2011 to provincial levels paving the way for Phase IV of the national response in the 'post-devolution' context. Public-private partnership with NGOs and CSOs are an integral aspect of Pakistan's response to this epidemic and are discussed separately.

National Response, Phase I: 1987-2003

The first HIV positive person was identified in 1987. The Federal Committee on AIDS was immediately composed at the time recommending the establishment of a national body on AIDS entitled the 'AIDS Prevention and Control Program' (APCP). The APCP mandate was mainly around a laboratory-based response focused on blood safety and detection of HIV positive cases through laboratories, blood banks/screening in the public sector hospitals as well as general awareness. In the early stages, the response was limited due to the small numbers of detected HIV and AIDS cases. In 1994, the AIDS program was brought under the 'Social Action Program Project' and its time-frame extended until 2003. With this change, additional activities focusing on HIV prevention and control were implemented within the overall health care infrastructure. Key Vulnerable Populations, including PWID, sex workers (male, female and Hijra), prison inmates and long distance truckers, were initially identified as most-at-risk groups in this phase. In 2001, as a result of global efforts on control of the AIDS, the GoP developed its first five-year National Strategic Framework (NSF-I) with the support of UNAIDS. The NSF-I identified nine broad priorities areas including:

1. Expanding the AIDS response
2. Accessing vulnerable, target and bridging populations
3. Women, children and youths
4. Surveillance and research
5. Sexually transmitted infections
6. General awareness
7. Blood and blood product safety
8. Infection control
9. Care and support

National Response, Phase II: 2003-2007

Following the Declaration of Commitment (DoC) in the 2001 UNGASS session, and in line with the NSF-I, the GoP approved the 'Enhanced HIV/AIDS Control Project' (EHACP) for 2003-8 funded by the World Bank, DFID and Government itself. The strategy of EHACP digressed from the previous approach in that it partially decentralized the program to five provincial (PACP) bodies. The EHACP addressed four principal components:

1. Interventions for most-at-risk populations: This involved provision of services under the auspices of the public-private partnership with a consortium of NGOs and CSOs. The service package included IEC, skill development, condom distribution, syringe exchange and other aspects of comprehensive drug harm reduction (including detoxification), preventive/curative care, and VCCT. Funding received from GFATM Round 2 was used to strengthen centers for treatment, care and support for PLHIV in the federal and provincial capitals as well as other gaps such as prevention among young people. The treatment centers provided ARV therapy from 2005 onwards, treatment for opportunistic infections and hospitalization. Capacity building measures were included as training of health-care professionals on HIV management. A national network of PLHIV was established during this period through the support of the UN and efforts for legislation dealing with their rights were embarked upon.

2. Establishment of a Second Generation Surveillance System: Supported by the CIDA, second-generation biological and behavioral surveillance amongst Key Affected Populations was implemented by GoP to track the HIV epidemic over time. The methodology was modified specifically for Pakistan and constituted mapping of these populations in the first phase and collection of behavioral and biological data in a second phase. The population size estimates were used to guide the national and provincial programs in scaling up service-delivery for PLHIV.

3. Preventing HIV transmission to the General Public through Blood and Blood Products: For this purpose, a Behavioral Communication Change (BCC) based media campaign was carried out for the general population; key policy/decision makers; political leaders; faith-based organizations; and the Ministries of Education, Narcotics, and Religious Affairs. The National Blood Transfusion Safety Ordinance was also formulated and promulgated.

4. Treatment, Care and Support services for PLHIV and Capacity-Building: Eleven ART centers were established at the time throughout the country for provision of free HIV diagnostics, ARV drugs, other medical care and support services to PLHIV. Capacity building was a cross-cutting component of the program and focused on both the public and NGO sectors involved in the implementation of interventions.

During Phase II, the 'National HIV/AIDS Policy Document' was developed with UN support with the aim of providing an enabling environment for HIV/AIDS prevention and care programs and services through a multi-sector approach at all levels of government and community. The 'HIV/AIDS Prevention and Treatment Act, 2007' was also formulated, which was meant to establish National and Provincial AIDS

Coordination Committees to provide a multi-sector forum for coordination of the national and provincial response. This act also supported the Government in providing HIV-specific information, care, support, equitable access to treatment and stigma/discrimination reduction for PLHIV, risk and vulnerable populations that have quasi-legal status as well as families and clients.

National Response, Phase III: 2008-2010

Following a Mid-Term Review (MTR) and a Situation and Response Analysis (SRA) of the national response to the HIV epidemic of Pakistan and consultations with stakeholders from the Government sector, UN agencies, multi and bi-lateral donors, service delivery organizations from the NGOs, and the Association of PLHIV, the second National Strategic Framework (NSF-II) was developed for 2007-2011.

The goal of NSF-II was "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" by "scaling-up effective national response to the threat of HIV and AIDS". The four major strategies outlined in this framework included: 1) creation of an enabling environment, 2) strengthening of the institutional framework, 3) building-up capacity, and 4) scaling-up program delivery. The priority areas of the AIDS program were increased from nine to twelve. New areas added included (10) Institutional Arrangements, (11) Commodities and Procurement, and (12) Management Information Systems.

In 2008, EHACP completed its five years of implementation. By then, the HIV response in Pakistan had evolved to a coordinated and multi-sector level. A brief summary of observations at that stage includes:

1. At the highest point of implementation, about 40% of the PWID and less than 15% of the three above-mentioned categories of sex work were being accessed by HIV prevention service-delivery programs.
2. Essential ARV medicines had been provided until 2008 by the GFATM R2 and later through the 'Continuation of Services' proposal of the same grant, until May 2010. Un-interrupted provision of this vital service was essential.
3. Scaling-up of safe blood transfusion was needed.
4. Increasing prevalence of HIV among partners and families of PWID suggested the need for comprehensive services for all Key Affected Populations.
5. Capacity building of program staff was essential, especially in the fields of research, surveillance, M&E and procurement.

Therefore, in order to meet the MDG Goal 6 by the year 2015, the PC-1 plan of the EHACP was revised in 2009-2010 to urgently to scale-up program interventions. An initial plan-of-action for US$ 99.4 million was approved by the World Bank and DFID, but could not be delivered as the focus and funds were channeled towards national disaster management relief and rehabilitation following the devastating floods of 2010. With Government resources at federal and provincial level and support from UN agencies and International NGOs, maintaining and scaling up of program interventions was carried out but at a much lower level than initially envisaged.

Key achievements during Phase III:

- HIV/AIDS was included for the first time as a priority area in the National Health Policy of 2009, with PWID, MSW, FSW and HSW identified as most-at-risk populations.
- Approval for Global Fund R9 grant of a total amount of US$ 43 million with NACP and Nai Zindagi as Principal Recipients, thereby ensuring funding till 2015.
- An "HIV/AIDS Safety and Control Bill 2009" was proposed.
- A Supreme Court of Pakistan ruling in 2009, and its implementation in 2010, giving Hijra complete citizenship rights and registered as a 'third Sex', designating their gender on national identity papers which was to enable them to access the services of state social welfare departments and financial support programs.

National Response, Phase IV: 2011 onwards

The 18th Amendment to the Constitution of Pakistan was passed by the National Assembly in April 2010. Under the 18th Amendment Bill, the devolution plan of 17 Federal Ministries, including the MoH, from the national to provincial levels was implemented in progressive phases in 2011 achieving full devolution by 30th June 2011.

The MoICP of the GoP was assigned to coordinate between the provincial and federal governments in the economic, social and administrative fields. The mandate and resources pertaining to the national vertical programs, including the NACP, were to be handed over to the Provinces for complete autonomy and authority for direct implementation. However, funding will remain with the federal government through the IPC Ministry until the end of the of the National Finance Committee (NFC) award (i.e. 2014-15) with the commitment that expenditures will continue without any gap as far as the direction of the program is concerned. As per the Constitution, the role of coordination lays with IPC Ministry who will also be responsible for inter-provincial coordination.

To this effect, the role of NACP has been reduced. While some other national vertical health programs were completely devolved in 2011, given that AIDS, Tuberculosis and Malaria programs were recipients of Global Fund grants, they have been exceptionally maintained with specific Terms of Reference (ToRs). These include: (1) To act as the Principal Recipients for all Global Fund-supported health initiatives; (2) To prepare proposals and liaise with international agencies for securing support of such partner agencies; and (3) To provide technical and material resources to the Provinces for successful implementation of disease control strategies and disease surveillance.

Pakistan AIDS Strategy, 2012 - 2016

The NSF-II completed its five-year time-frame in December 2011. The NSF-III is therefore currently being developed, the process for which started in late 2011. Due to devolution, each Province is developing its

own provincial AIDS strategy tailored to their specific context with costed action plans. The final document will be a consolidation of the four provincial documents under one overarching framework entitled the Pakistan AIDS Strategy-III (PAS-III). The context of the PAS-III will be in line with the overall health and development strategies as well with international commitments and MDGs.

The main goal of the PAS-III 2012-2016 is to prevent new infections, and to improve health and quality of life of people living with HIV which will be achieved through grouping strategies under three main objectives:

- Increase the quality and coverage of HIV prevention services;
- Increase the quality and coverage of HIV diagnostic, treatment, care and support services; and
- Improve response management at national, provincial and local levels.

The strategic priorities reflected in the PAS-III 2012-16 differ from past strategies in that they are:

- Based on a more decentralized strategy of development and response management.
- Place greater emphasis on reducing cost and increasing cost-effectiveness in the context of reduced international HIV resources.
- Emphasizes an even more targeted response dealing with a concentrated epidemic among Key Affected Populations.
- Aim to rationalize intervention design based on international evidence and local lessons learned.
- HIV will be introduced into and mainstreamed in health and social services, work plans and budgets.
- New ways will be identified of working with and strengthening civil society and community participation.

The guiding principles of the PAS-III are the following:

- Prioritization: The PAS-III is based on a prioritized approach in order to remain effective and feasible. Priorities are weighted, which means that certain strategies may be conditional on availability of additional resources.
- Evidence based: Priorities are based on evidence from epidemiological, public health and social research from Pakistan, the region or globally.
- Results based: It includes specific, measurable, specific and achievable objectives with targets based on the Universal Access principle as well as other international and national commitments.
- Efficiency and sustainability: Globally, resources for HIV responses are decreasing and the same is observed for Pakistan. One overall strategy of the PAS-III is to increase sustainability, reduce reliance on external funding and integrate AIDS-related services into health and social welfare systems.

- Participatory: The strategy is developed with inputs from all relevant stakeholders, including local, provincial and federal authorities, civil society including PLHIV and the affected communities, and development partners.
- Gender sensitive: Gender is an important determinant for vulnerability to HIV infection and access to HIV services, and has therefore been particularly focused in this strategy.

Global Fund Round 9

The GFATM grant proposal for Round 9 (R9) was a resubmission of the R8 proposal and was prepared through participatory consultative processes involving a broad range of stakeholders. Pakistan has two PRs for this grant, namely NACP and Nai Zindagi. The grant was designed to assist Pakistan's transition towards more comprehensive coverage of HIV services. The goal is to reduce HIV-related morbidity and mortality -- i.e. reduce burden of HIV. The expected outcome of the grant is improved access to the 'Continuum of Prevention and Care' (CoPC) for PWID and their spouses and 'Community and Home Based Care' (CHBC) for PLHIV and associated populations. It also links with key services already in place such as PPTCT already established under phase III.

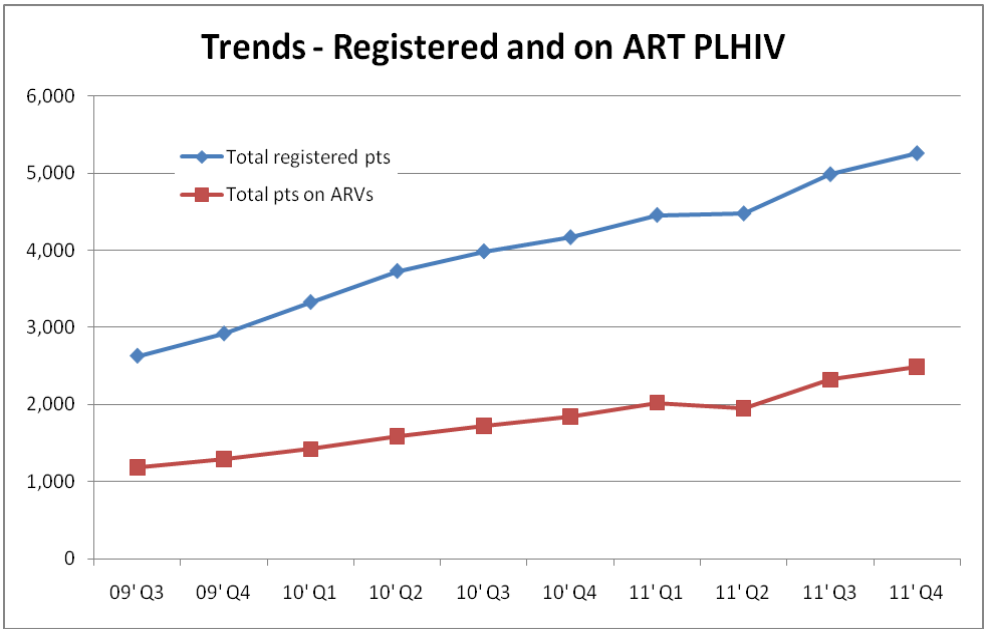
Under Objective 1 of the grant proposal, services will be provided to 28,000 PWID (31% of the estimated total need) as well as for 2,800 spouses and partners of PWID in Punjab and Sindh Provinces—that together account for around 95% of Pakistan's total PWID population. The package for PWID is largely community-based and will be delivered by seven Sub-Recipients (SRs) to cover unmet needs in 24 cities and surrounding rural communities. Nai Zindagi is the PR for Objective 1.

The Objective 2 of the grant proposal will offer means to access HIV care and support to 24,000 PLHIV and associated populations (i.e. Care and support for 6,000 PLHIV and 18,000 family members and ARV treatment for 2,000 PLHIV). This would be provided through CHBC and the ART centers which now number 17. Furthermore, seven (7) existing CHBC sites that are either operated by or involving considerable participation of PLHIV and the opening of an additional 23 new sites in underserved districts, will serve as entry-points to gender sensitive care and support, including psycho-social support; ART, PPTCT and pediatric care referral; VCCT; nutritional support; and linkages to social services.

In total, 54 community-based sites (CoPC and CHBC) will provide outreach for the prevention and referral services to PWID, PLHIV and other segments of population from Key Affected Populations. CoPC and CHBC packages are designed to complement each other with strong cross referral supported through community-based human resource and logistic support for the PWID, PLHIV and associated populations.

The Objective 3 of the grant proposal aims at strengthening of the National and Provincial AIDS Control Programs, as well as NGOs and PLHIV organizations towards effective implementation of Global Fund R9. Human resources and logistics have already been provided to the programs in 2011, particularly in the context of Monitoring and Evaluation. The NACP is PR for the objective 2 and 3. It will implement these Objectives through 5 SRs which were selected at the time of proposal submission.

By 2009, the estimated total population of PLHIV in Pakistan was around 98,000. Relative to this estimate, the number of registered PLHIV within the health care system, while markedly increasing in 2010-2011, remains low. According to the NACP, by December 2011 there were 5,256 PLHIV registered in 17 ART centers, including 4,047 adult males, 1,018 adult females and 189 children. Out of these, there were 2,491 PLHIV on ART, including 1,740 adult males, 646 adult females and 105 children[11]. Looking at trends, there is a gradual increase in the number of persons registered at ART centers and on ART. On an average, there was about 40-45 new persons on ART every month in 2011.



Role of NGOs and CSOs

Since the beginning of the coordinated response to the HIV epidemic in Pakistan, service-delivery interventions have been implemented largely by a consortium of NGOs and CSOs under a private-public partnership. The crucial and integral role of NGOs and CSOs is based on their comparative advantage of accessing and providing services to marginalized populations, most of the latter having have a quasi-legal status, in a focused manner. The success of their service-delivery implementation hinges on establishing close contacts with concerned community members starting at the grass root level and extending to district, provincial and in some cases, national levels.

The number of members of this consortium has increased substantially from initially a handful to approximately currently over 50 dedicated AIDS-organizations or those with a focus on HIV or specific populations across the country in the area of HIV prevention, treatment, care and support. A number of CSOs providing care and support services in collaboration with NACP are PLHIV organizations, some of

[11] *http://www.nacp.gov.pk/program_components/hiv_prevention/hiv_care*

which are founded and headed by PLHIV themselves. The National Association of PLHIV (APLHIV) was formed in 2007 and has now burgeoned into setting-up four provincial chapters. The key role of the APLHIV 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. The APLHIV has evolved rapidly and today plays a more important role in the national and provincial AIDS responses: it is a sub-recipient of the Global Fund R9 and a regional Global Fund R10. Other CSOs – including among transgender, men who have sex with men and sex workers – are being supported either through the GFATM regional grant for men who have sex with men in South Asia, international NGOs and the UN though as yet have not a unified and coordinated approach. There are several CSOs who are PRs and SRs of Regional Global Fund R9 that have initiated activities in 2011.

CORE INDICATORS FOR GLOBAL AIDS RESPONSE PROGRESS

Target 1: Reduce sexual transmission of HIV by 50 per cent by 2015

Indicator 1.1:

Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

This indicator is relevant, but complete data is not available in Pakistan since population-based demographic or other national surveys do not include this question to unmarried men and women based on concern with socio-cultural acceptability. In the previous report, partial data on this indicator was reported from the Demographic Health Survey (DHS) 2007 where 'ever-married women' were asked the concerned questions under this indicator. In the current reporting period, there has been no updated DHS survey hence this indicator is not reported on.

