

ACRONYMS – PAKISTAN

AIDS	Acquired Immunodeficiency Syndrome
ANF	Anti-Narcotics Force
ART	Antiretroviral Therapy
ARV	Antiretroviral
ATS	Amphetamine Type Substance
AusAID	Australian Agency for International Development
BCC	Behaviour Change Communication
CNSA	Control of Narcotic Substances Abuse
DFID	Department for International Development (United Kingdom)
DIC	Drop-In Centre
DU	Drug User(s)
EU	European Union
FHI	Family Health International
FSW	Female Sex Worker
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HAPDHRP	HIV/AIDS Prevention with Harm Reduction in Pakistan
HASP	HIV/AIDS Surveillance Project
HIV	Human Immunodeficiency Virus
HR	Harm Reduction
HSS	HIV Sentinel Surveillance
IDU	Injecting Drug User(s)
IEC	Information, Education, Communication
INGO	International Non-Governmental Organization
ILO	International Labour Organization
LCCS	Low Cost Community Based Care and Support
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MoU	Memorandum of Understanding
NACP	National AIDS Prevention and Control Program
NCD	Narcotics Control Division

NGO	Non-Governmental Organization
NSP	Needle and Syringe Programs
OST	Opiate Substitution Therapy/Treatment
PACP/s	Provincial AIDS Control Programme/s
PHAC	Public Health Agency of Canada
PLI	Peer Led Community Outreach Intervention
PLWHA	People living with HIV/AIDS
PNAC	Pakistan National AIDS Consortium
PTF	Provincial Task Force
Rs	Rupee (Pakistani currency)
SIDA	Swedish International Development Cooperation Agency
STI	Sexually Transmitted Infection
SP	Safer Practices
ST	Substitution Therapy/Treatment
TACA	Technical Advisory Committee on AIDS
TOR	Terms of Reference
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children’s Fund
UNODC	United Nations Office for Drugs and Crime
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organization
WFP	World Food Programme

1. National Program Support

	Ministry / Agency Responsible	Systems / Frameworks In Place (List Relevant Items)	
		Existing	Gaps
Political Commitment	Ministry of the Interior: Narcotics Control Division (NCD), 1989 (Ministry of Narcotic Control) Anti-Narcotics Force, 1995 Ministry of Health (HIV/AIDS issues) ¹	<ul style="list-style-type: none"> • Control of Narcotic Substances Abuse (CNSA) Act 1997 • National Drug Control Master Plan (currently being revised)⁷ • National AIDS Prevention and Control Program (NACP) 1987 • Enhanced NACP (2003-2008, funding from World Bank, UN agencies, and bilateral donors), envisages reducing the vulnerability of specific population sub-groups including IDUs and jail inmates. • Objectives set out in the National HIV/AIDS Strategic Framework, elaborated in the Enhanced HIV/AIDS Control Program and issued as a Program Implementation Plan, provide a definite mandate for harm reduction interventions with IDUs and their sexual partners. • Implementation by Provincial AIDS Control Programmes, which have identified and delegated service packages to NGOs, including VCT, HR, and condom distribution. • The Provincial AIDS Control Programmes are also responsible for the implementation of education programs for the public, and clinic and laboratory personnel.¹⁵ 	<ul style="list-style-type: none"> • There is no provision in the CNSA that enables the Government to assist, support or regulate non-governmental drug treatment set-ups.¹⁵ • Registration and compulsory detoxification provisions under the CNSA have not been implemented.¹⁵ • Drug treatment and rehabilitation is not a high priority on the list of healthcare issues.⁷ • There is no large-scale, Government-run, drug ST program.¹ • Drug users have little access to effective treatment.⁷ • With a few exceptions, the services provided by Government-run drug treatment facilities are limited to the management of acute withdrawal symptoms.³ • Most of the drug treatment facilities in the public sector are situated within the departments of psychiatry in teaching or district headquarter hospitals.⁷ • Treatment services in prisons, if any, are limited to medical management of acute withdrawal symptoms.³

