National HIV and AIDS Strategic Framework-2007 – 2012

The National HIV and AIDS Strategic Framework 2007– 2012aims to contribute the realization of the national aspirations with respect to the Vision 2030. It is a reflection of national commitment to implement an aggressive, comprehensive, and expanded multi-sectoral and multi-level response to fight against the emerging HIV epidemic in Pakistan. It translates the national Policy of HIV and AIDS by providing strategic guidance to the planning of programmes, projects and interventions by various stakeholders. It spells out the basic approaches and principles that will guide the national response and identifies goal, objectives and strategies for the period 2007-2012.

1. HIV and AIDS in Pakistan

Introduction

During the last three decades, the HIV pandemic has entered our consciousness as an incomprehensible calamity. HIV and AIDS has already taken a terrible human toll, laying claim to millions of lives, inflicting pain and grief, causing fear and uncertainty and threatening economic devastation.

While Sub-Saharan Africa remains the worst affected region in the world, there is increasing concern about the emergence of HIV and AIDS in Asia, which is home to more people than any other region of the world. Though the epidemic in Asia is less severe than in other parts of the world and rates of infection in the general population remain relatively low, it is clear that HIV has started spreading rapidly through the region and massive Asian population is increasingly at risk.

Pakistan is the second largest country in South Asia that stands only a few steps behind India and Nepal in terms of HIV epidemic. Despite many efforts, the HIV infection rate has increased significantly over the past few years and infact, the country has moved from a low prevalence to concentrated epidemic with HIV prevalence of more than 5% among injecting drug users (IDUs) in at least eight major cities.[1] Other high-risk groups, such as men who have sex with men (MSM), hijra sex workers (HSWs) and female sex workers (FSWs), also look set to reach this threshold level. Many bridging populations, totaling almost five million persons, are in direct sexual contact with these groups and are exposed to HIV infection through unprotected sexual activity. The heterogeneity and interlinking of high risk injecting and sexual behaviour, combined with low levels of HIV knowledge and prevention, and high levels of other sexually transmitted infections (STIs), indicates that HIV could spread rapidly to marriage partners or sex clients and result in generalized epidemic.

[1] NACP-HASP (2007), Summary Report – *Integrated Biological and Behavioural Surveillance Study*: HASP, Islamabad.

Risk Factors and Vulnerabilities

With an early concentrated epidemic, Pakistan fits the typical "Asian epidemic model"[2] that has a scenario where once the epidemic gets settled among the high-risk groups; it spreads rapidly to the general population due to prevalent risk behaviours and vulnerabilities. There are a number of socio-cultural factors that have helped to slow down the initial pace of HIV epidemic; still the country has an array of risk factors that put it at a substantial risk of witnessing a full-blown HIV epidemic. These risk factors and vulnerabilities include:

- **Concentrated epidemic among Injecting Drug Users (IDUs):** IDUs are at higher risk of acquiring HIV and other blood borne infections because they often resort to unsafe injecting practices such as needle and syringe sharing. The number of drug users in Pakistan is estimated to be about 500,000, of whom an estimated 150,000 inject drugs[3]. Recent biological and behavioural data on HIV clearly indicates a widespread concentrated epidemic among IDUs with highly prevalent risk behaviours such as use of non-sterile injecting equipment, sexual contacts with other high-risk groups like FSWs, MSMs and HSWs, and low condom use.

- **Emerging epidemic among Men who have Sex with Men (MSMs) & Hijra Sex Workers (HSWs):** In the past there was very little documentation about the extent to which men engage in sexual activity with men in Pakistan, but the data available through various rounds of integrated biological and behavioural surveillance (IBBS) and other mapping exercises clearly suggest that such activity is highly prevalent in the country i.e. estimated 19,320 MSMs in twelve major cities[4]. Similarly throughout the country there is a significant number (estimated 14,725 in twelve major cities) of highly mobile population of transvestites, transsexuals and eunuchs known as *Hijras*, who commonly indulge in unsafe sexual practices[5]. The data from last two rounds of IBBS and various other studies also indicate an emerging HIV epidemic among MSMs and HSWs in at least two major cities with highly prevalent risky behaviours such as low condom use and sexual networks with IDUs and FSWs.

- **Well-established commercial sex industry:** Commercial sex work especially female sex work is highly prevalent in all major cities of Pakistan. Recent data from BBS suggests that there are around 50,000 female sex workers (FSWs) in twelve major cities, who operate from brothels, *kothikhanas*, homes and streets. Most of these FSWs have very little understanding of safe sexual practices[6]. Condom use in various types of sexual acts and encounters is very low and there are well-established sexual networks with other high-risk groups i.e. IDUs and MSM.

- **Inadequate blood transfusion screening, high number of professional donors and unsafe injection practices:** Lack of organized Blood Transfusion Services (BTS) with

[2] T. Brown and W. Peerapatanapokin (2004), Asian Epidemic Model: a process model for exploring HIV policy and programme alternatives in Asia. Article in: Sexually Transmitted Infections.
[3] Situation and Response Analysis report (2006, NACP).
[4] NACP-HASP (2007), Summary Report – *Integrated Biological and Behavioural Surveillance Study*: HASP, Islamabad.
[5] ibid
[6] ibid

inadequate screening for blood borne infections is a major issue across the country especially in the private sector. It is estimated that 40percent of the 1.5 million annual blood transfusions in Pakistan are not screened for HIV[7]. Similarly, the country has a very poor voluntary blood donor base and a high proportion of blood available for transfusion is collected from either family replacement donors or professional blood donors. In addition, the country has a high rate of unsafe injection practices both in formal and informal health sector involving the use of non-sterilized needles and used syringes.

- **Large number of migrants and refugees:** Pakistan has a very large number of in-migrants, out migrants and refugees who are highly vulnerable to acquire HIV infection. There are large number of workers who leave their villages to seek work in larger cities, in the armed forces, or in industries. A significant number (around 4 million) are employed overseas especially in Gulf countries[8]. In addition, the country has hosted around 4-6 million Afghan refugees over the last three decades and is even now hosting around 2.5 million Afghan refugees[9].

- **Low-income levels and income inequalities:** In Pakistan, nearly one third of the population lives below the official poverty line of Rs. 784.56 (US $ 13) per adult per month[10]. Research all over the world has shown a strong association between low income levels and vulnerability to acquire HIV infection e.g. Over (1997), while estimating HIV prevalence rates at international level found a strong association between income inequality and spread of HIV and AIDS[11]. Though, Pakistan is an economically progressing country, income disparities are still very prevalent and have the potential to fuel HIV epidemic anytime.

- **Low levels of literacy and education:** Literacy and education have a strong link with safe behaviours and sexual practices. Though the government of Pakistan has focused on raising literacy levels, still a major proportion of population remains illiterate e.g. current female literacy rate is estimated around 42%[12].

- **Large number of unemployed youth, out-of-school youth and street children:** Youth, especially unemployed youth, out-of school youth and street children are more vulnerable to risky behaviours that are associated with HIV spread. Pakistan currently has a total number of some 53.6 million youth many of whom are unemployed and out-of-school[13]. Similarly, there are about 3.3 million children below the age of 18 years

[7] World Bank (2007), HIV/AIDS in Pakistan.
[8] ibid
[9] UNHCR Pakistan, Afghan Refugee Statistics available at http://www.un.org.pk/unhcr/Afstats-stat.htm
[10] Planning Commission (2002), "*Between Hope & Despair: National Report on the Pakistan Participatory Poverty Assessment*. GOP, Islamabad.
[11] Over, M. (1997). The Effects of Societal Variables on Urban Rates of HIV Infection in Developing Countries: An Exploratory Analysis. European Commission.
[12] World Bank (2007), HIV/AIDS in Pakistan.
[13] National AIDS Control Programme (2005), *Situation Assessment of Adolescents in Selected Districts of Pakistan for Life Skills and HIV Prevention*, NACP, Islamabad

involved in various types of labour in Pakistan[14]. Overall, the combination of demographic and economic factors makes this large proportion of Pakistani population highly vulnerable to HIV infection.

- **Silence, denial, stigma and discrimination:** There are a number of social and cultural values that have checked the initial pace of HIV epidemic in Pakistan. However, on the other hand, factors like silence and denial about risk factors that are highly prevalent can easily fuel the epidemic by limiting the scope of awareness programmes and efforts to mobilize communities and resources. Similarly, stigma and discrimination faced by people living with HIV and AIDS (PLHIV) and quasi-legal marginalized populations such as FSWs, MSMs and HSWs can be the most serious obstacle to an effective national response.

- **Gender inequalities:** Gender inequalities play a facilitating role in the spread of HIV and AIDS. Pakistan is a male-dominated society where women and girls have lower socio-economic status (Gender Development Index (GDI) = 105 among 136 countries)[15]. They are denied access to inheritance rights, adequate food and nutrition, freedom of expression, freedom of mobility, employment, participation in community activities, and decision-making. Domestic violence and sexual harassment – and the fear of both – are widespread. Although there has been some improvement in the status of women over the last few years, significant gaps remain particularly in education and health that could help fuelling HIV epidemic.

Implications for Pakistan

The growth of HIV and AIDS epidemic in any country has an impact that goes far beyond the health sector. Evidence from around the world has shown that mortality and morbidity associated with AIDS not only indents the population pyramids but also erodes institutions and overall economy. While Pakistan has not yet seen a visible change in development arena due to HIV and AIDS, some impact is occurring; and we can certainly speculate about the possible implications, if the epidemic is not checked. Some of these implications could be as follows:

- **Macro-economic implications:** Economically the most productive segment of the population is hardest hit by HIV epidemic, leaving behind a highly vulnerable generation of orphans. The macro-economic impact of HIV and AIDS is already evident in the form of increasing number of returning migrant workers who are HIV positive and unable to take any kind of re-employment.

- **Implications on human capital:** If the spread of HIV in Pakistan moves from concentrated to generalized epidemic, it would distort the population pyramid with serious consequences for the country's social and economic development. It would deplete the human resource and reduce the accumulation of knowledge, skills, and other important human capital assets. It would also effect social cohesion, flow of

[14] International Labour Organization and Federal Bureau of Statistics (1996).
[15] Human Development Report 2006, UNDP

knowledge from parents to children, production in the formal and informal sectors, social service delivery and the education of young people.

- **Implications on development targets:** HIV and AIDS has eroded the developmental gains and jeopardised the efforts of many countries in achieving the planned development objectives like Millennium Development Goals (MDGs). It has already created a number of fragile economies across the world that are struggling under the burden of losing their most economically active members of society. However, the situation in Pakistan has not yet deteriorated and if the country takes concrete measures to prevent HIV spread into the general population, it stands a fair chance of meeting its development objectives including MDGs.

- **Implications for private sector:** If the prevalence of HIV among general population in Pakistan rises, it will start to impact all business especially industries such as construction, manufacturing, mining, transport and other industries. There will be decreased productivity and increased labour costs, arising from early retirement or death of employees, which disrupts industries' operation, raises treatment costs, pension bills, and increases recruitment and training cots.

- **Implications for public sector:** The impact on public sector at this stage is minimal in terms of public spending on HIV prevention, treatment and care. If the epidemic enters to the general population the impact would be much more wider with increased spending on universal coverage of services for high-risk groups, vulnerable populations and even general population.

- **Impactions for households:** The impact of HIV and AIDS on individuals, families and households is always catastrophic. Those who are infected or affected face multiple challenges like: reduced access to education, reduced income streams, reduced capacity to perform domestic work, reduced capacity to take care of dependents and possibly structural changes within household cohesion that ultimately destroy the society.

2. National HIV and AIDS Strategic Framework 2001-06

The first case of AIDS in Pakistan was reported in 1987 in Lahore. Soon after, it became evident that an increasing number of Pakistanis, mostly men, are becoming infected with HIV while living or traveling abroad. Realizing the need to address the issue the Ministry of Health (MoH) established the National AIDS Control Programme (NACP). Over the years, the NACP achieved a number of milestones. However, the changing HIV situation both in the region and within Pakistan at the beginning of the century demanded a strategic vision to understand and address the emerging scenario. Therefore, being fully cognizant of the needs, the National AIDS Control Programme, Ministry of Health using a participatory approach, developed the National Strategic Framework 2001-06 (NSF-One) for HIV and AIDS Prevention and Control. The framework identified nine priority areas in light of the Situation and Response Analysis exercise that was carried out with participation of a number of stakeholders including civil society and various bilateral and multilateral partners.

The NSF-One was indeed the product of relentless collective effort of many of the country's HIV and AIDS stakeholders to plan for and initiate an urgent, prioritized and strategic agenda for action before an important window of opportunity was lost for the country. As a corollary effect, the document supported development of new partnerships essential for success of Pakistan's efforts to combat a significant HIV and AIDS epidemic.

The NSF established fundamental principles for guiding the national response to HIV in the country. It identified clear priority areas where increased attention was likely to have the greatest impact on preventing the further spread of HIV and AIDS in Pakistan, and on reducing the impact of epidemic for those already infected and affected. The document highlighted the fact that HIV and AIDS was a development issue and required a broad and multi- sectoral response that addresses both the dynamic web of underlying causal factors of HIV and AIDS as well as its equally complex consequences. In summary, the NSF-One benefited from both the international best practices of HIV and AIDS prevention and control and from the country's unique socio-cultural context, moral and ethical values.

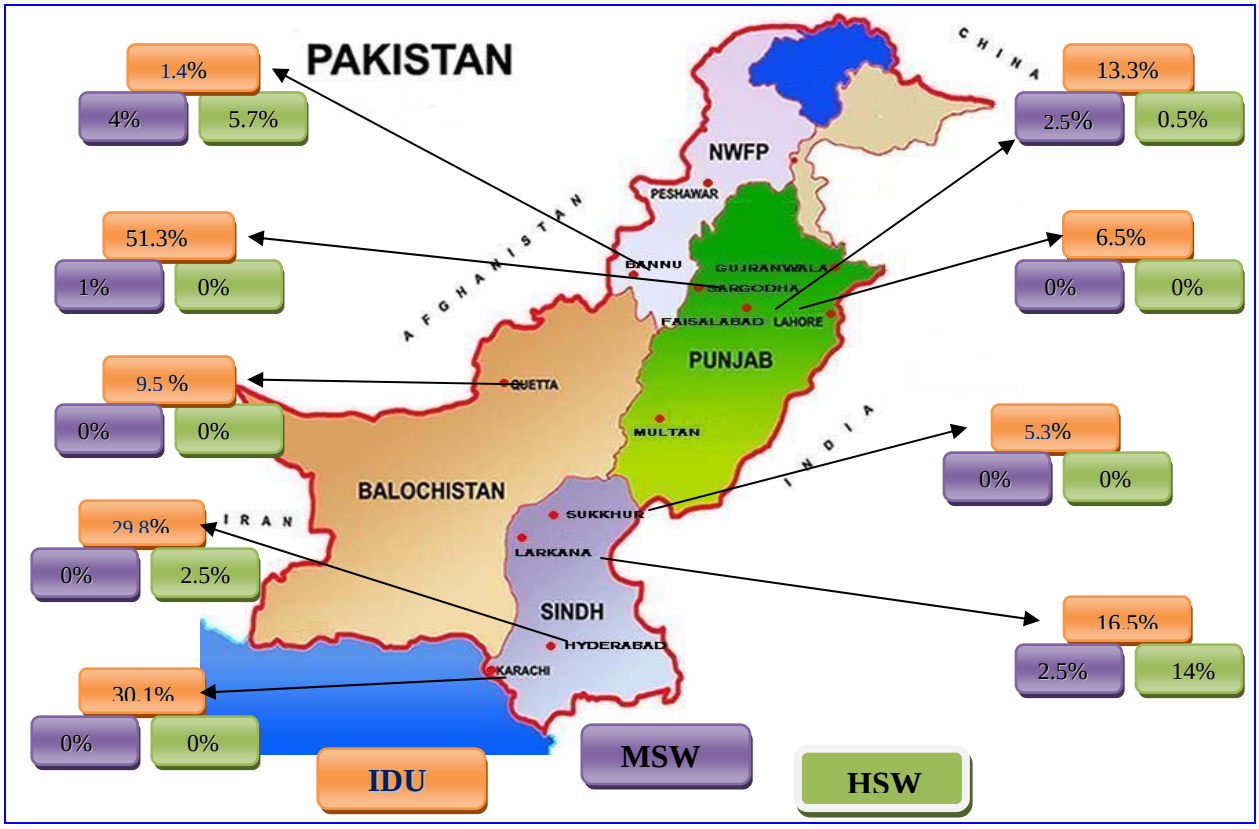
3. Country Situation and Response

3.1 Situation Analysis

Overview:

Pakistan still has a window of opportunity to act decisively to prevent the further spread of HIV. Although the estimated HIV burden is still low – below 0.1 percent of the adult population (70-80,000) – the country is facing an early concentrated epidemic among IDUs in at least eight major cities **(Figure-1)**.

