UNGASS Indicators
Country Report

Pakistan

National AIDS Control Program

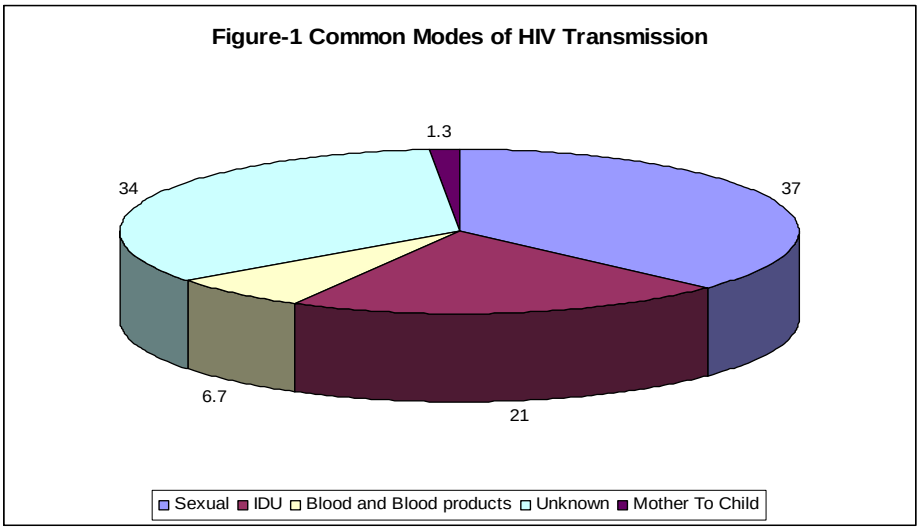
Reporting period: January 2003 – December 2005

Status at a glance

Status of HIV/AIDS in Pakistan

Pakistan at present is categorized as "Low-Prevalence High Risk" country for Human Immunodeficiency Virus (HIV) infection. According to the National AIDS Control Programme/Ministry of Health estimates using WHO/UNAIDS Epiforecast model the number of HIV infected individuals in Pakistan at the end of 2005 are between 70-80, 000 in a total population of 157 million, with a prevalence of 0.1% among general population. Data reveals that most infections occurred between ages of 20-44 years, with males out numbering females by a ratio 7:1. The sexual transmission, i.e. both hetero-sexual and male-to-male, accounted for majority of the reported cases (37%) whereas other modes of transmission in order of occurrence included: injecting drug abuse (21%); infection through contaminated blood and blood products (6.7%); and mother to child transmission (1.3%); however in 34% of cases the mode of transmission remained unknown, probably due to stigma and lack of awareness [1](Figure-1).

Figure-1 Common Modes of HIV Transmission



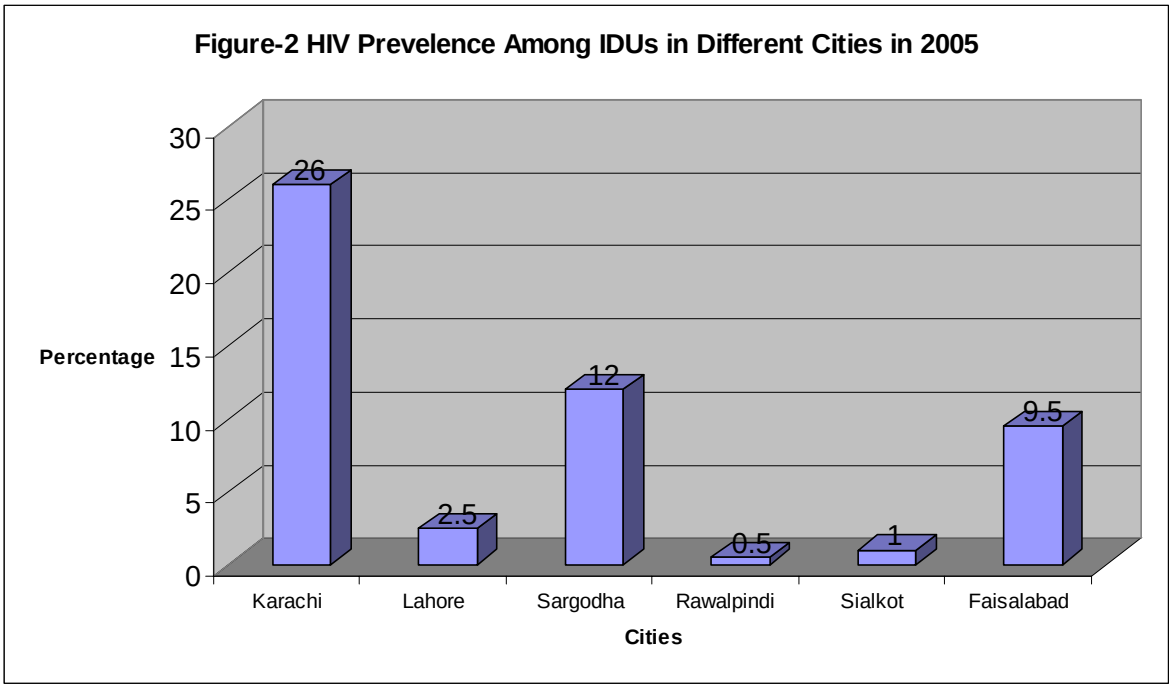
Source:
National AIDS Control Programme, Sept 2005

Concentrated Epidemic (2004 onwards)

In July 2003, an outbreak of HIV infection was identified among the Injection Drug Users (IDUs) in Larkana, Sindh province. Given a ten months period (August 2003 to June 2004) the number of reported

1 National AIDS Control Programme, Sept 2005

HIV cases increased from 19 to 69 among the IDUs in jail. During the same time period similar trends were observed in Karachi, where 7% (57) of IDUs were reported as HIV positive against the total number screened (n=800) by the Sindh AIDS Control Programme. This indicated a rise in proportion of HIV infection among IDUs in Karachi which was further validated through several studies reporting the rising prevalence from 0.4 % in January to 7.6% in August 2004[2] and then to 23%[3] and 26 %[4] respectively. This increasing level of HIV among high risk vulnerable groups indicates that HIV and AIDS epidemic in the country has shifted from low level to "concentrated" among the IDUs in Karachi, Sindh. The HIV prevalence among IDUs in various cities of the country also reported increasing prevalence; 26% in Karachi; 2.5% in Lahore; 12 % in Sargodha; 0.5% in Rawalpindi; 1% in Sialkot; and 9.5% in Faisalabad[2,5] (Figure-2).



Source:
Pilot Study conducted by the HIV/AIDS Surveillance Project, March 2005,
Baseline Study on HIV and STIs Risks Among IDUs in Lahore, Sargodha, Faisalababd and Sialkot, June-July 2005, Nai Zindagi and Associates

2 National AIDS Control Programme Surveillance, 2004
3 National Study of Reproductive Tract and Sexually Transmitted Infection, National AIDS Control Programme, 2004
4 Pilot Study conducted by the HIV/AIDS Surveillance Project, March 2005,
5 Baseline Study on HIV and STIs Risks Among IDUs in Lahore, Sargodha, Faisalababd and Sialkot, June-July 2005, Nai Zindagi and Associates

Overview of the AIDS epidemic

Impact indicators

• Rising HIV prevalence

Despite low prevalence of HIV and AIDS in the general population, reports show local outbreaks among injecting drug users whose linkages and sexual networking with mainstream population makes Pakistan vulnerable to the threat of generalized epidemic. Moreover, the existence of a number of high risk sexual behaviors among general population, internal and external migration, high level of injection use, unsafe invasive medical practices and inadequate health and social services are some of the factors increasing the risk of generalized HIV epidemic in the country. Particular behaviour pattern or exposure to potential risk avenues make some groups of people more-at-risk of infection, and these groups include Female Sex Workers (FSW), Male Sex Workers (MSW), Injecting Drug Users (IDUs), jail inmates, coal miners, etc. Further, denial about risks and vulnerability, and social stigma attached to HIV and AIDS further aggravates the problem.

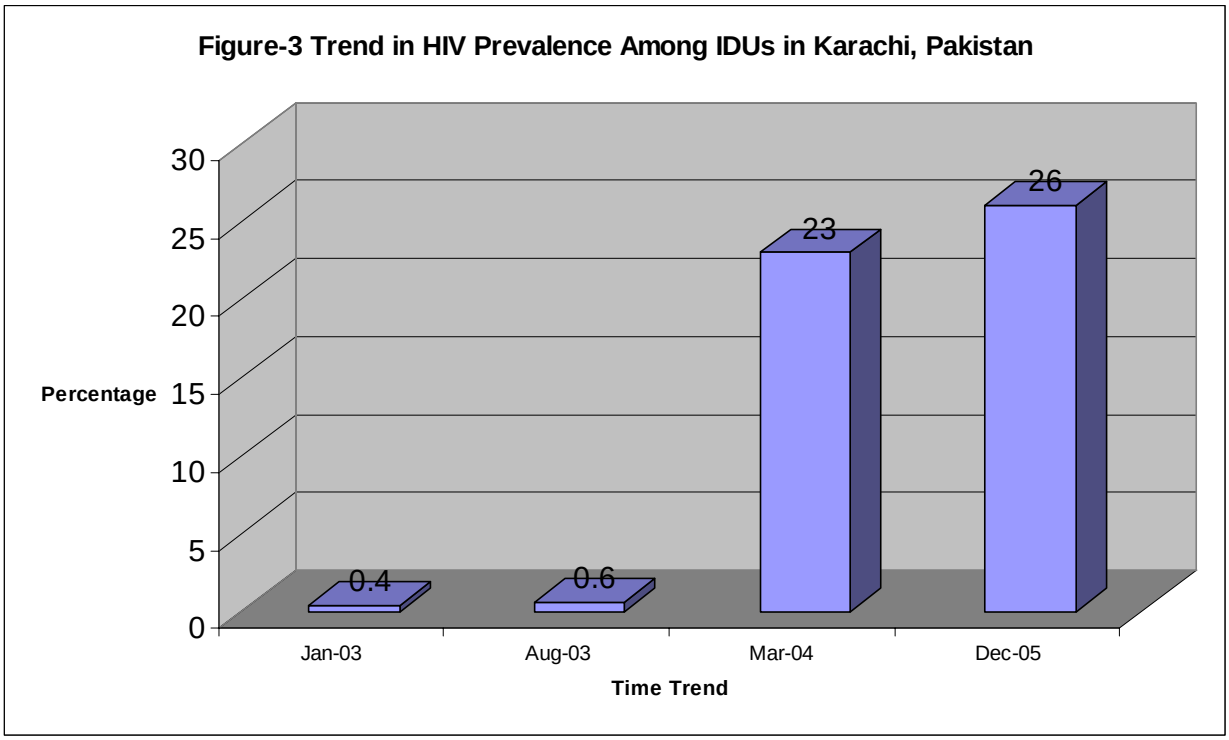
Pakistani women in general are more vulnerable to HIV and AIDS infection due to biological and socio-economic factors. Gender inequalities also play a facilitating role in transmitting HIV and AIDS to them. Since women in the country in general have lower socio-economic status, less mobility and lacks decision making power, all of these factors further contribute to their HIV vulnerability. For example, because of gender disparities in educational enrolment, the literacy rate is much lower among female (41%) than male (64%). Thus, while illiteracy presents an obstacle for HIV and AIDS prevention efforts in general, it is much harder to reach women than men with information about how they can protect themselves from HIV infection. Additionally, restrictions on mobility often make it difficult to access health and social services, including basic reproductive health care services. Finally, in situations where their decision making power is restricted, it is unlikely that all women are equipped with skills to negotiate with their partners for safer sexual practices.

Pakistani youth like rest of the world are also vulnerable to HIV infection as adolescence is a time when young people may be curious about sex and drugs, are forming their habits and values, and are heavily influenced by their peers. Moreover, other contributing factors like unemployment, easy availability of narcotic drugs, and economic frustration can all influence young people to engage in unsafe behaviour which may put them at increased risk of HIV infection. The special vulnerability of young people is, at least in part, related to lack of information and awareness about reproductive health in general and HIV and AIDS and other Sexually Transmitted Infections specifically. Because social taboos related to sexuality inhibit the open discussion of issues related to sex and reproductive health, opportunities to

gain accurate information about such issues and to learn skills with which to protect oneself from infection are often quite limited for the vast majority of youth. In addition street youth is more exposed to sexual violence and abuse.

In Pakistan it is a common practice for men to travel away from their homes to find work, either within the country (20 million in-migration annually by Labour Force Survey) or abroad. In addition there are certain professions such as long distance truck drivers, uniformed personnel, overseas migrants, etc., who have to remain away from their families for longer durations ranging from days to months depending upon specific situations. This separation from their spouses, families and communities leading to loneliness and isolation, and increase their vulnerabilities. Because of these risks they may indulge to high risk sexual behaviour and can acquire HIV/AIDS and can transmit infection to others.

In relation to HIV transmission and potential epidemic, the most alarming statistics is the rising trend in the prevalence of HIV among IDUs in Karachi from January 2003 (0.4%) to 2005 (26%) (Figure-3).