		<ul style="list-style-type: none"> • Medium Term Development Framework includes the target to reduce the prevalence of HIV/AIDS among vulnerable groups by 50%. 	
Donor Commitment	<p>Government of Pakistan commitment</p> <p>External donors (World Bank is the largest funder of HIV/AIDS programs, also UN agencies, DFID, CIDA, USAID, EU, GFATM, AusAID, SIDA, and others)</p>	<ul style="list-style-type: none"> • Enhanced NACP (Rs. 2.9 billion) • UNAIDS has established a Theme Group and a Technical Working Group on HIV/AIDS. The theme group includes ILO, UNICEF, UNFPA, UNODC, UNESCO, WHO, UNDP, WB, WFP, UNAIDS, national and provincial program managers, and representatives of NGOs.² • Provision of free ARV therapy under the Global Fund at 4 treatment centres⁶ • HIV Prevention and HR services for IDUs initiated under a DFID grant (HIV/AIDS Prevention with Harm Reduction in Pakistan (HAPDHRP), 7 projects in all 4 province's headquarters implemented by Futures Group) have been continued under government financing⁶ • Under UNODC¹, a comprehensive service package, consisting of Peer Led Intervention, Safer Practices, Oral Substitution Therapy (buprenorphine and methadone), Low Cost Community Care and Support, and Rapid Situation and Response 	

¹ Under UNODC's H13 program, the components being supported for Pakistan are: Advocacy to support change in policy and practice; Effective Risk Reduction Approaches to reduce HIV transmission among IDU; and, Scaled-Up Risk Reduction Interventions to reduce HIV transmission among IDUs. During Phase II of the program, 8PLIs, 6 LCCS, 2 SP and 2 OST initiatives will be set-up/supported.

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		Assessments.	
Costed National Strategy			
Legal Environment	Ministry of Narcotic Control	<ul style="list-style-type: none"> • Control of Narcotic Substances Abuse (CNSA) Act 1997 (extended in 1998): Chapter VI deals with treatment and rehabilitation of addicts.⁷ • The Ministry has mainstreamed HR policy and decriminalized drug use.⁶ • Anti Narcotics Force has established two Model Addiction Treatment and Rehabilitation Centres.¹⁴ 	<ul style="list-style-type: none"> • No laws and regulations that protect people or certain groups of people (e.g. IDUs) against discrimination⁶ • In terms of its legal status, the NSP does not breach provisions under the CNSA Act. However, it could be viewed as being contrary to the religious edict against intoxicants as contained in the Prohibition (Enforcement of <i>Hadd</i>) Order 1979.¹⁵ • Inconsistent legal approaches to drug use: The Prohibition (Enforcement of <i>Hadd</i>) Order makes use of intoxicants a serious offence, whereas CNSA does not criminalize drug users.¹⁵
Policy Environment	Government of Pakistan	<ul style="list-style-type: none"> • The Government has started working on revision of its National Drug Control Master Plan.⁷ • Policies in Pakistan provide for needle and syringe exchange.¹ • Pakistan has endorsed buprenorphine substitution policy as part of its national HIV/AIDS strategy.¹ • Government approved the introduction of HR and/or treatment and rehabilitation services in prisons. • Guidelines for BCC attempt to develop a streamlined approach to BCC for HR service 	<ul style="list-style-type: none"> • Methadone is not approved by the National Drug and Cosmetics laws and the National Drug Control Authorities as required by the Narcotic Control Board.¹ • No policy to ensure equal access for men and women to prevention and care⁶ • Existing policies to promote and protect human rights in relation to HIV/AIDS are not always enforced.⁶