Figure-1: Early Concentrated Epidemic in Major Cities of Pakistan



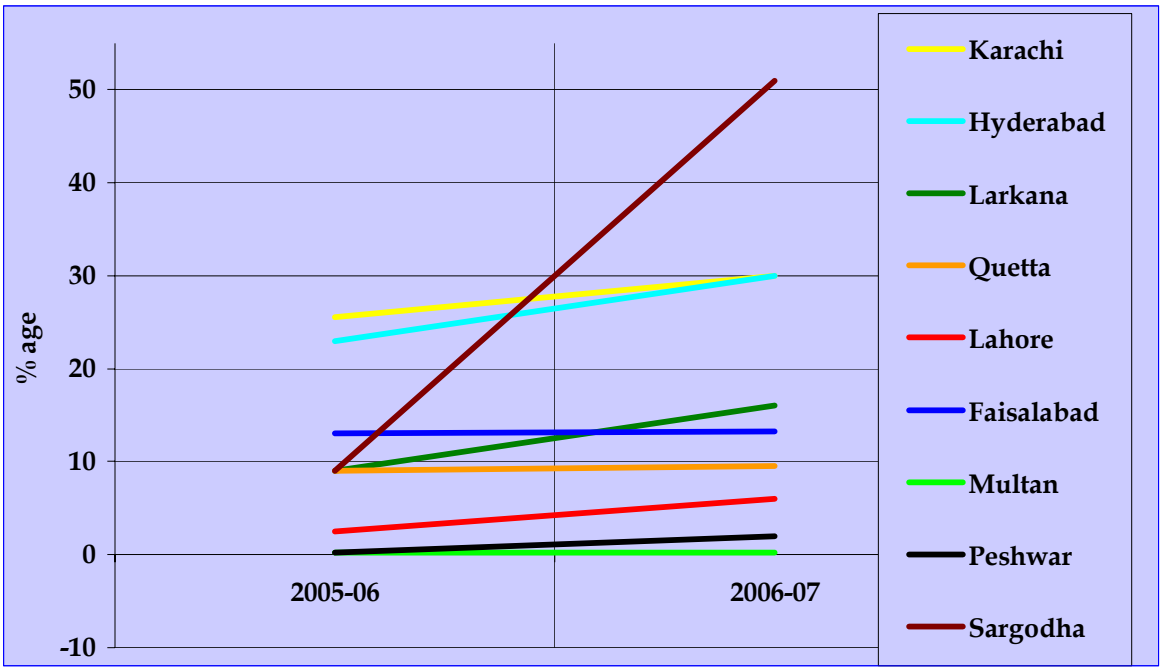
Source: NACP & HASP Surveillance report-2007

Epidemiology

Biological data

- Limited data are available from the initial years of the epidemic to illustrate the advent of HIV in Pakistan. Most of the HIV cases reported after 1987 were among migrant workers deported from other countries. The first major reported outbreak among IDUs was in 2003 in Larkana. Subsequently a number of other studies not only confirmed this, but revealed concentrated epidemic among IDUs in other cities as well. For example, a study in 2005[16] reported 23% HIV prevalence among IDUs in Karachi, which later in the same year was shown to have risen to 26% by pilot integrated biological and behavioural surveillance (IBBS). In 2006 the results of the round 1 of IBBS that was conducted in 8 major cities revealed that HIV has established its footholds in IDUs group. It reported HIV prevalence of more than 5% in five major cities i.e. Karachi-26.5%, Hyderabad-18.3%, Sukkur-19.6%, Quetta-9.1% and Faisalabad-13.3%. Now, the data from round 2 of IBBS shows an even worse picture with concentrated epidemic among IDUs in eight major cities i.e. Karachi-30.1%, Hyderabad-29.8%, Sukkur-5.3%, Quetta-9.5%, Faisalabad-13.3%, Larkana-16.5%, Lahore-6.5% and Sargodha-51.3% as shown in **Figure 2.**

Figure-2: HIV Prevalence Trends Among IDUs in Major Cities of Pakistan



Source: NACP & HASP Surveillance reports-2006 & 2007

- Not only HIV levels are increasing among IDUs, also of concern are the rising levels of HIV prevalence among other high-risk groups especially the MSM, and HSWs. In Karachi, the HIV infection rate has recently increased from 4% to 7.53% among MSM and from 1.6% to 3.04% among HSWs[17]. Round 2 IBBS results also revealed an emerging

[16] Family Health International (2005), *National Study of reproductive Tract and Sexually Transmitted Infections: Survey of High-Risk Groups in Lahore and Karachi.* NACP/DFID, Islamabad.
[17] NACP-HASP (2006), Summary Report – *Integrated Biological and Behavioural Surveillance Study*: HASP, Islamabad.

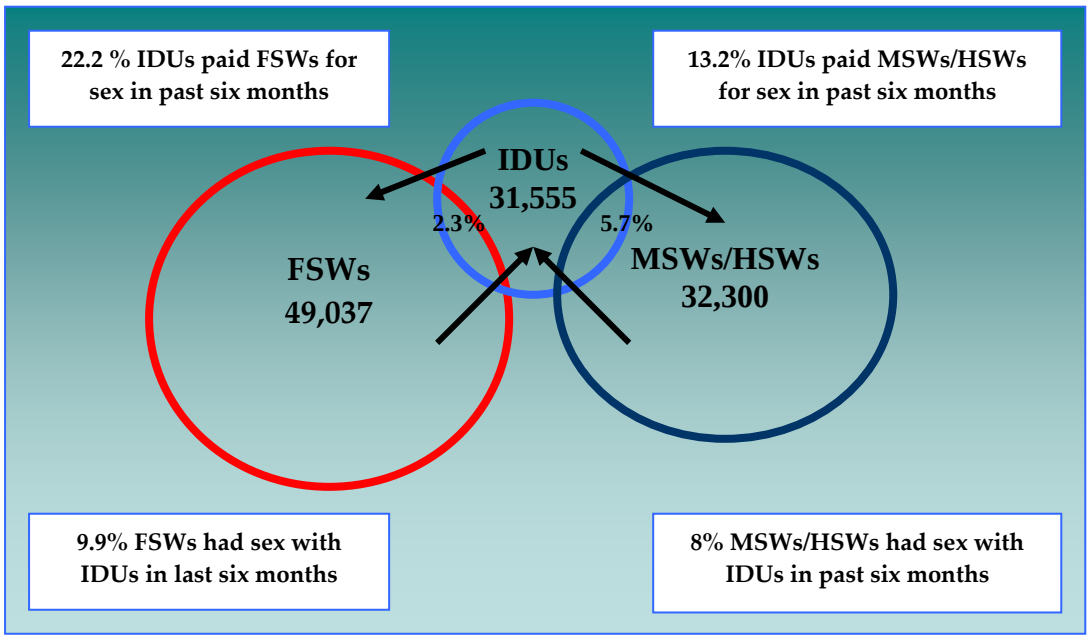
epidemic among HSWs and MSMs in some other cities i.e. Larkana and Bannu. On the other hand, biological data on FSWs has not yet revealed any significant findings, however the opinions differ with some still reporting it to be an early epidemic, and other suggesting that the low transmission rate is a question of lack of adequate testing.

Behavioural data and network Interactions

- In 2007, with a prevalence of HIV among IDUs of more than 5% in eight different cities, the risks associated with sharing needles and unprotected sex are a major threat to accelerated spread of HIV infection. In Sargodha, for example, where HIV prevalence among IDUs is almost 50%, the results of round 2 IBBS reveal that 68% IDUs shared needle/syringe at their last injection with either friends or family members and 40% had sex with a commercial sex worker in the past six months[18]. Furthermore, the results revealed that only 12% FSWs in Sargodha reported consistent condom use with their clients. The situation was also not so different for other two high-risk groups i.e. MSMs and HSWs. Across the twelve cities only 7.7% of MSMs and HSWs reported that they always used condom with their client during the last month.

- In Pakistan, although HIV infection rates among FSWs remained very low, a number of studies including various rounds of IBBS revealed that there were established sexual networks among various high-risk groups. For example the results of round 2 IBBS revealed that approximately 2.3% of FSWs and 5.7% of both MSWs and HSWs reported that they were also IDUs. About 10% of FSWs and 8% of MSWs reported having sex with an IDU in last six months, and 22% of IDUs reported having paid FSWs for sex, and 13.2% reported paying a MSW and/or HSW for sex during last six months **(Figure-3)**.

Figure-3: Interactions between the IDUs, FSWs, MSWs and HSWs population (12 cities)- 2006-07-HASP



[18] NACP-HASP (2007), Summary Report – *Integrated Biological and Behavioural Surveillance Study*: HASP, Islamabad.

Transmission through Bridge Populations

- The HIV epidemic in Asian countries typically starts with IDUs, but reaches the general population through sexual networks between IDUs, MSMs, FSWs and prisoners[19]. Persons in these groups are interconnected among themselves and with the general population through clients or bridging populations by social, sexual, and drug use networks. HIV continues to be transmitted among persons in these key populations due to their lack of knowledge and risky behaviour, especially unprotected sexual activity. Interconnection by marriage, sharing injecting equipment, and by buying and selling unprotected sex provides open channels for HIV transmission. A very similar picture for Pakistan was observed in IBBS round II as shown in **Figure 4.**

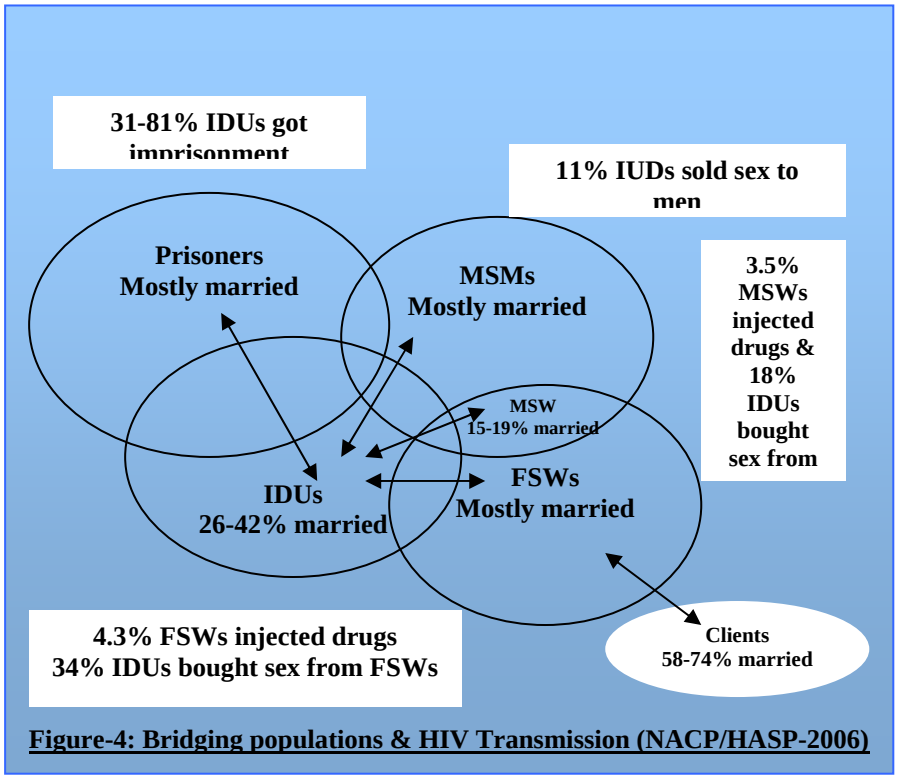


Figure-4: Bridging populations & HIV Transmission (NACP/HASP-2006)

3.2 Response Analysis

Public sector response

Pakistan's Federal Ministry of Health established National AIDS Control Programme (NACP) in 1987. In its early stages, the program focused on laboratory diagnosis of suspected HIV cases, but progressively it began to shift its focus towards HIV prevention and control interventions. The development of NSF-one in 2001 provided strategic vision to the national response and government of Pakistan with support from World Bank launched an enhanced response in the form of Enhanced HIV and AIDS Control Programme (EHACP).

Presently NACP and its provincial counterparts (PACPs) are implementing the programme throughout the country. The principal components of the EHACP are the interventions for target groups, HIV prevention for general public, prevention of HIV transmission through blood and blood products, capacity building and programme management. In addition, the NACP with Canadian support has established HIV and AIDS Second Generation Surveillance System (SGS) to track HIV epidemic in Pakistan.

The salient achievements of the national response since the development of NSF-one are summarized as under:

[19] T. Brown and W. Peerapatanapokin (2004), Asian Epidemic Model: a process model for exploring HIV policy and programme alternatives in Asia. Article in: Sexually Transmitted Infections.

- Substantial expansion in the number and scope of HIV prevention interventions for high-risk groups and vulnerable populations through public sector financing;
- Strengthened role of public-private partnerships in service delivery i.e. partnership with over 350 NGOs under the umbrella of national and provincial AIDS consortia;
- Inclusion of condom promotion as an integral component of service delivery packages for high-risk and vulnerable populations;
- Establishment of a network of VCCT centers (16) throughout the country under Global Fund Round II support to fight against AIDS, Tuberculosis, and Malaria;
- Introduction of an extensive mass media campaign to raise awareness among general adult population about the methods of HIV transmission and its prevention;
- Promoting active involvement of other ministries and departments like Ministry of Education, Ministry of Narcotics, Ministry of Religious Affairs and others.
- Development and implementation of protocols and operational guidelines in a number of areas like VCCT guidelines, guidelines for laboratory diagnosis of HIV and AIDS, infection control guidelines, and guidelines for syndromic management of STIs and others.
- Development and promulgation of National Blood Transfusion Safety Ordinance to prevent HIV spread through transfusion of blood and blood products;
- Establishment of eight Antiretroviral (ARV) treatment centers in tertiary hospitals to provide treatment to AIDS patients;
- A number of research studies to understand biological and behavioural trends of STIs and HIV among high-risk and bridge populations;
- Development of National Monitoring and Evaluation (M&E) Framework to feed into policy and programme planning;
- Establishment of National Network of PLHIV and preparation of legislation dealing with human rights;
- Formulation of National HIV and AIDS Policy and Legislative Framework, the work on which is still under progress; and
- Mobilization of more than US $70 million during 2003-07 to fight against HIV and AIDS in Pakistan.

Private sector participation

Private sector organizations, whether they be for-profit or non-profit have the comparative advantage of accessing marginalized sub-populations and providing them prevention and treatment services in cost-effective manner. Over the past few years the NACP and its provincial counterparts (PACPs) have entered into multiple engagements with private sector firms and large NGOs through public-private partnership (PPP) arrangements. Some of the most important PPP arrangements include:

- Around 20 contracts with NGOs throughout the country to provide HIV prevention and control services to high-risk groups;
- Engagement of media firm to create HIV awareness among the general adult population in the country;
- Engagement of a management firm to: (i) monitor services provided by private firms and NGOs to target populations (ii) build the capacity of the implementing firms and NGOs and (iii) build the capacity of NACP and PACP staff;

- PACP has engaged a private consulting firm for the Process Evaluation of HIV prevention services related to the screening of blood and blood products;
- Engagement of Marie Stopes Society (MSS) to operate 16 VCCT centers and PAVHNA to operate five drop-in centers for street children under Global Fund support; and
- Under the EU/DFID funded TAMEER project 74 NGOs have been engaged to provide services to high-risk and bridge populations.

Donor response

Donor community have equally risen to emerging HIV crisis in Pakistan and using parallel financing arrangements, in partnership with the private sector, have committed over US$ 28 million since 2003. Some of the most prominent contributions of bilateral, multilateral donors and UN agencies (excluding World bank) are:

- Global Fund committed US$ 8.3 million for four years to provide ARV drugs, VCCT services and interventions for youth;
- CIDA financed equivalent of US$ 5.8 million to establish Second Generation Surveillance (SGS) system;
- EU and DFID contributed equivalent of US$ 5.1 million through Interact Worldwide (international NGO) to implement TAMEER project;
- USAID provided assistance of US$ 3.6 million from 2004-07 through FHI, largely for youth-related activities;
- DFID financed equivalent of US$ 2.85 million to: (i) provide harm reduction services to IDUs (ii) conduct National STIs/RTIs study and (iii) technical assistance through Technical Assistance Management Agency (TAMA); and
- UN agencies (UNICEF, UNFPA, UNAIDS, UNODC, and WHO) contributed US$ 2.63 million during 2004-05 for a number of activities to support national response.

4. Reformulation of National Strategic Framework

4.1 Need to Revisit National Strategic Framework

Despite substantial efforts by the Government of Pakistan and Development Partners, the country witnessed an obvious surge in HIV prevalence over the past few years. The situation demanded revisiting and reformulation of strategies to:

- Re-install a sense of increased commitment and leadership among the national authorities and the leaders at all levels;
- Bring in-line the long-term development policies (vision 2030 and poverty reduction strategy) and programme efforts to HIV and AIDS prevention and control;
- Integrate efforts of various stakeholders around a broad-based multisectoral response to contain HIV and AIDS epidemic;
- Combine coverage of large parts of the population with long-term commitment to the programmes;
- Re-orient financial mechanisms effective, more transparent and adaptable to the emerging needs of the clients; and
- Respond to the rising needs for expensive and high quality management of PLHIV in a way that safeguards the health needs of the entire population.

4.2 Strategic Planning Process

Responding to the rapidly changing scenario and an array of needs highlighted above, the Ministry of Health (MOH) and National AIDS Control Programme (NACP) in early 2006, engaged a team of independent experts to undertake a detailed situation and response analysis followed by a mid term review of the national response to HIV.

The team reviewed available data, ongoing interventions and undertook broad based consultations with representatives from public sector HIV and AIDS Control Programmes, UN system, bilateral donors, NGOs, People living with HIV and AIDS, and other public and private sector stakeholders. The team summarized its findings in two reports:

(1) HIV/AIDS in Pakistan: A Situation and Response Analysis (SRA); and
(2) Mid-Term Review of the National Response to HIV in Pakistan (MTR).

These reports highlighted a number of gaps and constraints in the current response. Some of these gaps and constraints included:

1. ***Denial:*** Despite the fact that Pakistan's status has changed from that of a 'high risk, low prevalence' country to one that has a concentrated epidemic, there is still a reluctance to accept that there is a danger of a generalized epidemic.

2. ***Susceptibility, social distance and homophobia:*** Cultural, social and religious taboos concerning the discussion of sexual behaviours have inhibited the public discussion of reproductive health and sexual behaviours.

3. ***Low coverage of services for target populations:*** The coverage of HIV prevention and control services to target populations especially high-risk groups (HRGs) remains low, both in terms of numbers and types of target populations.

4. ***Little or no services for bridge populations:*** Sexual links of HRGs and their clients or bridge population are important determinant of HIV spread. Till date there has been very little effort to deal with bridge populations except long distance truckers and migrants.

5. ***Lack of targeted services for youth:*** The broad category of 'youth' as a vulnerable population has not been identified under specific categories and implementation of interventions to educate youth on reproductive and sexual health is at infancy.

6. ***Low quality of care:*** The quality of care in counselling and treatment services has suffered due to lack of integration, and, more importantly, due to lack of access and participation by persons in the target groups.

7. ***Minimal public-private partnerships:*** Minimal partnerships with NGOs, CBOs and other civil society organizations that are best placed to access the target population for successful containment of the HIV epidemic.

8. ***Programme implementation issues:*** There are several implementation constraints that remained un-addressed so far and can also hamper the future response, namely; (i) the constraint faced in the contracting of the implementing partners; (ii) the lack of

operational research to provide evidence of good practice and deeper knowledge of target groups which thus help inform the development of the most appropriate targeted interventions; (iii) more effective monitoring of programmes and projects; and (iv) adherence to certain standards, especially in terms of service quality, confidentiality, recording and reporting.

9. ***Lack of effective Communication:*** Effective communication, central to all efforts to expand and scale up the national response, has been affected by a host of constraints like: (i) quality of basic themes in the present messages; (ii) available media options; and (ii) the language(s) of communication.

10. ***Coordination issues:*** There have been several coordination issues in the on-going national response. Increase in the scale and effectiveness of the response requires better communication and coordination between the different actors involved in the process, whether they be at national, provincial or district level, public or private partners, or NGOS that are the front line of the response.