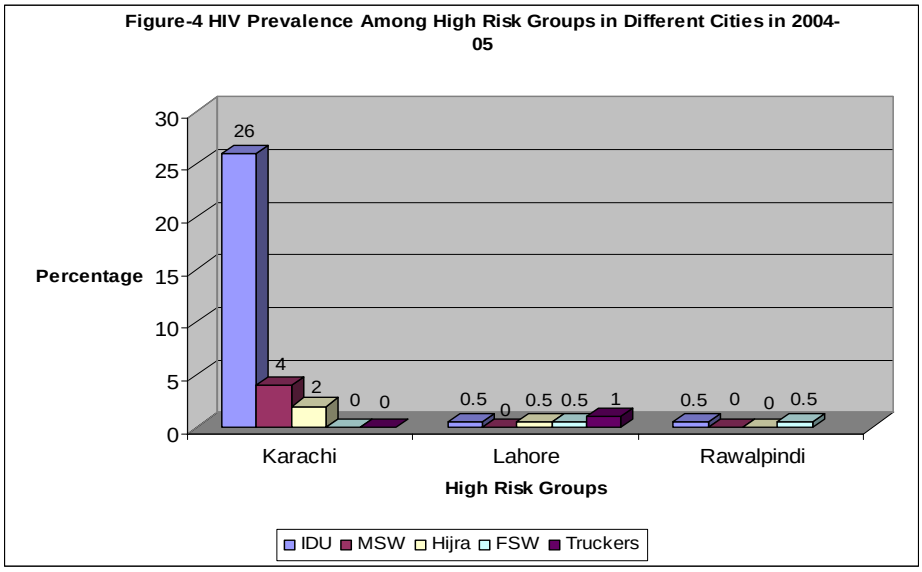


Source:
National RTI/STI Study. National AIDS Control Programme, Ministry of Health,
Pilot Study conducted by the HIV/AIDS Surveillance Project, 2005
Altaf A, et al. Harm reduction among injection drug users in Karachi, Pakistan. Presented at the XVth International HIV/AIDS Conference, Bangkok, 2004 and National Study of Reproductive Tract And Sexually Transmitted Infections [3]

6 Altaf A, et al. Harm reduction among injection drug users in Karachi, Pakistan. Presented at the XVth International HIV/AIDS Conference, Bangkok, 2004 and National Study of Reproductive Tract And Sexually Transmitted Infections [3]

- **HIV Prevalence in Most-at-Risk Populations -High Risk Behaviour Groups**

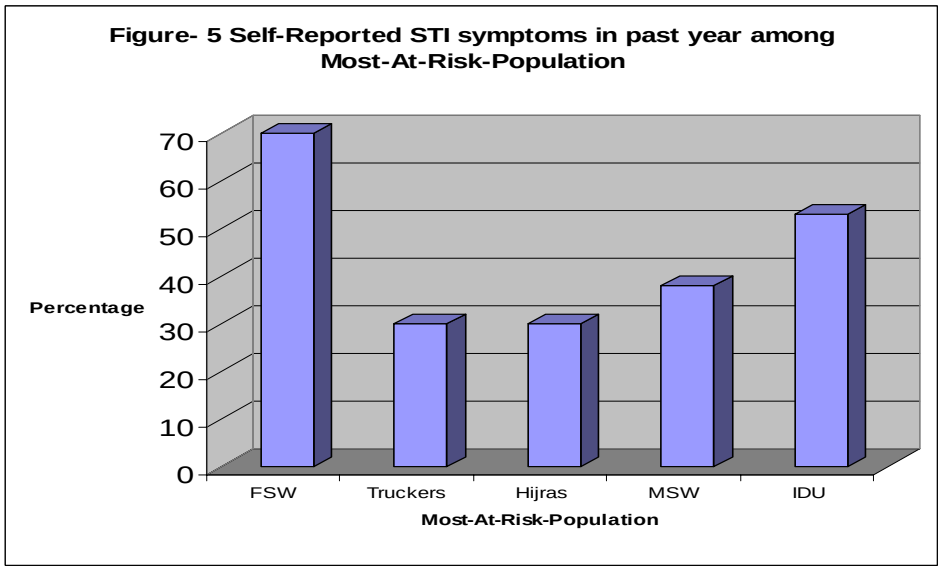
Two studies conducted by National AIDS Control Programme (NACP)/ Ministry of Health (MOH) reveal high HIV prevalence among few of the risk groups in one city of the country (Figure-4).



Source:
National Study of Reproductive Tract And Sexually Transmitted Infections, Survey of High Risk Groups in Lahore and Karachi, March-August 2004, National AIDS Control Programme, Ministry of Health, Government of Pakistan,
Pilot Study under the HIV/AIDS Surveillance Project, National AIDS Control Programme, March 2005

- **STI Symptoms Among Most-at-Risk Populations -High Risk Behaviour Groups**

The same study shows that a significant proportion from every high risk group reported symptoms of STI during the past one year. At least 30% of the respondents in all groups reported STI symptoms in the previous year; the highest percentage was among FSWs (70%) followed by IDUs (53%) (Figure-5).



Source:
National Study of Reproductive Tract And Sexually Transmitted Infections, Survey of High Risk Groups in Lahore and Karachi, March-August 2004, National AIDS Control Programme, Ministry of Health, Government of Pakistan

National Response to the AIDS epidemic

1. National Response

Government of Pakistan's Commitment

Pakistan is signatory to a number of international conventions including International Conference on Population Development (ICPD), United Nations' latest agenda of Millennium Development Goals (MDGs), United Nations Special Session on HIV and AIDS (UNGASS), etc.; all of which embrace goal and targets for combating HIV and AIDS. In addition, Pakistan is one of the countries that has always shown persistent and earnest commitment to fight the epidemic. The Government has reflected these commitments through incorporating RTI/STIs and HIV as one of the priority issues into its policy documents including, National Policy for Development and Empowerment of Women[7], Population Policy of Pakistan[8], Reproductive Health Services Package 1999[9], National Health Policy 2001[4] and Poverty Reduction Strategy Papers 2003[11].

Furthermore, in its Medium Term Development Framework (MTDF) (2005-10)[12] the government has included the target to reduce the prevalence of HIV and AIDS among vulnerable groups and pregnant women by 50% under the National Response to fight HIV and AIDS during the planned period. The Government has translated these policies through designing and implementation of Enhanced National AIDS Control Programme for five years (2003-08) costing Rs. 2.9 billion. Within this program the federal and provincial governments have promulgated ordinances on safe blood transfusion services for ensuring blood safety. This is also earmarked as a priority programme with enhanced budget allocation for the next decade in the Pakistan's Plan of Action, 2005 [13].

The government's commitment is also evident from public private partnership and use of other government and civil society organizations to support HIV and AIDS preventive interventions. Furthermore, the process for the development of the national policy for HIV and AIDS for mainstreaming HIV and AIDS into all sectors has been initiated and is expected to be completed in early 2006. In addition to create conducive political environment and commitment, efforts with UNAIDS support has been initiated to expedite the response by involvement of parliamentarians at federal and provincial levels.

7 National Policy for Development and Empowerment of Women, GoP
8 Population Policy of Pakistan, MoPW, GoP
9 Reproductive Health Services Package 1999, Ministry of Health and Ministry of Population Welfare, GoP
10 National Health Policy 2001, MoH, GoP
11 Poverty Reduction Strategy Papers 2003, GoP
12 Medium Term Development Framework, 2005-10, Planning Commission, GoP, May 2005
13 Pakistan Plan of Action to Implement SAARC Social Charter, Planning Commission, GoP

Ministry of Health (MoH)

Historical Perspective

Pakistan began testing for AIDS as early as 1986; however, a more formal national response to HIV and AIDS began in 1987 with the establishment of Federal Committee on AIDS (FCA). The FCA defined the broad policy guidelines, though, at this stage the programme was mainly laboratory oriented and technical support mainly came through World Health Organization (WHO). The first government financed program was initiated in early 1990 in the form of the National AIDS Control Programme (NACP) with a focus on HIV and AIDS awareness campaign and increased facilities for HIV case detection. Subsequently in 1994, program was brought under Social Action Program (SAP) with a more pragmatic agenda including information education, blood safety, and establishment of independent provincial and Azad Jammu and Kashmir (AJK) implementation units.

Pakistan National AIDS Control Programme

There is a progressive effort by the Government of Pakistan, with support from UN agencies and other bilateral and multi-lateral development partners, for continuously strengthening the national response against HIV and AIDS to ensure an effective, well coordinated and sustainable multi-sectoral programme through advocacy, institutional capacity building, policy support and innovative strategies. The government is scaling up its nationwide HIV and AIDS programme linking prevention, care and treatment with major focus on high risk behaviour groups of the population. The Government of Pakistan is channelizing its response to the scourge of HIV and AIDS through the National and Provincial/AJK AIDS Control Programmes, the response is coordinated through a federal cell that lays down the policy guidelines, develop standardized services, protocols and indicators for implementation through Provincial AIDS Control Programmes(PACPs). NACP has been able to successfully bring under one umbrella the fragmented HIV and AIDS interventions which were taking place by different organizations and institutions. The programme has been able to develop systems in relation to financial flow mechanism, service delivery and monitoring and evaluation.

In order to promote interaction and coordination between government, development partners, private sector, civil society and People Living With HIV and AIDS (PLWHA) for implementing HIV and AIDS strategies and programmes a number of bodies with clear Terms Of References (TORs) have been established. These bodies facilitate implementation and surveillance and provide technical inputs and include: (1) National Steering Committee (NSC); (2) National Technical Advisory Committee on AIDS (TACA), this committee is in process of developing its plan of action; (3) Provincial Task Force (PTF),

operating at respective provinces. In addition there is also a national civil society HIV and AIDS body namely Pakistan National AIDS Consortium (PNAC) that is supporting coordination of HIV related services by civil society organizations. The objective of PNAC, having one federal and four provincial bodies, is to organize and build capacities within civil society for implementation of HIV and AIDS related services. Another support to GoP funded activities is a coordinated UN response in the form of United Nations Implementation Support Plan (UNISP) which is currently under revision.

Strategic Framework

In 1999-2000 the Government of Pakistan with UNAID support developed a National Strategic Framework for HIV/AIDS through a consultative process involving a large number of stakeholders. The first step in this consultative process was Situation and Response analysis which identified the gaps and weaknesses in the national response to HIV and AIDS and also laid the foundation for the formulation of National Strategic Framework 2002-2006. The nine priority areas of the Strategic Framework which the GoP had endorsed and implementation are part of national response are:

1. Expanded Response
2. Vulnerable and High Risk Groups
3. Surveillance and Research
4. Youth
5. Sexually Transmitted Infections
6. General Awareness
7. Blood and Blood Product Safety
8. Infection Control
9. Care and Support

It also provides a basis for the policy framework and gives policy mandate for HIV/AIDS interventions in public as well as in private sector. Later the strategic framework was translated into a Plan of Action currently being implemented under the World Bank supported Enhanced HIV and AIDS Programme (2003-2008). In addition to GoP commitment, UN agencies, DFID, CIDA, USAID, EU, GFATM and other development partners are also contributing to the national response.

2. Enhanced HIV/AIDS Control Programme (2003-2008)

This is the major response to HIV and AIDS epidemic being implemented under the leadership of MoH. The main objectives of the Enhanced programme are:

- Increase prevalence of safe behaviour and improved availability of STI services among vulnerable populations.
- Increase knowledge and practice of HIV preventive measures including use of high quality STI services, reduce the vulnerability of youth, labour and uniform personnel
- Reduce transmission of HIV through transfusion of blood and blood products
- Strengthening capacity to effectively manage HIV and AIDS programme in public and private sector.

Design

The programme was designed on scientific basis and a total of 13 research studies were undertaken that formed the basis for prioritization of the key areas and design of intervention for implementation. The programme was designed using a broad-based consultative process with major stakeholders including development partners, civil society, etc.

Implementation

In the programme the Government of Pakistan through its federal programme is mainly responsible for:

i. Providing policy guidance,
ii. Developing standardized training material, guidelines and protocols,
iii. Monitoring and supervision,
iv. Surveillance and research and
v. Networking, coordination and advocating with donor agencies at national and international levels.

Whereas the provincial programmes are primarily responsible for:

i. Implementing the interventions
ii. Networking, coordination and advocating at provincial and district level.

The major focus of the programme is public private partnership where NGOs through TACA, Provincial Task Force (PTF) and other respective committees and bodies are being involved in all the phases of the programme including; planning; designing; implementation; execution; management; and monitoring and surveillance.

Public-Private Partnership

Since access to these high risk population groups was a challenge for the public sector, therefore innovative approaches e.g. public private partnership was used to provide services to them. This is one of the pioneer programmes of MoH undertaking key implementation of services under public private partnership initiative. Not only the private sector, NGOs and PLWHA are also involved in the following key areas:

- Programme design
- Service delivery
- Research
- Monitoring and Surveillance
- Capacity Building

In addition, the national programme also contributes technically in capacity building initiatives by various donors and private sector /civil society organizations. One of the examples is TAMEER project in which NACP with support from European Commission (EU) is coordinating NGO capacity building.