Indicator 1.6:

Percentage of young people aged 15-24 who are living with HIV

Since 2003, Pakistan has been classified to be in a *'concentrated'* phase of the HIV epidemic and has not reported on this indicator. However, during IBBS 2011, HASP of the NACP and the provincial AIDS programs conducted a survey on antenatal clinic attendees in 9 districts in all four Provinces of the country to understand the HIV status among general population. The districts included 5 'high' and 4 'low' HIV prevalence districts, with a total sample size of 26,510 antenatal clinic attendees from 41 health facilities/Antenatal Clinics (ANC). Any pregnant woman between 15-49 years of age attending regular antenatal services in one of the selected ANC clinics and having her first haematological screening at the ANC facility during the study period was selected for participation in the study. The HIV tests were carried out on blood from pregnant women coming for routine antenatal tests and socio-demographic data was obtained from the ANC cards used by the health facility. Out of the total 26,510, around 34.3% (9,095) women were in the age bracket of 15-24 years with an HIV prevalence of 0.044% -- i.e. 4 confirmed positive out of 9,095. The overall HIV prevalence was 0.045% - i.e. 12 confirmed positive out of 26,510.

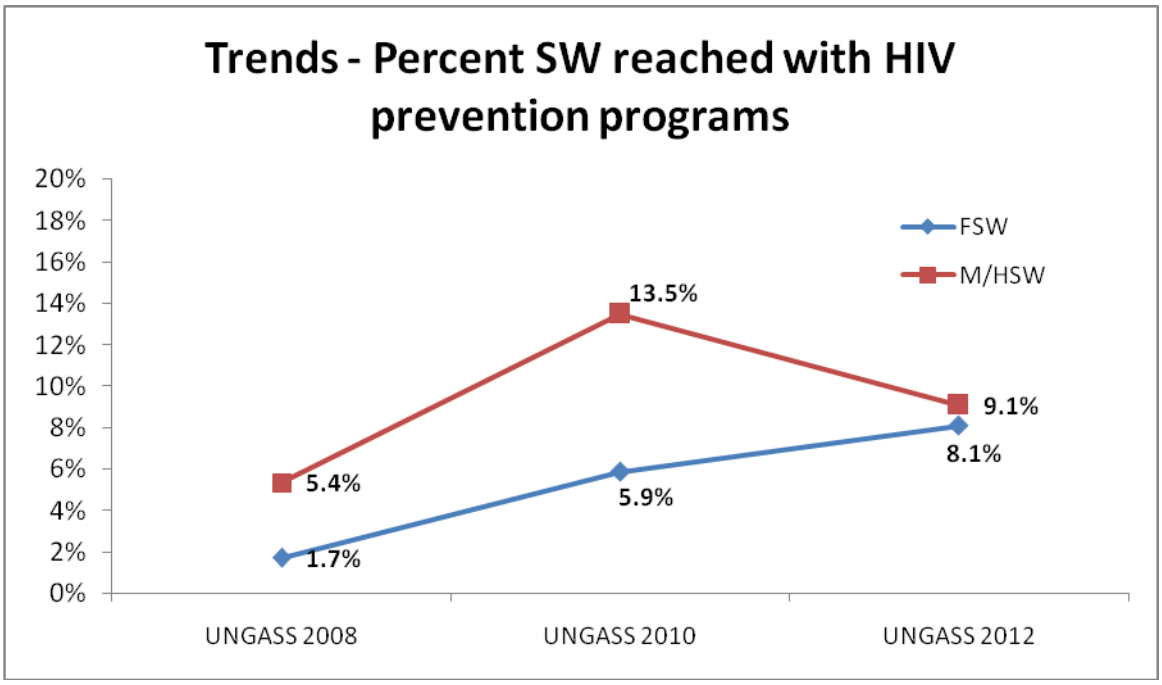
This indicator is relevant but complete data is not available in Pakistan since all population-based demographic or other national surveys do not include this question to unmarried men and women based on socio-cultural acceptability. In the previous UNGASS report, partial data on this indicator was reported from the Demographic Health Survey (DHS) 2007 where 'ever-married women' were asked the concerned questions under this indicator. In the current reporting period, there has been no updated DHS survey hence this indicator is not reported on.

Indicator 1.7:

Percentage of sex workers reached with HIV prevention programs

This indicator measures progress in implementing HIV prevention programs among sex workers. Pakistan reported on this indicator in UNGASS 2010, but with slightly different definitions for the enumerators compared to the indicator guidelines. These statements were modified in the IBBS 2011 round and data was captured on both the questions required for this indicator - i.e. *"Do you know where you can go if you wish to receive an HIV test and in the last twelve months?"* and "*In the last month, have you been given condoms?"* However, in the second question the period of 12 months was replaced by last month.

The data on this indicator (percentage of sex workers who answered "Yes" to both questions) clearly indicates that the overall coverage for sex workers is low - i.e. 8.7% (<25= 7.5%, 25+= 9.9%). For FSW, it is around 8.1% which is slightly higher than the last reported figure and for M/HSW it is 9.1% (MSWs= 5.2%, HSWs= 12.9%) - slightly lower than the last reported figure. Looking at the individual answers, the reported figures are higher – i.e. 18.7% sex workers answered "Yes" to question 1 - i.e. *"Do you know where you can go if you wish to receive an HIV test?"* and 17.8% answered "Yes" to question 2 - i.e. *"In the last one month, have you been given condoms?"*

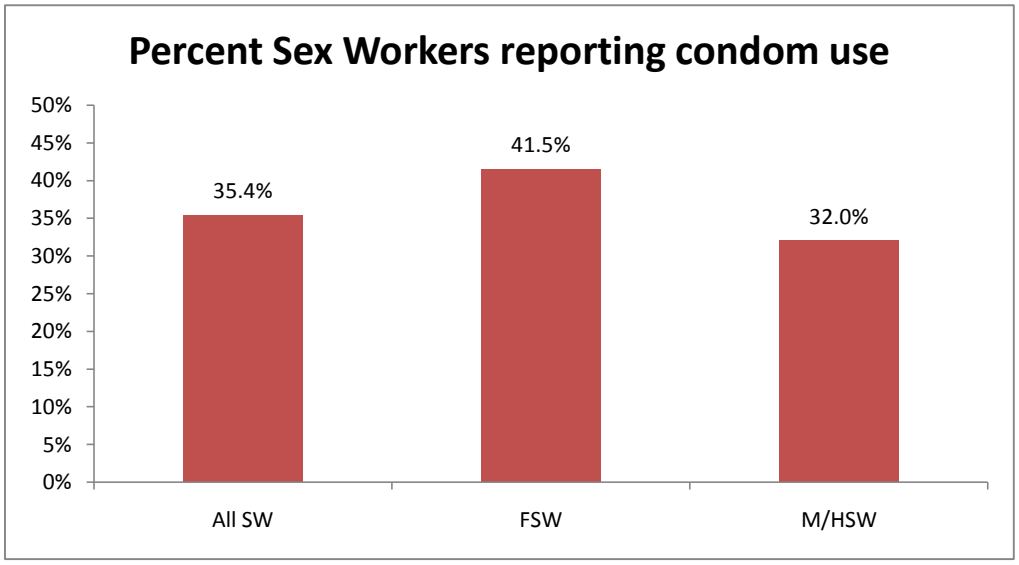


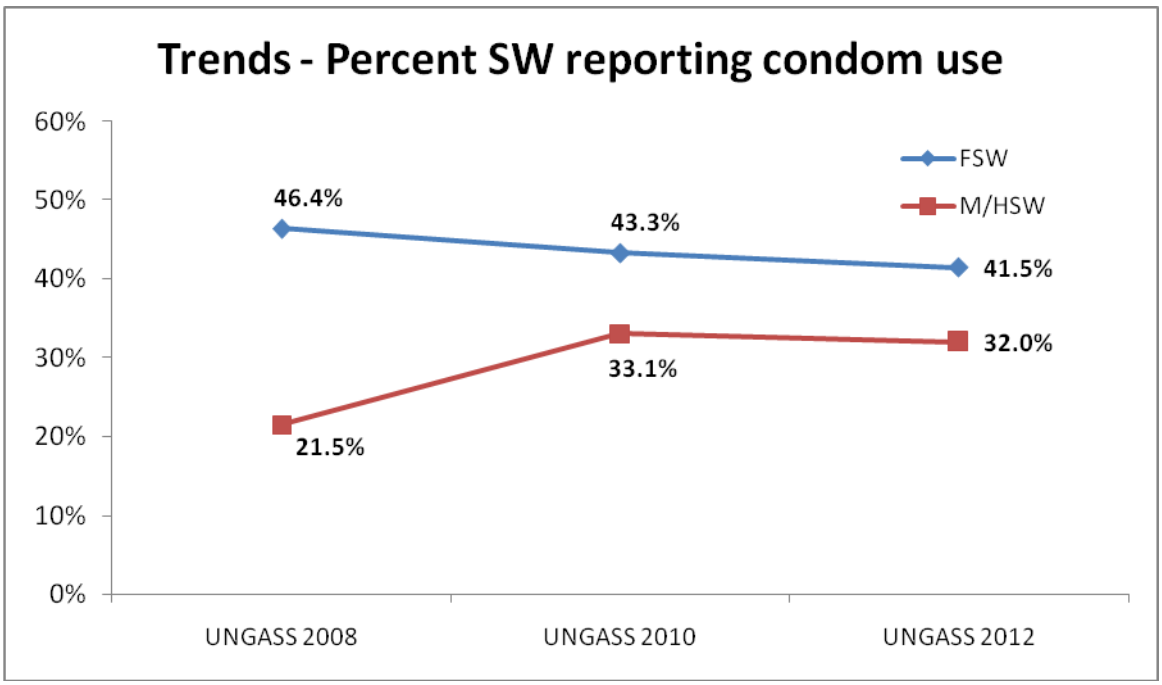
Indicator 1.8:

Percentage of sex workers reporting the use of a condom with their most recent client

The IBBS 2011 mapped sex workers in 17 major cities of the country. The exercise to extrapolate from this mapping to update national estimates of sex workers is under progress. The reported condom use for all sex workers was 35.4% (<25= 33.3%, 25+= 37.2%) and not much different from the last reported figures. Around 41.5% reported condom use with their most recent client. However, only 33.2% FSWs reported that they always used a condom with their clients in the last month, with brothel-based FSWs reporting substantially higher condom use than all other categories of FSWs. It was also observed that the overall condom use declined with age and there was an inverse relationship between education and consistent condom use. The longer the number of years in school, the more consistent condom use was.

Condom use with most recent client among M/HSWs was around 32%. Looking at the two sub-groups separately, among MSWs condom use with most recent client was lower (27.3%) compared to HSWs (36.4%).





Indicator 1.9:

Percentage of sex workers who have received an HIV test in the past 12 months and know their results

Starting from 2003-2004 until 2008-2009, the National and Provincial AIDS Control Programs implemented various HIV prevention service-delivery projects for sex workers through public-private partnership. The provision of VCCT was envisaged as an integral component of these prevention programs. However, this could not be achieved across the country due to various reasons. Accordingly, the VCCT provision and its uptake remained low. In addition, Global Fund R2 HIV project supported the establishment of 16 stand-alone VCCT sites in the country, but their utilization and yield of positive case detection also remained low due to lack of a revision of the strategy in place.

The data for this indicator is regularly collected through IBBS rounds in the country. In all previous IBBS rounds, the data for this indicator was collected on being 'ever tested' rather than 'tested in last 12 months'. However in 2011, the questionnaire was modified to include a question on testing status in last 12 months.

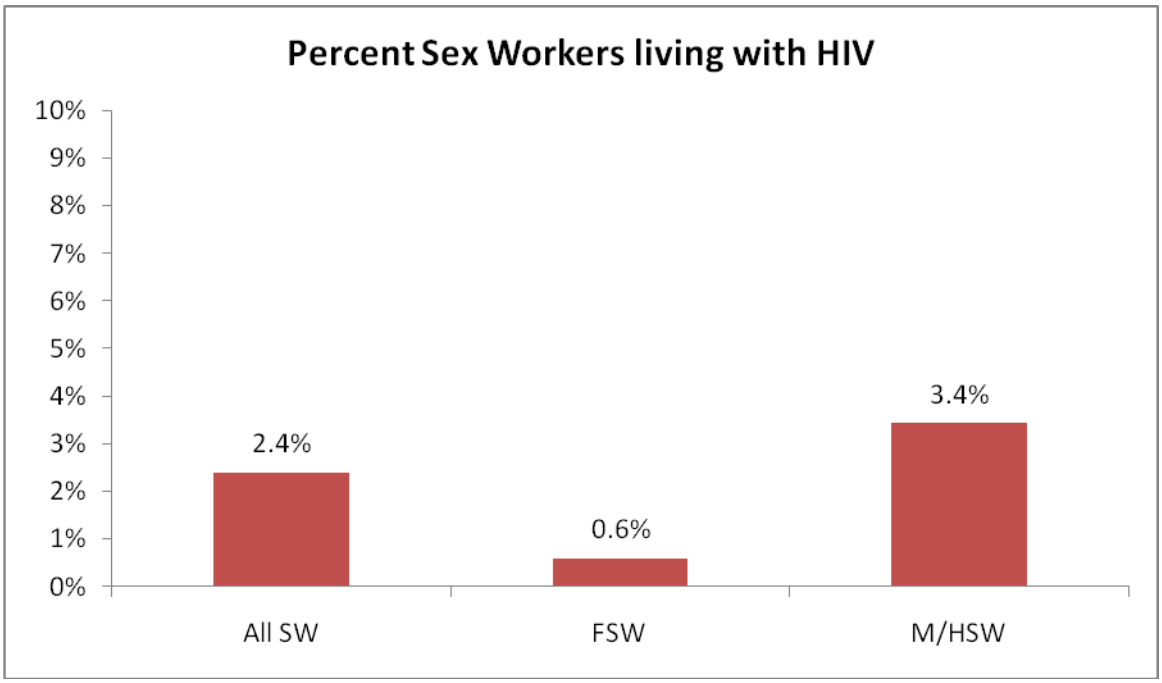
The results on this indicator clearly demonstrates that the VCCT uptake among sex workers in Pakistan is low -- i.e. out of 11,758 sex workers surveyed in last IBBS round only 948 (8.1%) reported receiving an HIV test in the past 12 months and knew their results. Looking at age breakdown there was not much difference among those who were <25 (6.2%) and +25 (7.4%). The results also indicate the highest figure is among Hijra with 13.9%. The trend analysis of this indicator depicts that there has been a further decline in the VCCT uptake after the closure of EHACP service-delivery projects for sex workers

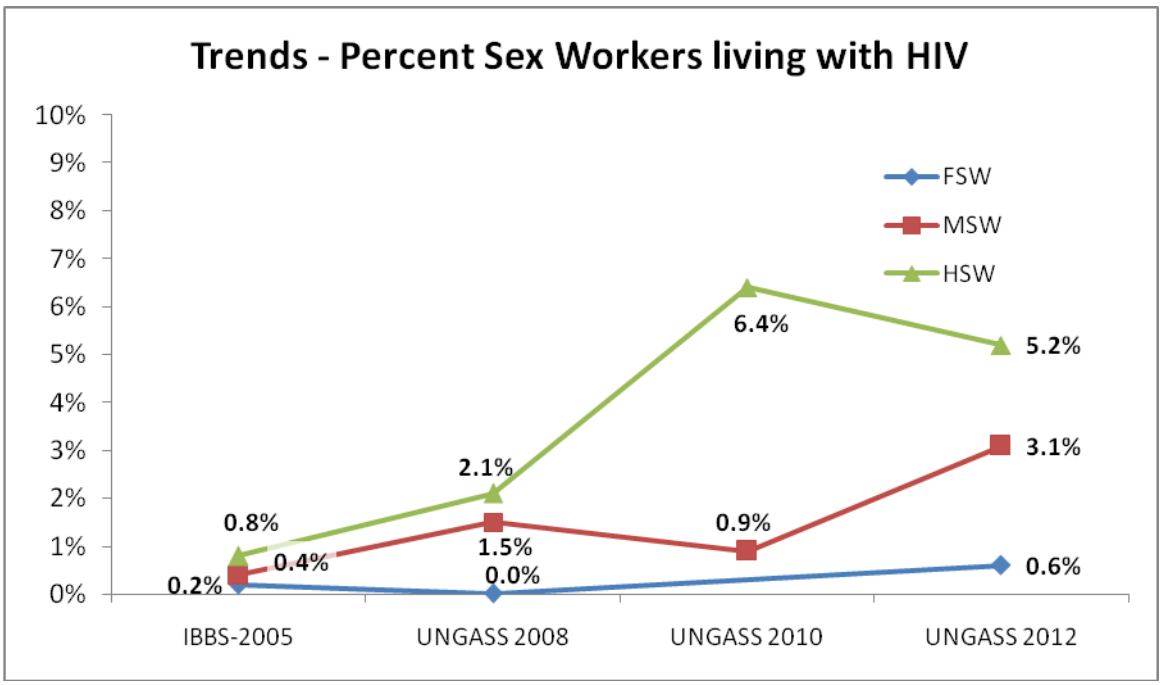
across Pakistan. As mentioned above, at present there are service-delivery projects for sex workers in country running through support from UNFPA and other partners. However, their scale is limited to have an impact on the epidemic and results of these indicators at national level.

Indicator 1.10:

Percentage of sex workers who are living with HIV

Unlike the classical Asian Epidemic Model, where HIV, after taking root among PWID, spreads to FSWs, in Pakistan it is partly 'bridging' to HSW and MSW. IBSS 2011 round reported 2.4% HIV prevalence among all sex workers with slight difference among those aged <25=. 2.2% and +25= 2.6%. As previous trends, it remained low among FSWs - i.e. 0.6%, with more cases detected in the Province of Sindh compared to other Provinces. The combined result for M/HSWs was 3.44%, with higher prevalence among HSWs (5.2%) compared to MSWs (1.6%).





Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015

Indicator 2.1:

Number of syringes distributed per person who injects drugs per year by needle and syringe programs

Injecting drug use is the main driver of the HIV epidemic in the country. Under the EHACP, numerous harm reduction service-delivery projects were implemented for PWID. However, earlier achievements need to be sustained. At present, harm reduction programs are under implementation through GoP, UN and international NGO support in several districts, and beginning in 2012 they will be mostly supported under the GFATM R9.