11. ***Information gap:*** Information is key to action. For an effective national response quantity and quality of data are critical. There have been several information gaps in the current response. In future, more and quality data would be required through routine reporting, research, and monitoring and evaluation activities to improve communication and coordination at all levels.

12. ***Capacity issues:*** There is limited availability of human resources with right skills mix throughout the country. Capacity building requires improvement both in terms of numbers and knowledge. The four major areas of capacity gap that have been identified include: (i) critical shortage of technically qualified persons (ii) effective training to rectify the widespread lack of knowledge about HIV and STIs among government health workers and private medical care workers (iii) NGOs capacity to effectively scale up successful interventions, and (iii) capacity gaps among NACP and PACPs staff in terms of technical skills and programme management.

Based on these findings of SRA and MTR reports, the team's recommendations were discussed with stakeholders to develop consensus and determine priorities, which led to the preparation of the National Strategic Framework-Two for next five years (2007-2012). To finalize the revised framework, ensure ownership and develop consensus, active participation of wide range of stakeholders was ensured through individual meetings with NGOs, UN partners, bilateral and multilateral donors, private and public sectors representatives, and People living with HIV and AIDS. The process was further consolidated through provincial consultations with all stakeholders including district representatives facilitated by the Provincial AIDS Control Programmes. The final step in the process was a national retreat to discuss the findings and recommendations of the MTR report, to debate the prioritization and to elaborate the NSF.

5. National HIV and AIDS Strategic Framework 2007-12 (NSF-Two)

5.1 Introduction

The national HIV and AIDS strategic framework for 2007-12 articulates a vision for Pakistan in line with the recently formulated national policy on HIV and AIDS and elaborates through guiding principles, goal, strategic objectives and priority areas, the direction for future national response against the emerging HIV and AIDS epidemic. It does not include operational or implementation plans attributable to any one sector, or detailed budgets for specific interventions, rather it provides strategic direction, guides programme development and activities by all HIV and AIDS stakeholders including government departments and ministries, non-governmental organizations (NGOs), community-based organizations (CBOs), private companies, researchers, professional associations, development partners, trusts and foundations, and PLHIV in the country over the next five years.

5.2 Guiding Principals for Future National HIV and AIDS Response

The NSF is underpinned by a number of basic guiding principles for HIV and AIDS response that support and provide guidance for the framework's more specific goal, purpose, strategic objectives and activities. These principles are summarized in **Figure 5** and explained below:

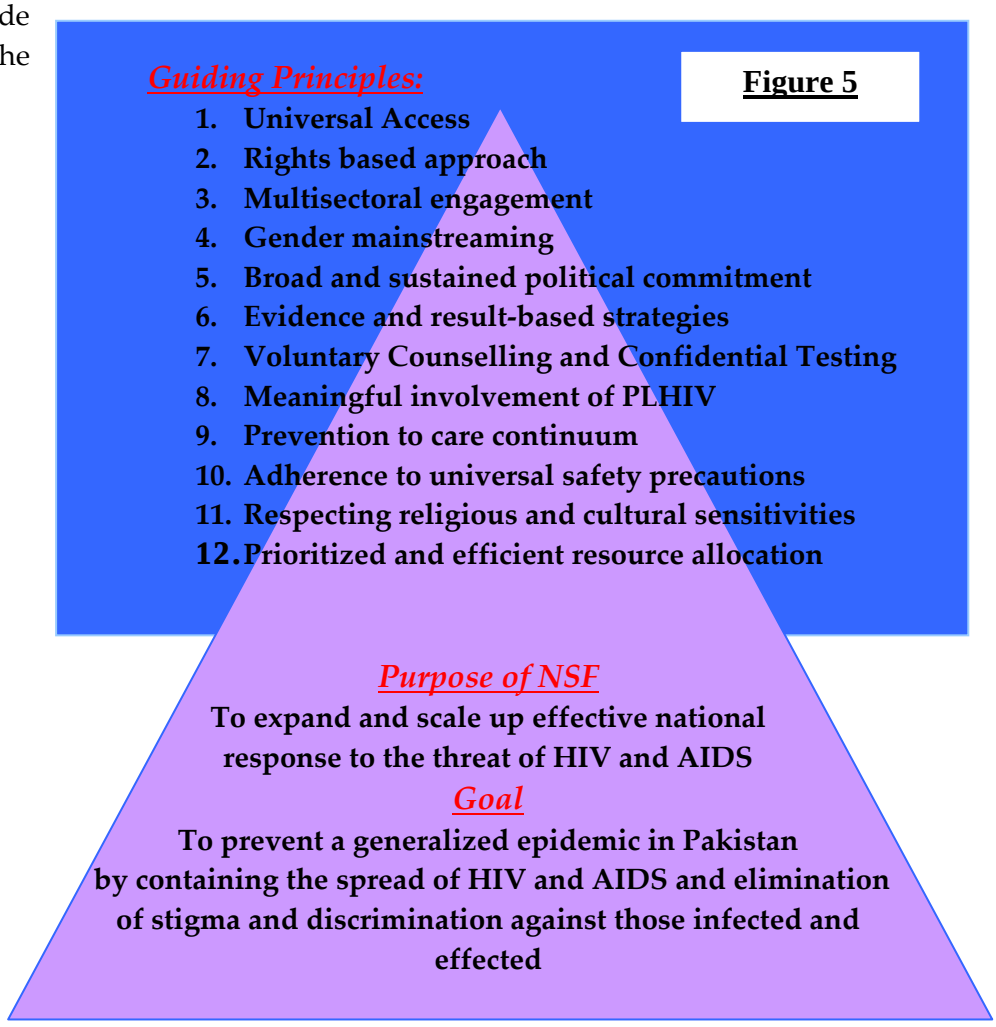


Figure 5

1. ***Universal access:*** All persons living in Pakistan, including displaced populations and refugees have the right to protection from HIV infection and other STIs. Additionally, they have the right to access information about HIV and other STIs, and the means to protect themselves from HIV and other STIs without any discrimination.

2. ***Rights based approach.*** People living with HIV and AIDS (PLHIV) and their families and communities should have the same rights as all other citizens, and should not be discriminated on the basis of their HIV status, gender, socio-economic status or HIV-risk factors. In addition, the individual and human rights of the people infected and affected by HIV/AIDS including their right to confidentiality would be respected and protected.

3. ***Multisectoral engagement.*** HIV and AIDS is a complex and multi-dimensional issue. It requires a multisectoral response at national, provincial, and district levels by government, civil society, and private sector, assisted by bilateral and multilateral partners. Furthermore, sustainability of the response should be promoted by incorporating HIV and AIDS prevention and care initiatives into existing programmes.

4. ***Gender mainstreaming.*** The vulnerable position of women, youth (especially girls) and children in society should be addressed to ensure that they do not suffer discrimination, nor remain unable to take effective measures to prevent or treat HIV infection. Furthermore, no person should be denied access to health and social support because s/he has become infected with HIV.

5. ***Broad and sustained political commitment.*** The formulation of socio-economic development policies and programmes should include consideration of the impact of HIV and AIDS and should always be backed up by sustained political commitment and resource allocation.

6. ***Evidence and result-based strategies.*** Continued efforts should be made to constantly improve HIV and AIDS prevention and treatment programmes, taking into account lessons learned at the national, regional and/or global levels. Furthermore, capacity building at all levels should be emphasized to accelerate HIV and AIDS prevention and control efforts.

7. ***Voluntary Counselling and Confidential Testing (VCCT).*** All HIV tests should be voluntary with guaranteed confidentiality and adequate pre- and post-test counselling, except in those cases where testing occurs under unlinked and anonymous conditions e.g. research, or in the screening of donated blood.

8. ***Meaningful involvement of People Living With HIV and AIDS (PLHIV).*** People Living With HIV (PLHIV) have enormous potential to contribute to national HIV and AIDS prevention and care response, particularly with regard to prevention messages and interventions, and socio-economic mitigation initiatives. Active engagement of PLHIV in strategic planning, implementation and M&E should be sought wherever possible.

9. ***Prevention to care continuum.*** A keystone to the response to HIV and AIDS is the recognition and adoption of programmes that address the epidemic in a holistic manner from prevention to care, treatment, support and mitigation. Effective care and support strategies not only improve the quality and length of life of PLHIV and those affected by HIV and AIDS but also greatly enhance prevention of HIV.

10. ***Adherence to universal safety precautions.*** All persons should be protected from HIV transmission while performing health related procedures through wide dissemination of information and implementation of universal safety precautions and mandatory screening of blood and blood products before transfusions.

11. ***Respecting religious and cultural sensitivities.*** All efforts to combat HIV and AIDS should be considerate of and sensitive to the socio-economic, religious and cultural context of Pakistan. Mass media should be utilized in a positive manner to create and promote awareness on HIV and AIDS in the population as a mean of change in behaviour.

12. ***Prioritized and efficient resource allocation.*** Decisions regarding resource allocation should take into consideration the unique vulnerabilities of and risks posed to various population sub-groups and communities. Major part of these resources should be spent on service provision with minimum administrative costs.

5.3 Goal

The overarching goal of the national response to HIV and AIDS is **"to prevent a generalised epidemic in Pakistan by containing the spread of HIV and AIDS and elimination of stigma and discrimination against those infected and effected"**.

5.4 Purpose

The purpose of the National HIV and AIDS Strategic Framework 2007-2012 is **"to expand and scale up effective national response to the threat of HIV and AIDS"**. This document is a broad national strategic plan designed to guide the country's response as a whole to the epidemic. It is not a sector specific, but a statement of intent for the country as a whole, both for the government and donors. It is envisaged that over the next five years all government departments, organizations and stakeholders will use this document as the basis to develop their own strategic and operational plans so that all our initiatives as a country can be harmonized to maximize efficiency and effectiveness.

6 Strategic Objectives for Future Response

The NSF-Two describes a frame of strategies to guide the various stakeholders in the national response against HIV and AIDS in their planning and implementation of programmes, projects, and interventions during the period 2007-12. It identifies strategic objectives, priority areas and core strategies to be perused in the future response. Various stakeholders can identify specific priority areas, and strategies in relation to their areas of comparative advantage and implement appropriate programmes, projects and interventions.

Guided by the outcomes of the mid-term review and situation and response analysis of the current national HIV and AIDS response, the present NSF is based on four key strategic objectives:

A. Scale up programme delivery
B. Create an enabling environment
C. Build the right capacity
D. Strengthen the institutional framework

These four strategic objectives are the cross-cutting themes across twelve identified priority areas and are the roadmap to address emerging HIV epidemic in Pakistan.

6.1 Strategic Objective A: Scale Up Programme Delivery

Scaling-up of the current national HIV and AIDS response is the key objective to contain HIV epidemic at present level i.e. concentrated epidemic and to prevent it from becoming a generalized epidemic. Scaling-up does not only mean an expansion in absolute numbers, but a more refined and focussed effort to address the challenge. In context of the present NSF it comprises:

(a) Expansion in the level of existing services to provide greater coverage both geographically and numerically;
(b) Expansion in the range of services based on the needs of the key target groups and linking them to the formative and operational research for refinement; and
(c) Greater focus on quality of services while ensuring minimum standards set for service delivery.

6.2 Strategic Objective B: Create an Enabling Environment

An enabling environment is a prerequisite for a successful HIV and AIDS response. The enablers should reflect the social cohesion of a society faced with HIV. The existence of HIV can cause tensions in society that result in isolation of persons who may be or are HIV positive, stigmatization and discrimination against those who are associated with HIV, and reduction in individual's ability to be productive and enjoy good health. It comprises a number of tangible and intangible factors that support in achieving other strategic objectives. Some of these factors are:

(a) Legislation to provide overarching framework under the national response and to protect the rights of individuals;
(b) Attitudes and practices that uphold the guiding principles and seek to address prevailing attitudes towards issues that can negatively affect behaviour, vulnerability, access to services, and participation. The most striking examples of negative attitudes are stigma and discrimination;
(c) The development of a wide range of rules to which institutions, practitioners and should adhere to; and
(d) Increasing awareness and changing behaviours to reduce stigma and discrimination associated with HIV infection.

6.3 Strategic Objective C: Build the Right Capacity

Capacity building is a cross cutting issue that demands design and delivery of appropriate skill development programmes for various categories both for private and public sectors. It refers to the possession by any institution of the necessary resources for it to be able to deliver according to its remit. These resources include:

(a) A sufficient number of suitably qualified, trained and experienced personnel;
(b) Space and accommodation adequate in size meeting minimum standards; and
(c) Availability of suitable equipment and supplies.

6.4 Strategic Objective D: Strengthen the Institutional Framework

The institutional framework constitutes the formal structures that are – or should be – necessary to deliver the national response. These structures include many partners that are directly involved with the national response, such as the Ministry of Health and its institutions (notably hospitals), social sector ministries and departments, NACP and PACPs, implementing NGOs, development partners, and representatives of interest groups i.e. most at risk populations and people living with HIV infection. The objective of strengthening institutional framework has several dimensions like:

(a) Strengthening organizational structures delineating the allocation of roles, responsibilities and reporting relationships internally;
(b) Strengthening the structures and mechanisms, both formal and informal, which permit participation and interaction; and
(c) Strengthening structures that formulate and establish the rules that various institutions and individuals follow and/or are responsible for i.e. regulating activities and quality standards.

7. Priority Areas - Core Strategies & Implementation Priorities

As stated earlier the mid-term review of the national HIV and AIDS response identified twelve priority areas. The first nine areas are for strengthening the previous NSF. The three new priorities are the cross cutting areas of institutional linkages/arrangements, procurement of goods and services, and management information system. These areas emerged as critical themes over the past five years implementation experience and are vital to realization of an effective national response.

Prioritization of these areas is based on the stage of epidemic, which infact is the key to successful attainment of the NSF objectives. However, setting priorities is a difficult process and choices have to made based on a range of factors e.g. relative importance of a proposed action, availability of resources and dependence on preceding decisions and other actions. The hierarchical relationship between goal, objectives and the priority areas is summarized in **Figure 6.**

7.1 Priority Area 1: Expanded Response:

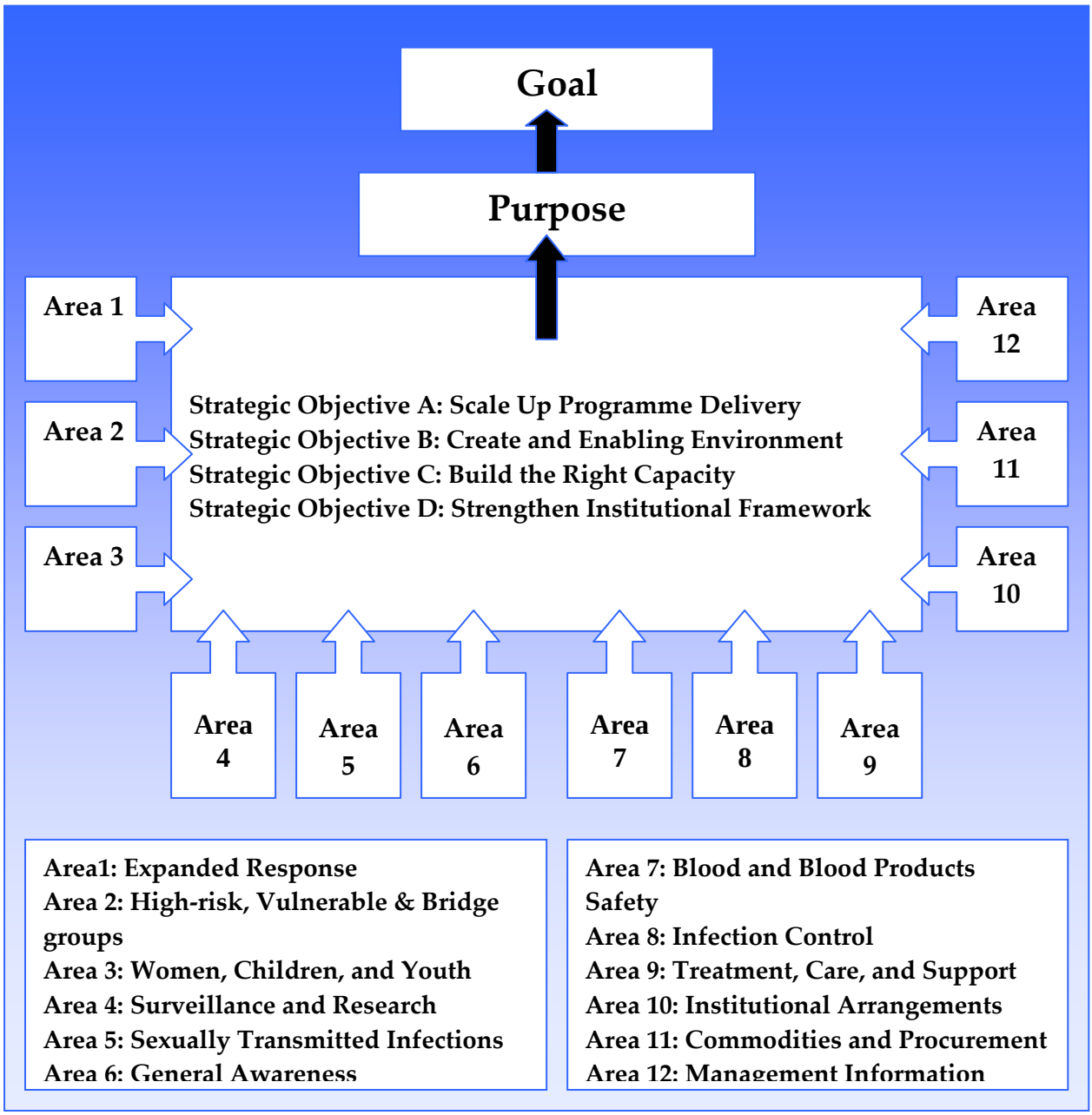
Area objective: To ensure an effective, well-coordinated, and sustainable multi-sectoral response to HIV and AIDS in Pakistan.

Justification & implementation requirements

- The Ministry of Health and Provincial Departments of Health (DoHs) take a lead role in implementing the national and provincial HIV prevention and control programmes respectively. However, the sphere of HIV prevention activities is generally multi-sectoral and cuts across a number of ministries and departments e.g. Health; Education; Interior; Women development, Social Welfare, and Special Education; Defence; Law, Justice and Human Rights; Labour, Manpower and Overseas Pakistanis; Narcotics Control and Anti Narcotic Force; Local Bodies and Rural Development; Industries; Population welfare; Information; Religious Affairs and many others. Mainstreaming HIV and AIDS into the work of government/ non-government organizations and private sectors is a cost-effective

strategy to address the direct and indirect causes and impact of the epidemic. Sustained partnerships bringing together a range of stakeholders is a key strategy for an expanded response.