Components

National response results from government's sincere and continuous commitment and a close and effective coordination between government, developmental partners and NGOs, including international, national and local. The major components of national response can be described under the following main intervention areas:

1. Prevention

The prioritized areas in this are:

i. Interventions among the Vulnerable Populations:

The national programme envisages reducing the vulnerability of specific population sub-groups, identified on the basis of prevalent risky behaviour and practices, and these groups include FSWs, MSWs, IDUs, long distance truck drivers and jail inmates. The services provided under the programme are:

a. **Providing Services to the Vulnerable Populations Through the NGOs:**

The major focus of the programme is on providing specific services to the vulnerable populations through NGOs. The respective PACPs have identified and delegated service package to selected NGOs and are supervising and facilitating management and supervision of NGO activities at the provincial level. PACPs are also facilitating research activities and

service delivery to the vulnerable groups. The package of services for high risk groups include:

i. Primary Health Care including Reproductive Health
ii. STI management
iii. Voluntary Counselling and HIV Testing
iv. Behavioural Change Communication intervention
v. Empowerment
vi. Harm reduction-Detoxification
vii. Referral for other medical problems –including treatment for opportunistic infections and antiretroviral therapy.
viii. Condom distribution
ix. Social services

b. **Pilot Testing of Innovative Approaches:**

Grants are allocated in the programme for research and trying out small scale innovative models for service delivery among high risk groups. Some of the initiatives are:

i. Intervention trial of female condoms among FSWs, Karachi
ii. Empowerment of women legislators through capacity building in Balochistan
iii. Female youth capacity building through vocational skill training to change health care seeking behaviour in Chakwal.
iv. Intervention on the involvement of religious leaders of mosque's and Madressa's in FATA in raising awareness about HIV and AIDS.

ii. Prevention of HIV/STI Transmission through Blood Transfusion

The initiative has been launched with a focus on regularization of private sector and bringing them in line with the standardized quality assurance mechanism. The following initiatives have been undertaken promoting blood safety:

- Enactment of Blood Safety Ordinance (Federal and Provincial Levels)
- Quality Assurance System developed and implemented
- Screening of all blood and blood products for HIV, HBV/HCV and other transfusion transmittable diseases
- Human Resource Development
- Establishment of a Monitoring System

iii. In addition, a number of initiatives with development partner support are at various stages of implementation including:

Injection Drug User Project

NACP/MoH, Ante-Narcotics Force (ANF)/ Ministry of Narcotic Control (MoNC) together with NGOs and civil society organizations with DFID support is implementing HIV Prevention and Drug Harm Reduction services through seven projects in all four province's headquarters. These projects upon cessation of DFID grant have been continued under government's financing. The major achievement of the project has been a policy change in the MoNC as it has mainstreamed Harm Reduction in its policy and also decriminalized drug use.

2. Knowledge and Behaviour Change

Behavioural Change Communication and Advocacy

The national response under its BCC component includes several projects which are in different design and implementation phases:

i. Prevention Among General Public

The national programme aims to improve the awareness level of general population to reduce their vulnerabilities through informing them about STIs (including the role of STIs in the spread of HIV), the need to create a supportive environment for PLWHA and promotion of condom use for disease prevention. In this regard the programme has contracted a BCC firm which has been utilizing the BCC and Advocacy strategy to first sensitize the general population about the issue and then gradually will move towards attitude and behaviour change related interventions. Various interventions which are being implemented include:

b. Print and electronic media
c. Public places/avenues and similar opportunities
d. Specific relevant occasions such as World AIDS Day, etc

ii. Prevention Among Vulnerable Groups

a. Youth

NACP/MoH, Ministry of Education (MOE) with support from UNICEF, UNESCO, USAID through Family Health International and GFATM has taken various initiatives and implemented several projects for youth, both in school and street children/youth, using Life Skill-based Education

approaches. The main initiatives under these projects are: development of life skill-based curriculum for training school teachers; teacher training manual; development and production of guidebook (in Urdu); and development and implementation of BCC strategies and interventions.

b. Migrant workers

About four million Pakistanis are working abroad who although are low risk group, yet, since 258 migrant workers were tested positive; the national programme plans to approach them under its BCC intervention. Some of the initiatives in which national programme is collaborating and working with other partners are:

- NACP in collaboration with Ministry of Labour (MoL) with the support from UNDP and ILO has developed a preventive HIV/AIDS Education programme with the aim to create awareness about HIV and AIDS among the organized labour workforce including factory workers, truck drivers and migrant labours.
- NACP with MoL out of its resources has also implemented a project for the prevention and awareness on HIV and AIDS for industrial workers and overseas migrant workers (approximately 150, 00-200,000).

3. Treatment, Care and Support for PLWHA

NACP/MoH with UNICEF, WHO, UNFPA support has developed standardized technical guidelines and protocols for the management of PLWHA. A Human Resource and Development Plan is currently being implemented. Under this initiative the NACP and PACPs have established four treatment centres at three provinces and federal capital territory and providing services including management of opportunistic infections and TB Management. The most important initiative is provision of free Anti-Retro Viral (ARV) therapy under the Global Fund financing for PLWHA through these centres.

Programme Budget:

Expenditures: Amount of National Funds Disbursed by Government

The strong and persistent GoP commitment towards the prevention of HIV and AIDS epidemic is evident from a rising trend in the budget allocation during the past 12 years as it has increased from Rs 30 million during the year 1994-95 to Rs 394 million during 2005-06 (Table 1).

Table-1
Trend in GoP Funds Status Allocation, Releases and Expenditure At federal Level

Serial #	Years	Allocation	Releases	Expenditure
1	1994-95	30.00	29.16	28.199
2	1995-96	71.00	71.00	70.751
3	1996-97	50.00	29.25	29.250
4	1997-98	40.00	20.00	20.000
5	1998-99	80.00	80.00	80.000
6	1999-2000	80.00	80.00	77.221
7	2000-2001	92.00	67.00	64.448
8	2001-2002	184.00	184.00	177.592
9	2002-2003	180.00	158.805	142.106
10	2003-2004	173.00	32.394	28.922
11	2004-2005	200.229	162.499	148.779
12	2005-2006	253.00 141.216**	77.499* 141.216**	113.494* 141.216

*Upto December, 2005
** Global Fund Budget
Source: National AIDS Control Programme, Ministry of Health, Government of Pakistan

During the financial year 2004-05 the national programme with support from World Bank has been able to spend Pakistani Rs 437.984 million (7.2 million US $) for the prevention of HIV/AIDS. A further break down of this amount in terms of funding source and disbursement location is given below (Table-2).

Table-2
National Funds Disbursed for HIV/AIDS Prevention

Place of Disbursement	Total
Federal Level	148.779
Punjab	105.732
Sindh	59.083
NWFP	23.773
Balochistan	7.625
Ministry of Labour	41.662
Ministry of Education	51.39
Total	437.984 (7.2 million US $

Source: National AIDS Control Programme, Ministry of Health, Government of Pakistan

Monitoring and Evaluation (M & E)

National Monitoring department is currently under development, however, a number of important blocks of the system are already in place and under implementation. Currently monitoring is being done through:

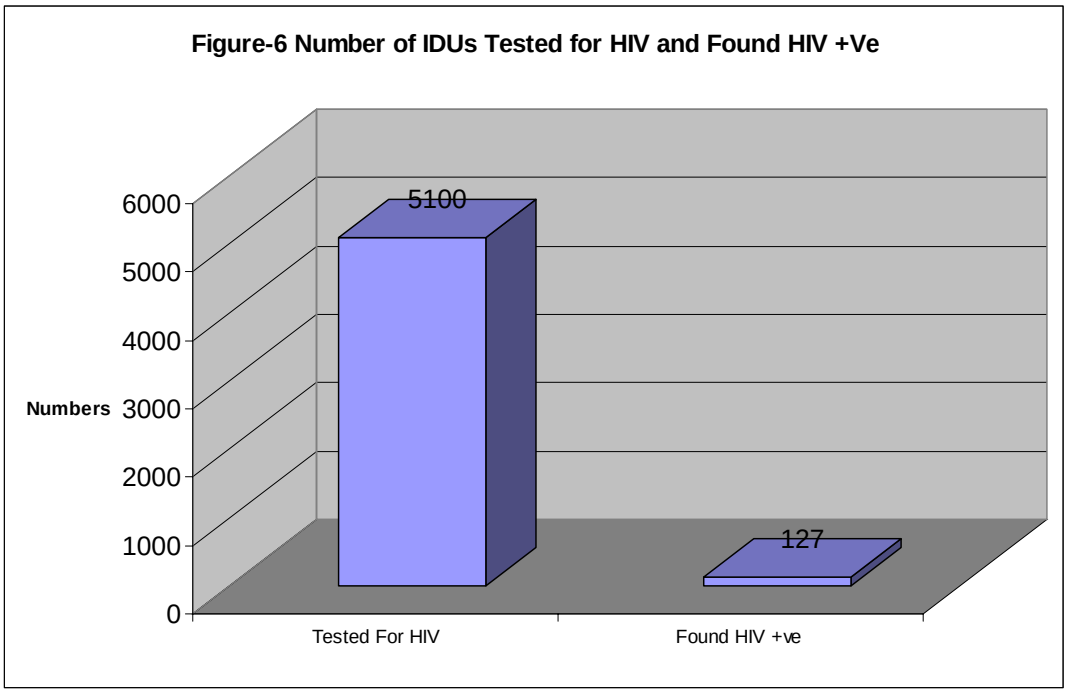
1. Monitoring and capacity building of implementing NGOs through a management firm.
2. Integrated Biological and Behavioural Surveillance is being conducted with support from CIDA-HIV and AIDS Surveillance Project (HASP)
3. Third party evaluation and HIV case reporting through 47 surveillance centres and all tertiary and secondary health care facilities from all the provinces and federal territories. This system monitors the trend of epidemic on regular basis and also the programme implementation status routinely.

National Programme Indicators:

Most-at-risk populations: HIV testing

Percentage (Most-at-risk populations) who Received HIV Testing in the Last 12 Months Who Know the Result

A Drug Harm Reduction (DHR) in Pakistan project launched under NACP has tested 5,100 IDUs, out of these 127 were found to be HIV positive estimating for a prevalence of 2.4 %. (Figure-6)



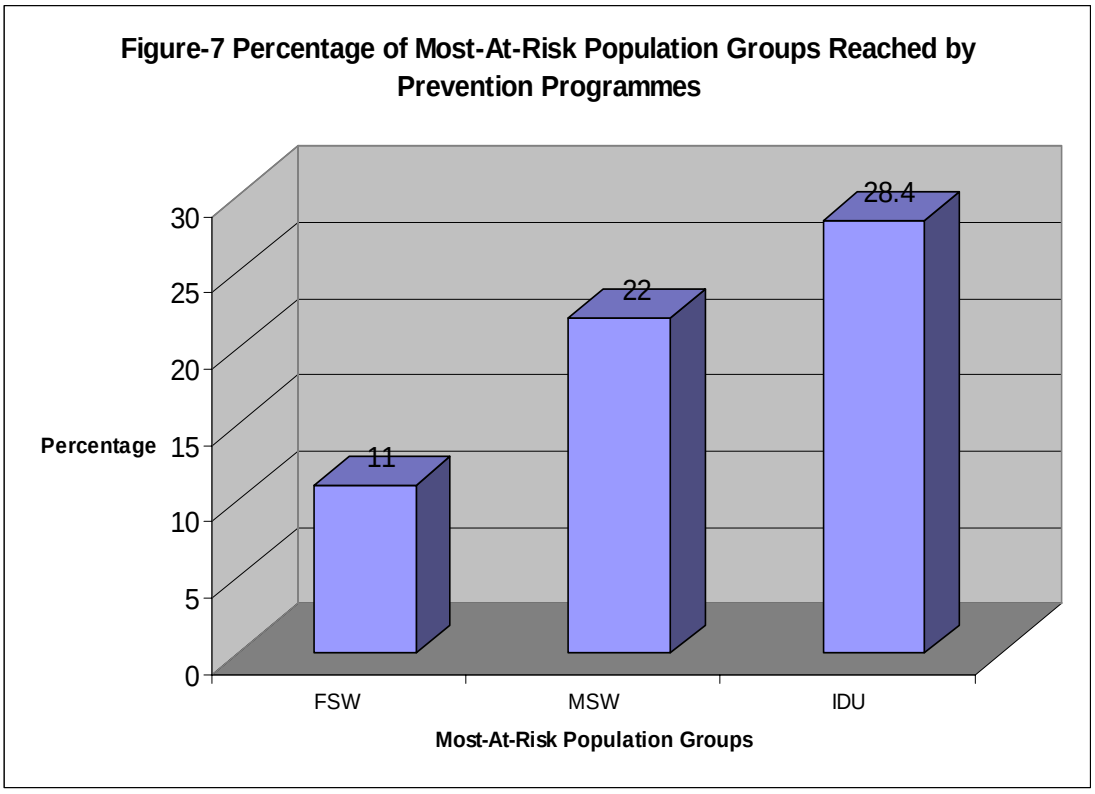
Source: HIV and AIDS Prevention with Drug Harm Reduction in Pakistan Project, Futures Group Europe, Funded by DFID 2002-05, Nai Zindagi, supported by PASP, MoH, Government of Pakistan

Similarly another project with FSW under the NACP has been able to test a total of 298 FSWs, out of which none was found HIV positive.