Current scale of coverage is lower than the Universal Access targets making it difficult to impact on the epidemic. The provision of harm reduction services through Global Fund CoPC sites has just been initiated in numerous districts in the provinces of Sindh and Punjab. Through CSOs, the provincial AIDS control programs in Punjab and Sindh have also mobilized additional resources for harm reduction.

Data collected from CSOs from across the country providing Needle and Syringe Exchange indicated that in the past 12 months 3,856,659 syringes were distributed amongst 18,488 PWID registered under their organizations. Using 91,000 as the estimated number of PWID in the country as a denominator, 42 syringes are being distributed per person per year.

Indicator 2.2:

Percentage of people who inject drugs who report the use of a condom at last sexual intercourse

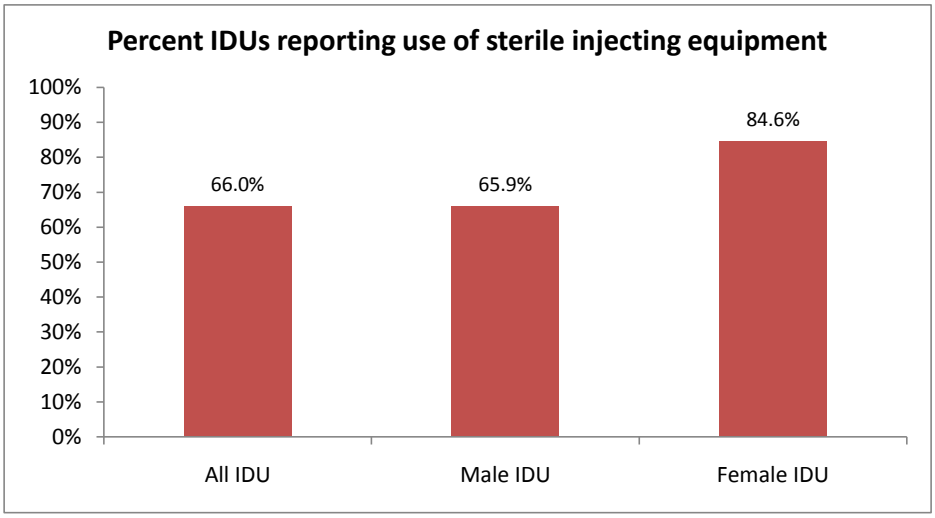
The IBBS 2011 reported 22.6% PWID using a condom during last sexual intercourse (<25= 21.9%, +25= 22.7%). The reported condom use was much higher in female PWID - i.e. 45% compared to male PWID - i.e. 22.3%. However, the study included very small number of female PWID (N=39). Looking at trends, there is a decline in the reported condom use during last sex among PWID and this may be related to coverage of harm reduction services for PWID across the country.

Indicator 2.3:

Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected

Almost three quarters (71.5%) of PWID reported injecting between two to three times a day in the past month, while 21.1% reported injecting more than three times a day in 2011. The mean number of injections per day ranged from 1.5 to 3.3 injections across cities. A phenomenon of interest observed was the role of '*professional injectors/street doctors'* in injecting practices. The 2011 results indicate that about two-thirds of all PWID reported that they had sought help from these *professional injectors/street doctors.*

The results from all survey IBBS rounds show that poly-drug use is common in Pakistan and different types of opiates, anti-histamines, narcotic analgesics, psychotropic drugs and heroin are injected. Overall, 38.6% of PWID reported that they always used a new syringe in past month with substantial variation across cities. Despite that harm reduction services were being implemented at a lower scale across the country in 2011, 66% PWID reported using sterile injecting equipment the last time they injected. This proportion was higher among females 84.6% (33/39) as compared to male PWID (3,239/4,917). Looking at trends, these figures are lower than the UNGASS 2010 reporting and also reflect the decreased coverage and availability of harm reduction services across the country after the withdrawal of donor funding.



Indicator 2.4:

Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results

The HIV/AIDS risk and harm reduction programs, through public-private partnership, have remained the mainstay of the response in Pakistan. These projects have significantly contributed to improving the HIV knowledge and practices of Key Affected Populations. Accordingly, IBBS 2011 indicates that around 86.7% of PWID had heard of HIV/AIDS. Among them, 87.2% knew that HIV can be transmitted by sharp instruments/needles (syringes) and 83.3% were aware of sexual intercourse as a mode of transmission. Results also indicate that around 64% believed that they were at risk of acquiring HIV, but only 32.8% knew of a place where they could undergo testing for HIV.

Among all PWID surveyed in this round, 9.1% had received an HIV test in the past 12 months and knew their status whether positive or negative. Among male PWID, only 8.8% (321/3,637) received an HIV test in past 12 months and knew their status. Among females, the ratio was comparatively high - i.e. 48.8% (15/31) and this may be due to the small sample size.

Indicator 2.5:

Percentage of people who inject drugs who are living with HIV

The HIV epidemic in Pakistan is mainly concentrated among PWID. Since 2003, there have been a number of studies indicating considerable infection among this group and recent studies indicate a growing geographical spread as well. The results also indicate significant network interactions among PWID and sex workers leading to potential 'spill-over' of HIV between different populations. The overall

prevalence of HIV among PWID was 27.2% (weighted= 37.8%). Among male PWID, it was 27.3% (1,341/4,914) and among female PWID it was 17.9% (7/39).

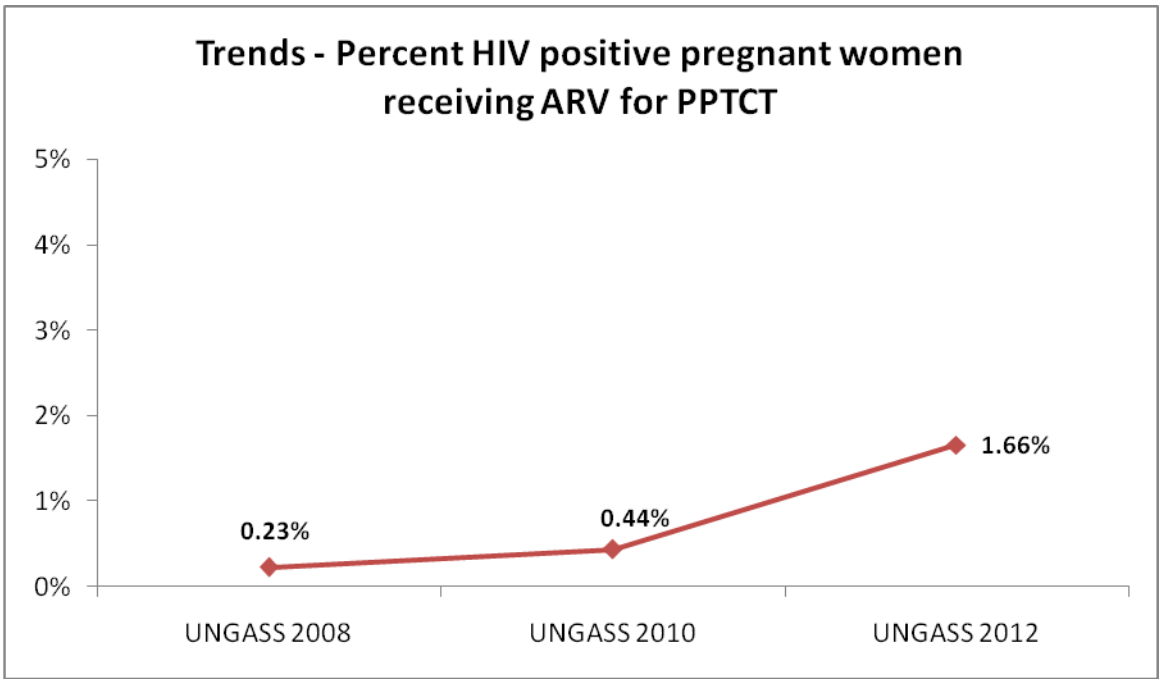
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal death

Indicator 3.1:

Percentage of HIV positive pregnant women who receive Anti-Retrovirals to reduce the risk of mother-to-child transmission

In Pakistan, the PPTCT program for HIV positive pregnant women was initiated in early 2007 and now has a total of 7 PMTCT centers in major cities across the country. The first National PPTCT Guidelines were developed in 2006 and revised in October 2011. So far, a cumulative of 122 HIV infected pregnant mothers has been registered and availed or are still availing treatment. Of these, 90 women delivered live babies, 9 miscarried and 23 are pregnant. Of the 90 babies, 4 tested positive, 56 negative and 30 either await the results or could not be tested for logistics reasons. Pakistan is in the infancy of this service-provision therefore the total number of registered mothers is low as compared to the estimates.

For reporting on this indicator, the denominator was estimated using the recent Spectrum methodology and, as per these estimates, there were 3,418 HIV infected women in the country in 2011 eligible to receive PMTCT services. Of the registered HIV-positive pregnant women, 66 were/or are on ART and 53 received and/or are receiving Maternal Triple ARV to reduce the risk of mother-to-child transmission.



Indicator 3.2:

Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth

This is new indicator for GARP reporting. The data for this indicator has been obtained from 7 PPTCT centers established across the country. According to the requirement of this indicator of testing of infants <2 months, 8 infants were born to 41 HIV positive women (19.5%) who received a virological test for HIV within 2 months of birth and all were found to be negative.

However, of the 41 live births in the last 12 months, a total of 23 infants (56%) inclusive of <2 months, were tested out of which 2 test results were positive, 16 negative and 5 are awaiting result reports; 18 infants could not be tested due to logistic issues. The HIV testing facility is available in all PPTCT centers across the country and almost all infants born are tested for HIV as per national PPTCT guidelines.

Indicator 3.3:

Mother-to-child transmission of HIV (modeled)

This indicator measures the efforts made to prevent mother-to-child transmission of HIV. The PPTCT centers have been established in both public and private sector hospitals and are closely linked to 17 ART centers providing free ART-related services to the PLHIV. Considering the fact that Pakistan is in concentrated phase of the HIV epidemic, there are very few HIV positive pregnant females who have been accessed through VCCT or community-based services, and further efforts are needed to bring these figures closer to the estimated need.

The data for this indicator has been generated using the Spectrum model and according to this there were an estimated 3,418 HIV positive women who delivered in the previous 12 months with an estimated 1,239 newly infected children due to mother-to-child transmission - i.e. there would be an estimated 36.2% infections among children from HIV-infected women who delivered in the past 12 months.

In comparison to the 2010 report, the Spectrum modeled figure of estimated pregnant positive mother was calculated at 5,663 then. The difference in figures obtained could be attributed to the up-dated versions of Spectrum available in the current reporting period as well as the fact that the estimate had input from ANC data which was not available in the previous reporting period.

Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2011

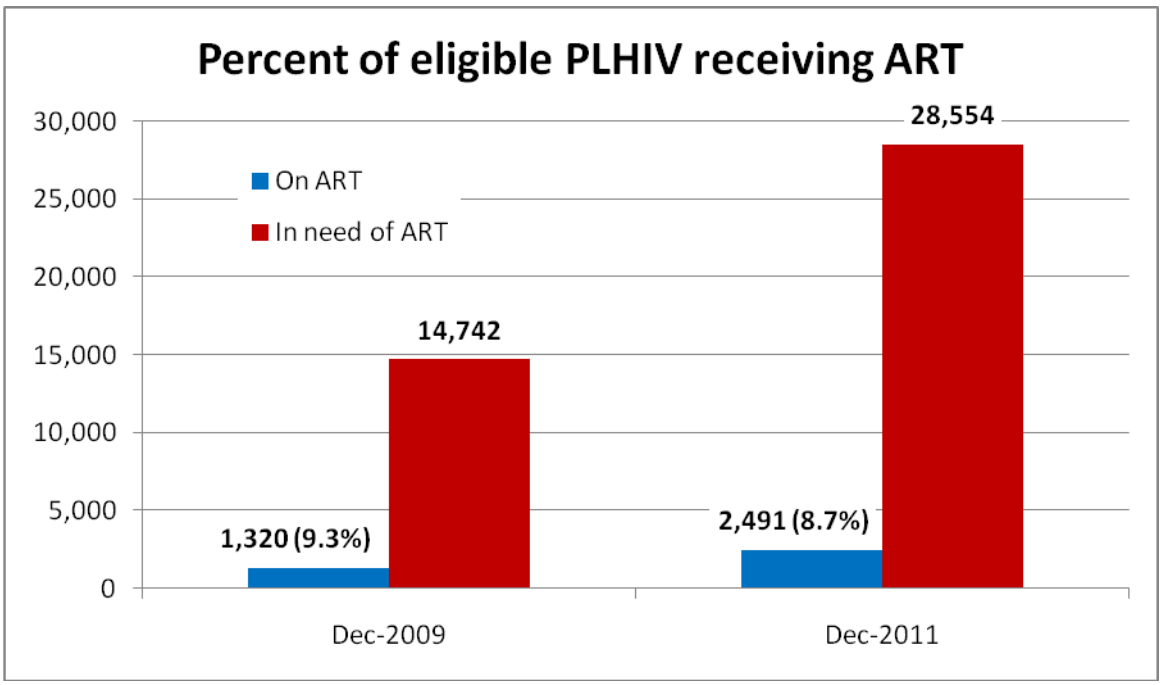
Indicator 4:

Percentage of eligible adults and children currently receiving antiretroviral therapy

The provision of ARV to PLHIV in Pakistan started in 2005 in the public sector under the EHACP and with the support of the GFTAM R2. The program envisaged establishing five ART centers in five major cities of the country, including the four provincial capitals. However, the program expanded as per need of the PLHIV and at present there are 17 functional ART centers across the country both in public and private sector providing free ART services to PLHIV.

Till date, the NACP is responsible for procuring and distributing ARV across the country. These ARVs since 2005 have been mainly procured through Global Fund R2, DfID funding and some funding from the 'One UN" in gap periods. From 2012 onwards, Global Fund R9 grant would be used for procurement of ART until the completion of phase 1 of the grant. USAID has committed to support provision of kits for HIV testing, CD4 and viral load testing for next two years.

By December 2011, there were 5,256 PLHIV registered with 17 ART centers, including 4,047 males, 1,018 females and 189 children. Out of these, there were 2,491 PLHIV on ART including 1,740 males, 646 females and 105 children. Looking at trends there was a gradual increase in the number of PLHIV who were registered at ART centers and put on ART. On average, there were about 40-45 new PLHIV put on ART every month in the year 2011. The data for denominator of this indicator has been obtained using Spectrum estimates and there were around 28,554 PLHIV in the country eligible for ART with 2,491 at the end of December 2011 receiving ART – i.e. 8.7%.



Target 6: Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries

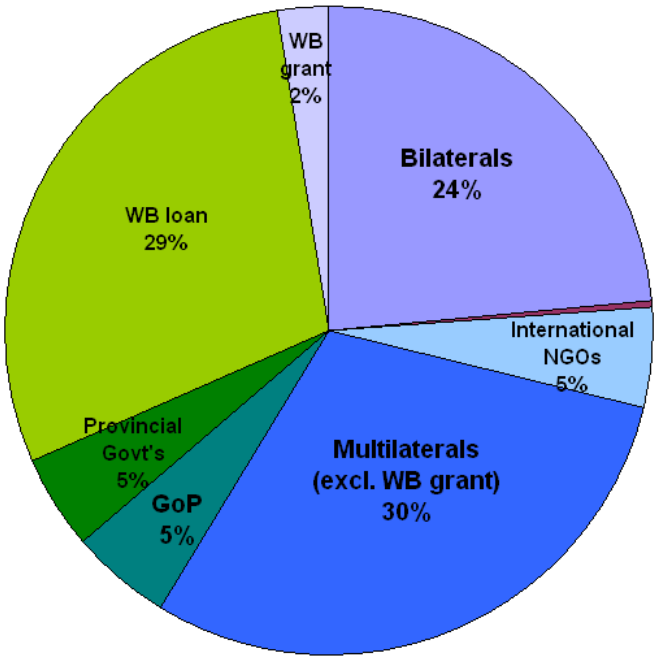
Indicator 6.1:

Domestic and international AIDS spending by categories and financing sources

Pakistan conducted its first National AIDS Spending Assessment (NASA) in 2011. The assessment focused on tracking national HIV expenditure for the fiscal period 1st July 2008 – 30th June 2009 and 1st July 2009 – 30th June 2010 to correspond to the Government fiscal year (FY). The total spending on AIDS in Pakistan in the period from July 2008 to June 2009 was 14 million US Dollars. Another 13 million US Dollars were spent in the next fiscal period from July 2009 to June 2010. Annually, Pakistan spends around 8 US Dollars on HIV activities in per capita terms.