Figure-6: Relationship between Goal, Purpose, Strategic Objectives, & Priority Areas



- Since the development of first NSF there has been an increased recognition of the importance of a multi-sectoral response to HIV and AIDS in Pakistan. However, most sectors in Pakistan have yet to become fully engaged. Multi-sectoral initiatives to date are limited but with the changing face of epidemic there in an urgent need to engage all sectors to foster an effective and sustained national response.

- Government leadership in this regard would be a crucial element and it would be necessary to rally support for the nation's response to the epidemic at the highest political level. Furthermore, an expanded national response would also require strong institutional leadership, and management and coordination capacity to deal with many initiatives and stakeholders. Therefore, MoH through the National AIDS Control Programme at federal level, and Provincial Health Departments through the Provincial AIDS Control Programmes in the provinces would have to focus on advocacy, co-ordination and technical support. Emphasis would also have to be laid on continuous follow up and support to ensure that ownership is created within the partners in Government, Civil Society and Private Sector. In order to ensure that the inputs are converged into one unified effort the national and provincial programmes would have to create structures and systems for partnerships with such organizations and agencies.

- Civil society organizations would have to be as equal partners in the programme and not merely the organizations that are contracted to carry our projects and specific interventions. Owing to their comparative advantages like field experience, proximity to the community, knowledge of their needs and expectations, and ability to analyze factors driving the risk behaviour they can play a strategic role in planning, designing and monitoring of the programmes. Their involvement as Public Private Partners (PPPs) would have to be ensured to address the challenge.

Enablers

- Growing political will and commitment to address the HIV and AIDS challenge;
- Recognition of the fact that HIV and AIDS is not merely a disease but a developmental issue that needs a well-coordinated and sustained multi-sectoral response;
- Increasing interest of various ministries and departments of the government in HIV and AIDS related issues;
- Fairly well established national and provincial HIV control programmes with enough growth potential to meet the challenges as they emerge;
- Increasing interest and commitments of various multilateral and bilateral donors to strengthen the national HIV and AIDS response; and
- Growing and committed civil society under the umbrella of national and provincial AIDS consortia.

Barriers

- Weak coordination and partnership between NACP/PACP and other ministries that have a crucial role to play in the national response;
- Lack of elaborated strategies and action plans to ensure a multisectoral response;
- Frequent changes in federal government and provincial programme's management;
- Dearth of technical human resource, especially in provinces to lead a well-coordinated multisectoral response; and
- Limited private sector especially corporate sector involvement with no strategy to involve and tap these resources.

Core strategies to achieve relevant strategic objectives

Strategic objective: Scale up programme delivery

1.1 Seek to expand Private Public Partnerships (PPPs), with attention given on how to engage smaller NGOs and CBOs.

- **Resource:** Technical Assistance (TA); **Responsibility:** PACPs; **Partners:** NACP, Civil Society Organizations (CSOs), target communities, district Governments and Development Partners.

Strategic objective: Create an enabling environment

1.2 Prepare a strategy and implementation plan for achieving a multisectoral response. As part of this:

(i) Take early steps to improve communication and coordination;

(ii) Adopt the National HIV and AIDS Policy (NHAP) and lobby for early passing of the supporting legislation dealing with human rights aspects of HIV and AIDS;

(iii) Examine and recommend to Government on policies on controversial issues including the provision of ART (free treatment for all or some form of cost recovery), substitution therapy and ART for IDUs, condom promotion for disease prevention, distribution of needles and condoms in prisons, and coordination with law enforcement agencies;

(iv) Identify champions of change to help in high-level advocacy and sensitization;

(v) Integrate the activities that form the national HIV and AIDS response with other relevant programmes (notably Reproductive Health (RH), Hepatitis B and C, and TB-DOTS); and

(vi) Improve and facilitate linkages with VCCT and ARV centers to improve referrals.

- **Resource:** Concerned departments; **Responsibility:** NACP, PACPs, Line ministries and departments; **Partners:** CSOs, Parliamentarians at federal and provincial levels and their fora, development partners, and Ministry of Population welfare (MoPW).

1.3 Constitute an HIV committee for federal and provincial level parliamentarians within existing federal and provincial level parliamentarian fora, and ensure its smooth functioning.

- **Resource:** Policy level support; **Responsibility:** NACP, PACPs **Partners:** UNAIDS, CSOs, target communities.

1.4 Plan and facilitate mainstreaming of HIV/AIDS in all government ministries and public institutions.

- **Resource:** MoH/provincial departments of Health (DoHs); **Responsibility:** Planning and Development (P&D) both at federal and provincial levels; **Partners:** All line ministries and departments, CSOs, development partners, private sector.

1.5 Review and develop strategies for resolving the issues that are inhibiting the enabling environment, namely: (a) leadership; (b) denial of the scale of the problem; (c) stigma and discrimination; (d) socio-cultural inhibitions, notably the need to gain acceptance for the more general promotion of condoms for HIV and STI prevention; (e) inadequate knowledge of and communication on HIV and SRH-related issues; (f) the need for quality sensitization; and (g) lack of collaboration with law enforcement agencies.

- **Resource:** TA; **Responsibility:** NACP; **Partners:** PACPs, CSOs, development partners.

1.6 Mediate to resolve the differences between MOH and MOPW that have so far restricted condoms promotion as infection protection device.
- **Resource:** National Steering Committee, Technical Advisory Committee on AIDS (TCA); **Responsibility:** MoH, NACP; **Partners:** private marketing firm.

1.7 Ensure government policy and resources to support NGOs operating Needle Syringe Exchange Programmes (NSEPs) for IDUs.
- **Resource:** National Steering Committee, Technical Advisory Committee on AIDS (TCA); **Responsibility:** NACP, PACPs; **Partners:** Implementing organizations.

1.8 Take early steps to publicize the NHAP among all service providers, with emphasis given to the unacceptability of stigmatization.
- **Resource:** Behaviour Change Communication (BCC); **Responsibility:** NACP; **Partners:** Development partners, NGOs, high risk groups (HRGs), line ministries.

1.9 Develop strategies and procedures for ensuring coordination with law enforcement and other relevant agencies.
- **Resource:** District task force committees; **Responsibility:** PACPs; **Partners:** Implementing organizations, NGOs, district government, local leaders, law enforcement agencies.

Strategic objective: Build the right capacity

1.10 Put a system in place to ensure that the different training needs assessments are merged and routinely updated; and assess the human and financial resources required by NGOs and other (non-health) sectors and actors working in HIV/AIDS.
- **Resource:** TA; **Responsibility:** NACP, PACPs; **Partners:** Line ministries and departments, Public and private sector academic institutions.

1.11 Establish a cadre of professionals with the requisite skills in HIV and AIDS, as well as related issues (such as gender, reproductive health, infectious diseases and STIs) through the preparation and implementation of a national training programme (HRD Plan) for HIV/AIDS that covers:
(i) The technical and programme management needs of NACP/PACPs and those implementing PPPs;
(ii) Training requirements for physicians, consultants, general practitioners, pharmacists and other staff at various levels in hospitals, clinics, surgeries, blood banks, medical colleges, nursing schools and VCCT centers;
(iii) Training for NGOs, especially for scaling up HIV communications in participating NGOs;
(iv) Training for government ministries and other public sector institutions; and
(v) The timing and priorities for delivery.
- **Resource:** TA; **Responsibility:** NACP, PACPs; **Partners:** Line ministries and departments, Public and private academic institutions.

1.12 Scale up the resources necessary to deliver the training programme including:

(i) Developing in-country training delivery capacity through training of trainers with emphasis on upgrading the knowledge and skills required to deal with issues related to stigma and discrimination, gender, and empowerment; and

(ii) Preparing materials, guidelines, protocols, and standard operating procedures that will support the multi-sector response.

- **Resource:** Relevant training institutions, TA; **Responsibility:** Line ministries and departments; **Partners:** Training Institutes.

1.13 Through TACA, establish a nationally constituted capacity building committee on HIV/AIDS and under its aegis devolve training resources to sectors.

- **Resource:** Concerned departments; **Responsibility:** TACA, P&D both at federal and provincial levels; **Partners:** NACP, PACPs.

1.14 Develop public sector capacity building training programme within the national response capacity building programme (see below) covering: (i) technical skills; (ii) financial management, procurement and MIS; (iii) leadership (management, emotional intelligence, team building; (iv) M&E; and (v) communications, BCC, counselling, understanding stigma and discrimination.

- **Resource:** TA; **Responsibility:** MoH, DoH; **Partners:** Management consultants and public sector institutions.

1.15 Develop NGO capacity building in collaboration with their representative organization(s) according to the National Capacity Building Plan.

- **Resource:** TA; **Responsibility:** PNAC. **Partners:** NACP and PACPs.

Strategic objective: Strengthen the institutional framework

1.16 Ensure the effective functioning of the various steering committees and TACA at federal and provincial levels.

- **Responsibility:** NACP and PACPs; **Partners:** TACA and provincial Technical Advisory Committees (TACs).

1.17 Develop proactive relationships with service providers delivering HIV interventions and also with broader civil society.

- **Resource:** TA (MIS); **Responsibility:** NACP and PACPs; **Partners:** CSOs.

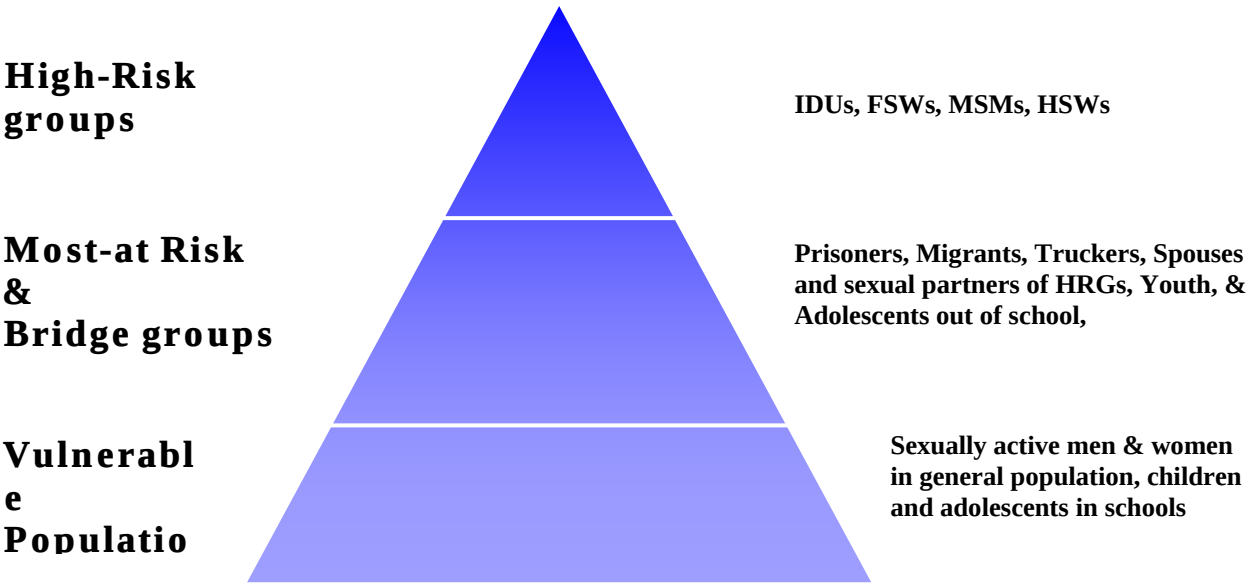
7.2 Priority Area 2: High-risk, Vulnerable, and Bridge Populations

Area objective: To reduce risk of HIV infection amongst high-risk, most-at risk, vulnerable and bridge populations.

Justification and implementation requirements

Pakistan has a concentrated HIV epidemic that can be most efficiently controlled by working in a targeted manner with high-risk, most-at risk, bridge and vulnerable populations that include:

- Injecting drug users;
- People who engage in sexual behaviour that puts them at risk (FSWs, MSMs, and HSWs);
- Migrant workers;
- Long distance truck drivers and associated population;
- Jail inmates; and
- Sexual partners, spouses and children of the people in these groups.



Risk Pyramid[20]

- Injection drug use is becoming a preferred method of drug abuse in Pakistan. Injection Drug Users (IDUs) are at higher risk of acquiring HIV infection through the widespread sharing of contaminated needles. Recent data also to suggest that IDUs also engage in unprotected sexual activity, often with Commercial Sex Workers (CSWs). Populations such as FSWs and MSMs are at the highest risk of acquiring HIV due to their social marginalization, occupation, and unsafe sexual practices. Migrant workers, other mobile populations and jail inmates are also at most risk because they live without their wives or regular partners for long durations and often engage in risky behaviours with strangers.

- The primary focus of the HIV prevention efforts will be on reducing HIV infection risks among these populations. These populations would have to be reached and provided with services specific to meet their requirements in order to reduce transmission of HIV to and from other members of the group and to general population. Sustained behaviour change interventions through coverage of population at the highest risk with a package of preventive services, creation of an enabling environment conducive for community mobilization and empowerment would be the important strategies that could significantly contribute to the halting and reversal of the epidemic.

[20] Adapted from National AIDS Control Project III -India

- The hallmark of HIV prevention in Pakistan would be aimed to halt/reverse the spread of HIV infection by 2012 by providing each of the target groups with a minimum package of prevention services between 2007 and 2012. Efforts would be geared to achieve following coverage targets by 2012:
  - Coverage of at least 80% of IDUs and 60% FSWs of estimated populations with a minimum package of prevention services;
  - Coverage of at least 60% of men who have sex with men, trans-genders, long distance truckers, jail inmates, most at risk adolescents and coal mine workers; and
  - Coverage of at least 50% of medium and low-risk groups (general population) with a minimum package of prevention services.

- Non-Governmental Organizations (NGOs) and Community Based Organizations (CBOs) working across the country with some systems and structures are best suited to reach out HRGs that the government finds difficult to access. Over the past few years, a number of NGOs and CBOs have done excellent work with these groups and have implemented effective models of interventions. There has been a significant increase from 50 to over 350 participating NGOs with around 32 interventions and strengthening of NGO community through establishment of national and provincial AIDS consortia. However, new partnerships would have to be created to bring services as close as possible to the communities most affected, to ensure a long-term connection between services and these communities.

Enablers

- Concentrated HIV epidemic that is still limited to one high-risk group i.e. Injection Drug Users;
- More reliable information available on the geographical location of HRGs through a number of mapping exercises;
- Biologic and behavioural data on HRGs available from various rounds of Second Generation HIV Surveillance and other research studies;
- Broad consensus on prioritizing interventions to most-at risk and vulnerable populations in Pakistan;
- Increasing NGOs and CBOs interest, capacity and participation to work with most-at risk and vulnerable populations;
- Number of intervention packages providing quality services to most-at-risk population groups;
- Commitment among policy makers/decision makers to allocate resources needed to contain the epidemic; and
- Substantial change in the behaviour and skills of most-at-risk populations to adopt preventive measures like condom use, and needle and syringe exchange.

Barriers

- A narrowing window of opportunity due to rapid progression of HIV epidemic among IDUs;
- Geographic and numeric spread of the most-at risk and vulnerable populations across the country as evident from HASP trend data;
- Quasi-legal status to access most-at risk populations in the country;
- Universal issues of HIV associated stigma and discrimination along with societal denial about the extent to which certain risky behaviours are prevalent in Pakistan;

- Ever evolving dynamics of HIV transmission among most-at risk and vulnerable populations; and
- Limited technical resources to achieve higher coverage rates.

Major strategies to achieve relevant strategic objectives

Strategic objective: Scale up programme delivery

2.1 Scale up interventions, geographically as well as by service, to reach a much greater proportion of the key and target populations through:

(i) Coordination with relevant partners and programmes;

(ii) Expand coverage;

(iii) Encouraging an increased uptake of services through enabling environment;

(iv) Empowerment activities e.g. more Drop In Centers (DICs); and

(v) Improving monitoring and evaluation.

- **Resource:** Implementing partners, TA, Evidence from HASP data & SRA/MTR; **Responsibility:** NACP, PACPs; **Partners:** ANF, PLHIV groups, NGOs, NIV treatment and care centers, Micro-credit organizations, Development partners, Human rights activists.

2.2 Improve and encourage access of the key populations to HIV care and treatment (including putting in place patient support groups, facilitating access to ART centres, ensuring on-going counselling, and resolving issues related to ART for IDUs).

- **Responsibility:** Implementing NGOs; **Partners:** ART centers.

2.3 Enhance the technical scope of HIV intervention projects so that, to the extent possible, they offer VCCT and testing services (HBV, HCV and syphilis as appropriate) to their clients with minimal referrals.

- **Resource:** TA, Provision of rapid tests kits; **Responsibility:** NACP, PACPs; **Partners:** Implementing organizations, HIV treatment and care centers.

2.4 Focus on interventions to increase the uptake of STI services.

- **Resource:** TA; **Responsibility:** Public and private sector health care providers; **Partners:** NACP, PACPs.

2.5 Ensure pre- and post-test counselling and referral for all groups (notably migrant workers).

- **Responsibility:** NACP, PACPs; **Partners:** Bureau of Immigration, VCCT centers.

2.6 Design interventions to increase the consistent use of condoms supported by messages that emphasize the transmission of HIV and STIs through non-regular sex partners.

- **Resource:** Formative research findings; **Responsibility:** Implementing organizations; **Partners:** NACP, PACPs.

2.7 Include VCCT, promotion of safer sexual practices including condom provision and implement harm reduction interventions in prisons.

- **Resource:** TA in advocacy with jail departments; **Responsibility:** NACP, PACPs, Implementing organizations; **Partners:** Ministry of labour (MoL), Jail departments, NGOs, Human rights activists.

2.8 Design specific interventions for bridging populations, including support groups for wives of IDUs, migrant workers and other target groups as appropriate.

- **Resource:** TA; **Responsibility:** NACP; **Partners:** Members of bridging populations, NGOs.

2.9 Examine and resolve the issues concerning testing for HIV, notably the confusion among NGO service providers concerning the accuracy of different tests.

- **Resource:** TA in rapid test technology; **Responsibility:** NACP, PACPs; **Partners:** Sindh Institute of Urology and Transplants (SUIT), Shaukat Khanum Memorial Trust (SKMT), NGOs.

Strategic objective: Create an enabling environment

2.10 Re-examine the appropriateness of HIV communication messages and materials for the key populations, increase the engagement of members of these groups in BCC design and activities, and revise accordingly.