Most-at-risk populations: prevention programmes

Percentage (Most-at-risk populations) Reached by Prevention Programmes

Following are some of the most-at-risk population who are being reached by different intervention projects working under the national programme (Figure-7).

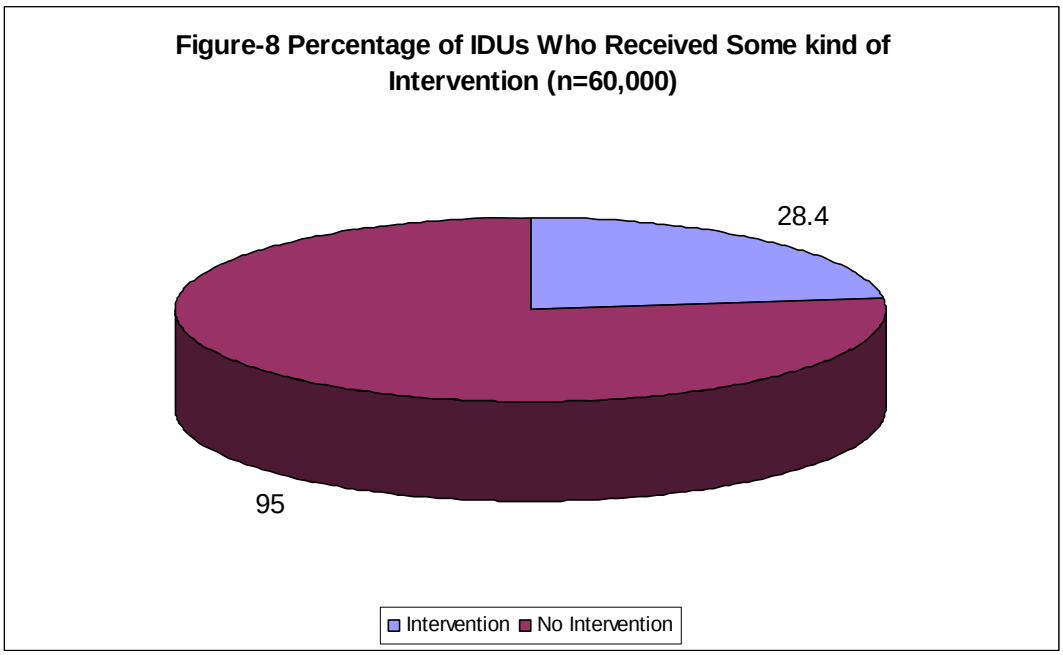


Source: Monitoring Programme 2004-05, National AIDS Control Programme, Ministry of Health, Government of Pakistan, Delivery of Primary health Care and Preventive Services for Men Having Sex with Men, Contech International Health Consultants, Amal human Development Network, Futures Group Europe.

Injection Drug Users

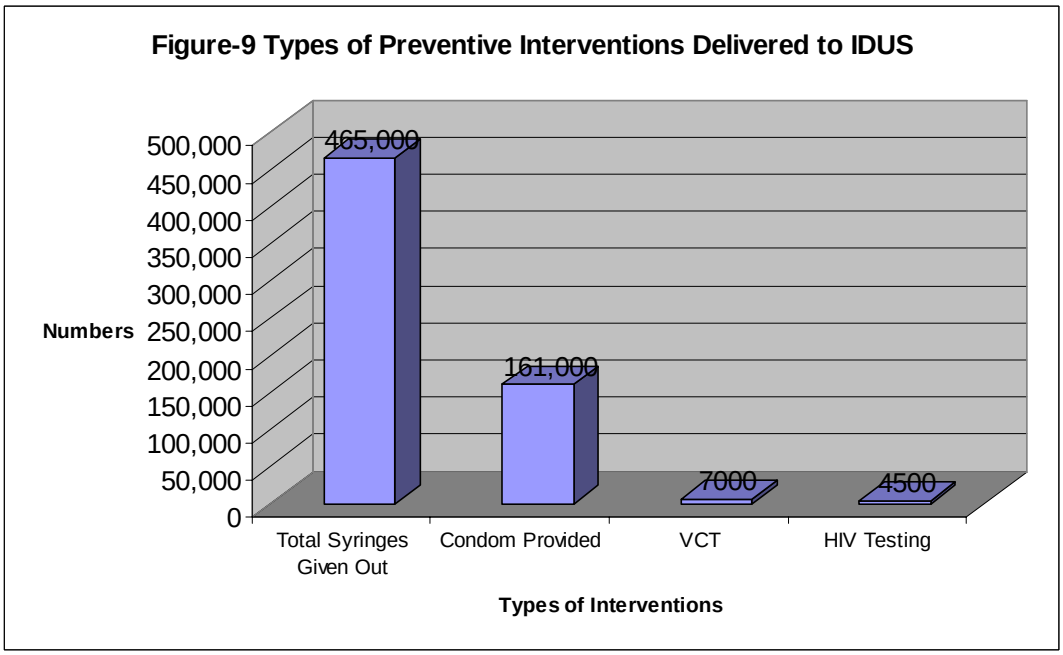
According to estimates there are about 500,000 hard-core heroin addicts in Pakistan', of which 60,000 (12%) are IDUs, mostly in urban areas. NACP plans to reach 27,000 IDUs through service packages. The services are already established in Karachi, Lahore, Rawalpindi, Peshawar, Faisalabad, Sialkot, Sargodha and Quetta. Two projects working with IDUs under the national programme reports that that

28.4% of the IDUs were reached and received some kind of harm reduction intervention during 2004-05(Figure-8).



Source: Futures Group Europe. Nai Zindagi, Monitoring Programme 2004-05, National AIDS Control Programme, Ministry of Health, Government of Pakistan

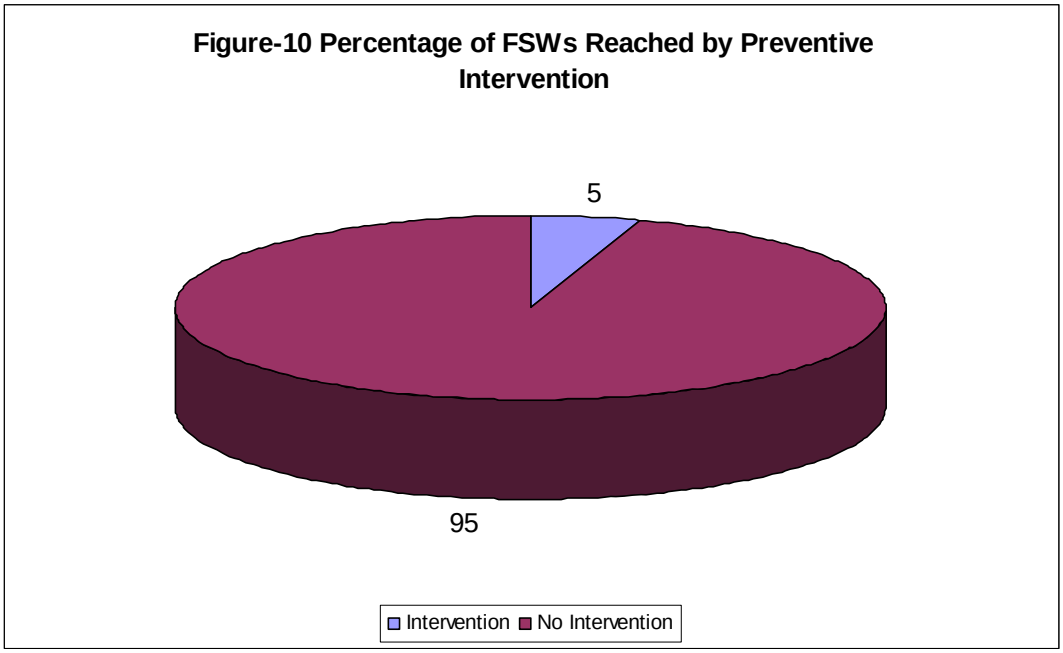
One of the project reached 16, 200 IDUs in different cities of the country and provided various preventive interventions including: syringes (465,000 with 88%exchange rate); condoms (161,000); VCT (7000); and HIV testing (45,000, out of these 2.5% were found to be HIV positive (Figure-9)



Source: Futures Group Europe. Nai Zindagi, Monitoring Programme 2004-05, National AIDS Control Programme, Ministry of Health, Government of Pakistan

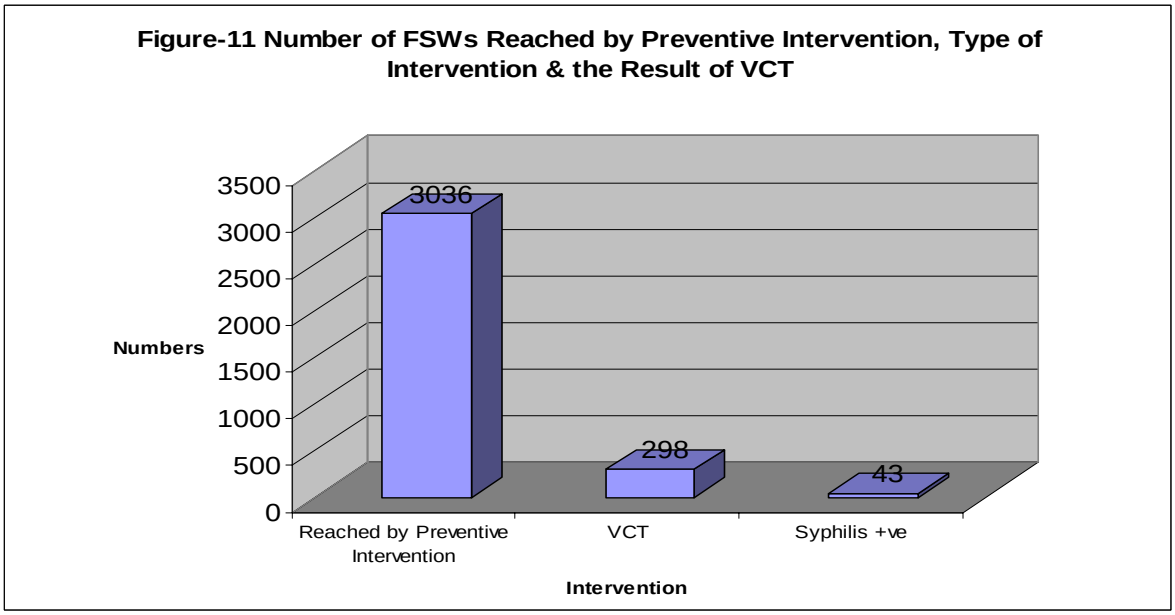
Female sex workers

According to a study undertaken by NACP in three cities of the country during 2000 estimated that there are around 99,000 FSWs in various categories i.e. brothel-based, Kothi Khana-based and street workers. A project working with FSWs, under the national programme, has been able to reach 5% (3036) FSWs out of a total of 62000 functioning in Karachi. (Figure-10).



Source: Amal Human Development Network, National AIDS Control Programme, Ministry of Health, Government of Pakistan

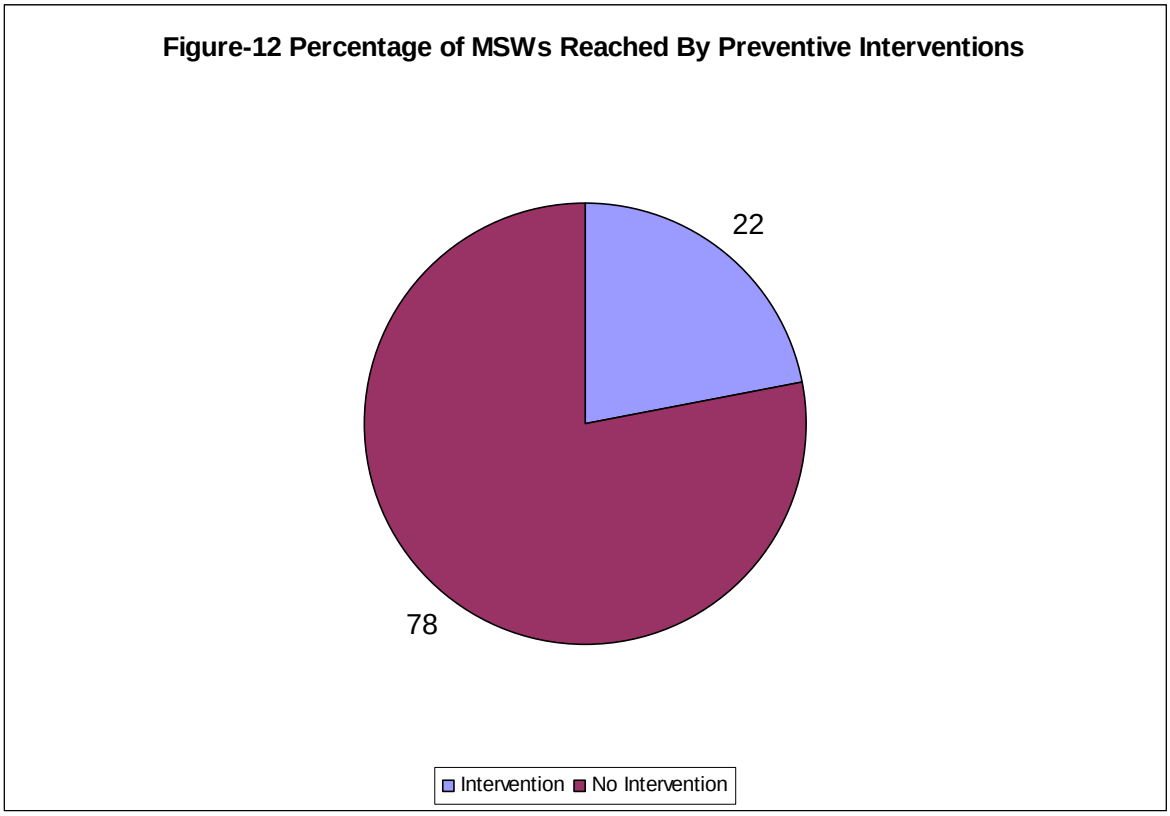
Out of these 3036 FSWs reached by preventive intervention, 10% (298) were provided with VCT services and after being tested, 14% (43) were found to be positive for Syphilis, but none was HIV positive (Figure-11).