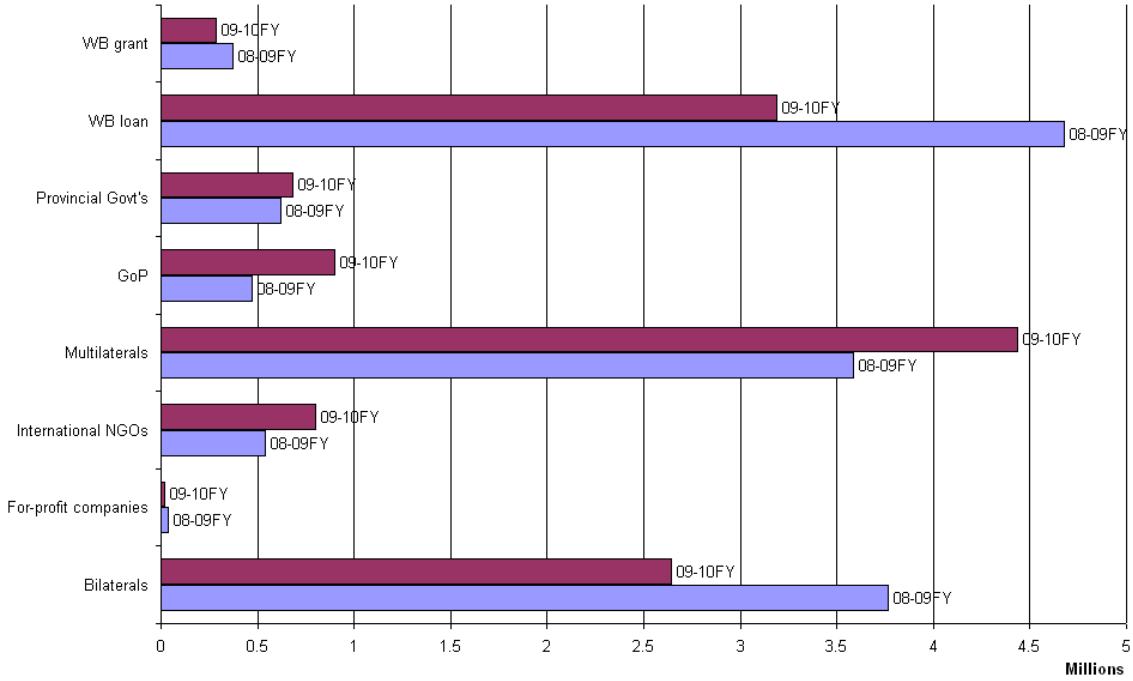
The HIV response in Pakistan largely relies on international financing sources which provided over 60% of funding over the two fiscal years. The loan of the World Bank remained the largest public source (29% of the HIV response). Multilateral funding covers the majority of HIV-related spending – 30% excluding World Bank grant (non-reimbursable). Bi-lateral sources contributing to the response included: Governments of Australia (1% **of** bilateral funds), Canada (24%), UK (30%), EU (<2%), Japan (<1%), Netherlands (<1%), Norway (6%), Switzerland (2%), Spain (1%), US (20%). Figure 2 shows the financing sources of the HIV response in Pakistan for both fiscal years.

Figure 2: Financing sources of the HIV response in Pakistan for both fiscal years



On comparing the two fiscal years, detailed analysis per year shows that the share of the World Bank loan significantly decreased – from 4.7 million US Dollars to 3.2 million US Dollars. However, the gap was partly covered by multilateral sources, mainly through UN agencies. The central budget contribution of the GoP almost doubled, while provincial budgets' share maintained the spending at the same level with some increase in absolute figures. Figure 3 shows a detailed comparative fiscal analysis.

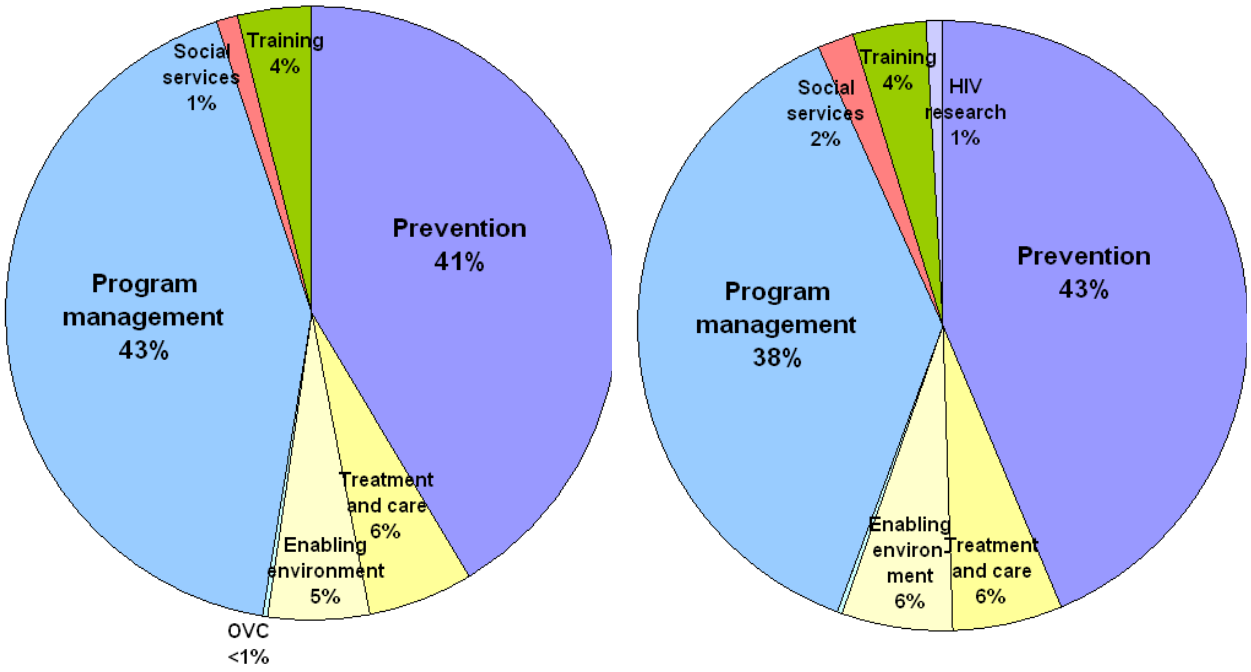
Figure 3: Financing sources of the HIV response in Pakistan: fiscal years analysis.



Analysis of the AIDS Spending Categories show Program Management and Prevention are the most funded programmatic areas in Pakistan. Figure 4 shows fiscal year analysis per programmatic areas.

Figure 4: HIV Response profile: main programmatic areas

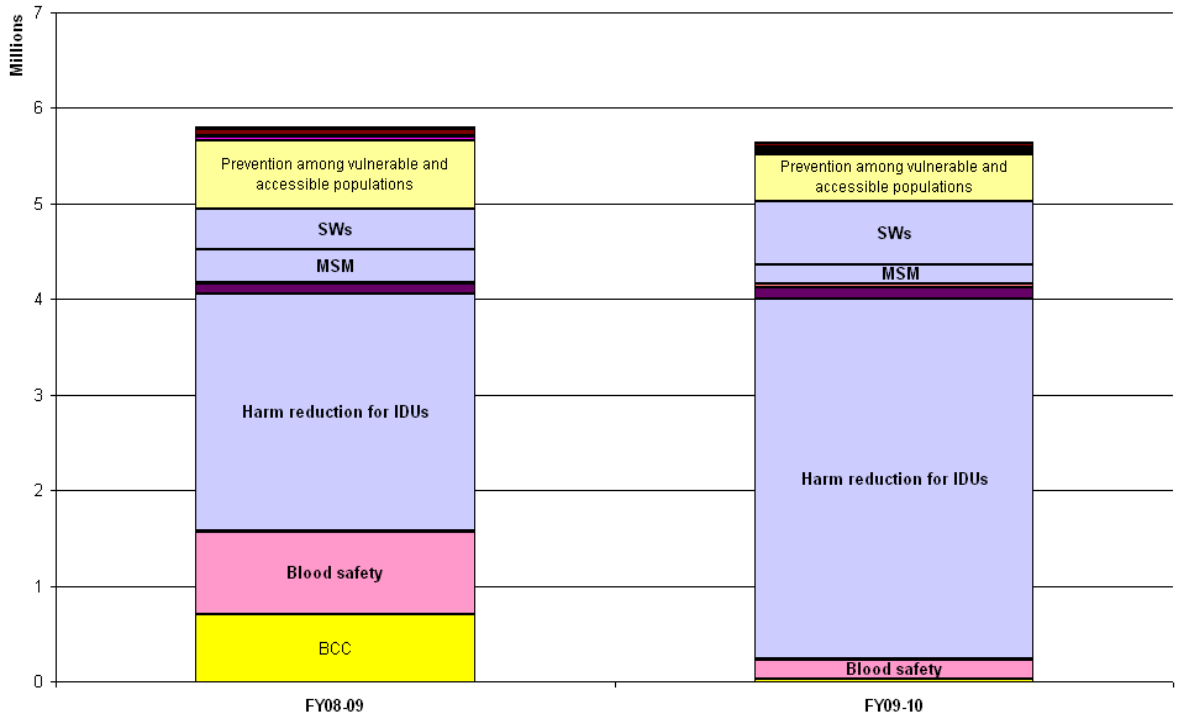
FY 2008-2009 **FY 2009-2010**



Program management includes spending on the activities and programs related to the coordination of the HIV response at the national and provincial level as well as the coordination of specific projects (not related to actual service-delivery), development of policies and guidelines, conferences, meetings of the stakeholders, etc. This category also includes expenses of the offices of the concerned international NGOs and bilaterals.

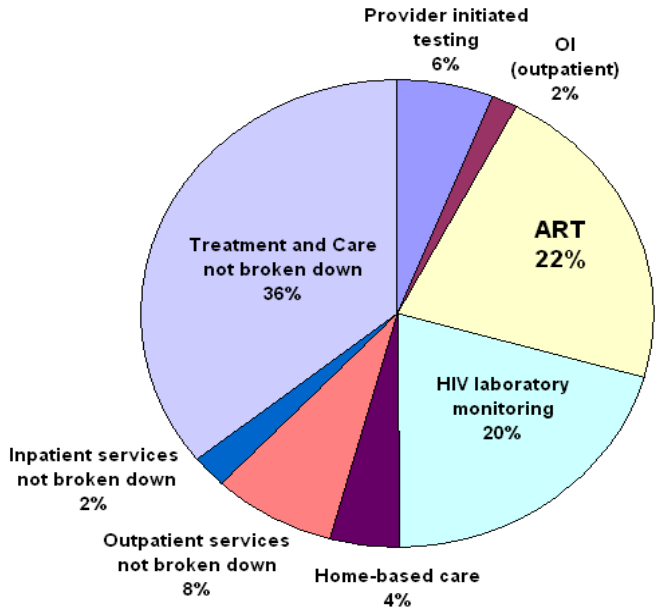
The overall spending for HIV Prevention slightly decreased during two years, although in the overall picture the share of this program increased from 41% in FY 2008-2009 to 43% in FY 2009-2010. Within this category, most of the funding went to harm reduction programs targeting PWID and their partners, especially in the FY 2009-2010 when it rose from 2.5 to 3.8 million USD. Blood safety spending dropped in the last fiscal year. Figure 5 describes prevention interventions in more details.

Figure 5: AIDS Spending Category – Prevention



Treatment, care and support amounts to only 6% of the overall spending each year and within this category ART is the most funded activity. Treatment and Care programs mainly consist of ARV and ARV-related laboratory monitoring (CD 4 counts, Viral loads) – 42% of the total treatment and care costs. Due to difficulties in identification of specific interventions, a substantial number were coded as Treatment and Care and not broken down further by type (Figure 6).

Figure 6. AIDS Spending Category – Treatment and Care



Target 7: Critical Enablers and Synergies with Development Sector

Indicator 7.1:

National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination and monitoring and evaluation)

Attached as Annex II

Indicator 7.4:

External economic support to the poorest households in the last three months

The Benazir Income Support Program was initiated in 2008-2009 for poverty alleviation and women's empowerment among the underprivileged segments of Pakistan society and implemented in all Provinces of the country. Evaluation of the level of wealth was undertaken by the Poverty Score Card survey – a scientific-tool based on Proxy Means Testing. According to these results and the budget allocated by the GoP to the Benazir Income Support Program, a cut-off value of 16.17 was determined below which 6 million household lived in the lowest wealth quintile. Of these, 2.5 million households were not eligible for support due to lack of country national identity papers. The remaining 3.5 million received a cash grant of PKR 1,000 per household which enhances a monthly household income of PKR 5,000 by 20%. This indicator is reported as 58.3% of the poorest households received external economic support in the last three months.

BEST PRACTICES

The HIV epidemic has evolved in the past decade to a concentrated stage among Key Affected Populations in Pakistan. Throughout this period, the following best practices are to be noted:

Harm Reduction: Pakistan's HIV epidemic is primarily driven by PWID and the early and continuous provision of comprehensive HIV prevention services, inclusive of harm reduction, has been one of the notable best practices in place. The Harm Reduction program was initially funded by UNAIDS and DFID in 2000-2003 and later expanded by the GoP with the support from the World Bank from around 2005 onwards. By 2009, harm reduction services were being provided to PWID through a number of NGOs. Consecutive rounds of IBBS and program M&E indicated the decrease in sharing of needles and syringes particularly in cities where interventions for PWID exist.

In 2010-2011, the relevance of harm reduction programs became more evident as the country experienced a transitional situation with a decline in donor funding for HIV prevention services. Evidence exists that the discontinuity of harm reduction services, and in particular needle and syringe exchange programs (NSEP), even temporarily has serious ramifications. Regardless of the rates of coverage achieved under NSEP up to 2009, there is now need for establishing programs across nearly all key large and medium-size cities over the country and sustaining them over time. Despite considerable challenges in maintaining political commitment, resources, organization, and monitoring and evaluation, the experience base to tackle this scale-up exists in Pakistan. Harm reduction service-delivery package have been well defined, but the scale of implementation has been insufficient to arrest the upward trend of prevalence among PWID due to funding constrains.

One of the relevant recent findings is that where services remained in place in 2010-2011, readiness and access among beneficiaries is high with more than 74.6% PWID utilizing the services more than once a week. In addition to HIV prevention services being scaled up under the PC-1, an additional 28,000 PWID are expected to be encompassed progressively under Global Fund R9 Grant from 2012 onwards. The Global Fund implementation is providing guidelines, Standard Operating Procedures (SOPs), monitoring and evaluation system and NGO institutional base that, hopefully, could assist in efforts to cover larger national needs when additional investment of domestic and international resources is secured.

Community and Home Based Care: The concept of CHBC has been in place in Pakistan for almost a decade now as it was initiated by PLHIV themselves through CBOs. Based on their experience, the concept of CHBC was further refined and scale-up of services was included into the Global Fund R9, which will help complete the previously more intermittent continuum of care being provided to people living with and affected by HIV - i.e. this now includes psycho-social, socio-economic, education and nutritional support to families, health care, referral as well as other services in addition to ARV. Through this grant, 6,000 PLHIV are expected to benefit from these services. In addition, 18,000 family members of PLHIV are also expected to receive an appropriate package of services under the same grant.

Embedded within these services are VCCT and outreach, which allows these sites to facilitate reaching PLHIV and increase the uptake of services. CHBC, therefore, represents a pro-active approach towards reaching PLHIV and providing them with comprehensive and useful support services in addition to ART.

Humanitarian Crisis: The unprecedented monsoon rains in July 2010 caused devastating floods in Pakistan affecting up to 20 million people across the country with over 1,800 deaths in 70 districts. In all Provinces, inundation caused devastation and damage to communities, homes, infrastructure [roads, bridges, railway networks, and dams], communications, health and education facilities, livestock, agricultural crops, shops and workplaces, and livelihoods in general. Among the large number of the general public affected by these floods, PLHIV and their families were also amongst the particularly vulnerable groups. At that time, the MoH with the support of Joint UN Team on AIDS ensured the inclusion of PLHIV in the humanitarian response that was being mounted [Note: Similar support was provided in 2011 for the floods affecting mainly Sindh]. The objectives of the inclusion of HIV in the humanitarian response were to: (a) Ensure continuity of services for people living with HIV and, where possible, other populations; (b) Assess HIV-related vulnerabilities for the displaced and otherwise flood-affected populations; and (c) Provide HIV-related information, services and programs for those in need among the displaced and flood-affected populations.

Based on the above objectives, the facilitation of the continuity and non-disruption of ARV for people living with HIV in flood-affected districts was defined as a priority as well as ensuring continuum of care and support for them and their families. Care and support packages were developed, including medicines for opportunistic infections, multi-nutrients, condoms, essential food and non-food items, and transportation costs to ART Treatment Centers. The purpose was to ensure continuity in treatment, home-based care and to reinforce the immune system of PLHIV. Treatment and care for 1,200 PLHIV and 3,600 family members was ensured for three months through Government and UN resources, and subsequently covered for an additional seven months.

In addition, an effort was made to ensure inclusion of HIV information and messages into existing facility and community-based health care provision for all flood-affected populations, including health promotion messages as well as a referral system to specialized AIDS-services. Lastly, operations research was undertaken to develop a better understanding and assessment of risk and vulnerability in the humanitarian context in Pakistan[12]. **S**teps involved an initial desk review and mapping of risk patterns and trends in each Province; and a community-based assessment for PLHIV, Key Affected Populations, women and young people as well as health care workers of the consequences of the floods on HIV.

The outcomes of the above-mentioned activities included (a) increased adherence to treatment and reduced morbidity among PLHIV; (b) Identification and better understanding of risk situations among service providers and development of appropriate preventive and protective interventions; and (c)

[12] *Assessment on HIV prevention, Treatment, Care and Support among Flood affected populations in Pakistan 2010, NACP, PACPs and Joint UN Team on AIDS*

Sensitization of health care providers on HIV transmission dynamics and functional referral systems across concerned districts.

Second Generation Surveillance: Second Generation Surveillance (SGS) has led the national HIV response in Pakistan by providing a solid evidence base for planning. As part of EHACP, CIDA provided financial and technical assistance for the establishment of SGS through HASP. The project developed a country-specific methodology for surveillance that encompasses two components: mapping of Key Affected Populations in major cities to derive size estimates, location and operational typologies followed by the collection of behavioral and biological data. Since 2004-2005, HASP has conducted four rounds expanding to 19 cities in the last round. Apart from understanding the epidemic and evolving patterns, data has been used extensively by National and Provincial AIDS Programs at different levels:

- ***Policy development and advocacy***: For a long time, limited information existed among the partners involved in the national response about the number of sex workers and other populations. IBBS provided a base for estimating numbers of Key Affected Populations. Mapping data was used as an advocacy tool to sensitize stakeholders, especially policy makers and community leaders, about the consequences of an unfolding epidemic. This led to national strategy and policy development.
- ***Development of an integrated national response and resource allocation***: SGS data provided valuable information for the development of NSF-II as well as the Global Fund proposal R9. At the national level, size estimations of populations have helped determine the national Universal Access targets in line with the MDGs.
- ***Designing and Scaling-up of services***: The behavioral component of the SGS was utilized to develop and refine service-delivery programs. Biological data was used to channel resources to groups and localities 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, human resource needs, service infrastructure, and commodities.
- ***Program monitoring:*** Data collected has helped in output, outcome and impact monitoring of the interventions for Key Affected Populations. The combined analysis of SGS data-sets with evidence from programs provides a valid assessment of results.