		<p>provision.¹³</p> <ul style="list-style-type: none"> • Guidelines for the Use of ARV Therapy in HIV Positive Adults and Adolescents in Pakistan (NACP, June 2005) mention IDUs.⁹ • HIV VCT Guidelines for Pakistan include section on IDUs (3.2) and support HR strategies, though no details on how to implement them is given.¹⁰ • Under the CNSA, the Federal Government may establish a National Fund for Control of Drug Abuse to allocate resources for drug supply and demand reduction activities including treatment and rehabilitation of drug users.¹⁵ 	<ul style="list-style-type: none"> • These guidelines state that “enrolment in and successful completion of drug rehabilitation programs is mandated prior to initiation of ART in drug users”.⁹
M & E Systems/ Research Capacity	<p>National AIDS Control Programme (NACP)/ Ministry of Health (National Monitoring department is under development) Provincial AIDS Control Programmes (PACPs) Private sector NGOs PLWHAs⁶</p>	<ul style="list-style-type: none"> • Grants are allocated in the NACP for research and pilot projects.⁶ • The M&E framework is currently being developed.⁶ 	<ul style="list-style-type: none"> • M&E and research needs strengthening.⁶ • Capacity to monitor the coverage and quality of programmes.⁷ • Relatively little research has been done on the consequences of drug abuse in Pakistan.⁷ • No systematic follow-up is done on the success of drug treatment.⁷
Surveillance Systems	<p>Government of Pakistan Public Health Agency of Canada NGOs 39 countrywide</p>	<ul style="list-style-type: none"> • NACP: Survey of High Risk Groups in Lahore and Karachi, 2005 • Canada-Pakistan HIV/AIDS Surveillance Project (HASP) project, to enhance the capacity of the Government of Pakistan to implement an effective second generation 	<ul style="list-style-type: none"> • A second-generation HIV surveillance needs to be implemented.² • Surveillance data has not always been reliable.¹²

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	surveillance and diagnosis centres (HIV/AIDS) AIDS Surveillance Centre Karachi ²	system for HIV/AIDS surveillance. This system involves repeated cross-sectional sampling of vulnerable, high-risk populations to obtain information on risk behaviours in addition to a biological sample for testing of HIV and other disease agents. The surveillance program will be expanded into 12 cities. ⁴	
Multi-sectoral Involvement	Government of Pakistan Development partners Private Sector Civil Society PLWHA ⁶	<ul style="list-style-type: none"> • Multi-sectoral National HIV/AIDS Strategic Framework (2002-2006)¹ (vulnerable and high risk groups represent one of the 9 priority areas), translated into plan of action (Enhanced NACP, see above) • In order to promote interaction and coordination between Government, development partners, private sector, civil society and PLWHA a number of bodies have been established: (1) National Steering Committee, (2) National Technical Advisory Committee on AIDS (TACA), (3) Provincial Task Force (PTF), and (4) the Pakistan National AIDS Consortium (PNAC), a civil society HIV and AIDS body. • NGOs serve as members of the Provincial HIV/AIDS Consortium, which coordinates HIV/AIDS prevention and control in all four provinces. 	<ul style="list-style-type: none"> • NGO and private sector involvement in program management needs to be increased.⁶ • Organizations (whether NGOs or private drug treatment facilities) are often operating in isolation.¹¹ • HIV and AIDS should be mainstreamed into other ministries.⁶
Law enforcement involvement	Narcotics Control Division Anti Narcotics Force Police		

Involvement of IDUs in Response	Government of Pakistan	IDUs have been involved at various national forums. ⁶	
Capacity building	Government of Pakistan Development partners Private sector NGOs PLWHAs ⁶	<ul style="list-style-type: none"> • Recent scaling up of response to HIV/AIDS with a special focus on reducing the exposure of high-risk groups (see Enhanced NACP)² • NACP plans to reach 27,000 IDUs through service packages⁶ • The TAMEER Project – a joint programme of the Pakistan National AIDS Consortium and development partners - aims to prevent the spread of HIV among the most vulnerable groups in Pakistan by increasing the capacity NGOs.⁴ 	<ul style="list-style-type: none"> • Problems with building capacity at the provincial level.² • Technical assistance to contracted NGOs is required.²

2. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
1. Political commitment	1.1 Lack of understanding about the mechanisms, approaches and strategies for social reintegration and rehabilitation. ⁷	NACP/MoH Ministry of Narcotic Control Anti-Narcotics force	The coming on board of the ANF, the foremost anti-narcotics agency, on to the harm reduction agenda is said to present a significant lesson in drug use and HIV/AIDS harm reduction programming. ¹⁵
	1.2 Lack of an enabling environment for implementation of interventions and for service providers. ⁷		
	1.3 Lack of emphasis on oral drug substitution treatment. ⁷		
	1.4 The overall advocacy element needs strengthening and should go beyond the standard elements of sensitization conferences for garnering policy commitment. ¹²		
2. Community commitment	2.1 Widespread social stigma ² and discrimination, which dissuades PLWHAs from approaching support networks ¹⁵	NACP/MoH NGOs PLWHAs	The NACP aims to improve the awareness level of the general population and has contracted a BCC firm. ⁶
	2.2 Lack of knowledge among the general population (including IDUs and sex workers) and health practitioners ² , low literacy levels		
	2.3 Male resistance to condom use ²		
	2.4 Low status of women ² , restrictions on women's and girls' mobility limits access to information and preventive and support services ²		
3. Legislative / policy	3.1 Many drug users have experienced unpleasant encounters with the law, and hence distrust or fear government or hospital based services. ¹⁰		
	3.2 Laxity of Government-run institutions especially with regard to VCT and partner-notification are well known. ¹²		
4. Comprehensive Services	4.1 Limited surveillance and VCT systems. ²		
	4.2 Inadequate blood transfusion screening (drug users often exchange blood for money) ²		
	4.3 NGOs active in HIV/AIDS prevention activities are reaching <5% of the vulnerable population ²		