Source: Amal Human Development Network, National AIDS Control Programme, Ministry of Health, Government of Pakistan

Male Sex Workers

The national programme estimates that there about 14,000 MSWs in nine major cities of the country. According to the M & E reports from NACP, a total of 3055 MSW were been reached by some kind of preventive interventions, estimating to a proportion of 22% (Figure-12).



Source: Delivery of Primary health Care and Preventive Services for Men Having Sex with Men, Contech International Health Consultants

Percentage of Transfused Blood Units Screened for HIV

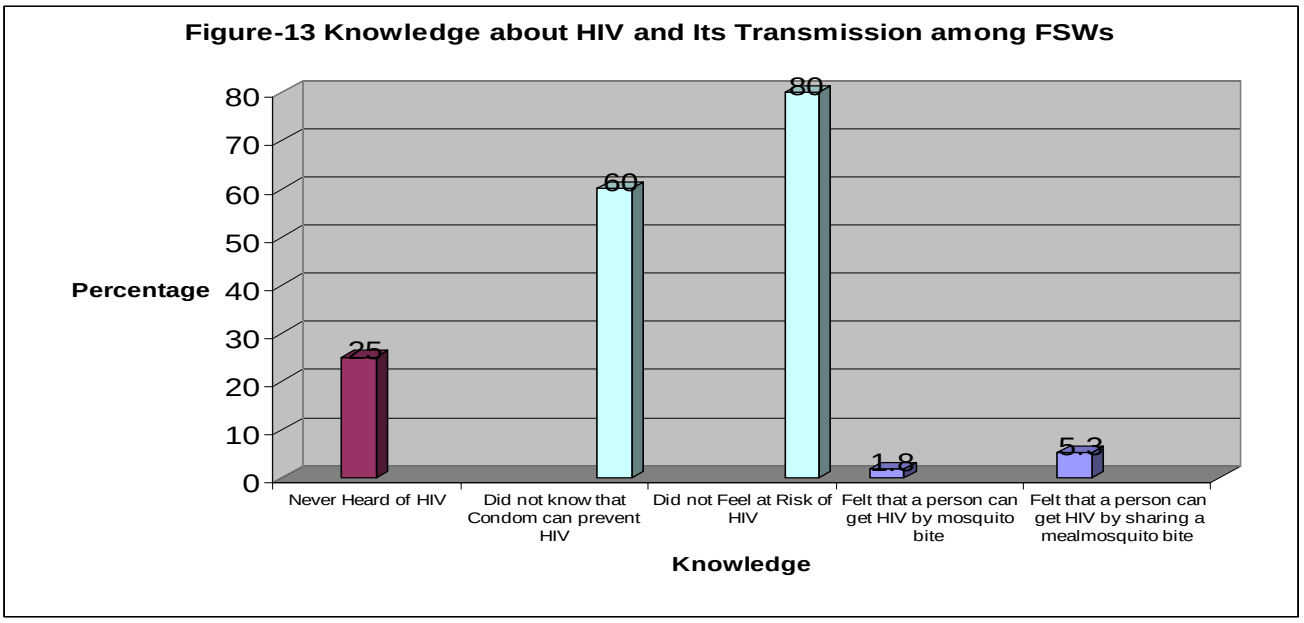
During the year 2005 a total of 224418 units of blood were screened for HIV, out of these 24 were found to be positive for HIV estimating to an HIV prevalence of 0.01% among those screened.

Most-at-risk populations: knowledge about HIV prevention

Percentage (Most-at-risk populations) who Both Correctly Identify Ways of Preventing the Sexual Transmission of HIV and who Reject Major Misconceptions about HIV Transmission

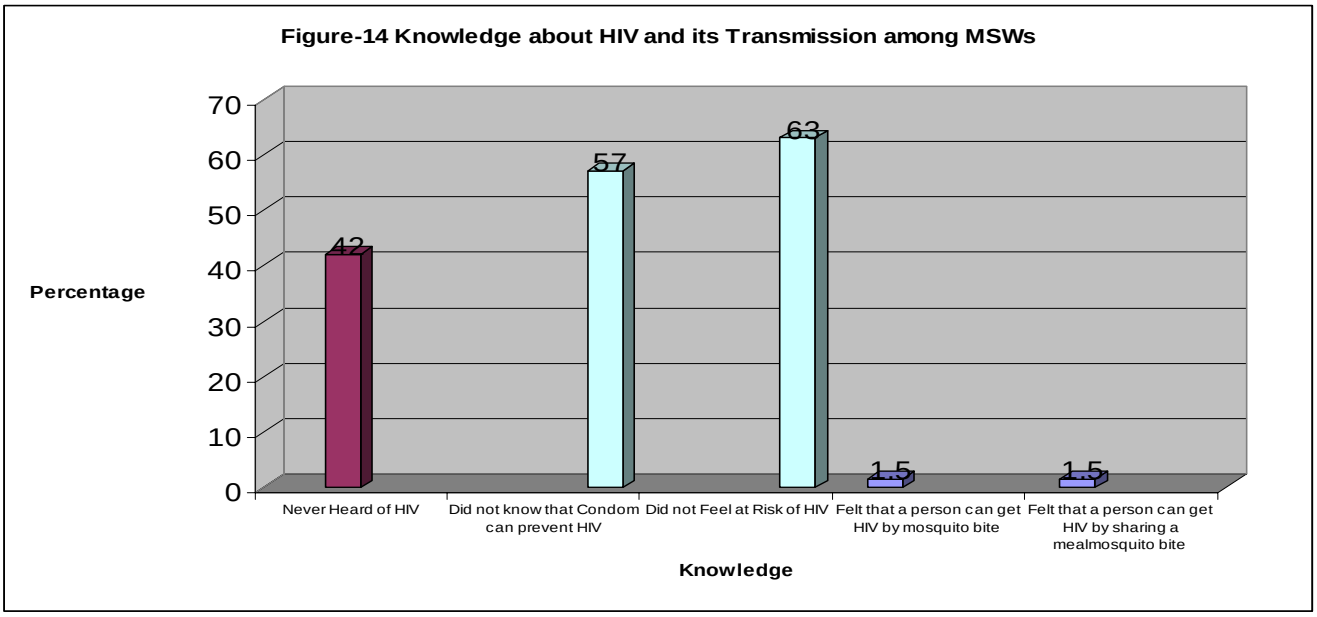
A national RTI/STI study conducted under the NACP assessed the knowledge and behaviour of most-at-risk populations during the year 2004. The study revealed that among the FSWs 25% had never even heard of HIV/AIDS, 60% did not know that condom can prevent HIV transmission, 80% did not feel at

risk for HIV, 1.8% felt that a person can get HIV by mosquito bite and 5.3 % felt that a person can get HIV by sharing a meal (Figure-13).



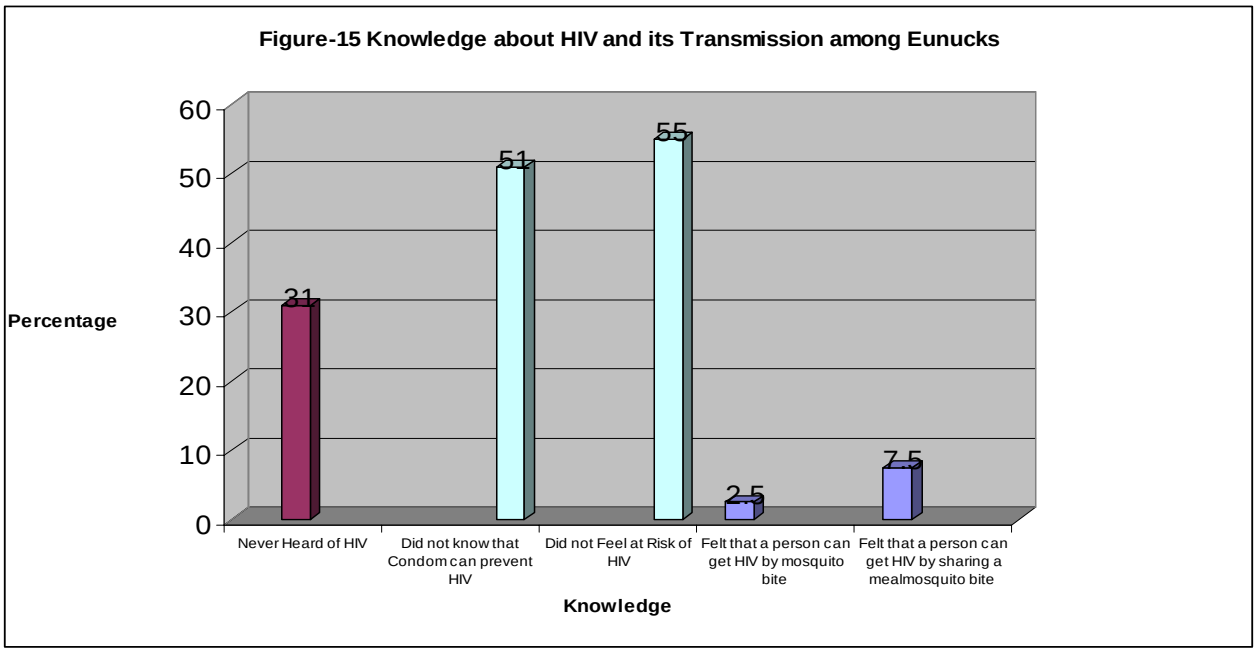
Source: National Study of Reproductive Tract And Sexually Transmitted Infections, Survey of High Risk Groups in Lahore and Karachi, March-August 2004, Family Health International, National AIDS Control Programme, Ministry of Health, Government of Pakistan

Similarly the knowledge about HIV and its transmission was also poor among MSWs and Eunuchs; among MSWs, 42% had never even heard of HIV/AIDS, 57% did not know that condom can prevent HIV transmission, 63% did not feel at risk for HIV, 1.5% felt that a person can get HIV by mosquito bite and 1.5 % felt that a person can get HIV by sharing a meal(Figure-14);



Source: National Study of Reproductive Tract And Sexually Transmitted Infections, Survey of High Risk Groups in Lahore and Karachi, March-August 2004, Family Health International, National AIDS Control Programme, Ministry of Health, Government of Pakistan

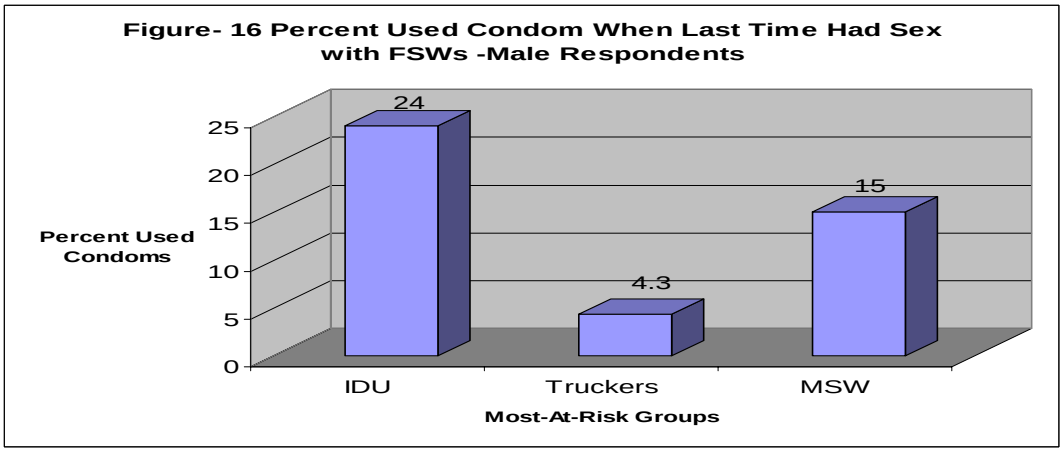
and among Eunuchs, 31% had never even heard of HIV/AIDS, 51% did not know that condom can prevent HIV transmission, 55% did not feel at risk for HIV, 2.5% felt that a person can get HIV by mosquito bite and 7.5 % felt that a person can get HIV by sharing a meal(Figure-15).