MAJOR CHALLENGES AND REMEDIAL ACTIONS

Progress on key challenges reported on in UNGASS 2010 report

Several remedial strategies to expand the scope of services and scale up HIV/AIDS interventions, and improve access and quality of these services were proposed in the 2010 UNGASS report. The progress in regard to the challenges mentioned in the previous report is described in the following points:

1. Funding gaps: While the donor funding that was expected to continue in 2010 did not materialize, Pakistan successfully secured a grant through the Global Fund R9 addressing HIV/AIDS prevention, treatment and care services specifically and some health systems strengthening issues as well with implementation starting in 2011. The total value of this grant is 43 million USD. Additionally, several Provincial AIDS Control Programs (PACPs), including in Punjab and Sindh, have had either their provincial PC-1s approved in 2010-2011 albeit it for a limited period of time in the case of the former, thereby making funds available for critical HIV treatment services. In Khyber Pakhtunkhwa, the public sector hospitals in which ART centers are located have pledged to take over these centers and integrate them within their mainstream services. The combined VCCT, ART, STI care, PPTCT and pediatric services offered in Peshawar, for example, are a model that could be utilized elsewhere. In Baluchistan, gap-funding by the UN has enabled to ensure prevention for Key Affected Populations. It is hoped that by 2012, PC-1s in all the four Provinces will be characterized by increased Government allocation to AIDS.

2. Capacity issues: While some of the issues remain as such, there are important developments for capacity building in the context of Global Fund's R9 grant. Objective 3 of this grant specifically addresses Health Systems Strengthening as a cross-cutting theme, and under this objective, two Sub-Recipients are being recruited solely for the purpose of conducting capacity building trainings for service-providers working on HIV/AIDS treatment, care and support service delivery. In addition, guidelines/SOPs have been developed/ updated where needed in the implementation of the services, including harm reduction, under Objective 1 and 2. Not only does this address the on-ground staff's capacity issues, but also includes trainings related to financial reporting, program management, M&E and other higher level functions. It is expected, that as a result of this objective, there will be significant improvement in HIV/AIDS related capacity/skills among the public and private sector organizations.

3. Quality of care: The Global Fund R9 grant envisages a comprehensive treatment, care and support service-package implemented with the involvement of community health centers to be established across the country. This conforms to the holistic approach towards HIV/AIDS that has been advocated internationally. Quality of care is ensured by capacity training in adult and pediatric HIV care of hospital staff who will also be encouraged for referrals if and when required. Formal training in CHBC services, and frequent quality assurance/coordination meetings are planned to ensure the best possible care delivery for PLHIV and their family members.

4. Insecurity: Pakistan continues to address the challenge of conflict and unpredictable security conditions – although there has been a notable improvement in the most conflict-affected Province, Khyber Pakhtunkhwa, in 2011 – and these continue to affect the workings of many organizations. However, many of the intervention sites for HIV/AIDS treatment, care and support, are located in large to medium cities in areas of relative security.

MAJOR CHALLENGES FACED IN 2010-2011

1. **Funding:** Mobilizing domestic and external resources presented a major challenge for continuity and scale-up of HIV prevention, treatment and care over the long-term. Uncertainty about funding from key donors increased pressure on the Joint UN Team on AIDS to redirect funds or mobilize new resources towards more immediate programmatic and human resource gaps. The current challenge remains to ensure resources – domestic and international – for the continuity and scale-up from 2012 onwards.
2. **Upward trend in prevalence among certain Key Affected Populations**: Despite evidence of limited HIV infection in the general population, prevalence continues to climb steeply among people who inject drugs and, to a lesser extent, among those involved in sex work and related vulnerabilities in Pakistan. In a densely populated country, the main focus of the AIDS response has been on these Key Affected Populations in urban centers, though there is some evidence of 1-2 localized outbreaks occurring in smaller towns and rural communities due to a mix of risk factors, including nosocomial infection. The immediate need is to urgently reinforce service-provision and tracking systems to reach and sustain harm and risk reduction for 60-80% of those in need, including for partners of Key Affected Populations
3. **Disaster response**: Pakistan had been facing re-occurring large-scale humanitarian crises between 2009 and 2011, economic and governance challenges, with a subsequent limited institutional and financial capacity to address a sustained and focused AIDS response requiring non-interruption in life-saving measures. Such measures, in particular, include needle syringe exchange, ART, condoms, and health care for socio-economically marginalized populations across a large geographical area.
4. **Devolution**: The decentralization of the health ministry from the national to the provincial levels necessitates advocacy for sustained domestic resources at provincial and district levels. While, on the long run, the effectiveness of the response will rely on government commitment and allocation of resources at the provincial levels, there is some void in leadership at federal level with the disappearance of the Ministry of Health. It is essential that new format for Government multi-sector, parliament and institutional coordination around AIDS be established in 2012 at national and provincial level. While the challenges over 2012 are clear, on the long-term devolution does provide an opportunity for seeking a wider and renewed multi-sector response involving Inter-Provincial Coordination, Human Rights, Drugs, Overseas Employment, and others.

Proposed remedial strategies

1. To address the above-mentioned ongoing or emerging challenges, the focus of policy dialogue will have to encompass but also expand beyond traditional AIDS stakeholders to account for increased decentralization of policies, finances, planning and implementation to the Provinces. Coordination bodies will remain essential at the level of the federal capital, Islamabad, but also in the provincial capitals of Karachi, Lahore, Peshawar and Quetta, whom, in turn, should coordinate implementation with districts. This will allow to leverage greater community participation and involvement of key sectors, such as health, planning, interior, home affairs, women, social welfare, narcotics control, overseas employment, human rights, and education.
2. The revision and development of the National Strategic Framework on HIV or PAS-III is currently under process. Among the thematic focuses of importance will be to enhance evidence on and address some of the long-standing key drivers and vulnerabilities related to the epidemic in Pakistan, including labor migration, the rights of socially marginalized populations, gender inequality and the situation of women, and policy-legislative barriers of relevance to the Key Affected Populations.
3. Efforts will be made to focus on specific key interventions that increase the number of persons reached, effectiveness and the active participation of beneficiaries in the provision of services. This will be achieved by developing a more pro-active VCCT as a vital link in the chain of services, targeted behavior change communication strategies for diverse populations as well as mobilizing more effective community participation and empowerment across Provinces.
4. Noting the alarming scale of HIV infection among PWID, it is essential that urgency be given to this issue above all with the aim of resolving two essential challenges: How do we ensure resources, capacity and monitoring and evaluation that raise coverage of harm reduction among PWID to 60-80% across the country? And, second, is to adapt a treatment approach that will ensure ART to the growing number of PWID in need of treatment, care and support alongside efforts on drug treatment? The same challenge applies to other key affected populations but at a lesser scale. This is a priority action for the Government, CSOs and UN agencies to tackle as of 2012.
5. Given the prevailing flattening out of AIDS resources globally as well as nationally, and competing development, health and humanitarian priorities in the country, more integrated approaches need to be developed in the health, social welfare and other relevant sectors. In terms of programs and services, an effort should be made for linkages and a staggered integration of some of the AIDS stand-alone programs and services within the health care system, drug treatment and others services, where feasible. This is while noting that certain AIDS-specific community outreach and others services will remain essential in the coming future.

SUPPORT FROM COUNTRY'S DEVELOPMENT PARTNERS

Development partners align their efforts with the Government's national response to achieve success in responding to the HIV epidemic. The roles for development partners defined in the under construction PAS-III will continue to be the same as outlined in the previous NSF-II. Summarily they are to:

1. Provide strategic technical guidance and financial assistance that facilitates the government in attaining the national goals and MDG targets related to the 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 mandates, 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.

In Pakistan, bilateral and multilateral donors and other development partners have been key collaborators in mounting a national response to HIV. The major partners – listed in no specific order -- include UNICEF, UNFPA, UNAIDS, WHO, UNODC, UNDP, UNESCO, UNHCR, UN Women, IOM, ILO, FAO, GTZ, USAID, World Bank, GFATM, DFID, CIDA and others. The UN agencies function within the framework of a Joint UN Team on AIDS. These partners play a key role in updating the National Strategic Framework to its second version, and are now also contributing in the development of the third Pakistan AIDS Strategy. In the past years, they have regularly extended technical and financial assistance at strategic and operational levels. The support of these development partners has been important for strengthening the Association of PLHIV that represents and advocates for PLHIV community. They are also essential in creating an enabling environment for taking up initiatives with parliamentarians, media and religious leaders and women groups.

Continued support is however needed from the various development partners both on financial and technical fronts as Pakistan's national programs transition into a more devolved form over the coming years. Support in building the capacity of provincial counterparts will be a key cornerstone in ensuring the continuation of HIV prevention services and surveillance at these levels. Commitment from donors is also needed for ensuring the provision of ARV medicine for an increasing number of HIV patients who are on ART, and to avoid the potential disruption of ART in 2014 onwards.

MONITORING AND EVALUATION ENVIRONMENT

Overview of the Current M&E system

Monitoring & Evaluation for HIV/AIDS in Pakistan is guided by four principles:

- A multi-sectoral approach
- Developed based on national priorities
- Built on existing systems and practices
- Government-owned and led

The goal of this system is to ensure effective use of available data for evidence-based decision making in policy and program development, advocacy, and resource mobilization and allocation. A set of core national indicators have been outlined in the national M&E framework for this purpose. The principal role of the NACP and Provincial M&E Unit is to coordinate surveillance and M&E activities all over the country and between Provinces with three primary functions:

1. M&E of the interventions that are implemented.
2. Coordination of HIV national surveillance that was conducted by HASP until January 2012.
3. Collate and assimilate all epidemiological and program information available in the country in order to analyze the current stage and future epidemic directions of the country and to inform about the effectiveness of the response.

Due to the devolution of Health Ministry in June 2011, the provincial chapters have been given more autonomy in managing programs, including the M&E function. While the program outputs are monitored by implementation units at both provincial and national levels, direct monitoring of treatment centers is primarily done by Provincial Programs and secondarily by the National Program. However, the interventions implemented under the Global Fund R9 grant are being directly monitored by PR units at national level through their Sub-Recipients. In addition, all international reporting (e.g. UNGASS or the Global AIDS Response Progress Report) is done by the NACP. Routine program data gathering is done by provincial level units and analyzed to generate quarterly provincial level reports. Subsequently, the data is forwarded to the federal unit that manages the central national HIV and AIDS database/repository established in the NACP.

The M&E activities are also coordinated by M&E sub-committee of TACA/TWG at a national level including representatives from public and private sectors, PLHIV and development partners. The sub-committee provides technical inputs and uses the M&E data to track the HIV epidemic and advises program interventions accordingly. In addition, the NACP contracts independent firms/organizations to conduct third-party evaluation for Blood Safety, VCCT 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
- Others: AIDS Case reporting System, DHS, HMIS, Statistical Bureau

The National M&E Framework of Pakistan was developed in consultation with all the stakeholders and 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.

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 [PWID, MSWs/HSWs, FSWs and long distance truck drivers] in addition to VCCT and STI services. This will also be undertaken in the coming years.

Challenges faced in implementation of M&E system

The key challenges being faced in the implementation of M&E system is the limited capacity at the implementation level for data collection and its usage, lack of standardized tools for data collection, compilation and non-use of electronic forms of data collections and reporting.

Remedial Actions

National and Provincial programs, in collaboration with UNAIDS, CIDA, University of Manitoba and other partners have conducted several trainings for the implementing partners at provincial level. As part of the review of the M&E plan 2010, a comprehensive action plan has been developed to address the capacity, data collection tools and database gaps that exist at various levels. Under the Global Fund R9, the M&E system is being strengthened through several measures. For the first time, the NACP PR2 unit has developed standardized data collections tools for ART centers and CHBC sites, similarly Nai Zindagi PR1 is developing tools with regard to harm reduction. These have been disseminated and staffs at sites are being trained in the use of these tools. In addition, an online version of the MIS is also being developed which will allow fast and accurate collection of data and reporting. Specialized M&E staff has been hired at both national and provincial levels to address the human resource issues. These measures are expected to facilitate strategic planning, monitoring, evaluation, surveillance and research.

ANNEX I: CONSULTATION PROCESS

The NACP in collaboration with UNAIDS initiated the process of developing the GARP report 2012 by creating a Technical Working Group (TWG) composed of representatives from the HASP, UNICEF, UNFPA, WHO, UNODC and one CSO. The first meeting of the TWG took place in February 2012 to outline the way forward and process methodology for the development of the NCPI indicator of GARP Report 2012.

Meeting of Working Group on Global AIDS Progress Reporting

Venue: UNAIDS

Date: 6th February 2012

Participants:

	Name	organization
1	Oussama Tawil	UNAIDS Country Coordinator
2	Dr Muhammed Imran	SPO, GFTAM
3	Dr Quaid Saeed	WHO
4	Dr Safdar Kamal Pasha	UNFPA
5	Mr Salman Qureshi	Nai Zindagi
6	Dr Nasir Sarfraz	UNICEF
7	Dr Shazra Abbas	UNICEF
8	Mr Kazutaka Sekine	UNICEF
9	Dr Muhammad Saleem	UNAIDS

Proceedings:

- The meeting began with an introduction of participants.
- UNAIDS briefed the participants of the meeting on background of the Global AIDS Progress Reporting 2012. Points highlighted were the change in this report as compared with the previous UNGASS reports in reference to the June 2011 Political Declaration on AIDS. The main differences were the introduction of three new indicators and modification of five previous indicators, for a total of 30 indicators under seven targets.
- This was followed by WHO explaining the Health System Response to Universal Access report. Participants were informed that both reports are due by 31st March 2012.
- The revised reporting guidelines were shared with the participants and the group agreed to the recruitment of a consultant to start work on the data collection and narrative report.
- List of the indicators for GARPR was reviewed and those relevant to the Pakistan's epidemic and response were identified.

Decisions reached:

1. NACP and UNAIDS will develop and finalize the ToRs of the consultant for data collection and report writing.

2. Relevant document for the desk review of the NCPI were identified and staff from the NACP/PR Unit nominated to second the consultant for technical support.
3. Respondents for Part A and B were identified.
4. The working group will support the consultant in data collection and drafting of the report.
5. Relevant indicators for reporting were identified; HASP team was to be consulted to initiate sharing of figures relevant for these indicators from the IBBS round 4 findings. The working group will support the consultant to start collecting information on these indicators.
6. The NASA report of 2011 was decided to be used to report for the Indicator for domestic and International AIDS spending by categories and financial sources which have reported on fiscal years 2008-9 and 2009-2010. Reporting for the fiscal year 2010-2011 was not applicable due to interrupted funding during the devolution phase in 2011.
7. WHO will share format of the health system reporting tool with the participants of the meeting and request Provinces for relevant information.
8. Draft report to be prepared by 20th March and shared with all stakeholders in a consultative meeting to be held in the last week of March 2012.

Follow up Actions

1. All relevant documents were shared with NACP by UNAIDS and HASP
2. UNAIDS and NACP followed the necessary protocols for hiring

The Consultant was hired and directed by the TWG to begin collecting information on NCPI. Respondents for Part A and B were informed of their nominations for collection of data by the consultant. Interviews with respondents were conducted, all results tabulated and analyzed for the first draft of the NCPI report which was shared with UNAIDS and NACP. This draft was validated in the validation and Consensus Meeting held on 26th March 2012.

Validation and Consensus Meeting for GARP Report 2012

Venue: NACP Conference Room
Date: 26th March 2012
Participants:

	Name	Organization	Designation
1	Dr. Sofia Furqan	NACP	SPO
2	Dr. Amir Maqbool	NACP	SMO
3	Oussama Tawil	UNAIDS	Coordinator
4	Dr. Salman Shahid	PACP-Punjab	PD
5	Nasir Sarfraz	UNICEF	Program Specialist
6	Kazn Sekine	UNICEF	UNICEF
7	Dr. Shazra Abbas	Health officer	UNICEF
8	Dr Rajwal Khan	PACP-KPK	M&E Specialist

9	Nayyar Majeed	President	APLHIV
10	Khurram Shahzad	GS	APLHIV
11	Dr. Munawar Khan	BCC Coordinator	SACP Sindh
12	Dr. M. Saleem	UNAIDS	M&E Advisor
13	Dr. Nadeem Rehman	UNODC	Advisor
14	Dr. Safdar kamal	NPO HIIV	UNFPA
15	Dr. Mohiuddin	GFATM	Program Officer
16	Dr. Usman Raza	GFATM	Program Officer
17	Dr. Rubina Mumtaz	Consultant	PPM
18	Dr. Muhammad Imran	GFATM	SPO
19	Tariq Zafar	NZ	CEO
20	Imran Zali	Member CCM	APLHIV
21	Dr. Ali Razaque	GFATM	M&E Specialist

Proceedings:

- The meeting began with an introduction of participants.
- UNAIDS Coordinator, Mr Oussama Tawil set the pace for the workshop by briefly discussing current opportunities and scale of challenges with a focus on funding challenges for the national response. It was observed that currently the main funding is available through Global Fund Round 9 grant. The allocation of resources by Provinces, particularly Sindh and Punjab, was appreciated and it is hoped that the allocation for the HIV response will be scaled up and sustained and similar allocation will be made by KPK and Baluchistan after finalization of the AIDS strategies and PC-1s in these two provinces.
- The first presentation was by Dr Mohammed Saleem, UNAIDS, describing the June 2011 Political Declaration on AIDS and giving the background to the Global AIDS Response Progress Reporting 2012 and its changed format where 3 new indicators have been added, 5 indicators modified with all 30 indicators now categorized under seven targets. Pakistan is reporting on 17 indicators. He gave a brief background of the UNGASS DoC 2001 and Political Declarations of 2006 and 2011.
- Dr Muhammad Imran, SPO GFTAM and Dr Muhammad Saleem presented Indicators 1.1 to 1.14 and 2.1 to 5.1 respectively and facilitated discussion for consensus for each indicator.
- Dr Rubina Mumtaz, Consultant, presented Indicator 6.1 and the NCPI highlighting points that needed reconciliation and consensus.