- **Resource:** TA; **Responsibility:** NACP, PACPs; **Partners:** Targeted population groups; Media agencies; NGOs.

7.3 Priority Area 3: Women, Children and Youth

Area objective: To reduce the vulnerability of women, children and youth to HIV and AIDS.

Justification and implementation requirements

- Pakistan is a male-dominated society and violence against girls and women remains a problem. In societies where women are not empowered to develop life skills, such as problem solving, decision making, and critical thinking, they lack confidence and control and are much more susceptible to acquiring HIV. Infact, increased susceptibility of women to HIV is a combination of many factors i.e. (i) their physiology (ii) inadequate knowledge about HIV (iii) insufficient access to preventive services (iv) limited ability to negotiate safer sex (v) and lack of self control on their own lives. In addition girls and women are often driven into sexual bondage because of poverty and thereby they put themselves and their clients at risk of HIV transmission. Uptil now the national HIV response has been patchy to address women and girls related issues. NSF-two does outlines a number of activities in various priority areas- a commitment to mainstream gender related issues in the forthcoming national HIV response.

- With more than 55% of its population under 25 years, Pakistan is demographically a young country[21]. Being in the most productive phase of its demographic transition,

[21] Based on 2002 estimations, NIPS, Pakistan Census Organizations, Census Report of Pakistan 1998, Islamabad.

Pakistan needs to capitalize the asset i.e. its youth. However, in the context of HIV and AIDS the same segment posses a great threat to economic prosperity. Based on the level of vulnerabilities the National HIV Prevention Strategy for Young people classifies Pakistani youth into three categories: (i) most at risk young people (young people living on the street, sex workers, IDUs); (ii) vulnerable young people (adolescent labourers and out of school youth, and young married): and (iii) the general population of young people (at home and in school). There has been very little documentation on the extent to which young people of these different categories engage in risky behaviours. However, the available evidence indicates that while some young Pakistanis may possess limited knowledge about reproductive/sexual health and HIV and AIDS, the majority does not have even the most basic information. In addition, myths and misconceptions about sexuality, STIs, and reproductive health in general are commonplace. Parents and teachers are often uncomfortable or are otherwise unprepared to talk with young people about issues related to sexual and reproductive health, and thus youth rely on information gleaned from the mass media or from their peers—both of which sources are likely to offer faulty or incomplete information. In addition, sexual and reproductive health services are not easily accessible by young people, due to constraints on their mobility, denial by caregivers that such services are needed, and/or the stigma attached to care seeking for issues related to sexual and reproductive health. Clearly all this information suggests that in order to bring a change there would be a need to design targeted interventions with active involvement of young people, from the conceptual phase through implementation and evaluation.

- The impact of HIV and AIDS on the children is systemic and not linear. It negatively influences financial conditions of the family, in addition to the psychological impact of stigma and discrimination. Furthermore, children by themselves are vulnerable to acquiring HIV especially street children and those without family care, children at risk of being trafficked, children using injecting drugs, children of sex workers and those who face gender based risks. All these vulnerabilities suggest strong need to mainstream children related interventions in the national HIV response by enhancing linkages, scope and coverage.

Enablers

- Low HIV prevalence among women, children and youth;
- Some basic research available to understand the vulnerabilities of these population subgroups;
- Development of the Life Skills Based Curriculum (LSBC) as an initiative of the National AIDS Control Programme;
- Development and distribution of educational material about HIV and AIDS in schools;
- Development of partnership with Ministry of Education as part of multisectoral approach to address HIV epidemic;
- Increasing number of youth-oriented NGOs that work at the community level, which could involve youth in HIV and AIDS prevention for themselves and their peers; and
- Increasing financial commitment to address vulnerabilities of children and youth e.g. ongoing Global Fund interventions.

Barriers

- Religious and cultural sensitivities to discuss sex related issues with women, children and youth;
- A very large proportion of Pakistani population with different implementation challenges;
- Issues of accessibility especially to street children and out of school youth as mostly they are not an organized group;
- Illiteracy i.e. a large proportion of women and youth is illiterate and need specialized interventions to address the challenge; and
- Poor coordination with some related ministries e.g. Ministry of Women Development, Social Welfare and Special Education, Ministry of Youth.

Core strategies to achieve relevant strategic objectives

Strategic objective: Scale up programme delivery

3.1 Expand, design and implement services for out-of-school youth.

- **Resource:** GFATM financed small-scale interventions, Family Health International (FHI) and UNFPA (Reproductive Health Initiative for Young Adults-RHIYA); **Responsibility:** NACP, PACPs; **Partners:** Implementing NGOs.

Strategic objective: Create an enabling environment

3.2 Resuscitate and implement the LSBC; and develop and implement a strategy for reaching youth in public and private sector schools, colleges and universities.

- **Resource:** Finalized LSBC, Existing training infrastructure; **Responsibility:** Ministry of Education (MoE); **Partners:** Educational Institutions and NGOs.

3.3 Treat most-at-risk youth as a high-risk group (or groups) and design and implement interventions accordingly.

- **Resource:** Existing projects of HRGs, TA (in design and training); **Responsibility:** NACP, PACPs, NGOs; **Partners:** Youth at risk, Gatekeepers, Implementing organizations.

Strategic objective: Build the right capacity

3.4 Train education departments on SRH education and HIV/AIDS.

- **Resource:** TA; **Responsibility:** MoE/DoE; **Partners:** NACP, MoH, Ministry of Population Welfare, UNFPA.

Strategic objective: Strengthen the institutional framework

3.5 Ensure coordination with women's health projects and services to use them effectively as channels for HIV communication and awareness raising.

- **Resource:** Existing infrastructure, TA (design and integration of existing components in existing projects), Trainings; **Responsibility:** NACP, PACPs; **Partners:** MoH, DoHs, LHW Project, District governments, Women political leaders, PAIMAN project, UNICEF, NGOs, Social marketing networks.

3.6 Research the types of social services that would complement health services and help extend the reach to more women, children and youth who are at risk.

- **Resource:** TA (research); **Responsibility:** NACP and PACPs; **Partners:** Ministry of Women Development, Social Welfare and Special Education, MoY, NGOs, Research Institutes.

7.4 Priority Area 4: Surveillance and Research

Area objective: To expand the knowledge base in order to facilitate planning, implementation and evaluation of HIV and AIDS, and STI programmes.

Justification and implementation requirements

- The importance of a systematic HIV and AIDS surveillance system to establish biological and behavioural trends can never be overemphasized. A systematic surveillance approach can help identify population sub-groups who are at increased risk for HIV and other STIs, and provide timely warning of sudden changes in levels and distribution of HIV and other STIs in those population sub-groups. Social and behavioural research is also critical to HIV and AIDS prevention efforts, and combined with surveillance, can greatly strengthen the national response. Social science research on the extent and nature of risk behaviours and their actual and potential contribution to the overall HIV and AIDS burden of the country can guide in intervention planning. Such research can also contribute through study of social, cultural and religious values that influence (promote or constrain) the transmission of HIV. Other kinds of research efforts particularly the formative and operational research can illuminate the pathways of success, and can test new or experimental strategies to respond to the HIV and AIDS threat.

- One of the significant outcomes of the Enhanced HIV and AIDS Control Program over the past few years has been the establishment of a well functioning and credible HIV and AIDS Second Generation Surveillance System (SGS) in Pakistan. Biological and Behavioural data from pilot and a couple of other rounds is now available to feed into policy, and programme planning & implementation. Similarly there has been an upsurge in HIV-related research in the past two years. However, much remains un-validated, scattered and underutilised because of poor documentation and dissemination practices. Certainly, there is much more to learn and probe. Refinements in terms of scope and methodology of HIV and AIDS Second Generation Surveillance along with inclusion of formative and operational research with appropriate dissemination strategy to feed into national Monitoring and Evaluation (M&E) system and international commitments (UNGASS) would be the ultimate objective of the future response. In addition, research in relevance to ART and emerging drug resistance patterns would be required in near future.

- Furthermore, the National AIDS Control Programme would have to position itself as the lead national body. Its mandate would be to promote and coordinate HIV and AIDS research through partnerships and networking, capacity building for research through academic and other research institutions, and act as a central repository of all relevant resources, research documents and data base on HIV and AIDS in the country.

Enablers

- Growing culture of surveillance and research to support planning and implementation i.e. evidence based policy, planning and programme implementation;

- Well established HIV and AIDS Second Generation Surveillance System- biological, behavioural and mapping data from more than twelve main cities;
- Substantial biological and behavioural data (HIV and STIs) from National level studies on most-at risk and bridging populations;
- Willingness and growing capacity of academic and research institutions to participate in HIV and AIDS related research;
- Growing capacity of NGOs and CBOs to conduct mapping, surveillance and HIV and AIDS related research; and
- Donor commitment to enhance the scope of HIV and AIDS Second Generation Surveillance in Pakistan with CIDA commitment to fund HIV and AIDS Surveillance and Control Project (HASCP) for next five years;

Barriers

- Lack of capacity and enough human resource to conduct surveillance and HIV related research in provinces;
- No strategy to coordinate, conduct, analyze, and disseminate research and surveillance information;
- Religious and cultural barriers to conduct research on sensitive issues i.e. discuss sex related issues with women, children and youth;
- Limited capacity of scientific bodies for ethical review of STIs and HIV and AIDS related research;
- Weak passive HIV surveillance system to get incidence data i.e. poorly working HIV surveillance centers; and
- Relatively new concept of national Monitoring and Evaluation (M&E) system, which will be the ultimate system to generate all kinds of HIV and AIDS, related information in the country.

Core strategies to achieve relevant strategic objectives

Strategic objective: Scale up programme delivery

4.1 Expand and improve mapping of target groups, notably street-based CSWs, and bridging populations.

- **Resource:** TA; **Responsibility:** NACP, PACPs; **Partners:** NGOs, Consortia, SDPs.

4.2 Conduct operational and formative research, to improve contact with key and target groups and ensure that service design and delivery matches their needs.

- **Resource:** NACP, PACPs, MoH, DoHs; **Responsibility:** NACP, PACPs; **Partners:** Research Institutions (RIs), Academia, Independent researchers, HRGs, Implementing NGOs.

4.3 Improve integration, harmonization and information sharing with stakeholders, partners in response, interested professionals, and civil society through expanded and improved dissemination efforts. This should include establishing forums, such as a clearinghouse, a website and a regular newsletter, to share and update information, new research, best practice and lessons learned.

- **Resource:** MoH/DoH; **Responsibility:** NACP, PACPs; **Partners:** NGOs, Service Delivery Providers (SDPs).

4.4 Design, circulate and provide training to improve and standardise intervention recording and reporting systems in order to simplify reporting, facilitate comparison and aggregation of data, and to help track service quality.

- **Resource:** TA; **Responsibility:** NACP and PACPs; **Partners:** Training Institutes (TIs).

4.5 Improve service reporting and record keeping throughout the public, NGO and private sectors.

- **Resource:** TA; **Responsibility:** NACP, PACPs; **Partners:** Implementing organizations, PPPs.

Strategic objective: Build the right capacity

4.6 Plan and take the necessary steps to implement the M&E Framework.

- **Resource:** TA; **Responsibility:** NACP, PACPs; **Partners:** Development partners, NGOs.

4.7 Take steps to ensure that the sentinel surveillance is fully functioning and Improve HIV and AIDS case reporting.

- **Resource:** Sentinel centers; **Responsibility:** NACP, PACPs; **Partners:** SDPs, NGOs.

4.8 Standardize mapping methodology and case definitions of most at risk populations.

- **Resource:** HASP, UNAIDS; **Responsibility:** NACP and PACPs; **Partners:** Development partners.

7.5 Priority Area 5: Sexually Transmitted Infections (STIs)

Area objective: To reduce the prevalence and prevent the transmission of sexually transmitted infections (STIs) both as an important public health issue in its own right and as part of the effort to reduce HIV transmission.

Justification & implementation requirements

- Sexually transmitted infections (STIs) are one of the determinants of HIV transmission. They increase the risk of HIV transmission in the event of unprotected sex. Thus prevention, proper diagnosis, and treatment of sexually transmitted infections are always essential components of an effective HIV prevention strategy. In addition if left untreated, STIs can result in a wide variety of serious diseases, conditions and outcomes including but not limited to pelvic inflammatory disease, ectopic pregnancies, and fertility problems.

- Awareness and knowledge of reproductive health issues is limited, and often erroneous, among the men and women of Pakistan due in part to the generally low levels of education, and also due to their limited access to effective reproductive health services. Men and women alike are often unaware of the differences between reproductive and sexual "health" and reproductive and sexual "disease". When they do become aware of a possible sexual or reproductive problem, they often seek care from traditional healers (hakims) or from one of the many unregulated "sex clinics" in the informal health sector.

- The general lack of research and information regarding the extent and nature of infections that are sexually transmitted among Pakistan's general population makes it impossible to accurately assess the impact of STIs or their prevalence. There is no nationally representative information on the prevalence of STIs (except for some most-at risk and vulnerable populations in selected cities), the sensitivity of drugs used to treat STIs, determinants leading to STIs, and treatment seeking behaviour among various segments of the population. Small-scale studies show that symptoms related to STIs and RTIs are common among women. Service providers and the general adult population are not fully aware of the links between STIs and HIV infection, and there is a state of complacency given the high prevalence rates of STIs and RTIs.

- In Pakistan, STI services are mainly provided at the district level hospitals in the gynaecological outpatient department (OPD) for females and in dermatology OPD for males. Service providers at OPDs are overworked and unable to respond effectively to the needs of STI patients, especially with reference to privacy during examination, counselling and partner management. The main challenges for access to quality STI services include: (i) the limited number of service delivery outlets; (ii) inadequately trained service providers; and (iii) insufficient back-up laboratory support.

- Considering the importance of preventing and treating STIs to prevent HIV transmission the national response would have to adopt a multi-prong approach ranging from a well-designed preventive strategy to improving diagnostic, treatment and research facilities throughout the country.

Enablers

- STIs prevention and treatment has been a prioritized component of the national response over the past few years i.e. it has been an integral part of all service delivery packages for most-at risk populations;
- Syndromic management guidelines for STIs management have been adopted and are widely available for use;
- A healthy number of medical staff has been trained using syndromic management guidelines;
- Baseline data on STIs prevalence and their determinants among most-at risk populations is now available;
- A couple of other national level STIs prevalence and risk factors studies among most-at risk and bridging population are underway;
- A state of art national referral laboratory is now available to conduct and promote STIs related research; and
- An accessible health services network exists from provincial to the district and tehsil level, which can be strengthened through skill development in syndromic management of STIs.

Barriers

- Lack of reliable nationally representative surveillance and epidemiological information along with serious deficiency in terms of data recording and reporting;
- Wide capacity gaps to counsel, diagnose and treat STIs, both in public and private sectors;
- Low levels of general public awareness about the signs and symptoms of STIs, which leads to inadequate and often inappropriate care seeking behaviour;

- Stigma about STIs, combined with a perception that there is a lack of confidentiality and privacy at health care facilities that inhibits appropriate care seeking;
- Sociocultural barriers which prevent open and frank discussions on topics related to STIs such as "sexuality" and the "promotion of condom use";
- Multiple myths and misconceptions about sexually transmitted infections;
- Substantial unregulated private sector, which caters to a substantial proportion of the population suffering from STIs and often provides inappropriate STIs treatment;
- Unavailability of diagnostic and treatment services except at the tertiary hospitals, and in large cities, where mostly the services are available through dermatologists and gynaecologists;
- Absence of culture to referrer STIs patients for VCCT; and
- General perception, among both health care providers and health care seekers, that STIs is not our problem due to strong religious, cultural and social values and traditions.

Core strategies to achieve relevant strategic objectives

Strategic objective: Scale up programme delivery

5.1 Develop and implement social marketing programmes to promote condom use for the prevention of STIs and HIV. A specific target should be STI clinics.

- **Resource:** NACP, PACPs, Social marketing, NGOs; **Responsibility:** NACP, PACPs; **Partners:** Private social marketing.

5.2 Ensure provision of counselling services at STI service delivery points and provide appropriately trained staff in counselling.

- **Resource:** NACP, PACPs, DoH; **Responsibility:** Program manager NACP & PACPs; **Partners:** District governments.

5.3 Improve standards of STI clinics and services by: (i) developing a standardised checklist of necessary supplies and appropriate environment for STI management (e.g. private area for counselling); and (ii) regular inspection and assessment reporting. Iii) SOPs and protocols for waste management.

- **Resource:** TA, NACP, PACPs, DoH/MoH, Teaching hospitals; **Responsibility:** STI section of NACP & PACP, TA; **Partners:** FHI, MOPW, UNFPA, Teaching hospitals.

5.4 Strengthening of labs for STI treatment protocol monitoring, initially in model referral centers.

- **Resource:** NACP, PACPs; **Partners:** Provincial governments.

Strategic objective: Create an enabling environment

5.5 Mediate to resolve the differences between MOH and MOPW that have so far restricted condoms from being promoted as infection protection devices.

- **Resource:** Policy level; **Responsibility:** MoH, MoPW, TACA; **Partners:** NACP, PACPs.

Strategic objective: Build the right capacity

5.6 Train service providers in public and private sector including in-service training and regular update on: (a) syndromic management of STIs; and (b) ethical aspects of health

care delivery to ensure the right of patients to privacy and thus empower persons to engage in sexual consultations.
- **Resource:** MoH/DoH, NACP, PACPs; **Responsibility:** STI section of NACP/PACPs, PHDCs; **Partners:** MOPW, UNFPA.

5.7 Improve STI recording and reporting at clinics and outpatient departments to feed into M&E data. This should be linked with HMIS.
- **Resource:** MoH/DoH, NACP, PACPs; **Responsibility:** M&E officer, STIs officer; **Partners:** HMIS section.

5.8 Establish/improve referral systems between STI clinics, VCCT and ARV Treatment centers And ANC services.
- **Resource:** NACP, PACPs; **Responsibility:** STI officer/Consultants; **Partners:** district governments.

Strategic objective: Strengthen the institutional framework

5.9 Improve coordination with private sector providers to institutionalise syndromic management of STIs. Ensure reporting is fed into the M&E system.
- **Resource:** NACP, PACPs; **Responsibility:** STI section and NGO coordinators of NACP and PACPs; **Partners:** NGOs, Private sector.

7.6 Priority Area 6: General Awareness

Area objective: To reduce the risk of infection amongst the general public through an increase in awareness levels.