Source: National Study of Reproductive Tract And Sexually Transmitted Infections, Survey of High Risk Groups in Lahore and Karachi, March-August 2004, Family Health International, National AIDS Control Programme, Ministry of Health, Government of Pakistan

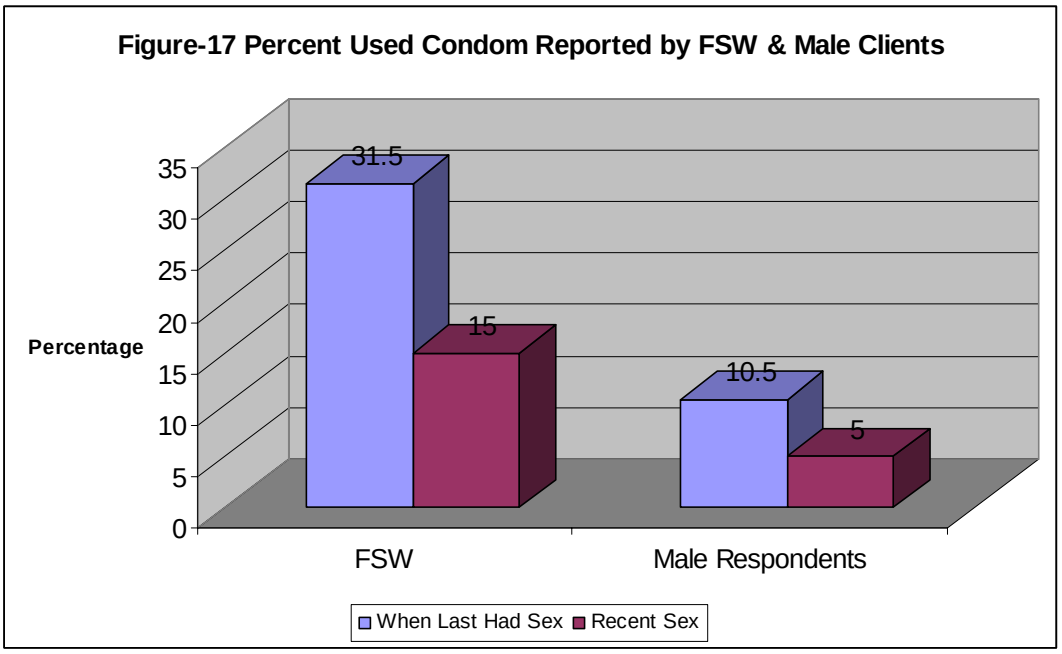
Percentage of Female and Male Sex Workers Reporting the Use of Condom with Their Most Client
Percentage of Men Reporting the Use of Condom the Last Time They Had Anal Sex A Male Partner

Despite having some degree of knowledge about HIV/AIDS among the high risk groups the condom use is consistently low among most groups (Figure-16).



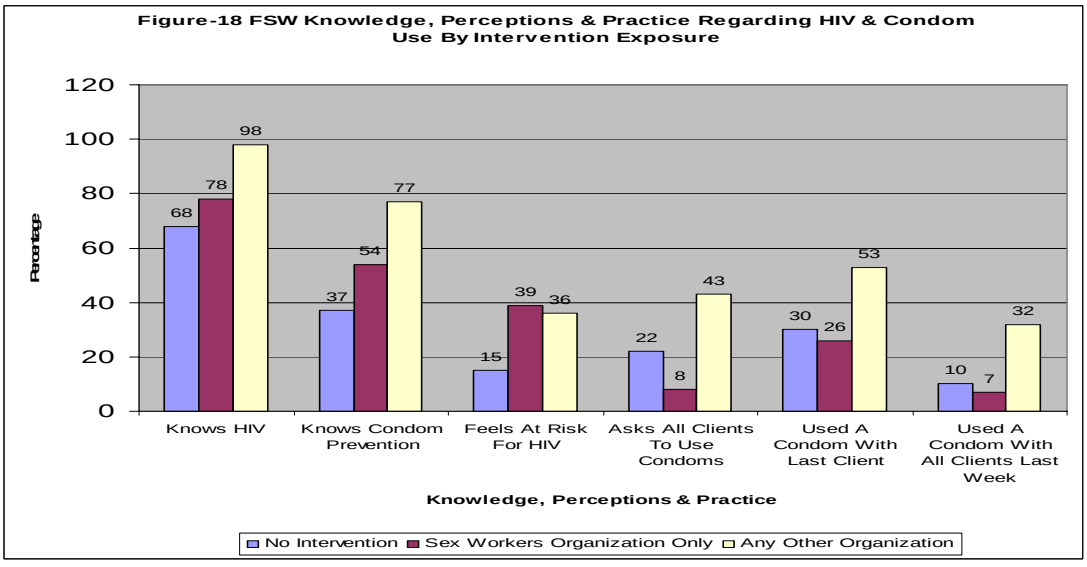
Source: National Study of Reproductive Tract And Sexually Transmitted Infections, Survey of High Risk Groups in Lahore and Karachi, March-August 2004, Family Health International, National AIDS Control Programme, Ministry of Health, Government of Pakistan

Moreover, low condom use in commercial sex was revealed when reports of condom use by female sex workers and male clients at last sex and consistent condom use are compared. The percentage of consistent use of condoms among those who are involved in commercial sex is very low and the data indicates that over two third of all commercial sex acts were not covered by condom, and the real percentage of condom use is probably even less (Figure-17).



Source: National Study of Reproductive Tract And Sexually Transmitted Infections, Survey of High Risk Groups in Lahore and Karachi, March-August 2004, Family Health International, National AIDS Control Programme, Ministry of Health, Government of Pakistan

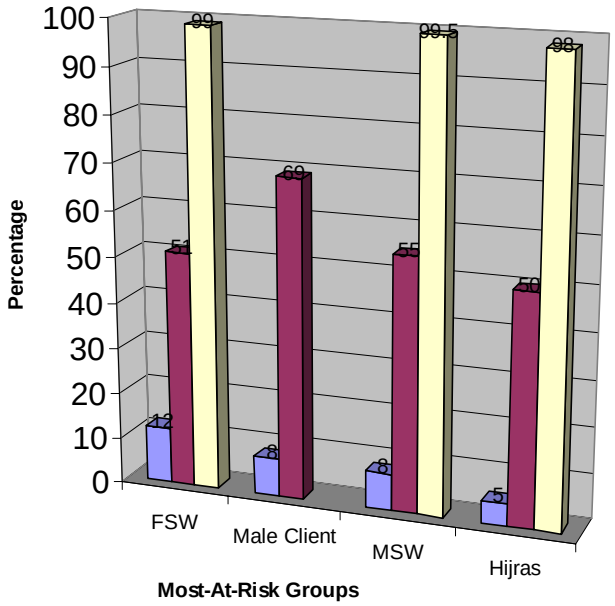
Even more startling is the fact that the exposure of the FSWs to HIV intervention and support has only increased knowledge and has very little, if any, effect on the high risk behaviour and practice (Figure-18).



Source: National Study of Reproductive Tract And Sexually Transmitted Infections, Survey of High Risk Groups in Lahore and Karachi, March-August 2004, Family Health International, National AIDS Control Programme, Ministry of Health, Government of Pakistan

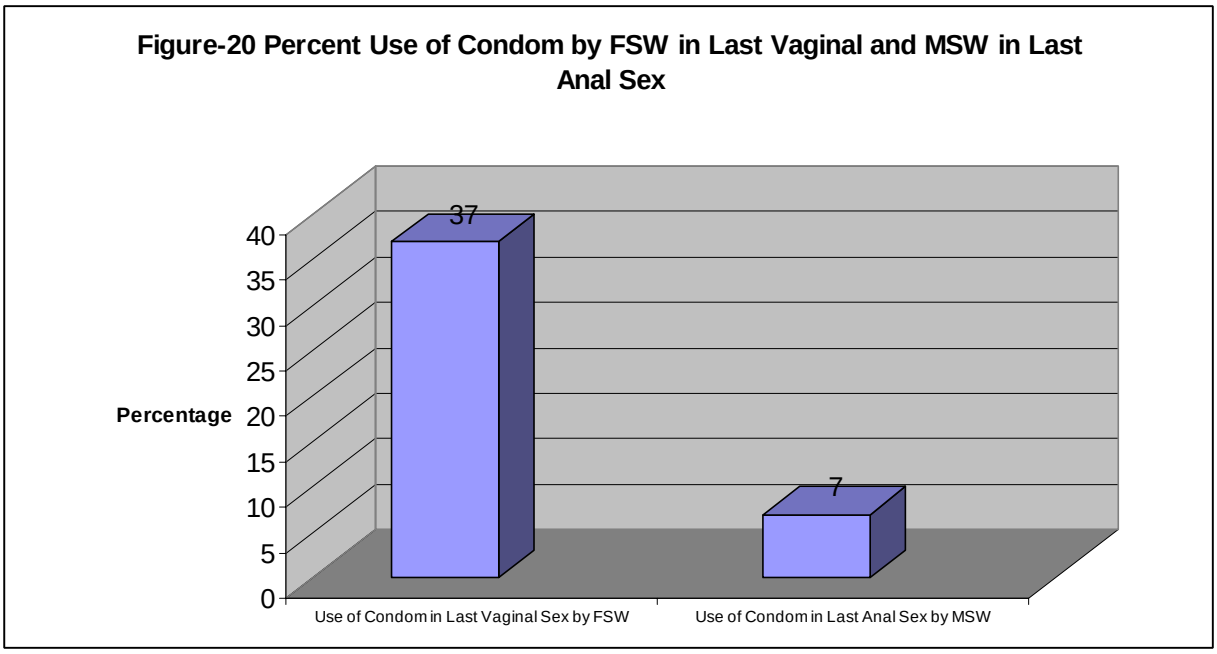
The disparity between knowledge and practice is also evident from the fact that under 2% of those groups who sell sex were carrying condom and over 50% of commercial sex participants did not feel the need for condom (Figure-19).

Figure-19 Condom Knowledge, Importance & Carriage Among Most-At-Risk Populations



Source: National Study of Reproductive Tract And Sexually Transmitted Infections, Survey of High Risk Groups in Lahore and Karachi, March-August 2004, Family Health International, National AIDS Control Programme, Ministry of Health, Government of Pakistan

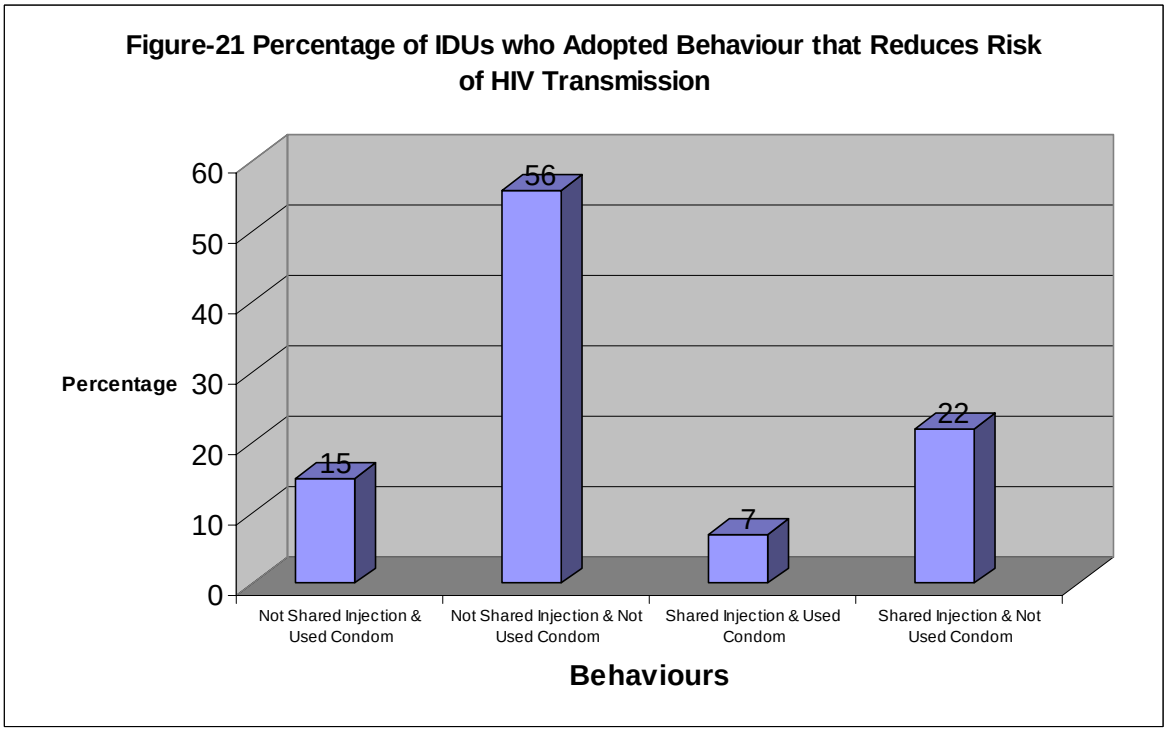
Further to the gaps in knowledge the condom use was low in last vaginal sex by FSW and anal sex by MSWs (Figure-20).