Decisions reached:

1. It was decided that Indicator 1.1 was not to be reported as data is not available on this indicator. The only source of this data is the Demographic Health Survey (DHS). In the last UNGASS 2010 report we had reported on this indicator with partial data from the DHS 2007. The DHS has not been updated since then. For indicators 1.2-1.5, no reporting will be done due to lack of data. Indicators 1.6-1.10 are being reported based on the IBBS Round IV report. The participants agreed to the statistics obtained although apparent discrepancies were noted. Indicators 1.11 to 1.14 are not reported as all MSM activity under the concentrated epidemic is targeted at MSWs

and HSWs. Since the global reporting mechanism does not have a category for Hijras, for reporting purposes we will group HSWs under the MSW category, as was done in the previous report. This point will be highlighted in the narrative report.

2. Indicators 2.1 to 2.5 raised several questions about the disparity in the figures when comparing the high prevalence among PWID in relation to the injecting practices [using new syringe while injecting]. Various reasons were discussed and it was concluded that the data available through IBBS Round 4 will be used as it the only recent source of information available.
3. Indicators 3.1 to 3.3 raised the question as to why the spectrum modeled number of estimated positive mothers in 2010 was 5,633 and in the 2012 calculations it was reduced to 3,418. The explanation was that spectrum updated versions were now available and additional data was fed into the program in the current reporting period which has been lacking in the last estimates.
4. For reporting for Indicator 6.1, the first NASA report of Pakistan developed in 2011 was agreed upon for reporting.
5. For questions that are common to NCPI Part A and B in prevention, treatment, care and support, about half of the conflicting opinions were resolved. For the remaining differences, it was decided to report them as such.
6. Key achievements and main challenges for each sub-part were presented for review and approval.
7. For indicator 7.4, efforts will be made for obtaining information from the Benazir Income Support Programme.

Follow up actions:

The data was entered online and shared with stakeholders. Comments and observations were in cooperated into the narrative report and shared electronically. There was consensus and all the efforts put into compilation of the GARPR 2012 report was appreciated by all.

ANNEX II: NATIONAL COMMITMENTS AND POLICY INSTRUMENT (NCPI)

Name of National AIDS Committee Officer in charge of the NCPI submission and who can be contacted for questions if any:	Dr Muhammed Imran Senior Program Officer Global Fund Round 9 National AIDS Control Program
Postal Address:	NACP. NIH, Chakshazad, Islamabad 44000, Pakistan
Telephone:	+92-51-9255629
Fax:	+92-51-9255623
E-mail:	drimrannacp@gmail.com
Date of Submission	31st March 2012

Process used for NCPI data gathering and validation:

The TWG on the Global AIDS Response Progress Report 2012 identified 6 respondents for Part A and 7 respondents for Part B in their first meeting in February 2012. Each respondent was allocated sub-parts relevant to their organizational response to HIV. All respondents were informed of the revised structure of the 2012 report and permission was sought to conduct interviews at their convenience. Five interviews were conducted face-to-face while the remaining eight respondents chose to complete and submit the questionnaires electronically.

Respondents to Part A (Administered to Government officials)

Organization		Names/position	Sub-parts respondent was queried on					
			A-I	A-II	A-III	A-IV	A-V	A-VI
1	NACP	Dr Sajid Ahmed National Program Manager	√	√	√	√	√	√
2	PACP Punjab	Dr Salman Shahid, Program Manager	√	√	√	√	√	√
3	PACP Sindh	Dr Arshad Mehmood Program Manager	√	√	√	√	√	√
4	PACP KPK	Dr Sher Mohamad, Program Manager	√	√	√	√	√	√
5	PACP Baluchistan	Dr Nasir Khan, Program Manager	√	√	√	√	√	√
6	Planning Commission	Dr Asghar Abbasi, Chief Health	√	√	√	X	X	X

Respondents to Part B (Administered to civil society organizations and UN organizations)

Organization		Names/position	Sub-parts respondent was queried on				
			B-I	B-II	B-III	B-IV	B-V
1	Nai Zindagi	Mr Tariq Zafar, CEO	√	√	√	√	√
2	APLHIV	Ms Nayyar, President Executive Board	√	√	√	X	√
3	New Lights AIDS society	Mr Nazir Masih, Chief Executive	√	√	√	√	√

4	Pakistan Society	Mr Azhar Hussein, Project Manager	√	√	√	√	√
5	Saathi Foundation	Ms Laila Butt, Director	√	√	√	√	X
6	Socio Pakistan Quetta	Amanullah Kakar, CEO	√	√	√	√	X
7	UNICEF	Dr Nasir Sarfraz, HIV Specialist	x	x	√	√	√

Results were tabulated and analyzed according to the following mechanisms:

- The Yes/No responses were presented according to the majority response.
- The scale responses were presented by stating the mode value. For questions that had more than one mode, no mode or extremes of scale values, consensus was obtained during the validation meeting of key stakeholders.
- For open text questions, comments common to all respondents of the specific sub-part were listed. Additional comments were subjected to discussion and consensus during the validation meeting and recommended suggestions added to the list.

Process used for resolving disagreements, if any, with respect to the responses to specific questions

Validation and Consensus meeting was held and attended by representatives from NACP, UN agencies and civil society organizations. All questions having more than one response were highlighted and discussion encouraged achieving consensus for a single answer. The final rating for each sub-part of Part A & B with comments on key achievement and challenges were presented for a collective review and consensus achieved. Recommended answers were submitted.

PART A - I: STRATEGIC PLAN

Q1. Has the country developed a national multisectoral strategy to respond to HIV?

YES

If Yes, what was the period covered

Last one was 2007-11. New one is under development and is for the period 2012-2016.

If YES, briefly describe key developments/modifications between the current national strategy and prior one
In line with the 18th amendment to the constitution of Pakistan, from 1st July 2011 the MoH has been devolved and provinces have now the responsibility for strategic planning. The provinces are now developing their own AIDS strategies and the overall Pakistan AIDS Strategy 2012-16 is being developed in the 'post-devolution' scenario. This Strategy will be the consolidation of the four provincial strategies and will also a have strategic plan for the federally administered areas and AJK.

If YES, complete questions 1.1 through to 1.10; if NO, go to question 2

Q1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV

1. Ministry of Inter-Provincial Coordination,
2. Provincial Departments of Health,
3. Ministry of Narcotics,
4. Ministry of Education

Q1.2: Which sectors are included in the multi-sectoral strategy with a specific HIV budget for their activities?

Sector	**Included in strategy**		**Earmarked budget**	
Education	Yes		No	
Health	Yes		Yes	
Labor	Yes		No	
Military/Police	Yes		No	
Transportation		No		
Women		No		
Young People	Yes		No	
Other – Narcotics	Yes		Yes	

If NO earmarked budget for some or all of the above sectors, explain what funding is used ensure implantation of their HIV specific activities
Action plans are being prepared at provincial level which will be finalized and approved by respective health & planning departments in Provinces. The ministry and departments other than health use the resources allocated by the health sector for activities in the sectors - i.e. education etc. Ministry of Narcotics has a budget for Drug Rehabilitation centers across the four Provinces.

Women and young people do not have HIV specific funding since the epidemic in Pakistan is concentrated amongst the KAPs. However, women and young people within the KAPs benefit under their specific KAP targeted services and are also addressed in the activities targeted at the general populations on specific occasions like WAD.

Q1.3: Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS	
Men who have sex with men	Yes
Migrants/ mobile populations	Yes
Orphans and other vulnerable children	Yes
People with disabilities	No
People who inject drugs	Yes
Sex workers	Yes
Transgendered people	Yes
Women and girls	Yes
Other specific vulnerable sub-populations – Long distance truckers, coal miners in Baluchistan.	Yes
SETTINGS	
Prison	Yes
Schools	Yes
Workplace	No
CROSS-CUTTING ISSUES	
Addressing stigma and discrimination	Yes
Gender empowerment and/or gender equality	Yes
HIV and poverty	No
Human rights protection	Yes
Involvement of people living with HIV	Yes

Q1.4 What are the identified key populations and vulnerable groups for HIV programs in the country?

KEY POPULATIONS
• PWID, • MSWs, • HSWs, • FSWs, • Migrants, • Coal miners in Baluchistan • Spouses of PWID • Street Children • Long Distance Truckers

Q1.5 Does the multisectoral strategy include an operational plan

YES

Q1.6 Does the multisectoral strategy include?

A) Formal Program Goals?	Yes
B) Clear targets or milestones?	Yes
C) Detailed costs for each program area?	Yes
D) An indication of funding source to support program implementation?	Yes
E) A monitoring and evaluation framework?	Yes

Q1.7: Has the country ensure 'full involvement and participation' of civil society in development of multisectoral strategy?

Active involvement
IF ACTIVE INVOLVEMENT, briefly explain how this is organized
Most of the HIV/AIDS prevention and control interventions in the country since the beginning of the response to the epidemic have been implemented through public-private partnership. Even currently, all services to key at risk populations are being delivered through civil society organizations. Civil society and community groups, particularly PLHIV, have been part of the extensive consultative process undertaken for the development of the strategies at the provincial level. All the Provincial strategies will be compiled into a Pakistan AIDS Strategy.

Q1.8 Has the multi-sectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

YES

Q1.9 Have external development partner aligned and harmonized their HIV related programs to the national multi-sectoral strategy?

YES, most partners

If some partners or No, briefly explain for which areas there is no alignment/ harmonization and why?
Coordination with all partners is work under progress

Q2. Has the country integrated HIV into its general development plans such as in (a) National development Plan (NDP) (b) Common Country Assessment (CCA) /UN development Assistance framework (c) Poverty Reduction Strategy (PRS)and (d) Sector wide Approach (SWA)

YES

2.1 IF YES, is support for HIV integrated in the following specific development plans?

SPECIFIC DEVELOPMENT PLAN	
Common Country Assessment/ UN development assistance framework	Yes
National Development Plan	Yes

Poverty reduction strategy	Yes
Sector-wide approach	NA
Other: Annual Provincial Development Plan for each of the four Provinces	Yes

2.2. IF YES, are the following specific HIV related areas included in one or more of the development plans?

HIV RELATED AREA INCLUDED IN PLAN(S)	
HIV impact alleviation	No
Reduction of gender inequalities as they related to HIV prevention/ treatment, care and/or support	Yes
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and/or support	No
Reduction of stigma and discrimination	Yes
Treatment, care and support (including social security or other schemes)	Yes

Q3. Has the country evaluated the impact on its socio-economic development for planning purposes?

NO

Q4. Does the country have a strategy for HIV issues among its national uniformed services (military, police, prison, etc)

YES

Q5. Has the country followed up on 2011 political commitments on HIV/AIDS?

YES

Q5.1 Have HIV budgets been revised accordingly

YES

Q5.2 Are there reliable estimates of adults & children need ARV

Estimates of current and future needs

Q5.3: Is HIV Program coverage being monitored?

YES

(a) If YES, is it monitored by sex (male, female)?

YES

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

Yes
If YES, for which population groups
PWID, MSWs, HSWs and FSWs and spouses and children of PWID
Briefly explain how this information is used
The information is being used by provincial AIDS control programs to make programmatic adjustments and also to develop future strategies and design programs and interventions

(c) Is coverage monitored by geographical area

Yes
If YES, at which geographical levels (provincial, district, other?)
Mostly city and district wise

Briefly explain how this information is used
The information is being used by provincial AIDS control programs to make programmatic adjustments and also to develop future strategies, programs and interventions.

Q5.4 Has the country developed a plan to strengthen health systems?

Yes
Please include information as to how this has impacted HIV related infrastructure, human resources and capacities and logical systems to deliver mechanisms
The overall health system strengthening has been instrumental in dealing with HIV & AIDS issues at all levels e.g. up-gradation of hospital facilities and involvement of various vertical programs in support of HIV & AIDS - e.g. the LHW (Lady Health Worker) PHC and FP program for advocacy & referral to service delivery and capacity building and sensitization of Health care providers.

Q6. Overall, on a scale of 0-10, how you rate strategy planning efforts in your country's HIV programs

8
Since 2009,what have been key achievement in this area`
(a) Development of provincial AIDS strategies with action plans that cater best to the provincial needs. (b) Involvement of various key sectors/departments in HIV prevention and control response.
What challenges remain in this area
(a) Actual provision of funds to operationalise the strategies and scale up services. (b) Decreasing donor commitment to HIV prevention and control. (c) Increasing number of Key At-Risk populations, especially PWID. (d) The devolution of the Health Ministry to provincial level. The transition process was a challenge and continues to remain so. However, the same process can be simultaneously also be viewed as an opportunity as the Provinces are now more autonomous and could directly mobilize resources through bilateral contacts.

PART A - II: POLITICAL SUPPORT AND LEADERSHIP

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

A. Government Ministers YES

B. Other high officials at sub-national level YES

Q1.1 In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership to HIV?

Yes
Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership
• Last year, the Prime Minister of Pakistan met UN SG special Envoy on HIV/AIDS for Asia Pacific Ms. Nafis Sadiq at PM house and assured his support for HIV/AIDS and human rights issues in the country. • A number of provincial ministers have talked about HIV/AIDS issue in their respective Provinces in their public forum addresses. • Parliamentarians regularly conduct review meetings on HIV response in the National assembly and Senate. • Involvement with World AIDS Day activities as well as participation in high level HIV & AIDS conferences by delegations led by high officials

Q2. Does the country have an officially recognized multisectoral HIV coordination body (i.e. National HIV Council or equivalent?)

NO
If NO, briefly explain why not and how HIV programs are being managed?
At the national level, a Harm Reduction Advisory group exist which is chaired by the Secretary Ministry of Narcotics Control and has representation from Provinces beside civil society and health departments. Also a treatment, care and support coordination committee exists at national level which is multi-sector and has defined ToRs. At provincial level, multi-sector steering/coordination committees exist which are chaired by respective Health Ministers or Secretaries.

Q3. Does the country have a mechanism to promote interaction between government, CSOs and private sector for implementing HIV programs?

YES
IF YES, briefly describe the main achievement?
The CCM secretariat (Country Coordination Mechanism) has representatives from CSOs, donor agencies and Government of Pakistan. CCM provides a forum for interaction between Government, CSOs, PLHIV and private sectors on resource mobilization, and implementation of the HIV, TB and Malaria. Beside the CCM, several coordination forums exist at national and provincial levels for various thematic areas which provide sufficient opportunities for interaction between government, civil society, PLHIV and the private sector.
What challenges remain in this area
Devolution of Ministry of Health from the national level has left a vacuum at national level and Provinces will take some time for the institutionalizing of some roles which have been devolved to Provinces.

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

43%

Q5. What kind of support does the national HIV commission (or equivalent) provide to CSOs for implementation of HIV related activities?

Capacity building	Yes
Coordination with other implementing partners	Yes
Information on priority needs	Yes
Procurement and distribution of medications or other supplies	Yes
Technical guidance	Yes

Q6. Has the country reviewed national policies and laws to determine which are inconsistent with the National HIV Control policies?

NO

Q7. Overall, on a scale of 0-10, how would you rate the political support for HIV programs in 2011?

8
Since 2009, what have key achievements been in this area?
1. Successful devolution to provinces in accordance with the 18th Amendment of the Constitution of Pakistan. 2. Recognition of HIV issue at provincial level. 3. Commitment of provincial governments to provide funds from their own resources. Scaling-up of treatment care and support services across the four Provinces and doubling of the number of PLHIV who are on ART.
What challenges remain in this area?
1. Stronger commitment at national level required to reach targets defined in the 2011 Political Declaration. 2. Uncertainty about inter-provincial coordination, donor coordination and who will undertake surveillance related activities.

PART A - III: HUMAN RIGHTS

Q1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key population and other vulnerable groups? Circle yes if the policy specifies any of the following key populations and vulnerable groups

KEY POPULATIONS AND VULNERABLE GROUPS	
People living with HIV	Yes
Men who have sex with men	No
Migrants/mobile populations	No
Orphans and other vulnerable children	yes
People with disabilities	yes
People who inject drugs	No
Prison inmates	Yes
Sex workers	No
Transgendered people	Yes
Women and girls	Yes
Young women / young men	N/A
Other specific vulnerable sub-populations	N/A

Q1.2. Does the country have a general (i.e. not HIV specific) law on non-discrimination

NO

If YES to 1.1 or 1.2, briefly describe the content of the laws

YES to 1.1:

1. ***THE HIV & AIDS PREVENTION AND TREATMENT ACT, 2007***: It is a comprehensive law that lays down a complete and exhaustive procedure for the protection of PLHIV in Pakistan; Chapter III of the Act of 2007 specifically states that no person shall be discriminated against on the basis of his/her HIV status in any form in relation to any activity in the private, public sectors of employment, health facilities, education and accommodation.
2. ***Article 11 of the Constitution of Islamic Republic of Pakistan, 1973*** guarantees prohibition of forced labor under the age of 14. While ***Article 24(3) of the Constitution*** prohibits all kinds of acts of discrimination and provides an affirmative discrimination in favor of women and children to have special laws to the exclusion of other; ***18th amendment in the Constitution*** states it has become a fundamental right of every citizen to get education free of cost.
3. ***Disabled Persons (Employment and Rehabilitation) Ordinance, 1981***: is a comprehensive code of conduct that protects the rights of people with disabilities
4. ***Prisoners Act, 1894***: As per Section 59 of the Parent Act of 1894, this is a provincial subject allowing provinces to amend rules; ***Pakistan Prisoners Rules, 1976*** governs in detail a complete and exhaustive law for maintenance, food, clothing, employment, education and medical facilities to be provided to the Prison inmates.
5. Acknowledgement of transgendered people as 'Third Gender" by a Supreme Court decision giving them the right to be issued a National Identity Card under the category of She-Male and hence the right to vote, own and inherit property
6. ***The Protection of Harassment of Women in the Workplace Act 2010*** which obliges all

workplaces in the public and private sector to adopt the polices outlined in the law to provide protection against sexual harassment and an avenue to address grievances; **Amendment of section 509. XLV of 1860 of the Pakistan Penal Code** deals with sexual harassment in the public place as well.