	4.4 Poor quality needle and syringe exchange programmes. ⁷		
	4.5 Facilities for detoxification both in the Government and outside were found to be inadequate and far short of what is required to fulfil the Government's statutory obligation. ¹⁵		
	4.6 Targeted interventions should place particular emphasis on FSWs who inject drugs, or whose partners inject drugs. ¹⁵		
5. Resources	5.1 Many NGOs need training in concepts such as social and vocational rehabilitation. ⁷	Government of Pakistan External donors NGOs	
	5.2 Sustainability and continuation of programs is often a problem. ¹¹		
	5.3 Many NGOs do not have the orientation or expertise to run their organizations as a business, or to apply good financial management. ¹¹		
	5.4 Increased participation is required. ¹²		
	5.5 Lack of skilled professional staff. ¹²		
	5.6 Ill equipped health system lacking in adequate infrastructure and suffering from poor coordination and accountability. ¹²		
	5.7 HIV counselling and testing services are not available. In the absence of counselling, antiretroviral treatment and support structures for persons testing positive, NGOs are sceptical of encouraging/referring IDU clients to government hospitals for HIV testing. ¹⁵		
6. Affected community involvement	6.1 Difficulty in accessing high risk populations. ⁶		
	6.2 Limited awareness of needle and syringe sterilization procedures. ⁷		
	6.3 Lack of clarity about concepts, methods and approaches with regard to this issue, e.g. family involvement is seen by many as a way of keeping watch over the drug user after release from		

	treatment. ¹¹		
7. Commodities			
8. Scaling up plans	8.1 Difficulty in accessing high risk populations. ⁶		
	8.2 Protocols need to be developed for community-based drug treatment programmes so that interested organizations can adopt and adapt, and demonstration projects should be developed at selected settings. ¹¹		
	8.3 Shortages of qualified staff, lack of technical and managerial expertise, and limited capacity of NGOs to deliver effective prevention services have delayed implementation of some of the Enhanced HIV/AIDS Control Program components. ¹⁵		
9. Capacity Building	9.1 Limited in-country capacity for scaling up interventions for high-risk populations. ²		
	9.2 Limited NGO capacity to implement effective interventions for high risk groups. ⁶		
	9.3 Prison authorities admit that they do not have the capacity to properly deal with drug users. ⁷		

3. Program Implementation

Estimated IDU Population: 3 million heroin users (2002: 60000 injecting)¹

Service Coverage: ~ 8000 IDUs/month access any of the services detailed below¹⁷

	Available Data							NSP coverage
	Provincial Coverage (% or Avg)	NGOs (Number)	Govt. Health Services (Number)	# Clients Accessing Services	Needle / Syringe Distribution (Number)	# Condoms Distributed	# of IEC Materials Distributed	
Outreach								
Drop-in Centres		9 All DICs are currently supported by government funds but managed by NGOs. ¹⁷						
VCT	16 VCT centres ¹⁴ (set up with Round 2 of the GFATM grant), cater to the general population and only nominally to the bridging populations ¹⁶ . Pakistan's Enhanced AIDS Program has prevention activities			7000 ⁶ +4500 HIV testing ⁶				