Source: National Study of Reproductive Tract And Sexually Transmitted Infections, Survey of High Risk Groups in Lahore and Karachi, March-August 2004, Family Health International, National AIDS Control Programme, Ministry of Health, Government of Pakistan

Percentage of IDUs who Have Adopted Behaviour that Reduce Transmission of HIV

In relation to behaviour that reduce transmission of HIV, only 15 percent of IDUs avoided using sharing injecting equipment and used condom, whereas 22% adopted the most-at-risk behaviour by sharing the injecting equipment and not using condom (Figure-21).



Source: National Study of Reproductive Tract And Sexually Transmitted Infections, Survey of High Risk Groups in Lahore and Karachi, March-August 2004, Family Health International, National AIDS Control Programme, Ministry of Health, Government of Pakistan

Major Challenges Faced and Actions Needed to Achieve the Goals/Targets

Following are the key challenges faced by national programme that hindered the national response:

1. Difficulty in accessing high risk populations such as sex workers especially street-based workers and MSMs.
2. Limited NGO capacity to implement effective interventions for high risk groups.
3. Inadequate capacity of implementing partners to respond to epidemic on fast track basis.
4. Limited experience and capacity to work with private sector and managing service delivery contacts.
5. Difficulties in operationalization of multi-sectoral approaches.

Based on the experience and lessons learned while striving against these challenges, following remedial actions are envisaged to ensure achievements of agreed UNGASS targets:

1. Continued advocacy for enabling environment
2. Capacity building of the public and private sector
3. Scaling up of coverage to keep up the pace and respond to the epidemic.
4. Mainstreaming of STI and HIV services within RH service delivery packages.
5. Increasing multi-sectoral involvement by mainstreaming HIV and AIDS in other ministries
6. Increasing NGO and private sector involvement in programme management
7. Strengthening monitoring, evaluation and research.

Support Required from Country's Development Partners

Although the epidemic is still in its early stage in Pakistan, yet there are alarming signs of expansion as the prevalence has increased several times in few most-at-risk populations. For dealing with the threat of generalized epidemic more effectively, and making the HIV and AIDS intervention more accessible and equitable the national response has been expanded to obtain support from a much broader group of developmental partners. The assistance of developmental partners is vital in areas including:

1. Further strengthening advocacy to create enabling environment
2. Technical assistance to build capacity of the public and private sector in programme planning, implementation and management

3. Capacity building of Planning and Development Division towards incorporating HIV/AIDS Prevention and Control strategies in all the development projects as an essential component to enhance multisectoral involvement and mainstreaming HIV/AIDS in all public sector related activities.
4. Capacity building of implementing NGOs to design needs based services and executing NGOs to establish and manage service delivery packages.
5. Expansion of services and interventions to vulnerable populations.
6. Research activities to help develop evidence-based planning and effective management

Monitoring and Evaluation Environment

The M & E framework is being developed currently and the country is in process of developing its comprehensive national M & E plan, in consultation with civil society and key stakeholders. The M & E plan includes: data collection, analysis, reporting and information feedback; well defined standardized set of indicators; guidelines on tools for data collection; and data management plan. The M & E functional unit is based at NACP, MoH, headed by a full time officer who is responsible for the M & E activities of the national programme and mechanisms are in place to ensure that all major implementing partners submit their response to this unit. Furthermore, the M & E activities including surveillance are being coordinated by M & E sub-committee of TACA that meets regularly and has representation from public and private sectors including PLWHA, and developmental partners. This M & E sub-committee is mandated to provide technical inputs and guide the national monitoring and evaluation and surveillance efforts to track the epidemic and seer the programme interventions accordingly. The M & E unit manages a central national data base and surveillance system. The national program has been releasing annual and quarterly reports since 1987, however with the upgradation in surveillance system, the annual and quarterly report will capture information in a more comprehensive manner.

Annex 1: Consultation/Preparation Process for this National Report

Pakistan received the guidelines for the preparation of report in May 2005. NACP with UNAIDS support started off the planning process and held the first stakeholders consultative meeting on 24th September 2005 with the aim to share the process and progress on developing the UNGASS 2006 report and seek input from development partners and civil society on the outline of the report. As per the decision of this meeting a technical working group was formed with two coordinators, one from civil society and the other from NACP. This group met twice, first on 8th October and then on 16th October 2005, and finalized the TOR for the consultant, identified key informants and set timelines for the upcoming tasks. Following this a consultant was hired from 1st December 2005 for the formulation of UNGASS 2006 report. A second consultative meeting was held on 21 December to share the draft UNGASS 2005 report and get the input from development partners and civil society. After incorporating the feedback received from this meeting the report was finalized.

Technical Working Group Meeting
UNGASS 2006 Progress Report
(21/12/05)
Minutes of Meeting

The technical working group (TWG) held a meeting on 21st December 2005 at the Hotel Holidy Inn, Islamabad. Following member of TWG participated in the meeting:

Purpose of meeting:
It was the third consultative meeting in regard to the preparation of UNGASS Report for the period of 2003-05. The main purpose of the meeting was to: (i) present the draft UNGASS 2003-05 report (ii) identify information gaps and controversial issues and (iii) get feedback from all participant.

Decisions:
Key suggestions made and decisions reached at the meeting for incorporation into the UNGASS report were:

1. Government's commitment for the response against HIV and AIDS in terms of policy change
2. National programme is coordinating and implementing the national response with support from private sector, NGOs (local, national and international) and development partners
3. Main features of national response include sustainability, public-private partnership, monitoring and evaluation and evidence-based decision making through research.
4. National programme has been able to develop health system and service delivery packages
5. The programme ahs been able to successfully brought under one umbrella the fragmented HIV and AIDS interventions
6. For indicators, the information on knowledge and behaviour would be taken from RTI/STI study while for coverage it will be drawn fron various projects working for most-at-risk population under the national programme.
7. Future direction include, continued advocacy for enabling environment, capacity building and scaling up of interventions and coverage.

Technical Working Group Meeting
UNGASS 2006 Progress Report
16th Oct 2005
Minutes of Meeting

The technical working group (TWG) held a meeting on October 16 2005 at the National AIDS Control Programme. Following member of TWG participated in the meeting:

1. Dr. Ismat Aziz, CIDA
2. Dr Mohammed Tariq, FHI
3. Dr. M. Saleem, UNAIDS
4. Dr Najma Lalji, NACP
5. Dr. Alice Wimmer, UNAIDS

Purpose of meeting:
It was continuation of meeting held on October 8 2005, when all the agenda items could not be addressed due to earthquake tremors. Main purpose of the meeting was to: (i) discuss and reach agreement on terms of references for the consultant, (ii) identify key informants and (iii) set timelines for upcoming tasks.

Decisions:
Key decisions reached at the meeting were:

8. Agreement was reached and terms of references were approved by members of TWG in the meetings of October 8 (*attended by Ms .Sadia Ahmed, CIDA, Mr. Qadeer Baig PNAC, Dr. M. Saleem & Dr.Alice Wimmer UNAIDS, Dr M. Tariq FHI and Dr. Najma Lalji, NACP)* and October 17 2005.

9. Key Informants identified for **Part A** of Questionnaire are: National Programme Manager, NACP, (2) Provincial Manager, NWFP, (3) Chief (Health) P&D, (4) Representative from Ministry of Women Development or Ministry of Law and Justice. However, it was discussed that due to current situation in the country it might not be possible to interview all the identified individuals and therefore at least three interviews should be acceptable (as outlined in the guidelines).

10. Key informants identified for **Part B** include representation from: (1) Pakistan National AIDS Consortium, (2) FHI, (3) Human rights commission of Pakistan, (4) Amal and (5) Nai Zindagi or Contech.

11. Mr. Qadeer Baig and Dr Najma Lalji, respective civil society and GoP coordinators, will conduct interviews. The coordinators will review information collected and identify discrepancies. In case of any such situation, TWG meeting will be called to discuss the matter. Key informant interviews will be conducted and forms will be reviewed by the end of this month i.e. October 31 2005. The process and information collected will be shared with the TWG in next meeting.

12. Consultant will be jointly selected by the P&D, NACP and UNAIDS. Chief (Health) P&D will chair the selection committee while NACP and UNAIDS will be the members.

13. NACP and UNAIDS will put together CVs of potential consultant by the end of this week and final selection will be made preferably in mid next week.

Consultative Meeting
UNGASS 2006 Progress Report
28th Sept 2005
Minutes of Meeting

A one day consultative meeting was held at Hotel Crown Plaza, Islamabad on September 24 2005. The meeting was jointly organized by the Planning & Development Division, the National AIDS Control Programme (NACP) and UNAIDS. The meeting was chaired by Dr. Shafiquddin, Chief (Health) P & D Division and attended by a number of representatives from development partners and civil society (list of participants is attached).

Purpose of meeting:
The meeting was held to: (i) share the process and progress on developing the UNGASS 2006 report, (ii) seek inputs from the participants on the outline of report and (iii) conduct selected key informant interviews to feed into the report.

Conclusion:
Two technical coordinators were nominated; Mr. Qadeer Baig of PNAC to represent civil society and one focal person from NACP to coordinate and represent MoH and GoP (the focal person to be nominated by the Manager, NACP).

A technical working group would be formed by the P&D, NACP and UNAIDS, including two members each from GoP, civil society and development members; to facilitate and oversee the process and technical details of the report.

First technical working group meeting would be held within a weeks time, to decide on the key informants to be included, and discuss and agree on terms of references for the consultant.

Following points were agreed regarding the report:

- NGOs involved in implementation of Enhanced HIV/AIDS Programme will be contacted to provide information on coverage, knowledge attitude and behaviour of high risk groups. A specified framework will be sent to NGOs to provide their responses. The implementing NGOs will provide information available with them along with copies of study sources.

- Data collected through FHI BSS tools will be included in the report, as specified in the UNAIDS guidelines.

- Policy level documents such as MTBF, Health Policy (2001), PRSP and MDG reports will be referred and mentioned in the report to reflect GoP commitment at policy level. In addition Beijing plus 10 report should also be included.

- Indicator number nine under the core set of generalized epidemic will be reported, as the information is available with the NACP.

- Under expenditure commitments, in addition to federal and provincial governments, in light of devolution, any resource allocation made by the district government should be included (Hyderabad).

- Commitments by MoPW and LHW Programme should also be mentioned, in terms of service delivery or training of the service providers, irrespective of the fact that the training is translated into service delivery or not. However, caution should be exercised to highlight only actual level of commitment that is made by various line ministries.

- Information on coverage provided by the VCT centres would be sought from the Marie Stopes Society.

Relevant Discussion Points:

- It was informed that Future Group Policy project and Panos are also conducting monitoring of the process for developing UNGASS report.

- Provincial AIDS Control Programmes in coordination with the respective AIDS consortia can sensitize the NGOs on the activity. However, at national level only relevant NGOs will be included in the process to provide their inputs.

- The report should be developed according to the standardized guideline as provided by the UNAIDS Secretariat, so that it can be incorporated in the global report.

Annex 2: National Composite Policy Index Questionnaire

Government HIV/AIDS policies

Indicator	Data Origin	Period	Value
NCPI-A-I-1 : Country has developed a national multi-sectoral strategy/action framework to combat HIV/AIDS	Pakistan	2005	1
NCPI-A-I-2 : Country has integrated HIV/AIDS into its general development plans		2005	1
NCPI-A-I-3 : Country has evaluated the impact of HIV and AIDS on its economic development for planning purposes		2005	-1
NCPI-A-I-4 : Country has a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services, military, peacekeepers and police		2005	1
NCPI-A-I-R : Strategy planning efforts in the HIV and AIDS programmes overall Rating		2003	4
		2005	8
NCPI-A-II-1 : The head of the government and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year		2005	1
NCPI-A-II-2 : Country has a national multisectoral HIV and AIDS management/coordination body recognized in law? (National AIDS Council or Commission)		2005	0
NCPI-A-II-3 : Country has a national HIV and AIDS body that promotes interaction between government, people living with HIV, the private sector and civil society for implementing HIV and AIDS strategies/programmes		2005	1
NCPI-A-II-4 : Country has a national HIV and AIDS body that is supporting coordination of HIV-related service delivery by civil-society		2005	1

organizations

GE-1 : Amount of national funds disbursed by governments in low- and middle-income countries	2005	1,500,000
NCPI-A-II-R : Political support for the HIV/AIDS programme overall rating	2003	5
	2005	7
NCPI-A-III-1 : Country has a policy or strategy that promotes information, education and communication (IEC) on HIV and AIDS to the general population	2005	1

Annex 3 :National Return Forms

Amal
PART B

I. Human rights

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

   Yes √*No* *N/A*

   Comments:

2. Does your country have non-discrimination laws or regulations which specify protections for certain **groups** of people identified as being especially vulnerable to HIV/AIDS discrimination (i.e., groups such as IDUs, MSM, sex workers, youth, mobile populations, and prison inmates)?

   Yes √*No* *N/A*

   IF YES, please list groups:

3. Does your country have laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations?

   Yes √*No* *N/A*

   IF YES, please list:

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

   Yes √*No* *N/A*

   Comments:

5. Has the Government, through political and financial support, involved vulnerable populations in governmental HIV policy design and programme implementation?