7. ***Prevention of Domestic Violence Act 2008*** covers all intentional acts of gender-based, physical and psychological abuse, but also includes "economic abuse, harassment, stalking, sexual abuse, verbal abuse and any other repressive behavior" committed against women, children or other vulnerable people, with whom those accused have been or still are in a domestic relationship.

Explanation of lack of law on non-discrimination

8. Pakistan does not have a general law specifically dealing with the subject of non-discrimination. However, Pakistan's constitution, on the other hand, has given constitutional guarantee under Article 3 of the Constitution whereby, it has been made obligatory on the state to eliminate all kinds of exploitation. Article 25 of the Constitution further guarantees that all citizens of the country shall be equal before law and shall be entitled to equal protection of law. The same Article further states that there cannot be any discrimination on the basis of sex. However, the state can make laws, which discriminates in favor of women and children (Affirmative Discrimination). Non-discrimination is a fundamental right. As per Article 8 of the Constitution, there can be no law in violation of the fundamental rights and any law if is in violation of fundamental rights shall be struck down to the extent of the inconsistency. Therefore, there can be no law in Pakistan which generally or specifically discriminates. Any law which would discriminate would be unconstitutional and can be struck down on the touchstone of the constitution.

Briefly explain the mechanisms in place to ensure that these laws are implemented

1. The PLHIV protection law binds the national and provincial AIDS control programs to provide PLHIV and other vulnerable groups ways and means to prevent AIDS transmission to others by using Universal Precautions including education, training, personal protective equipment and by employing safe working practices, including the distribution of condoms, provision of clean syringes etc.
2. NADRA, the government body was issued instructions by the Supreme Court to add a third category of 'She-Male' to gender of person. This was effectively carried out and transgender community members have been issued with national identity cards with which they can vote, own and inherit property and gain employment.
3. The women protection laws have been passed, but their implementation is slow and NGOs such as Meherghar and AASHA (Alliance Against Sexual Harassment) are advocating on these issues.

Briefly comment on the degree to which they are currently implemented

The HIV response in Pakistan fully endorses and implements the law protecting PLHIV against any stigma and discrimination.

The transgender community has been issued with National Identity Cards enabling them to gain employment and making them eligible for property inheritance. The Chief Justice of Pakistan is taking personal interest in the implementation of laws pertaining to this population

The Sexual Harassment law after its endorsement by the Parliament has been adopted by a wide range of government, NGOs and private sector organizations as part of their organizational

policies.

Q2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

Yes

IF YES, for which key population and vulnerable group?	
People living with HIV	No
Men who have sex with men	Yes
Migrants/mobile populations	No
Orphans and other vulnerable children	No
People with disabilities	No
People who inject drugs	Yes
Prison inmates	No
Sex workers	Yes
Transgendered people	No
Women and girls	No
Young women / young men	N/A
Other specific vulnerable sub-populations	N/A

Briefly describe the contents of these laws, regulations or polices

1. ***Section 377 (Pakistan Penal Code***) deals with MSM and states "Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment for life, or with imprisonment of either description for a term which shall not be less than two years nor more than ten years, and shall also be liable to fine. Penetration is sufficient to constitute the carnal intercourse necessary to the offense described in this section"
2. ***Section 269 and 270 of Pakistan Penal Code*** addresses transmission of infectious diseases relating to MSM activity state "Whoever unlawfully or negligently **OR** malignantly does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine, or with both."
3. ***Control of Narcotic Substances Act 1997***: Deals with laws relating to narcotic drugs, psychotropic substances, and control of production, processing and trafficking of such drugs and substances. No punishment is provided under this law for using drugs by an addict, rather treatment and rehabilitation is given under sections 52 and 53 of the Act.
4. ***Section 371A (Pakistan Penal Code) and Shariat Law*** make prostitution illegal in Pakistan. Whoever sells, lets to hire, or otherwise disposes of any person with intent that such a person shall at any time be employed or used for the purpose of prostitution or illicit intercourse with any person or for any unlawful and immoral purpose, or knowing it to be likely that such person shall at any time be employed or used for any such purpose, shall be punished with imprisonment which may extend to twenty-five years, and shall also be liable to fine
5. ***Section 371B (Pakistan Penal Code)*** - When a female is sold, let for hire, or otherwise disposed of to a prostitute or to any person who keeps or manages a brothel, the person

so disposing of such female shall, until the contrary is proved, be presumed to have disposed of her with the intent that she shall be used for the purpose of prostitution. For the purposes of this section and section 371B, "illicit intercourse" means sexual intercourse between persons not united by marriage. There is a special law i.e. ***Punjab Suppression of Prostitution ordinance, 1961*** which specially deal with the subject and prescribes punishment for such offences as well.
Briefly comment on how they pose barriers
All these laws have a common effect of that the KAP generally do not trust official authority personnel and avoid them. These laws present obstacles in access to sex workers (male, female and Hijra) to provide prevention service delivery by CSOs and NGOs. Sex workers tend to avoid formal settings where their identities may be revealed. Although use of drug is not a crime and in fact dictates the state to provide harm reduction and treatments, the anti-narcotics laws push drug users further underground into the shadows of society as they have daily dealings with drug peddlers who are, by legal definition, the real criminals. Hence, PWID generally avoid and harbor innate mistrust of uniformed persons and general society.

PART A - IV: PREVENTION

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

	YES
IF YES, what key messages are explicitly promoted	
Abstain from injecting drugs	YES
Avoid commercial sex	YES
Avoid inter-generational sex	NO
Be faithful	YES
Be sexually abstinent	YES
Delay sexual debut	YES
Engage in safe(r) sex	YES
Fight against violence against women	YES
Greater acceptance and involvement of people living with HIV	NO
Greater involvement of men in reproductive health programs	NO
Know your HIV status	YES
Males to get circumcised under medical supervision	NO
Prevent mother-to-child transmission of HIV	YES
Promote greater equality between men and women	NO
Reduce the number of sexual partners	YES
Use clean needles and syringes	YES
Use condoms consistently	YES
Other [write in below]:	N/A

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 to promote life skills based HIV education for young people?

NO

Q2.1 Is HIV education a part of the following schools

Is HIV education a part of the curriculum in	
Primary School	NO
Secondary School	NO
Teacher Training	Yes

Q2.2 Does the strategy include age appropriate, gender sensitive sexual & reproductive health?

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 information, education and communication and other preventive health interventions for key or other vulnerable population?

YES
Briefly describe the content of this policy or strategy
Addressed as part of National AIDS Strategic Framework.

Q3.1 If Yes, which populations and what elements of HIV prevention does the policy/strategy address? (check which strategy is used for which specific population?

	PWID	**MSM**	**SEX WORKERS**	**CUSTOMERS OF SEX WORKERS**	**PRISON INMATES**	**OTHER**
Condom Promotion	Yes	Yes	Yes	No	No	N/A
Drug Substitution Therapy	No	N/A	N/A	N/A	N/A	N/A
VCCT	Yes	Yes	Yes	No	Yes	N/A
Needle & syringe exchange	Yes	N/A	N/A	N/A	N/A	N/A
Reproductive Health, including STI prevention & treatment	Yes	Yes	Yes	No	Yes	N/A
Stigma and discrimination reduction	Yes	No	No	N/A	No	N/A
Targeted information on risk reduction and HIV education	Yes	Yes	Yes	No	Yes	N/A
Vulnerability reduction	No	No	No	No	No	N/A

(e.g. income generation)						

Q3.2 Overall what scale would you rate policy efforts in support of HIV prevention in 2011?

5
Since 2009, what have been the key achievements in this area
Commitment of resources for prevention interventions by the provincial governments to sustain the current service and scale it up in the coming years.
What challenges remain in this area
1. Post devolution, provincial policies development and implementation. **2.** Competing priorities due to natural disasters e.g. the floods of the 2010/2011 as well as securities issues. **3.** Standardization of data collection tools.

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

YES
IF YES. How were these specific needs determined
The needs were determined as part of NSF development process and included a detailed situation and response analysis in each of the four Provinces and federal level. The process was consultative and involved all relevant stakeholders.

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

The majority of people in need have access to …..	
Blood safety	Agree
Condom promotion	Agree
Harm Reduction for PWID	Agree
HIV prevention for out-of-school young people	Disagree
HIV prevention in the workplace	Disagree
HIV Voluntary Testing and Counseling	Agree
IEC on risk reduction	Disagree
IEC on Stigma and discrimination reduction	Disagree
Prevention of mother-to-child transmission of HIV	Agree
Prevention for PLHIV	Agree
Reproductive Health, including STI prevention & treatment	Agree
Risk reduction for intimate partners of key populations	Disagree
Risk reduction for MSM	Disagree
Risk reduction for sex workers	Disagree
School-based HIV education for young people	Disagree
Universal precautions in healthcare setting	Disagree

Q5.Overall, on a scale of 0-10, how would you rate the efforts in implementation of HIV prevention programs in 2011?

6

PART A - V: TREATMENT CARE AND SUPPORT

Q1. Has the country identified the essential elements of a comprehensive package of HIV treatment care and support?

YES
If YES, briefly describe the elements and what has been prioritized
It includes ARVs, provision of medicines for opportunistic infections, lab facilities including CD4 and viral load testing, VCT, nutritional support, psychosocial and legal support etc.
Briefly identify how HIV treatment care and support services are being scaled up
HIV treatment care and support services are available through 17 ART and 15 community and home based sites across the country. All services identified above are available free of cost to all PLHIV and also cover their immediate family members. These services will be further scaled up in coming three years under GF R-9 grant.

Q1.1. To what extent have the following HIV treatment care and support services been implemented?

The majority of people in need have access to …..	
Antiretroviral Therapy	Strongly agree
ART for TB patients	Strongly agree
Co-Trimoxazole prophylaxis for PLHIV	Strongly agree
Early Infant Diagnosis	Agree
HIV care and support in the workplace (including alternate working arrangements)	Disagree
HIV Voluntary Counseling and Testing for people with TB	Agree
HIV treatment services in workplace/referral system through workplace	Agree
Nutritional care	Agree
Pediatric AIDS treatment	Strongly agree
Post-delivery ART provision to Women	Agree
Post-exposure prophylaxis for non-occupational exposure to HIV	Disagree
Post-exposure prophylaxis for occupational exposure to HIV	Agree
Psychosocial support for PLHIV and their families	Agree
Sexually transmitted infection management	Agree
TB infection Control in HIV treatment and care facilities	Agree
TB preventive therapy for PLHIV	Agree
TB Screening for PLHIV	Agree
Treatment of common HIV related infections	Disagree

Q2. Does the government have a policy or strategy in place to provide social and economic support to people infected and affected by HIV?

NO
Please clarify which social and economic support is provided
However, on small scale such support is being provided to a certain percentage of PLHIV initially through International NGOs and UN agencies and now through GF R9 support. In one Province, efforts are being made to integrate these services in the social welfare ministry initiatives.

Q3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medication for HIV?

NO

Q4. Does the country have access to regional procurement and supply management mechanisms for critical commodities such as ART medications, condoms and substitutions medication?

YES
If YES, for which commodities
For ARVs, through Global Fund Voluntary Pool Procurement (VPP) and UNICEF. For CD4 and viral load kits through UNICEF procurement system.

Q5. Overall on a scale of 0-10, how would you rate the efforts in the implementation of HIV treatment care and support programs in 2011?

8
Since 2009, what have been the key achievements in this area?
• Free provision of all HIV treatment, care and support services. • Expansion of care and support services under GF R9 grant.
What Challenges remain in this area?
• Scale-up of VCCT services to reduce the difference between estimated and registered PLHIV. • New ART regimens and drug combinations. • Capacity to expand treatment services and expand community based care and support services • Getting PWID and other KAPs on ART.

Q6. Does the country have a policy to address the HIV needs of OVC?

NO

Q7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?

5
Since 2009, what have been key achievements in this area?
Development of care and support framework for HIV infected and affected children under support from SAARC secretariat.

What challenges remain in this area?
Recognition of OVC as at-risk population at strategy level.

PART A-VI: MONITORING AND EVALUATION

Q1. Does the county have one national Monitoring and Evaluation (M&E) plan for HIV?

YES
Briefly describe any challenges in development or implementation
Lack of resources and clarity on roles and responsibilities especially in post devolution scenario.

Q1.1. If yes, how many years

5

Q1.2. IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, some partners
Briefly describe what the issues are
Some partners work under their own organizational mandate and do not share their work plans and activities with NACP and Provincial AIDS Control Programmes.

Q2. Does the national M&E plan include?

A data collection strategy?	YES
IF YES, does it address	
Behavioral surveys	YES
Evaluation/ research studies	YES
HIV Drug resistance surveillance	NO
HIV surveillance	YES
Routine program monitoring	YES
A data analysis strategy?	YES
A data dissemination and use strategy	YES
A well-defined standardized set of indicators that include sex and age desegregations (where appropriate)	YES
Guidelines on tools for data collection	YES

Q3. Is there a budget for implementation of M&E plan?

In progress

Q3.1. if yes, what% of total HIV program budget is allocated for M&E?

Less than 5%

Q4. Is there a functional M&E unit?

YES
Briefly describe any obstacles
However, this unit lacks human resource and technical capacity especially after the devolution. With GFATM support, M&E officers have been put in PACP which will strengthen M&E capacity at provincial level.

Q4.1 where is the national M&E unit based?

In Ministry of Health	NO
In the National HIV Commission (or equivalent)	YES
Elsewhere	N/A

Q4.2 How many and what type of professional staff are working in the national M&E Unit?

POSITION		**SINCE WHEN?**
Epidemiologist	Full time	2005
M&E Specialist	Full time with Global Fund Unit [NACP being PR]	2011
M&E Officer	Full time with Global Fund Unit [NACP being PR]	2011

Q4.3. Is there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E unit for inclusion in the national M&E system?

NO
What are the major challenges in this area?
In post evolution scenario, mechanisms have yet to be developed for collation, analysis and use of information.

Q5. Is there a national committee or working group that meets regularly to coordinate M&E activities?

Yes

Q6. Is there a central national database with HIV related data?

YES
IF YES, briefly describe the national database and who manages it?
There is a Central Data Coordination Unit (CDCU) at NACP that mainly is responsible for conducting annual rounds of IBBS in the country and is managed by NACP.

Q6.1. IF YES, does it include information about content, key populations and geographical coverage of HIV services and their implementing organizations?

NO, None of the above

Q6.2. Is there a functional Health Information System?

At a national level?	Yes
At a sub-national level?	Yes
IF YES, at what levels? National, Provincial and District level Health Management Information	

System (HMIS)	

Q7. Does the country publish M&E reports including HIV surveillance data at least once a year?

YES

Q8. How is M&E data used?

For Programmatic improvement	YES
In developing/ revising the national HIV Response	YES
For resource allocation	YES
Briefly provide specific examples of how M&E data is used and main challenges if any	
Data used to develop NSF, all provincial programme plans and all proposals to donors including GFATM proposals.	

Q9. In the last year, was training in M&E conducted at?

At national level?	Yes
At sub-national level?	yes
At service delivery level including civil society?	Yes

Q9.1. Were other M&E capacity building activities conducted other than training?

YES
If YES, briefly describe the activities
Mainly under GF R9 for grant specific indicators that included ART center and CHBC site staff on data reporting

Q10. Overall, on a scale of 0-10, how would you rate the HIV related monitoring and evaluation (M&E) in 2011

7
Since 2009, what have been key achievements in this area?
• IBBS Round 4 across Pakistan in about 19 cities • Standardization of data collection tools and procedures in ART centers and CHBC sites
What challenges remain in this area
• Availability of dedicated funds for M&E plan operationalization. • Limited capacity in M&E. • Lack of clarity on roles and responsibilities of NACP in post devolution scenario. • Mechanism for verification of data needed.

PART B - I: CIVIL SOCIETY INVOLVMENT

Q1. To what extent (on a scale of 0-5) has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations

2
Comments and examples

• Fragmented effort on part of the CSOs; further disadvantaged by the fact that the total number of CSO dealing with HIV & AIDS are still limited in number, despite the fact that the number has increased over the past decade. • In the last few years, the Association of PLHIV has been able to strengthen its position and represent the community at national and provincial level forums to advocate for their rights particularly for treatment care and support services.

Q2. To what extent (on a scale of 0-5) have civil society representatives been involved in planning and budgeting process for the National Strategic Plan on HIV or the most recent current activity plan (i.e. attending planned meetings and reviewing drafts)?

2
Comments and examples
Civil society has been involved in the processes of the strategic planning and costing. During the development of provincial strategies civil society was part of the TWGs and think tank groups.

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

	Scale
The National HIV strategy	**4**
The National HIV Budget	**2**
The National HIV reports	**3**
Comments and examples	
• Often coverage is reported without focusing or mentioning quality of service being provided • Figures on coverage are often inflated. • Through One UN Team on AIDS and through UNFPA initiated few projects on Sex Workers in Pakistan which ended in Nov 2011. • CSOs often have to arrange other sources of funds through their own efforts for the welfare of vulnerable community they service because the budgets do not cover all the proposed aspects.	

Q4. To what extent (on a scale of 0-5) is civil society included in the M&E of the HIV response

	Scale
Developing the national M&E plan	**4**
Participating in the national M&E committee/working group responsible for coordination of M&E activities	**0**
Participate in using data for decision making	**1**
Comments and examples	
CSOs participated during the M&E framework development. However, the process of monitoring and evaluation in response of HIV is mainly owned by the Government**.** The use of M&E data for decision making was shared in previous years. In the current reporting period, it is not applicable since data is under collection and stage of using it has not yet	

reached due to devolution related interruption of the program.