Justification and implementation requirements:

- In order to build an effective response to prevent HIV among general population, it is vital to provide them with the information, skills and tools that they need to protect themselves from acquiring HIV infection. People must be informed about the risks posed by HIV and AIDS, ways that HIV can be transmitted, and effective methods to prevent HIV transmission. Apart from sexual transmission, attention must also be given on other modes of HIV transmission i.e. mother-to-child transmission, and transmission through exposure to contaminated blood and blood products (including through transfusions, unsafe injection practices, and exposure to contaminated instruments used for surgery, barbering, tattooing, piercing, and needle sharing). The public also needs to be informed about other STIs (including the role of STIs in the spread of HIV), and of the need to create a supportive environment for PLHIV. Once the people have necessary information, they need to be empowered through skills development in communication and decision making in order to put their new knowledge to use. Finally, equipped with new knowledge and skills, they need to have ready access to the means for reducing their HIV risk.

- Communication efforts in the past few years have raised the level of concern and awareness on various dimensions of HIV in some strata of the population through electronic and print media and advocacy with political leaders, youth, and some faith-based organizations. In addition inter-sectoral collaboration with various agencies has also been introduced, but still much remains to be done. Ideally, the future national response

in Pakistan should deploy all streams of communication i.e. behaviour change communication (BCC), advocacy, social mobilization and provision of links with health services and products to contribute to the goal of changing the course of epidemic.

- **Behaviour Change Communication:** The HIV epidemic is a changing phenomenon especially involving values, emotions, inequities and things normally left unsaid. BCC in such context is more than the transfer of information and messages or the distribution of pamphlets. It must be interactive, responding to the questions as people ask them, in settings where they feel able and comfortable to ask them and aimed to modify behaviours and practices.
- **Advocacy:** Advocacy creates political will for change at national and local levels. It also contributes to deepening peoples' understanding of the nature of epidemic and its required responses. It helps all parties including government, political leaders, religious leaders and many others to understand the issue relating to HIV and AIDS in their jurisdiction and promoting the HIV and AIDS response.
- **Social mobilization:** The HIV epidemic response commonly requires social mobilization that involves processes of awareness and understanding, which lead to change. Social mobilization around the HIV epidemic must give rise to social awareness based on tolerance, compassion and a respect for human rights and dignity.
- **Links to existing services:** Effective links to existing health care and support services can really augment the national HIV prevention response. It is not necessary that new organizations and networks be developed to meet the challenges related to raising general public awareness about HIV and AIDS. It is always far more efficient to build HIV and AIDS prevention and awareness-raising components into already existing initiatives of the health sector as well as of other sectors as appropriate.

Enablers

- On-board media firm at national level with mandate to create general awareness;
- On-going advocacy campaign with various stakeholders i.e. political leaders, government officials, religious leaders and others;
- Increasing interest of sectors other than health to incorporate HIV and AIDS related activities in their programmes;
- Increasing level of civil society participation in HIV and AIDS prevention efforts;
- Multiple opportunities to establish links e.g. well established mechanisms to provide family planning information and services that could be an avenue to integrate STIs and HIV and AIDS prevention efforts;
- Existing networks e.g. governmental health workers' network and vocational training centers network that could be utilized to provide HIV and AIDS information to the beneficiaries; and
- Extensive access to print and electronic media among general population that could be utilized to build an effective communication campaign.

Barriers

- Lack of technical capacity to design and implement a proper (strategic and targeted) behaviour change communication campaign especially at the peripheral level;
- Sociocultural barriers which prevent open and frank discussions on topics related to STIs and HIV and AID i.e. "sexuality" and the "promotion of condoms";

- Lack of STIs and HIV and AIDS related biological and behavioural data on general public that could be utilized to build an effective advocacy campaign;
- Lack of formative research about messages and target audience;
- Lack of audience research to judge objectively the effectiveness of disseminated messages and media campaign;
- Dearth of resources for training and professional communications; and
- Gender barriers, which disadvantage women in decision-making, and having access to services.

Core strategies to achieve relevant strategic objectives

Strategic objective: Scale up programme delivery

6.1 Appoint media firms in remaining provinces to help design and roll out campaigns.

- **Resource:** PACPs; **Partners:** GoP, World Bank.

Strategic objective: Create an enabling environment

6.2 Review and edit materials and messages to ensure clarity, completeness and accuracy including: (i) differentiating HIV from AIDS; (ii) toning down the deadliness of AIDS and providing information on ARV; (iii) making clear that sexual activity –and not blood transmission – is the most likely/frequent mode of transmission; and, linked to that message (iv) advising the use of condoms to prevent STI/HIV infection.

- **Resource:** TAG; **Responsibility:** MoH, Parliaments, Religious leaders, NACP & PACPs; **Partners:** CSOs, Academia.

6.3 Conduct audience research to judge objectively the effectiveness of disseminated messages and media.

- **Resource:** NACP, PACPs; **Responsibility:** BCC firm; **Partners:** CSOs.

6.4 Appoint media firms in remaining provinces to help design and roll out campaigns.

- **Resource:** PC-1; **Responsibility:** PACPs, Media firm; **Partners:** GoP, World Bank.

6.5 Identify champions among media personalities, sports celebrities, arts world, and among community and religious leaders, Nazims, and others. who can assist in engaging society and raising awareness.

- **Resource:** NACP, PACPs; **Responsibility:** Media firm; **Partners:** PSOs, CSOs, UN system.

6.6 Develop printed IEC materials for literate people in local languages, and illiterate people in pictorial medium.

- **Resource:** Media firm; **Responsibility:** Media firm; **Partners:** NACP, PACPs.

Strategic objective: Build the right capacity

6.7 Use PLHIV to help design and manage the communications response.

- **Resource:** Media firm; **Responsibility:** NACP, PACPs; **Partners:** PLHIV.

6.8 Put in place sensitisation training in collaboration with PLHIV organizations and NGOs.
- **Resource:** NACP, PACPs; **Responsibility:** NACP, PACPs; **Partners:** Donors, NACP, PACPs.

Strategic objective: Strengthen the institutional framework

6.9 Engage people from all strata of society including civil and religious leaders, military officers, and health workers, teachers, and employers, associations in order to increase awareness of HIV among the general population and to promote condom usage generally.
- **Resource:** MoH/DoH, Social welfare Departments (SWDs); **Responsibility:** NACP, PACPs; **Partners:** PSOs, CSOs.

7.7 Priority Area 7: Blood and Blood Product Safety

Area objective: To reduce the risk of transmission of HIV and other blood borne infections through blood transfusion.

Justification and implementation requirements

- Blood is an exceedingly important resource – every second, someone in the world needs blood to survival, and for many, it is the only option. However, blood is also an important transmission source for various infections like hepatitis B, hepatitis C, and HIV. A relatively high prevalence of hepatitis B and C infection among general population in country suggests that unsafe blood transfusion services and poor infection control measures are making a significant contribution in spread of blood borne infections. The unregulated blood transfusion facilities throughout the country are of primary concern in the control of blood borne infections including HIV. Ensuring blood and blood products safety can help eliminating transmission of HIV and other blood born infections due to blood transfusion.

- The blood transfusion services in Pakistan seem unorganized. Recent estimates by the national blood transfusion authority show that approximately 1.3-1.5 million units of blood are transfused annually in Pakistan. About 60 percent of these transfusions are carried out in the private sector, with the public sector accounting for the rest. Until 1996-97 professional/paid donors fulfilled at least 20 percent of the total demand for blood in the country while the majority of donors were family or replacement donors, and voluntary donors accounted for a minor 2-3 percent of total need. On average less than 40 percent of donated blood undergoes the complete battery of required screening tests, including screening for HIV, Hepatitis B and Hepatitis C.

- Over the years the GoP has taken several initiatives to ensure blood safety e.g. the National Blood Transfusion Ordinance for capital territories was enacted in 2002 after the development of the National Policy Document (1999). Other provinces developed their own laws related to blood transfusion services. A National Blood Transfusion Committee was established under the ordinance but its functioning has been hampered by inadequate budget and lack of commitment. Blood Transfusion Authorities (BTAs) were notified in the provinces and infact, some of them made good progress e.g. the Sindh BTA initiated registration and licensing of both public and private sector blood banks. In addition, over

the years the NACP has been supporting the screening of blood and blood products for HIV, Hepatitis B and C with some additional support of consumables and basic equipment to all public sector facilities through respective provincial BT programmes. Despite all these efforts, blood safety remains a major concern. There are a number of gaps in terms of application of laws and the quality of blood bank services. The area of blood and blood products transfusion in Pakistan needs reorganization of its structure and services, which can only be possible with continuous support from all actors.

Enablers

- Presence of National Blood Transfusion Ordinance that covers the capital territory and similar laws in provinces;
- Notified National and Provincial Blood Transfusion Authorities that are responsible for supervision of respective public and private sector blood banks;
- Regular provision of hepatitis B, hepatitis C and HIV screening kits in all public sector blood banks;
- Initiatives to involve private sector blood banks through Global Fund Round II support to ensure blood safety in large and medium size blood banks;
- High level of awareness among general public, policy makers, and blood transfusion-concerned personnel regarding the need for the screening of blood for HIV and other blood borne infections; and
- Donor commitment to restructure and reorganize blood transfusion services in Pakistan.

Barriers

- Resistance to the application of blood safety laws particularly in private sector blood banks in provinces;
- Absence of standing operating procedures (SOPs) for screening, quality assurance and management of blood bank wastes;
- Poor infrastructure and management control at many blood banks both in public and private sector;
- Lack of coordination, cooperation and liaison between public and private sector blood banks;
- Inadequate facilities for preparation of blood components and irrational use of whole blood;
- Inadequate motivation of blood transfusion staff to actively organize and participate in voluntary blood donation drives; and
- Few organized efforts to educate, motivate, and retain voluntary donors.

Core strategies to achieve relevant strategic objectives

Strategic objective: Scale up programme delivery

7.1 Speed up accreditation of blood banks (public and private).

- **Resource:** Blood transfusion authorities; **Responsibility:** Program managers for safe blood transfusion; **Partners:** Public and private laboratories and blood banks.

Strategic objective: Build the right capacity

7.2 Develop/prepare, review, approve and introduce SOPs for screening and quality assurance and management of blood bank waste.

- **Resource:** NACP; **Responsibility:** Program managers for safe blood transfusion; **Partners:** WHO, Public and private laboratories and blood banks.

7.3 Train all staff in the use of SOPs and other new procedures.

- **Resource:** Staff of safe blood transfusion programmes; **Responsibility:** Program managers safe blood transfusion; **Partners:** Teaching hospitals, Public and private laboratories and blood banks.

7.4 Introduce system of inspection to ensure that blood banks screen all blood for HIV, HBV and HCV and are adhering to all SOPs.

- **Resource:** Safe blood transfusion authorities; **Responsibility:** Program managers safe blood transfusion; **Partners:** NACP, PACPs, District governments.

7.5 Prepare and issue a standard supervisory checklist of essential equipment, supplies, staff and environmental conditions.

- **Resource:** Safe blood transfusion authorities; **Responsibility:** Program managers safe blood transfusion; **Partners:** NACP, PACPs.

7.6 Design and implement standard recording and reporting systems for testing of blood and blood products for HIV, HBV and HCV and syphilis.

- **Resource:** Safe blood transfusion authorities; **Responsibility:** Program managers safe blood transfusion; **Partners:** Public and private laboratories and blood banks.

7.8 Priority Area 8: Infection Control

Area objective: To prevent transmission of HIV in formal and non-formal health care settings through enhancing knowledge about and compliance with universal precautions.

Justification and implementation requirements

- The potential for transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus, and other blood borne pathogens in the healthcare or public service environment is of concern to patients, clients, health care workers, health care facilities, dental officers, mortuary and autopsy personnel, clinical laboratories, personal service workers, and the general public. Skin that is intact, that is without cuts, abrasions or lesions, is a natural defence against infections. Infections can enter body through cuts and sores or on sharp objects, which pierce the skin. Personal appearance services that involve skin penetration (whether accidental or intentional) can readily spread blood born diseases like HIV, hepatitis B and hepatitis C. These diseases spread by blood-to-blood contact, i.e. by instruments that are contaminated with blood from an infected person and used on another person without adequate sterilization.

- In Pakistan use of unsterilised or inadequately sterilized needles, syringes and other medical instruments and equipment is quite prevalent. Similarly, adherence to universal safety precautions and infection control procedures in laboratories and clinics is poor, and this is true in both the formal and non-formal health care sectors. In many hospitals and clinics there are frequent shortages of disposable or properly sterilized needles and syringes. Because of generally poor sterilization and infection control procedures, the

indiscriminate use of injections represents a potential threat for the spread of HIV infection. In addition, anecdotal evidence suggests that a large proportion of country's population do not have access to the formal health care system and many (through personal preference or necessity) resort to the use of *hakims*, or traditional healers. It is not uncommon for clinics in villages to be operated by self-described "doctors" who may actually have little or no formal medical training. This reliance upon unqualified practitioners compound the risk of further infection due to their lack of knowledge and the possibility of inadequate infection control measures during their therapeutic procedures.

- The National AIDS Control Programme has already made some progress by developing infection control guidelines for healthcare settings and protocols for post exposure prophylaxis. However, much remains to be done e.g. sensitization and training of health workers both in formal and non-formal sectors in infection control techniques, universal precautions and work practices that help prevent needle-sticks or other injuries and splashes of blood and body fluids. Beyond doubt, the most effective means of preventing HIV, hepatitis B, and hepatitis C transmission in health care settings would be through strict adherence to universal barrier precautions and established infection control practices which decrease the opportunity of direct exposure to blood and body fluids for both workers and patients.

Enablers

- Infection control particularly in healthcare settings is a priority intervention area for a number of disease prevention and control programmes i.e. HIV programme, Hepatitis programme, Immunization programme - an opportunity to design and implement collaborative response;
- National AIDS Control Programme has already started the groundwork i.e. infection control guidelines for healthcare settings and protocols for post exposure prophylaxis have been developed;
- There is an increasing awareness among general population regarding the hazardous effects of unsafe injection practices. This has been the focus of HIV prevention media campaign over the past few years;
- A number of public sector teaching and even some private hospitals have developed the facilities for safe hospital waste disposal; and
- The issue of implementing proper infection control guidelines in health care settings has become a prime concern due to very high prevalence of hepatitis B and hepatitis C among general population.

Barriers

- Large non regulated informal health care sector which is resistant to change;
- Low level of literacy and awareness in non-health care settings about the benefits of sterilization and infection control;
- High per capita injection rate with low level of awareness about sterilization procedures and infection control in health care settings; and
- Poor facilities for waste disposal, more so in private and informal health care settings; and
- Lack of collaboration among programmes, which have prioritized infection control as a major disease prevention strategy.

Core strategies to achieve relevant strategic objectives

Strategic objective: Build the right capacity

8.1 Ensure continuing wide dissemination of guidelines and protocols for post exposure prophylaxis and infection prevention.

- **Resource:** UN system, Academic Institutions, Internet; **Responsibility:** NACP, PACPs, Blood Transfusion Authorities (BTAs); **Partners:** Health professionals.

8.2 Implement the developed SOPs for identifying and dealing with hazardous and infectious waste.

- **Resource:** TA; **Responsibility:** DoH; **Partners:** NACP, PACPs, Hepatitis programme, Ministry of Environment.

8.3 Ensure continuity of appropriate supplies.

- **Resource:** PC-1s; **Responsibility:** NACP, PACPs; **Partners:** EDO Health, DoH, Donors.

8.4 Training of staff on infection control.

- **Resource:** Public sector health training institutes; **Responsibility:** MoH, DoH; **Partners:** STI section of NACP and PACPs.

Strategic objective: Strengthen the institutional framework

8.5 Liaise with relevant partners (MOH, DOH and others) and encourage the establishment of an inspection and monitoring system to ensure compliance with infection prevention measures.

- **Resource:** MoH, DoH; **Responsibility:** MoH, DoH, (BTAs); **Partners:** STI section of NACP and PACPs.

7.9 Priority Area 9: Treatment, Care and Support

Area objective: To improve the quality of life for people living with HIV and AIDS through the provision of quality treatment, care and support (including meeting their medical, social, and sometimes material needs), and ensuring a secure environment for all people infected and affected by HIV and AIDS.

Justification and implementation requirements

- The treatment, care and support needs of the people infected with HIV are determined by the stage of the disease. For the initial few years people are asysmptomatic, and face major problems that relate to stigma and discrimination. As the immunity falls, they get opportunistic infections (OIs), and other infections like tuberculosis (TB) and need appropriate medical treatment. As the immunity falls further, AIDS patients develop infections with organisms that are not normally pathogenic to healthy people. Appropriate and timely use of ART delays the onset of syndrome and further deterioration of immunity and quality of life. However, after 6-8 years of infection the condition of most patients deteriorates further necessitating palliative care for relief of symptoms and psychosocial support. So basically, the area of treatment, care and support for HIV infected people is a continuum that demands continuous efforts to help those who are infected or affected by the virus.

- At present, Pakistan is into an early phase of concentrated HIV epidemic and the number of registered AIDS cases is very low. There are few ARV treatment centers that have recently started delivering care and treatment services to AIDS patients. However, the treatment, care and support response in such scenario poses particular challenges. All people living with HIV have a right to care and health care but few facilities and providers have the capacity for HIV care. During the implementation period of NSF-Two the NACP and PACPs with collaboration from other stakeholders would make arrangements to ensure:

  1. Coverage of treatment to over 5000 AIDS patients;
  2. Access to quality treatment in all provinces;
  3. Provision of uninterrupted treatment using a patient-centred approach; and
  4. Equitable access to treatment that reflects the needs of various populations including IDUs.

- Building capacity across the system can lead to wastage of efforts and resources in such scenario. A staged approach to capacity building of clinicians, nurses and existing facilities with development of linkages and networks with VCCT services, service delivery organizations and PLHIV could be an appropriate strategy. In addition, development of synergies in care amongst HIV, TB, Hepatitis B, and related conditions as well as amongst HIV, reproductive and sexual heath, and trauma services for rape and violence can benefit the infected and affected.

- Furthermore, in scenario's like Pakistan the most common entry point for HIV care is through voluntary counselling and confidential testing (VCCT) services. The quality of counselling is a critical starting point for effective care. At this time limited counselling services are being offered through sixteen VCCT centers. Increasing number of people are likely to be diagnosed with HIV over the coming years, it would be important that confidential counselling services are strengthened and appropriately integrated into the treatment, care and support networks. In addition, there would be a need to address a number of ethical issues like equity in access to treatment, care and support, gender balance, couple counselling, and impact of HIV on families. Families would have to be involved in care and support as a mean of increasing social acceptance of PLHIV, reducing stigma and discrimination and gaining treatment effectiveness.