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	for most marginalized groups in most cities and VCT is a part of it. Very little of that has actually happened. In the treatment centres, of the nearly 400-500 patients registered throughout the country less than 5 are referred for VCT. ¹⁶							
Linkage to HIV Care and Support								
ARV	6 care & support centres with ARV are functional. ¹⁴			Not known for IDU ¹⁶				
Primary Health Care								
Needle and Syringe Programs	5-20% ⁷	<i>Nai Zindagi</i> (local NGO run by ex-users) + 6 other NGOs ¹⁷	2 Government projects ⁶	Not known ¹⁶	465,000 ⁶	161,000 ⁶		
Substitution Programs	No substitution programs ⁷	0	0	0				
Linkage to Rehabilitation and Detoxification		41 drug treatment centres in NGO/private sector ¹⁷	32 in Government sector ¹⁷	Numbers not known ¹⁶				
Peer								

education programmes								
Targeted IEC								
Plans for Scale Up								

Services in Closed Settings:

Harm Reduction Services

- Sukkur Blood Bank in Sukkur (decent) and Dost Foundation in Peshawar (struggling).¹⁶
- No HR services in prisons. Under Tameer project (EU funded) condoms are available in two prisons; however, no syringes or substitution.¹⁷

Estimated Prisoner Population: 78938⁸

Estimated % of Drug Offenders: ~20%⁷

Service	# of Clients Accessing Services
Voluntary Counselling and Testing	
Needle and Syringe Programs	
Peer Education Programs	
Substitution Maintenance	
Post-release Follow-up	
Primary Health Care	
Condoms	
Total	

Workforce

Estimated Required Workforce: Not Available

	Available Data						Standardised Training Programs in Place	Capacity Assessment (low/medium/high)
	Provincial Coverage (% or Avg)	NGOs (Staff No's)	Govt. Health Services (Staff No's)	Total	Current Workforce compared to Required Workforce (%)	% of Peers in Workforce		
Service Providers								
Plans for Scale Up								

4. Gap Analysis

1. There are no drug ST programs.
2. Legal approaches to drug use are inconsistent: The Prohibition (Enforcement of *Hadd*) Order makes use of intoxicants a serious offence, whereas CNSA does not criminalize drug users. The two statutes are at variance vis-à-vis the legal treatment accorded to persons with drug related problems. Furthermore, though Buprenorphine is endorsed, Methadone is not approved by the National Drug and Cosmetics laws and the National Drug Control Authorities as required by the Narcotic Control Board.
3. No policy to ensure equal access for men and women to prevention and care.
4. A second-generation HIV surveillance needs to be implemented.
5. HIV and AIDS should be mainstreamed into other ministries.
6. HIV counselling and testing services are not available in Pakistan. In the absence of counselling, anti-retroviral treatment and support structures for persons testing positive, NGOs are sceptical of encouraging/referring IDU clients to government hospitals for HIV testing

5. Recommendations

1. Combat stigma and discrimination.
2. Initiate drug ST programs.
3. Set up treatment services in prisons.
4. Make VCT available, and expand ARV, specifically targeting IDU.
5. Review relevant laws and policies to eliminate contradictions that may present obstacles for drug users seeking effective treatment.
6. Reach out to female drug users.
7. Build capacity for local staff, and engage IDUs and communities.

6. References

- ¹ UNODC (2007). *Prevention of transmission of HIV among drug users in SAARC countries*. H13 Phase II Project Document (TD/RAS/03/H13). New Delhi: United Nations Office on Drugs and Crime, Regional Office for South Asia.
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¹¹ UNODCCP (2000). *Study of Drug Treatment Modalities & Approaches in Pakistan*, Islamabad, Pakistan: United Nations International Drug Control Programme, United Nations System in Pakistan.

¹² UNDP: The HIV/AIDS Portal for Asia Pacific (2006). *Pakistan at a Glance*. [Online]. Available at <http://www.youandaids.org/Asia%20Pacific%20at%20a%20Glance/Pakistan/index.asp>.

¹³ Mohammad S and Afsar HA (2004). *Guidelines for BCC: Enhancing content and strategies for harm reduction service provision Guidelines for Pakistan*. The National AIDS Control Program, Ministry of Health, Government of Pakistan and United States: Futures Group (DFID-funded: HIV/AIDS Prevention with Drug Harm Reduction in Pakistan Project).

¹⁴ Farrukh Ansari, personal communication.

¹⁵ UNODC ROSA, personal communication.

¹⁶ Adnan Khan, personal communication.

¹⁷ Nadeem Rehman, personal communication.