Q5. To what extent (on a scale of 0-5) is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organizations and networks of PLHIV, sex workers, faith based organizations etc)?

2
Comments and examples
• The epidemic is concentrated, so diversity within the KAP is not so much – most groups dealing with the KAPs in Pakistan epidemic are included. • Civil society organization are playing a role in the representation of diverse groups, but community based organization are playing vital role in response to HIV.

Q6.To what extent (on a scale of 0-5) is Civil Society able to access:

	Scale
Adequate financial support to implement HIV activities?	**3**
Adequate technical support to implement its HIV activities?	**3**
Comments and examples	
• Decreased funding in the HIV sector means both types of support were difficult to access. • In 2011, there were no funds released because of the devolution, hence we got funds from UN for OI treatment and Lab tests, but no capacity training was done. • Small grants were offered by the government but mostly from the international NGOs/funders provided funds for the Implementation of the project activities.	

Q7. What percentage of the following HIV programs services is estimate to be provided by Civil Society?

PREVENTION FOR KEY POPULATIONS	**Percentage**
People living with HIV & AIDS	>75%
Men who have sex with men	>75%
People who inject drugs	>75%
Sex workers	>75%
Transgendered people	>75%
SERVICES	
Testing and counseling	25-50%
Reduction of stigma and discrimination	51-75%
Clinical services (ART/OI)	<25%
Home based care	>75%
Programs for OVC	<25%

Q7. Overall, on a scale of 0-10, how would rate the efforts to increase civil society participation in 2011?

7
Since 2009, what have been the key achievements in this area?
• Provincial Chapters (four) of the Association of PLHIV established. • National Association of PLHIV became a sub-recipient of GFATM R9 grant. • Principle Recipient of Regional Global Fund R10 was a CSO (APN+) and its main SR in Pakistan is the ALPHIV. • Involvement in effective policy making. • Moderate access of HIV prevention, treatment, care and support services to KAP continued despite the halting of funds due to donor policies and devolution process
What challenges remain in this area?
• Diminishing resources causing a tug of war between Federal and Provincial governments. • Devolution of governance has led to fewer resources and fewer interrupted services coverage to KAPs. • More resourcing for Stigma & Discrimination reduction required • Lack of communication and Advocacy Programs with General Public • Implementation of GIPA Principle at all levels • Limited technical capacity of civil society organizations

PART B - II: POLITICAL SUPPORT AND LEADERSHIP

Q1. Has the government, through political and financial support, involved PLHIV, key populations and/or other vulnerable sub-populations in government HIV policy design and program implementation?

YES
IF YES, describe some examples of when and how this happened?
1. Representatives of PLHIV and Key Affected Populations (KAP) were involved and contributed in the development of Interim Action Plan in 2010 for continuation of prevention services for KAPs in Punjab through government resources after discontinuation of International funding. 2. Similarly representatives of KAP and PLHIV were involved in the development of AIDS strategies (2012-16) in the provinces of Pakistan 3. The CCM has PLHIV as its member. 4. In national and provincial consultations members of PLHIV and other KAP communities are invited by government bodies. 5. In Sindh, PLHIV are some of the members of technical working groups that interact with government officials.

PART B - III: HUMAN RIGHTS

Q1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key population and other vulnerable groups? Circle yes if the policy specifies any of the following key populations and vulnerable groups

KEY POPULATIONS AND VULNERABLE GROUPS	
People living with HIV	Yes
Men who have sex with men	No
Migrants/mobile populations	No
Orphans and other vulnerable children	Yes
People with disabilities	Yes
People who inject drugs	No
Prison inmates	Yes
Sex workers	No
Transgendered people	Yes
Women and girls	Yes
Young women / young men	N/A
Other specific vulnerable sub-populations	N/A

Q1.2. Does the country have a general (i.e. not HIV specific) law on non-discrimination

YES
If YES to 1.1 or 1.2, briefly describe the content of the laws
1. ***The HIV & AIDS Prevention and treatment Act*** provides protection of PLHIV in Pakistan and ensures that a PLHIV is not discriminated against on the basis of his/her HIV status in any form in relation to any activity in the private or public sectors. 2. ***Disabled Persons (Employment and Rehabilitation) Ordinance, 1981***: is a comprehensive code of conduct that protects with people with disabilities. 3. ***The Prisoners Act, 1894***: provides protection to prisoners in terms of food, clothing, medical care and education facilities while in jail. Acknowledgement of transgendered people as 'Third Gender" by a Supreme Court decision giving them the right to be issued a National Identity Card under the category of 'She-Male' and hence the right to vote, own and inherit property. 4. ***The Protection of Harassment of Women in the Workplace Act 2010*** protects women in the workplace against sexual harassment and provides a protocol to address grievances; ***Prevention of Domestic Violence Act 2008*** protects women against all types of violence in the house. 5. ***Non-discrimination***: Pakistan's Constitution guarantees that all citizens of the country shall be equal before law and shall be entitled to equal protection of law. Non-discrimination is a fundamental right. Anyone can file a case against discrimination in the normal routine manner and it will be entertained in the court of law.
Briefly explain the mechanisms in place to ensure that these laws are implemented
1. The PLHIV protection law is implemented through the National and Provincial AIDS Control Programs and PLHIV are ensured provision of all prevention, treatment, care

and support services.

2. All transgender have been issued National Identity Cards and can now gain employment, own, manage and inherit property as well as vote.
3. The women protection laws have been passed but their implementation is slow and is being undertaken by NGOs such as Meherghar and AASHA (Alliance Against Sexual Harassment).

Briefly comment on the degree to which they are currently implemented

The HIV & AIDS response in Pakistan fully endorses and implements the law protecting PLHIV
Although the transgender community is now issued national Identity cards there are no further laws for their protection and welfare

Q2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

YES

IF YES, for which key population and vulnerable group?	
People living with HIV	No
Men who have sex with men	YES
Migrants/mobile populations	No
Orphans and other vulnerable children	No
People with disabilities	No
People who inject drugs	YES
Prison inmates	No
Sex workers	YES
Transgendered people	No
Women and girls	No
Young women / young men	N/A
Other specific vulnerable sub-populations	N/A

Briefly describe the contents of these laws, regulations or polices

1. ***Section 377 (Pakistan Penal Code***) condemns MSM activity making it punishable with life imprisonment or with imprisonment of either description for a term which shall not be less than two years nor more than ten years, and shall also be liable to fine.
2. ***Control of Narcotic Substances Act 1997***: Deals with laws relating to narcotic drugs, psychotropic substances, and control of production, processing and trafficking of such drugs and substances. No punishment is provided under this law for using drugs by an addict, rather treatment and rehabilitation is given under sections 52 and 53 of the Act.
3. ***Section 371A (Pakistan Penal Code) and Shariat Law*** make commercial sex work illegal in Pakistan making it punishable with imprisonment which may extend to twenty-five years, and shall also be liable to fines.

Briefly comment on how they pose barriers

These laws make access to the KAP a difficult process where the CSO have to first build trust and goodwill amongst the community before they can have any meaningful impact of their service interventions. Often goodwill and trust can evaporate overnight if a police raid takes place taking our impact a couple of yards back.

The PWID are a little different in that, although use of drug is not a crime and in fact dictates the state to provide harm reduction and treatments, the anti-narcotics laws pushes drug users further underground into the shadows of society because they have daily dealings with drug peddlers who are, by legal definition, the real criminals. Hence, PWID generally avoid and harbor innate mistrust of uniformed persons and general society.

Q3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?

YES
Briefly describe the content of the policy, law and regulation and the population included
Prevention of Domestic Violence Act 2008; This law is not HIV-specific, but applicable to all women of all ages in Pakistan. It covers all intentional acts of gender-based, physical and psychological abuse, but also includes "economic abuse, harassment, stalking, sexual abuse, verbal abuse and any other repressive behavior" committed against women, children or other vulnerable people, with whom those accused have been or still are in a domestic relationship. Under this law, protection committees – each consisting of female counselors, a female SHO, a sub-divisional police officer and a protection officer – would be set up at the tehsil level by provincial governments to handle all reported cases.

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

YES
If YES, briefly describe how human rights are mentioned in this HIV policy or strategy
• Human rights is specifically mentioned with National Strategic Framework • A policy of non-stigma and discrimination is being observed at all HIV Treatment centers in the country

Q5. Is there a mechanism to record, document and address cases of discrimination experienced by PLHIV, key populations or other vulnerable populations?

No
If YES, briefly describe the mechanism
At a national level, there is no complaint cell. However, discrimination against PLHIV or other key populations is often dealt with at the organizational level e.g. during delivery of positive pregnant women a member of the Association of PLHIV is designated to accompany the mother to a pre-designated hospital whose healthcare providers are given sensitization trainings. Feedback from each encounter guides the organization to address any gaps.

Q6. Does the country have a policy or strategy for free services for the following? Indicate if these services are provided free-of-charge to all, some people or provided at a cost?

	Provided free of charge to all the people in the country	**Provided free of charge to some people in the**	**Provided but only at a cost**

		country	
Antiretroviral Treatment	YES	------	--------
HIV prevention services	YES	------	--------
HIV related care and support interventions	-------	YES	--------
IF applicable, which populations have been identified as priority and for which services?			
Since the Pakistan epidemic is concentrated, all KAPs (i.e. PWID, male, female and Hijra Sex workers, migrants, truckers, prison inmates, MARAs) and PWID spouses/families have been identified as vulnerable. However, they all have to be first registered with an NGO or HIV Treatment Center before they can avail services. The Government of Pakistan provides ART, PPTCT and preventions services free of cost to all identified and registered key populations. Other clinical presentations (STIs/OIs/lab tests etc) are funded by UN agencies and undertaken by CSOs and NGOs.			

Q7. Does country have a policy or strategy to ensure equal access for women & men to access Treatment Care and Support?

YES

Q7.1. In particular, does country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

YES

Q8.1.Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?

YES
IF YES, briefly describe the content of this policy/strategy and the populations included?
No, written policy but all KAP have access to the prevention and treatment services but only on registration with the program. KAP in Pakistan are PWID, male, female and Hijra sex workers, migrants, truckers, prison inmates, MARAs and PWID spouses/families.

Q8.1. If YES, does this policy include different types of approaches to ensure equal access for different key and vulnerable populations?

YES
IF YES, briefly explain the different types of approaches to ensure equal access for different key populations and/or other key populations?
All KAPs are accessed by CSOs and NGOs who adapt their approach according to the cultural sensitivities. There is no one policy dictating these approaches - e.g. PWID are approached by offering NEP in the hotspots and then through them, their spouses/children are accessed; FSW and MSW are approached through their community leaders/in-charges. All KAP, once registered, have equal access to all services

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Q9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment, relocation, appointment, promotion, termination etc)?

NO

Q10. Does the country have the following Human rights monitoring and enforcement mechanism?

a) **Existence of independent national institutions for the promotion and protection human rights, including human rights commission, law reforms commission, watchdogs and ombudspersons which consider HIV related issues within their work?**

YES

b) **Performance Indicators or benchmarks for compliance with human rights standards in the context of HIV efforts?**

NO
IF YES on any of the above questions, describe some examples
Governmental Human Rights bodies in Pakistan include the Ministry of Human rights which has set-up a National Human Rights Commission of Pakistan and the 'Wafaqi Mohtasib' Ombudsman of Pakistan. The majority of work in the human rights arena is carried out by NGOs, mainly Human Rights Commission of Pakistan (HRCP), Asia Human Rights Commission (AHRC), Pakistan International Human Rights Organization (PIHRO), and Human Rights Forum Pakistan (HRFP). However, HIV related case work is seldom dealt with in the workings of both government and NGO human rights organizations.

Q11. In the last two years, have there been the following trainings and/or capacity building activities?

a) **Programs to educate, raise awareness among PLHIV and key populations concerning their rights (within the context of HIV)?**

YES

b) **Programs for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work?**

NO

Q12. Are the following legal support services available in the country?

a) **Legal aid systems for HIV casework?**

YES

b) **Private sector law forms or university based centers to provide free or reduced cost legal services to PLHIV?**

NO

Q13. Are their programs in place to reduce HIV related stigma and discrimination?

YES

IF YES, what types of programs	
Programs for health care workers	YES
Programs for the media	YES
Programs for the workplace	NO
Other	N/A

Q14. Overall, on a scale of 0-10, how would you rate the policies, laws and regulations in place to promote and protects human rights in relation to HIV in 2011

3

Since 2009, what have been key achievements in this area?
1. Swift implementation of the Supreme Court ruling acknowledging transgender as the 'Third Gender". The Chief Justice of the Supreme Court has taken a personal interest. All transgender have been issued national ID cards giving them for the first time in history, the right to vote, own, inherit and manage property and gain employment outside the sex/entertainment industry -- e.g. many jobs were created within NADRA (National Database and Registration Authority. 2. Establishment of the first ever MSM organization in Pakistan called the NAZ Male Health Alliance which has received funding for operations from Regional Global Fund R9.
What Challenges remain in this area?
The voice of the affected population is not loud enough to have any meaningful impact. The affected people organizations' need to unite on one forum to have an effect.

Q15. Overall, on a scale of 0-10, how would you rate the effort to implement human rights related policies, laws and regulations in 2011?

3
Since 2009, what have been the key achievements in this area?
Introduction of new laws addressing violence against women and sexual harassment of women in the workplace and public area are two key achievements.
What challenges remain in this area?
Implementation is a key challenge since many human rights issues are against the fabric of the Pakistani culture e.g. misogyny, prejudice against minority religion groups - e.g. Christians, Hindus and key populations such as sex workers and drug users.

PART B - IV: PREVENTION

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

YES
If YES, how were these specific needs determined?
• Mapping and HASP surveillance (integrated biological and behavioral surveillance) • Door to door qualitative surveys; focus group discussions during seminars • Identified based on program monitoring

1.1 To what extent has HIV prevention been implemented?

1.2

The majority of people in need have access to …..	
Blood safety	Agree
Condom promotion	Agree
Harm Reduction for PWID	Agree
HIV prevention for out-of-school young people	Disagree
HIV prevention in the workplace	Disagree
HIV Voluntary Testing and Counseling	Agree

IEC on risk reduction	Disagree
IEC on Stigma and discrimination reduction	Disagree
Prevention of mother-to-child transmission of HIV	Agree
Prevention for PLHIV	Agree
Reproductive Health, including STI prevention & treatment	Agree
Risk reduction for intimate partners of key populations	Disagree
Risk reduction for MSM	Disagree
Risk reduction for sex workers	Disagree
School-based HIV education for young people	Disagree
Universal precautions in healthcare setting	Disagree

Q2. Overall, on a scale of 0-10, how would you rate the effort in the implementation of HIV prevention programs in 2011?

3
Since 2009, what have been key achievements in this area?
Even after the completion of Enhanced HIV/AIDS Control Program in 2008 and with the extension up to 2010 implementation HIV prevention programs, in most provinces, continued, through government's own funding, e.g., in Punjab, or through UN support, e.g., in Sindh and Baluchistan.
What challenges remain in this area?
• Financial resources and capacities of service providers remain the biggest challenge in this area. • Inadequate coverage and interruption of ongoing programs also present a challenge • Poor planning augmented with diminished resources and inability to deliver previous targets has led to a substantial down scaling of prevention efforts in the country

PART B - V: TREATMENT, CARE AND SUPPORT

Q1. Has the country identified the essential elements of a comprehensive package for HIV treatment, care and support?

YES
IF YES, briefly identify the elements and what has been prioritized?
It includes ARVs, provision of medicines for opportunistic infections, lab facilities including CD4 and viral load testing, VCT, nutritional support, psychosocial and legal support, etc.
Briefly identify how HIV treatment, care and support services are being scaled up?
HIV treatment care and support services are being made available through 17 ART and 15 community and home based sites across the country. All services identified above are available

free of cost to all PLHIV and also cover their immediate family members. These services will be further scaled up in coming three years under GF R-9 support. Through a 'Family Care Center' in Khyber Pakhtunkhwa, inaugurated in 2011, all HIV related treatment, care and support services are now available under one roof. The model should be replicated in other three Provinces in coming years.

Q1.1. To what extent have the following HIV treatment care and support services been implemented?

The majority of people in need have access to …..	
Antiretroviral Therapy	Strongly agree
ART for TB patients	Strongly agree
Co-Trimoxazole prophylaxis for PLHIV	Strongly agree
Early Infant Diagnosis	Agree
HIV care and support in the workplace	Agree
HIV Voluntary Counseling and Testing for people with TB	Agree
HIV treatment services in workplace/referral system through workplace	N/A
Nutritional care	Disagree
Paediatric AIDS treatment	Agree
Post-delivery ART provision to Women	Agree
Post-exposure prophylaxis for non-occupational exposure to HIV	Disagree
Post-exposure prophylaxis for occupational exposure to HIV	Agree
Psychosocial support for PLHIV and their families	Disagree
Sexually transmitted infection management	Agree
TB infection Control in HIV treatment and care facilities	Agree
TB preventive therapy for PLHIV	Agree
TB Screening for PLHIV	Agree
Treatment of common HIV related infections	Disagree

Q1.2. Overall, on a scale of 0-10, how would you rate the efforts in the implementation of HIV treatment, care and support programs in 2011?

5
Since 2009, what have been key achievements in this area?
Despite interrupted funding due to the devolution process, with funding from UN, we ensured that all PLHIV registered with us had no break in their ARV therapy and all lab testing.
What challenges remain in this area?
• Poor planning, diminished resources and inability to deliver on previous targets has led to a down scaling to of HIV treatment, care and support efforts in the country. • More VCCT centers are needed to widen the catchment of at-risk populations. • We must introduce coordination with Hepatitis programs since both infections follow similar dynamics.

Q2. Does the country have a policy to address the HIV needs of OVC?

NO

Q7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?

5
Since 2009, what have been key achievements in this area?
Development of care and support framework for HIV infected and affected children.
What challenges remain in this area?
OVC are not a big group within vulnerable populations, so they are not recognized as a key population in Pakistan, which presents a challenge since in reality they are a vulnerable sub-population.

LIST OF FIGURES