- In low as well as in early phases of concentrated epidemic, HIV treatment, care and support can be an effective prevention strategy. It can assist in keeping infection rates low and can also provide an entry point for ensuing family support and acceptance of PLHIV. A comprehensive treatment, care and support system with elements of improved access to opportunistic infections and antiretroviral drugs, psychosocial support, nutritional support and other aspects of continuum of care to all, with special emphasis to women and children would be the ultimate outcome to be achieved in the coming years.

Enablers

- An early phase of concentrated HIV epidemic, which is limited to IDUs in some cities of the country;

- An increasing number of treatment and care centers mainly in public but also in private sector to provide ART to AIDS patients;
- Existence of a number of relevant guidelines that have been developed by the National AIDS Control Programme i.e. guidelines for VCCT services including confidentiality and disclosure, and guidelines for ART treatment for adults and children;
- Ongoing policy and legislative efforts to ensure sustainable supply of antiretroviral drugs;
- A critical mass of trained professionals i.e. clinicians and nurses now available to scale-up the treatment and care interventions;
- A strengthened network of laboratories particularly at national level is now available to support ART administration, monitor drug resistance and conduct relevant research;
- Though not optimally working, yet a growing network of VCCT services is now available to be utilized effectively in future; and
- A increasing number of NGOs and PLHIV networks are now actively involved in providing treatment, care and support services to HIV infected and affected;

Barriers

- Weak integration of VCCT and ART services;
- Fear and stigma related to HIV and AIDS which is keeping PLHIV away from treatment, care and support services;
- Epidemic limited to IDUs, who have to be detoxified and rehabilitated before initiating ART;
- Poor counselling skills, which are essential to establish and sustain an effective treatment, care and support system for people infected and affected by HIV;
- Limited capacity in both public and private sector health care facilities to understand complexity of HIV treatment, care and support services; and
- Total absence of some elements of continuum of care e.g. psychosocial support, nutritional support, and livelihood support.

Core strategies to achieve relevant strategic objectives

Strategic objective: Scale up programme delivery

9.1 Design and implement services for children born and living with HIV.

- **Resource:** NACP, PACPs; **Responsibility:** MoH, DoH; **Partners:** AIDS Consortia, PLHIV, CBOs, NGOs.

Strategic objective: Build the right capacity

9.2 To achieve and maintain acceptable standards, train care providers (healthcare workers, PLHIV, NGO staff, and non-health service staff) and introduce a routine process of reporting and review.

- **Resource:** NACP, PACPs; **Partners:** PNAC, DoH, training institutes.

Strategic objective: Strengthen the institutional framework

9.3 Involve PLHIV, their CBOs and related NGOs to ensure all aspects of continuum of care, treatment and support services.

- **Resource:** AIDS Consortia, NACP, PACPs; **Partners:** PLHIV, CBOs, NGOs.

9.4 Improve coordination and integration (functional proxy) of VCCT and ARV services, testing and counselling by SDPs.

- **Resource:** NACP, PACPs; **Partners:** SDPs, VCCTs, ARV centers.

7.10 Priority Area 10: Institutional Arrangements and Linkages

Area objective: To ensure the delivery of a well coordinated multisectoral response through workable and appropriate institutional arrangements and linkages.

Justification and implementation requirements

- An effective national response requires a multisectoral approach and national ownership. Mainstreaming as well as harmonization needs to be used as guiding principles so that through these, coordination of the national response is improved using workable and appropriate institutional arrangements. These arrangements require active participation of various sectors whose activities are interdependent with a need for proper coordination and management. Such coordination and management should aim at: (i) creating conducive environment and willingness among all partners to work together on achieving a common goal; (ii) providing the organizational, institutional settings and mechanisms for effective coordination and management; (iii) learning how to cooperate, gain experience and build trust among all partners; and (iv) perform tasks in line with their spheres of mandate.

- Over the past few years the institutions, systems and processes designed to implement the enhanced response have achieved some results. To some extent, the national response has been able to bring together, by direct recruitment, in-sourcing and out-sourcing, the complex array of skills needed to coordinate and manage the programmes at national and provincial levels. It has developed new paradigms for persons with clinical, diagnostic, social, psychological and programme management skills to work together. However, owing to the fact that HIV epidemic in Pakistan is a recent and dynamic phenomenon, most of the institutional arrangements have been characterized by ad-hoc and reactive additions of personnel and structures rather than process of organic evolution. The diversity of expertise required to coordinate and manage the national response has also limited the emergence of institutional arrangements. Since the present NSF proposes to scale up and broaden the national response with improved quality, the institutional paradigm would have to be reconfigured to achieve the objectives.

- The MoH through the National AIDS Control Programme has stewardship of the response to the epidemic. It would have to exercise this stewardship through partnership with other actors that come from within and outside the health sector to draw on the expertise required to successfully address the HIV and AIDS epidemic. The National AIDS Control Programme would have to lay emphasis on continuous follow up and support till the ownership is generated within the external partners in government, civil society and private sector. In order to ensure that the efforts are converged into one unified effort, both the national and provincial programmes would have to create structures and systems for partnerships with such organizations and agencies. The role of NGOs, CBOs and private sector HIV umbrella organizations would have to be strengthened so that the potential of their members and the comparative advantage of the networks could be fully harnessed. The participation of young people, women and PLHIV too in all coordination

bodies would have to be systematically improved. In the medium term the response would have to be translated at the district level and district governments would have to be encouraged to participate in the response by adopting approaches consistent with the national response. The Provincial AIDS Programmes would have to work closely with local authorities, sector departments, NGOs, CBOs, religious and traditional leaders to share information and jointly map and plan, monitor and evaluate local response.

Enablers

- Growing-will and commitment to address HIV and AIDS challenge;
- Increasing recognition of the fact that the worsening HIV epidemic in Pakistan can only be effectively addressed by establishing processes, systems and institutional frameworks and linkages;
- Growing mass of skilled people who have the vision and capacity to coordinate a multisectoral response;
- Increasing recognition of the fact that technical people should be hired on market-based salary packages;
- Advisory and technical bodies at both national and provincial levels to support multisectoral response;
- Growing interest of various sectors of the government in HIV and AIDS related issues;
- Fairly well established national and provincial HIV and AIDS control programmes with tremendous growth potential; and
- Growing commitment of civil society under the umbrella of national and provincial AIDS consortia.

Barriers

- Un-clarified plans, and roles and responsibilities of most sectors to support a well coordinated multisectoral response;
- Unclear mandate and function of national and provincial programmes to lead a multisectoral response;
- Dearth of technical capacity at district level to address the complexities of emerging HIV epidemic; and
- Uninformed and fragmented response planning by most sectors that have a critical role in addressing the challenge.

Core strategies to achieve relevant strategic objectives

Strategic objective: Build the right capacity

10.1 Develop HIV multi-sector plans incorporating the roles and responsibilities for each relevant ministry, department and district government and develop a series of sensitisation workshops for staff of all sectors.

- **Resource:** Focal points with NACP and PACPs; **Responsibility:** NACP, PACPs; **Partners:** Line ministries/ departments, District governments, Civil society.

10.2 Develop and circulate guidelines, incorporating them into training curricula, to ensure implementation of the rights-based approach.

- **Resource:** TA; **Responsibility:** NACP, PACPs.

10.3 Ensure regular updating of all management tools such as the financial manual/procurement guidelines and deliver regular in-service training on new tools.

- **Resource:** TA; **Responsibility:** NACP, PACPs, Management firm(s).

10.4 Provide technical assistance for management, research, capacity building, MIS and procurement.
- **Resource:** TA; **Responsibility:** Management firm(s).

Strategic objective: Strengthen the institutional framework

10.5 Constitute National Commission on AIDS, comprised of multi-sector public sector and CSO representation that will act as an institutional house with the mandate, leadership and capacity to effectively coordinate the active participation of all government sectors, civil society and the private sector in managing the HIV epidemic.
- **Resource:** NACP; **Responsibility:** TACA, Steering committee; **Partners:** Line ministries/ departments, Civil society.

10.6 Establish HIV focal points in each line ministry and department.
- **Resource:** Line ministries and departments; **Responsibility:** NACP, PACPs; **Partners:** NACP, PACPs

10.7 Devolve financial autonomy for sector HIV interventions to the sector ministries and departments.
- **Resource:** Financial guidelines from Ministry of Finance (MoF); **Responsibility:** NACP, PACPs, Line departments; **Partners:** Departments of Health and other concerned departments.

10.8 Include line ministries and departments in policy committees, as well as reinforce the Steering Committees and TACA.
- **Resource:** Line ministries and departments; **Responsibility:** NACP, PACPs; **Partners:** Public sector.

10.9 Draft and discuss with MOF and MOH, guidelines that would provide NACP and PACPs with flexibility to introduce implementation of an intervention not included in the original approved programme (PC-1).
- **Resource:** TA, Guidelines from MoF; **Responsibility:** MoH, DoH, MoF; **Partners:** Planning & Development (P&D) division and departments.

10.10 Establish a formal institutional mechanism for reporting on the funding, activities and results of donor-funded parallel interventions.
- Responsibility: Donor's group

10.11 Scale-up and implement the necessary management reforms within NACP/PACPs along the lines suggested in Chapter 3 of the MTR report with more delegation of responsibility and authority. This should include:

(i) Development of HR plans for NACP/PACPs and districts;

(ii) Recruitment of appropriate staff, and strengthening of the managerial and technical capacity of NACP, PACPs and districts with an appropriate skills mix;

(iii) To help achieve this, development and introduction of remuneration packages that will help attract and retain the appropriately qualified staff;

(iv) Establishment of new posts of liaison officers at federal and provincial levels to facilitate coordination activities;

(v) Redefinition of functions of existing posts;

(vi) Provision of job descriptions for all posts, with performance benchmarks;

(vii) The existing embargo on transfers of staff for a minimum period to be enforced, and linked to performance; and

(viii) Development of an induction programme for new staff and institute qualification training for NACP and PACP management-level staff.

- **Resource:** Management firm(s); **Responsibility:** NACP, PACPs, MoH, DoHs; **Partners:** MoF, P&D.

10.12 Review technical, policy and managerial committee structure and meeting and reporting arrangements, and membership.

- **Resource:** TA; **Responsibility:** MoH, DoH; **Partners:** Development partners.

10.13 Design and establish institutional arrangements between district and other levels.

- **Resource:** TA, High-risk groups; **Responsibility:** PACPs, District government; **Partners:** National Reconstruction Bureau.

10.14 Examine and determine how to finance district level implementation, including development of innovative pilot grants scheme in key districts.

- **Resource:** TA; **Responsibility:** PACPs, District task forces; **Partners:** District governments, Development partners, NGOs.

10.15 Revitalize Provincial and District AIDS Task Forces.

- **Resources:** PACPs; **Responsibility:** DoH; **Partners:** District governments.

10.16 Expand the partner base by exploring and building relationships with new partners such as Bait-ul-Mal, Central Zakat Foundation, Provincial Zakat councils, Pakistan Poverty Alleviation Fund, and others.

- **Resource:** Policy level support; **Responsibility:** NACP, PACPs, MoH; **Partners:** MoF.

10.17 In conjunction with contracted NGOs, examine the options for managing and monitoring NGO contracts after 31 December 2007 (see section 3.8) and, on the basis of the selected option, make appropriate arrangements well before that date.

- **Resource:** management firm(s); **Responsibility:** NACP, PACPs, MoH, DoH; **Partners:** MoF, MoH.

7.11 Priority Area 11: Commodities and Procurement

Area objective: To ensure the timely availability of quality commodities and services through a comprehensive and efficient system of procurement.

Justification and implementation requirements

- The success of health programmes is always dependent on their ability to reliably and consistently supply the essential commodities to support service delivery. It is also true for HIV and AIDS prevention and control efforts. Effective HIV and AIDS programmes rely on having a range of commodities available to the intended beneficiaries for both prevention and treatment. Improvements in procurement system can enhance programme impact, improve quality of care and increase cost- effectiveness.

- Implementation of the HIV and AIDS prevention and treatment response is a complex phenomenon. The term "procurement" for HIV and AIDS response covers many aspects of the programme and, in theory, relates to expenditure on any purchase for the programme, whether this be for commodities like contraceptives and essential drugs or services. Since the implementation of EHACP, the NACP and its provincial counterparts have made tremendous efforts to ensure timely procurement of quality commodities and services for an effective programme delivery. The recruitment of procurement management firm has also facilitated the prevailing supply chain mechanisms at both national and provincial levels. However, because of the special requirements for HIV and AIDS products many of the current procurement systems seem inappropriate. Most appear to be organized to suit the administrative set-ups rather than ensuring quality and efficiency. In addition the involvement of a number of actors in the current response has brought multiple rules and regulations for procurements. For most procurement there are multiple tiers of approval before finalization. The systems at places are highly centralized and complex and not appropriate for most HIV and AIDS products because of their shorter shelf life.

- All these bottlenecks require the development of a strong supply chain system that can ensure the "six rights" for commodity procurement and its distribution. The NACP and its provincial counterparts would have to adapt a comprehensive strategy to ensure the timely availability of quality commodities and services. For this they would have to strategize a number areas of commodity procurement like: (i) product selection; (ii) forecasting; (iii) storage and warehouses; (iv) inventory control; (v) transportation; (vi) logistic management information system; and (vii) availability of appropriate and adequate human resource.

The Six Rights

The **right** commodity
in the **right** quantity
in the **right** condition
in the **right** place
at the **right** time
for the **right** cost.

Enablers

- Will to develop a uniform system of commodity procurement that can ensure effective programme delivery;
- Growing body of experience to manage complex procurement procedures of various donors;
- Development of various procurement procedures and protocols by procurement management firm to facilitate the processes;

- Presence of financial and procurement management information system developed by procurement management firm; and
- Availability of technical staff at national and provincial level to strategize commodity procurement systems.

Barriers

- Complexity of rules and regulations that need to be followed for most public-sector and even donor driven procurements;
- Lack of coordination at various levels that is leading to duplication of efforts and wastage of resources;
- Centralized procurement system at various places affecting the timely availability of necessary commodities;
- No formal standardized protocols and guidelines for commodity selection, their prices, forecasting and safe storage;
- Lengthy and tedious payment mechanisms that are highly demoralizing for good competition; and
- Absence of computerized logistic management information system at provincial levels.

Core strategies to achieve relevant strategic objectives

Strategic objective: Build the right capacity

11.1 Within ACPs, at national and provincial levels, improve forecasting of requirements for ARVs, drugs for OIs, male condoms, female condoms, water based lubricants, and testing kits. In particular, provinces should each determine a stockholding for each of the ARV drugs for patients once they are registered for treatment, and these limited buffer stocks should be replenished by the NACP warehouse on a regular basis.

- **Resource:** TA; **Responsibility:** NACP, PACPs, MoH, DoH; **Partners:** UN System, Clinton Foundation, Suppliers.

11.2 Design and introduce improved storage procedures and facilities to ensure adequate storage conditions for ARVs and condoms.

- **Resource:** MoH/Finance department, Management firm(s); **Responsibility:** NACP, PACPs.

11.3 Develop, implement and circulate standardised price guidelines for commodities procurement within NACP and PACP's.

- **Resource:** Price research, MIS; **Responsibility:** MoH, DoH, NACP, PACPs; **Partners:** district governments, WHO, UNICEF, UNFPA.

11.4 Review existing procurement procedures and to ensure criteria and merit-based selection and a standardised mode of evaluation.

- **Resource:** TA; **Responsibility:** MoH, DoH, MoF, DoF, P&D; **Partners:** Development partners.

11.5 Take steps to ensure timely payment to contracted firms and eliminate bottlenecks for disbursement of funds.

- **Resource:** management firm(s), MoF, DoF; **Responsibility:** NACP, PACPs; **Partners:** P&D, P&DD, MoH, DoH.

7.12 Priority Area 12: Management Information System

Area objective: To enhance informed decision-making process through one MIS feeding into the national health information system.

Justification and implementation requirements

- Health management information systems are specifically designed to promote better delivery and monitoring of services in the health care fields. In relation to HIV and AIDS, these systems are particularly critical for tracking; (i) the state of the epidemic; (ii) the delivery and process of prevention, care, and treatment services; (iii) the effectiveness of interventions; and (iv) the capacity needed to improve programmes, meet planning and reporting requirements, and reach objectives and goals for impacting the epidemic.

- Although the fight against HIV and AIDS has recently enjoyed high priority, the biggest obstacle towards a successful effort in fighting the epidemic remains an integrated and coordinated information system to which all stakeholders have access. Lack of systematic and strategic information appears a barrier to successfully monitoring HIV prevention and control response in Pakistan. There are working financial and procurement management systems at few places like NACP, yet the availability of data in a consistent format, on interventions, funding, expenditure and service delivery for planning, resource mobilization, communications, consensus building and decision-making remains an issue.

- Over the past few years NACP, PACPs, NGOs and research institutions (RIs) have collected valuable data on HIV and STIs prevalence, behavioural risk factors, and programme implementation through multiple research studies, reviews and evaluations, but the effort to collate this information and maximize its use for decision-making has been minimal. This situation is detrimental to the effectiveness and relevance of the planning and decision making processes. Coordinated and systematic information gathering, its management and updating can be one of the most effective tool in fighting the emerging HIV epidemic. Presently, there is a critical need to develop a comprehensive, systematic and computerized national HIV and AIDS management information system that works as backbone of national HIV and AIDS monitoring and evaluation (M&E) system and has the capacity to collate data from: (i) HIV and AIDS sentinel surveillance; (ii) population based bio-behavioural surveys (IBBS) and facility surveys (ANC surveys); (iii) facility based information systems (service delivery programmes and AIDS treatment centers); (iv) programme level monitoring and reporting; and (v) targeted research , reviews and evaluation studies.

Enablers

- Development and implementation of national monitoring and evaluation (M&E) system under progress;
- Functional financial and procurement management information system at national level;
- Functional central data coordination unit (CDCU) at national level, with the vision to develop it as a hub for new management information system;
- Plenty of data available from various reviews, research studies and evaluation exercises that can be used to draw strategic information for decision-making; and

- A number of management information systems available with other partners (UN agencies and NGOs) that can be used to develop a comprehensive national HIV and AIDS management information system.

Barriers

- Ad-hoc approach and poor understanding of the importance of evidence-based decision-making at all levels;
- Lack of technical capacity to generate and utilize information generated through management information systems;
- Lack of appropriate feedback to the beneficiaries and programme implementers to improve outcomes;
- Questionable quality of data from some sources that cannot be utilized to generate strategic information; and
- Poor concept and systems to share information with key stakeholders;

Core strategies to achieve relevant strategic objectives

Strategic objective: Build the right capacity

12.1 Assess and deliver the IT requirements to operate the MIS.

- **Resource:** TA; **Responsibility:** NACP.