√*Yes* *No* *N/A*

IF YES, give examples:

PLWHA's TB patient Religious minority representative at CCM.

6. Does your country have a policy to ensure equal access, between men and women, to prevention and care?

Yes √*No* *N/A*

Comments:

7. Does your country have a policy to ensure equal access to prevention and care for most-at-risk populations?

Yes √*No* *N/A*

Comments:

8. Does your country have a policy prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits)?

Yes √No N/A

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

Yes √*No* *N/A*

9.1 *IF YES*, does the ethical review committee include civil society and PLHIV?

Yes √*No* *N/A*

Comments:

10. Does your country have the following monitoring and enforcement mechanisms?

- Collection of information on human rights and HIV/AIDS issues and use of this information in policy and programme development reform

  Yes *No*

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

  Yes √*No*

- Establishment of focal points within governmental health and other departments to monitor HIV-related human rights abuses

  Yes √*No*

- Development of performance indicators or benchmarks for compliance with human rights standards in the context of HIV/AIDS efforts

  Yes √*No*

11. Have members of the judiciary been trained/sensitized to HIV/AIDS and human rights issues that may come up in the context of their work?

    Yes *No*

12. Are the following legal support services available in your country?

    - Legal aid systems for HIV/AIDS casework

      Yes √*No*

    - State support to private sector laws firms or university based centers to provide free pro bono legal services to people living with HIV/AIDS in areas such as discrimination

      Yes √*No*

    - Programmes to educate, raise awareness among people living with HIV/AIDS concerning their rights

      √*Yes* *No*

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

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV/AIDS?												
2005	Poor											Good
	0	1	2	√3	4	5	6	7	8	9	10	
2003	Poor											Good

	0 1 √2 3 4 5 6 7 8 9 10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:	
Overall, how would you rate the effort to enforce the existing policies, laws and regulations?	
2005	Poor Good
	0 1 √2 3 4 5 6 7 8 9 10
2003	Poor Good
	0 1 √2 3 4 5 6 7 8 9 10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:	

II. Civil society participation

1. To what extent civil society has made a significant contribution to strengthening the political commitment of top leaders and national policy formulation?

   Low *High*
   0 1 2 3 4 5 6 √7 8 9 10

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

   Low *High*
   0 1 2 3 4 5 √6 7 8 9 10

3. To what extent the complimentary services provided by civil society to areas of prevention and care are included in both the National Strategic plans and reports?

   Low *High*
   0 1 2 3 √4 5 6 7 8 9 10

4. Has your country conducted a National Periodic review of the Strategic Plan with the participation of civil society in:

   Yes *No* *N/A*

   Month…….. Year……

5. To what extent your country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an independent national/local ethical review committee *in which PLHIV and caregivers participate*?

Low										*High*
0	1	√2	3	4	5	6	7	8	9	10

Overall, how would you rate the efforts to increase civil society participation?											
2005	Poor										Good
	0	1	2	3	4	5	6	√7	8	9	10
2003	Poor										Good
	0	1	2	3	√4	5	6	7	8	9	10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:											

III. Prevention

1. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV prevention policy/strategy?

   (*Check all programmes that are implemented beyond the pilot stage to a significant portion of both the urban and rural populations*).

	2003	**2005**
A programme to promote accurate HIV/AIDS reporting by the media.	a. _____	a. √
A social marketing programme for condoms	b. √	b.
School-based AIDS education for youth	c. _____	c. √
Behaviour change communications	d. _____	d. √
Voluntary counselling and testing	e. _____	e. √
Programmes for sex workers	f. _____	f. √
Programmes for men who have sex with men	g. _____	g. √
Programmes for injecting drug users, if applicable	h. √	h. √
Programmes for other most-at-risk populations*	i. _____	i. √
Blood safety	j. √	j. √
Programmes to prevent mother-to-child transmission of HIV	k.	k. √
Programmes to ensure safe injections in health care settings	l. √	l. √

** Please define*

Overall, how would you rate the efforts in the implementation of HIV prevention programmes?											
2005	Poor										Good
	0	1	2	3	4	5	√6	7	8	9	10
2003	Poor										Good
	0	1	2	3	√4	5	6	7	8	9	10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:											

IV. Care and support

1. Which of the following activities have been implemented under the care and treatment of HIV/AIDS programmes?

	2003	2005
HIV screening of blood transfusion	√	√
Universal precautions		√
Treatment of opportunistic infections (OI)		√
Antiretroviral therapy (ART)		√
Nutritional care		√
STI care	√	√
Family planning services	√	√
Psychosocial support for PLHA and their families		√
Home-based care		
Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)		√
Cotrimoxazole prophylaxis among HIV-infected people		
Post exposure prophylaxis (e.g. occupational exposures to HIV, rape)		
Other: (please specify)		

Overall, how would you rate the care and treatment efforts of the HIV/AIDS programme?											
2005	Poor										Good
	0	1	2	3	√4	5	6	7	8	9	10
2003	Poor										Good
	0	1	√2	3	4	5	6	7	8	9	10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:											

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

Yes √*No* *N/A*

2.1 Which of the following activities have been implemented under the OVC programmes?

	2003	2005
School fees for OVC		
Community programmes		
Other: (*please specify*)		

Comments:

Overall, how would you rate the efforts to meet the needs of OVC?											
2005	Poor										Good
	0	√1	2	3	4	5	6	7	8	9	10
2003	Poor										Good
	√0	1	2	3	4	5	6	7	8	9	10
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:											

PNAC
PART B

I. Human rights

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

   Yes (***No***) *N/A*

   Comments:

   Currently no laws and regulations are available that protect people living with HIV/AIDS against discrimination.

2. Does your country have non-discrimination laws or regulations which specify protections for certain **groups** of people identified as being especially vulnerable to HIV/AIDS discrimination (i.e., groups such as IDUs, MSM, sex workers, youth, mobile populations, and prison inmates)?

   Yes (***No***) *N/A*

   IF YES, please list groups:

3. Does your country have laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations?

   Yes (***No***) *N/A*

   IF YES, please list:

Population at risk i.e. MSMs, IDUs, FSWs are recognized as unlawful and law enforcing agencies instead of protecting them try to arrest them under the prevailing laws.

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

   Yes *No* *N/A*

   Comments:

   Human rights have been addressed in National Strategic Framework. Rights based approaches are also being advocated at various levels.

5. Has the Government, through political and financial support, involved vulnerable populations in governmental HIV policy design and programme implementation?

   Yes *No* *N/A*

   IF YES, give examples:

IDUs have been involved at various national forums. Vulnerable population is also represented by PLWHAs at National and International Level.

6. Does your country have a policy to ensure equal access, between men and women, to prevention and care?

   Yes *No* *N/A*

   Comments:

   Prevention and care is available for all irrespective of their sex.

7. Does your country have a policy to ensure equal access to prevention and care for most-at-risk populations?

   Yes *No* *N/A*

   Comments:

8. Does your country have a policy prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits)?

   Yes No N/A

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

Yes *No* *N/A*

9.1 *IF YES*, does the ethical review committee include civil society and PLHIV?

(*Yes*) *No* *N/A*

Comments:

10. Does your country have the following monitoring and enforcement mechanisms?

- Collection of information on human rights and HIV/AIDS issues and use of this information in policy and programme development reform

  Yes (*No*)

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

  (*Yes*) *No*

- Establishment of focal points within governmental health and other departments to monitor HIV-related human rights abuses

  Yes (*No*)

- Development of performance indicators or benchmarks for compliance with human rights standards in the context of HIV/AIDS efforts

  Yes (*No*)

11. Have members of the judiciary been trained/sensitized to HIV/AIDS and human rights issues that may come up in the context of their work?

    Yes (*No*)

12. Are the following legal support services available in your country?

- Legal aid systems for HIV/AIDS casework

  Yes (*No*)

- State support to private sector laws firms or university based centers to provide free pro bono legal services to people living with HIV/AIDS in areas such as discrimination

  Yes (*No*)

- Programmes to educate, raise awareness among people living with HIV/AIDS concerning their rights

  ( )

Yes *No*

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

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV/AIDS?		
2005	Poor	Good
	5	
2003	Poor	Good
	5	
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:		
Overall, how would you rate the effort to enforce the existing policies, laws and regulations?		
2005	Poor	Good
	3	
2003	Poor	Good
	3	
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:		

II. Civil society participation

6. To what extent civil society has made a significant contribution to strengthening the political commitment of top leaders and national policy formulation?

Low *High*

4

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

Low *High*

5

8. To what extent the complimentary services provided by civil society to areas of prevention and care are included in both the National Strategic plans and reports?

Low *High*

6

9. Has your country conducted a National Periodic review of the Strategic Plan with the participation of civil society in:

Yes (*No*) *N/A*

Month…….. Year……

10. To what extent your country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an independent national/local ethical review committee *in which PLHIV and caregivers participate*?

Low *High*

4

Overall, how would you rate the efforts to increase civil society participation?		
2005	Poor	Good
	7	
2003	Poor	Good
	7	
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:		

III. Prevention

1. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV prevention policy/strategy?

(*Check all programmes that are implemented beyond the pilot stage to a significant portion of both the urban and rural populations*).

	2003	**2005**
a.A programme to promote accurate HIV/AIDS reporting by the media.	a. _____	a. _____
b. A social marketing programme for condoms	b. _____	b. _ √_
c. School-based AIDS education for youth	c. __ √__	c. _ √__
d. Behaviour change communications	d. _____	d. _ √_
e. Voluntary counselling and testing	e. _____	e. _ √__
f. Programmes for sex workers	f. _____	f. _ √__
g. Programmes for men who have sex with men	g. _____	g. _ √__
h. Programmes for injecting drug users, if applicable	h. __ √__	h. _ √_

i. Programmes for other most-at-risk populations* j. Blood safety k. Programs to prevent mother-to-child transmission of HIV l. Programmes to ensure safe injections in health care settings	i. __√__ j. __√___ k. _____ l. __√__	i. _√__ j. _√__ k. _√__ l. _√__

** Please define*

Overall, how would you rate the efforts in the implementation of HIV prevention programmes?		
2005	Poor	Good
	5	
2003	Poor	Good
	5	
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:		

IV. Care and support

1. Which of the following activities have been implemented under the care and treatment of HIV/AIDS programmes?

	2003	2005
HIV screening of blood transfusion	√	√
Universal precautions		-
Treatment of opportunistic infections (OI)		√
Antiretroviral therapy (ART)		√
Nutritional care		
STI care	√	√
Family planning services	√	√
Psychosocial support for PLHA and their families	√	√
Home-based care	√	√
Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)	√	√
Cotrimoxazole prophylaxis among HIV-infected people		
Post exposure prophylaxis (e.g. occupational exposures to HIV, rape)		
Other: (please specify)		

Overall, how would you rate the care and treatment efforts of the HIV/AIDS programme?		
2005	Poor	Good
	4	
2003	Poor	Good
	4	
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:		

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

Yes (*No*) *N/A*

2.1 *Which* of the following activities have been implemented under the OVC programmes?

	2003	2005
School fees for OVC		
Community programmes		
Other: (*please specify*)		

Comments:

Overall, how would you rate the efforts to meet the needs of OVC?		
2005	Poor	Good
	2	
2003	Poor	Good
	2	
In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:		

Annex 4 Most-at-risk population (MARP) identification in CRIS

CRIS - Administration - Target Populations

Add New

Frequently Asked Questions
Documentation
About CRIS

Value	Marp	Visible	Data Origin	Edit	Delete
All	☐	☑	UNAIDS (Joint UN Programme on HIV/AIDS), International		
Hijras	☑	☑	National AIDS Control Programme (NACP), Pakistan		
Pregnant	☐	☑	UNDG (United Nations Development Group), International		
Truckers	☑	☑	National AIDS Control Programme (NACP), Pakistan		
Children/Orphans	☐	☐	UNAIDS (Joint UN Programme on HIV/AIDS), International		
Children	☐	☐	UNAIDS (Joint UN Programme on HIV/AIDS), International		
Orphans	☐	☐	UNAIDS (Joint UN Programme on HIV/AIDS), International		
Women/Men	☐	☐	UNAIDS (Joint UN Programme on HIV/AIDS), International		
Women	☐	☐	UNAIDS (Joint UN Programme on HIV/AIDS), International		
Men	☐	☐	UNAIDS (Joint UN Programme on HIV/AIDS), International		
MSM (men who have sex with men)	☑	☑	UNAIDS (Joint UN Programme on HIV/AIDS), International		
IDU (IV Drug users)	☑	☑	UNAIDS (Joint UN Programme on HIV/AIDS), International		
Sex Workers	☑	☑	UNAIDS (Joint UN Programme on HIV/AIDS), International		
Sex Workers Clients	☑	☑	UNAIDS (Joint UN Programme on HIV/AIDS), International		

CRIS - By Indicators

Start year: - All Years -

Status: - All Statuses -

Include operands

Indicator:
- All Indicators -
Percent of FSWs Intervention Contact
Percentage of FSW who know that a Healthy Looking Person can have HIV
Percentage of FSW who know that condom use reduce HIV transmission
Percentage of IUDs with Intervention Contact

Country (All)