12.2 Develop standard guidelines and provide training on the MIS.

- **Resource:** TA; **Responsibility:** NACP; **Partners:** PACPs, SDPs, NGOs.

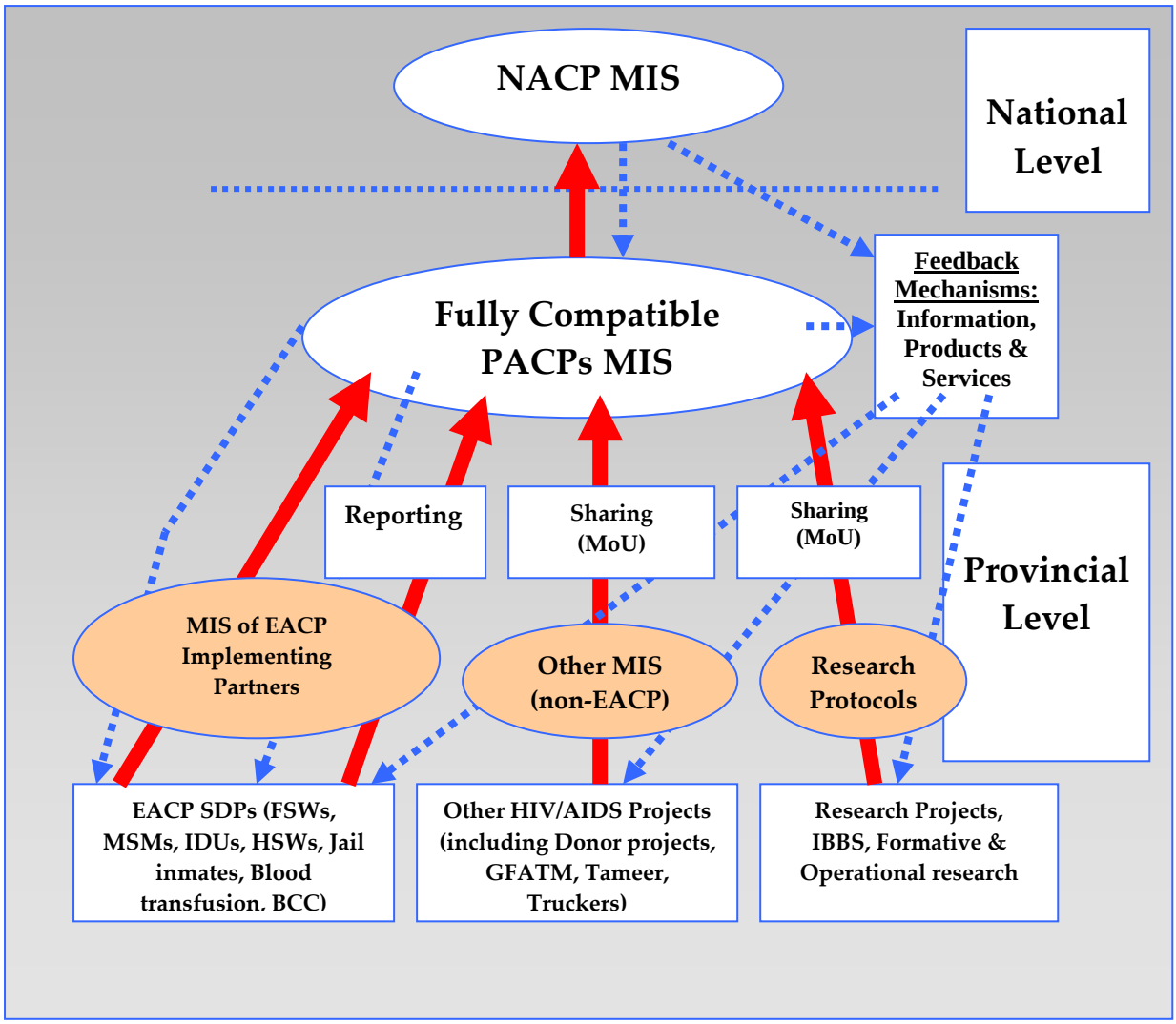
8. Monitoring and Evaluation (M&E)

8.1 National HIV and AIDS M&E System

Pakistan has responded to its nascent HIV epidemic with a comprehensive multi-faceted response. The experience of implementing the response has been rich with many lessons learnt and acted upon. One of the key lessons was identification of the need for a coordinated mechanism to track the HIV epidemic and its determinants for an ongoing assessment of the national response.

Pakistan is a large country and by necessity the HIV response is large and multi-dimensional in which government, civil society and a number of other national and international actors are playing vital roles. This response is generating a tremendous amount of valuable data at all levels that needs to be converted into meaningful and useable information. The government of Pakistan's initiative to develop a unified and comprehensive HIV and AIDS national M&E system is the reflection of its commitment to fulfill this need. The envisaged national M&E system **(Figure-9)** will help us better tracking the HIV epidemic and its underlying determinants and assessing the effectiveness and impact of national response. It will also generate useful and adequate information for programme planning, policy formulation, appropriate allocation of available resources, and rational decision-making.

Figure-9: M&E Framework for HIV and AIDS Response in Pakistan



8.2 Key Principles, Goal and Objectives

Key principles

The establishment of the national HIV and AIDS M&E system is guided by the following **key principles**:

- The national M&E system is based on national priorities;
- It is government-based and-led;
- It is multisectoral, with active involvement of all stakeholders; and
- It builds on existing system and practices.

Goal

The overall **goal** of the national HIV and AIDS M&E system is to ensure the effective use of available M&E data for *evidence-based* decision making by all national stakeholders for policy and programme development, (policy and legal) advocacy, social mobilization, and resource mobilization and allocation.

Objectives

The main **objectives** of the national HIV and AIDS M&E system are:

- To develop a uniform, comprehensive and computerized system to support the storage and analysis of all available HIV and AIDS data at different levels in the country;
- To improve the accessibility of HIV and AIDS information and data to all stakeholders;
- To increase the utilization of available data and generated information using multiple dissemination strategies i.e. passive dissemination, active dissemination and proactive dissemination; and
- To maintain institutional memory of HIV and AIDS national response by establishing a central database/repository.

8.3 Main Data Sources and Information Needs

The national HIV and AIDS M&E system aims to add value by improving the overall coordination and by systematising the flow of M&E data. It will mainly gather data from the following channels:

1. Integrated Biological and Behavioural Surveys (IBBS);
2. Monitoring and evaluation of programmes and projects;
3. Special studies and research;
4. Financial monitoring of the national response; and
5. Other sources (e.g. AIDS Case Reporting system, DHS, HMIS, Statistical Bureau)

All the available data at provincial levels will be analyzed to generate and disseminate provincial level information. Subsequently, the data will be forwarded to the national HIV and AIDS database/repository to generate national level information **(Figure- 9)**.

The specific information needs of different stakeholders vary according to the specific roles and responsibilities of each stakeholder, and the associated purposes for which they need the information **(Table-1)**. The national M&E system will help responding to these different needs by providing data and information on the following key areas:

- HIV, as well as STI prevalence rates among specific most at-risk population groups, and trends over time;
- Risk behaviours and other risk factors associated with HIV infection, and trends over time;
- Key characteristics, size and location of most at-risk population groups;
- Scope and coverage of the national and local response in specific programme areas, targeting different beneficiaries;
- Availability, disbursement and actual use of financial and other resources for specific programme components;
- Gaps and priorities in programme and service delivery according to specific of most at-risk population groups; geographic coverage and specific services;
- Effectiveness of interventions and lessons learned; and

- Provide more insight into the scope, nature and impact of the HIV/AIDS epidemic; its underlying risk factors; and impact on sectors and groups in society.

Table-1: Information Needs of Stakeholders

	INFORMATION NEEDS FOR:						
STAKEHOLDERS	Policy Making	Legislation	Programme development	Advocacy (Policy, Legislation, Rights)	Resource mobilization & allocation	Supportive environment	Research
Policy makers	√		√	√	√		
Programme Managers			√	√	√	√	√
Donors	√				√		
Interest groups				√	√	√	√
Advocacy & Rights organizations				√	√	√	
Legislators, Law enforcement agencies	√	√					

8.4 Core National Indicators

The National Indicators are a key element of the national M&E system, as they aim to provide an overview of the national HIV epidemic; underlying behavioural risk factors; the national response (programmes and their coverage); as well as the overall level of government commitment. The national indicators cover the government of Pakistan's international reporting commitments on progress towards the *UNGASS Declaration of Commitment; Millennium Development Goals* (MDGs); as well as the main programme areas of the national response.

A full list and detailed description of the National Indicators is given in **(Annex-2).** It also highlights the technical details related to the measurement of these indicators.

9. Major Roles and Responsibilities of Key Implementing Agencies and Stakeholders

This framework provides a broad multi-sectoral plan for response to the emerging epidemic. Each implementing agency and stakeholder is expected to develop specific plans based on its role/mandate and its capacity. All plans should focus on the sectors' comparative advantages in implementing this framework. The major roles and responsibilities of key implementing agencies and stakeholders are described as under:

9.1 Public Sector

Ministry of Health (MoH) and Provincial Departments of Health (DoH)

The health sector from national to grassroots level is the major and leading actor in the response against HIV and AIDS. The MoH and provincial DoH have the key responsibility of guiding the overall response to the epidemic. The majority of strategies elaborated in the framework are directly linked with the mandate of the health sector. These strategies will be implemented through NACP at national level and PACPs at provincial levels with support from other stakeholders.

National AIDS Control Programme (NACP)

The major roles and responsibilities of NACP are:

- Undertake advocacy for securing political support and mobilize partner ministries;
- Inter-sectoral co-ordination to ensure broader participation and partnership between the public sector and civil society to mainstream HIV and AIDS in the development agenda;
- Implement National HIV and AIDS policy in its true spirit;
- Facilitate development of technical and operational guidelines, protocols for standards of services, desk-guides and quality assurance system with ongoing review and revision;
- Facilitate, coordinate and provide technical assistance to DoH, NGOs and other sectors;
- Monitoring and evaluation of the program implementation;
- Manage HIV and AIDS surveillance including IBBS (Second Generation Surveillance);
- Research promotion including formative, operational and behavioral research on priority issues;
- Secure appropriate allocation for financing HIV and AIDS program at the federal and provincial levels;
- Inter-provincial co-ordination including exchange programs within and outside the country;
- International co-ordination including bilateral and multinational support agencies and overseas institutions;
- Information management, dissemination of information and lessons learnt;
- Undertake mass awareness campaigns using mass media, print media and through BCC strategy;
- Ensure proper financial management and timely audit of programme accounts; and
- Support provinces in procurement of goods and services.

Provincial AIDS Control Programmes (PACPs)

The major roles and responsibilities of PACPs are:

At provincial level:

- Undertake advocacy at the provincial level and below for ensuring political commitment and mobilize provincial departments and district governments for action;
- Inter-sectoral co-ordination to ensure broader participation and partnership between the public sector and civil society to mainstream HIV and AIDS in development agenda at the provincial level;
- Policy dialogue with the District Governments for mainstreaming HIV and AIDS in development agenda at the district level;
- Ensure implementation of national policy, technical guidelines and protocol for maintaining standards of services and their quality and monitor implementation through the District/City Governments and provincial level implementing departments;

- Ensure adequate provincial counterpart financing for the program at the provincial and district levels;
- Facilitate/procure/provide technical assistance to the District Governments for program implementation;
- Facilitate training of trainers, district managers and civil society in technical and operational guidelines, protocols for maintaining standards of services, and quality assurance mechanisms;
- Facilitate and assist federal government in serology and behavioral surveillance;
- Monitor implementation at the provincial and district level and provide monitoring reports to the federal government;
- Promote research on priority issues in line with broad national priorities and in consultation with various stakeholders;
- Undertake mass awareness through mass media in local languages and through promotion of inter-personal communication;
- Create enabling environment for private/non-government sector who would be engaged for delivery of services to the identified vulnerable groups as per agreement and supervise their work; and
- Undertake procurement of goods and services.

At District level

- Ensure that interventions are implemented in line with national and provincial guidelines following standards protocols and quality assurance mechanisms;
- Undertake advocacy at the district level for soliciting political commitment for the implementation of HIV and AIDS control interventions;
- Undertake training needs assessment and train staff in use of technical and operational guidelines, protocols for standards of services, and quality assurance methods;
- Monitor and supervise interventions in the district and provide regular monitoring reports to the provincial Program Manager;
- Monitor program activities in other sectors and private/non-government sector and provide support in technical areas;

Other Ministries and Departments

The NSF-two aims to avert HIV epidemic in Pakistan through a broad multi-sectoral response. There are a number of other ministries and departments like: Interior; Women Development, Social Welfare and Special Education; Defence; Law, Justice and Human Rights; Labour, Manpower and Overseas Pakistanis; Narcotics Control and Anti Narcotic Force; Local Bodies and Rural Development; Industries; Population Welfare; Information; Religious Affairs; and Education and others that will be the key partners in response implementation. All these partners will be expected to develop sector specific plans in collaboration with MoH, NACP and respective PACPs. Overall, the following scope of work is recommended for each sector:

- Identify the major determinants of the spread of HIV and AIDS specific to the sector;
- Identify sectoral strengths and weaknesses with respect to HIV and AIDS/STIs
- Identify major obstacles to the response within the sector;
- Develop specific HIV and AIDS sectoral plans and budget;
- Mobilize resources for interventions;

- Integrate HIV and AIDS activities with national plans and ensure their implementation;
- Document best practices within the sector and share experiences with others; &
- Prepare and submit regular reports to NACP & PACPs.

9.2 Private Sector and Parastatals

Private sector and parastatals mobilization is an integral part of the national response to HIV and AIDS. The prime responsibilities of the private sector and parastatal organizations are:

- Mainstreaming HIV and AIDS into their respective spheres;
- Mobilizing resources for combating the epidemic; and
- Organizing and operating workplace interventions (IEC/BCC, care and support) for their workers and clients.

Private sector and parastatal organizations will be expected to use the NSF as a guide for mainstreaming HIV and AIDS into their workplace programmes for their staff and workers. The NSF will also guide them in the articulation of areas of support or participation in national HIV and AIDS programmes based on their comparative advantage. In this regard private sector and parastatals will be encouraged to maintain implementation linkages with other service providers in addressing the HIV and AIDS needs of their workforce. NACP and its provincial counterparts, in collaboration with relevant partners, will facilitate a process where companies and firms can be assisted to develop well-targeted workplace programmes. NACP and PACPs will also ensure that the capacity of the private sector is built to implement, document and submit timely progress reports on HIV and AIDS initiatives.

9.3 Civil Society

Civil society is the frontline of national response to HIV epidemic. Over the years, civil society in Pakistan has grown and is now actively shouldering the implementation burden with public sector. The expansion of civil society has also led to the emergence of network structures like provincial AIDS consortia and their apex body-PNACP, which are playing critical role in facilitating and coordinating civil society efforts. With their increasingly important and active role in the fight against HIV and AIDS, their experience must be harnessed, capacities expanded and systems strengthened. Following are some important roles and responsibilities of civil society in the national HIV and AIDS response:

- Be at the frontline of national response and deliver quality services to target populations;
- Work closely with other implementing partners and coordinating bodies based on mandate and areas of comparative advantage;
- Undertake advocacy and lobbying activities in support of prevention, care, and support initiatives;
- Assist with scaling-up HIV and AIDS interventions and conceptualizing new and innovative strategies;
- Take active role in HIV related research particularly operations and evaluation research; and
- Assist local communities to mobilize human, financial and material resources to support the fight against HIV and AIDS.

9.4 Associations of People Living with HIV and AIDS (PLHIV)

PLHIV are the key actors of the national response. They are expected to organize themselves in associations that can help fighting against HIV in the country. These associations/CBOs are expected to focus on:

- Protecting the rights of their members;
- Educating the public at large through sharing their life experiences;
- Promoting and participating in the provision of compassionate care to PLHIV;
- Fighting stigma and discrimination at all levels;
- Advocating for responsible behavior among their members; and
- Advocating for access to ART and policy formulation and legislation.

9.5 Development Partners

Development partners and UN agencies are the key collaborators in Pakistan's national response to the HIV epidemic. They are instrumental in providing necessary inputs, in terms of financial resources, technical expertise and material supplies in the fight against the epidemic. It is envisaged that throughout the period of NSF-two i.e. 2007-12, this partnership would continue to promote the attainment of the goal, objectives and, ultimately the success of the national response. Development partners and UN agencies will work in close collaboration with government and other partners to establish what roles they may be in a position to play within the national response and where they can offer strategic technical and financial support based on their comparative advantage. A key role for Development Partners will be to seek out and make available evidence-based interventions that may assist in the implementation of the national response and the attainment of national goal. Following are some important roles and responsibilities of development partners to support national response:

- Continually forge partnerships to address emerging or unattended priorities;
- Ensure, within the context of their existing agreements, adaptability to respond to emerging priorities;
- Support the modalities of the national response that government partners see as core challenges, but are excluded in their programme development; and
- Channel their assistance through a single entry point for HIV and AIDS interventions in the country to avoid duplication and ensure sustainability of services;
- Support exchange visits to other countries for sharing international experience and skill development.
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10. Tentative Costs of National Strategic Framework 2007-12

Costing of the NSF-Two is based on the unit cost exercise that was conducted by NACP in line with the financial systems of the Government of Pakistan and prevailing market rates. The total requirement to implement the NSF -Two is Pak Rs. 17580 million / US $ 293 million. Summary of the priority areas' cost in Pak Rupees and US Dollars ($) is given in **(Table-2)**.

Table-2: Summary of Tentative Priority Area Wise Costs-NSF-Two

	Priority Areas	Cost (million)		Percentage Distribution
		Pak Rupees (Rs)	US Dollars ($)	
1. & 2.	Expanded response & Vulnerable, target and bridging populations	10200	170	58%
3.	Women, children and youth	420	7	2.39%
4.	Surveillance and research	900	15	5.12%
5.	STIs	180	3	1.02%
6.	General awareness	1320	22	7.51%
7.	Blood and blood product safety	1320	22	7.51%
8.	Infection control	300	5	1.71%
9.	Treatment, care and support	1380	23	7.85%
10.	Institutional arrangements & linkages	480	8	2.73%
11. & 12.	Commodities & procurement & Management information system	1080	18	6.14%
Grand Total		**17580**	**293**	

11. Annexure

Annex-1:

Annex-2: