

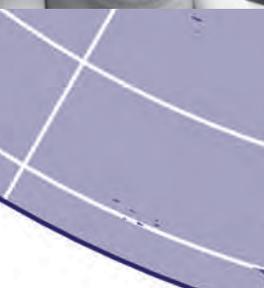
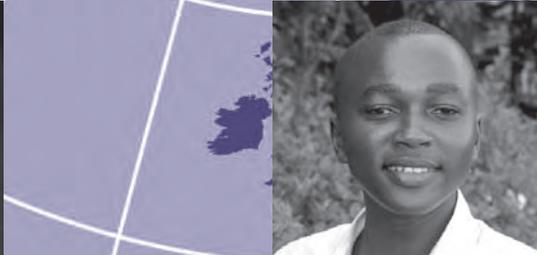
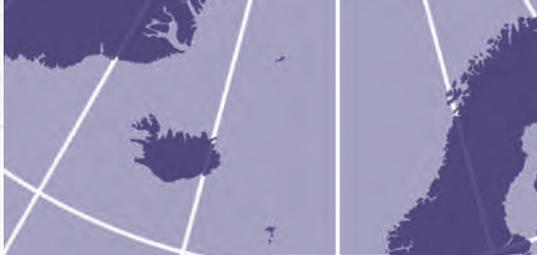
PAKISTAN FINAL REPORT

October 1997–September 2007

USAID'S IMPLEMENTING AIDS PREVENTION AND CARE (IMPACT) PROJECT



USAID
FROM THE AMERICAN PEOPLE



Final Report
for the
Implementing AIDS Prevention and
Care (IMPACT) Project in
Pakistan



October 2002 to September 2007



Pakistan Final Report

Submitted to USAID

By Family Health International

May 2007

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In partnership with

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GLOSSARY OF ACRONYMS

| | |
|---------|--|
| AIDS | Acquired immune efficiency syndrome |
| ASEER | Awareness on Social, Economic, Education Right |
| CSC | Community Support Concern |
| CSO | Community service organization |
| FANA | Federally Administered Northern Areas |
| FATA | Federally Administered Tribal Areas |
| FHI | Family Health International |
| FSW | Female sex worker |
| HIV | Human immunodeficiency virus |
| IA | Implementing agency |
| IDU | Injecting drug user |
| IEC | Information, education, and communication |
| IMPACT | Implementing AIDS Prevention and Care Project |
| IR | Intermediate Result |
| LOP | Life of project |
| M&E | Monitoring and evaluation |
| MARP | Most-at-risk populations |
| MOU | Memorandum of understanding |
| MSM | Men who have sex with men |
| MSW | Male sex worker |
| MWT | Mehran Welfare Trust |
| NACP | National AIDS Control Program |
| NGO | Nongovernmental organization |
| NLACS | New Lights AIDS Control Society |
| NWFP | North West Frontier Province |
| ORW | Outreach worker |
| OSD | Organization for Social Development |
| PACP | Provincial AIDS control program |
| PAVHNA | Pakistan Voluntary Health and Nutrition Association |
| PE | Peer educator |
| PLHA | People living with HIV/AIDS |
| PLYC | Pakistan Lions Youth Council |
| PMP-PIR | Performance Monitoring Plan-Performance Indicator Reference |
| SACHET | Society for the Advancement of Community Health, Education, and Training |
| SBC | Strategic behavioral communication |
| SO | Strategic objective |
| STI | Sexually transmitted infection |
| UNAIDS | Joint United Nations Program on HIV/AIDS |
| USAID | US Agency for International Development |
| VCT | Voluntary counseling and testing |
| WHO | World Health Organization |

EXECUTIVE SUMMARY

In 2002, Family Health International (FHI) conducted an assessment of the HIV/AIDS situation in Pakistan and made programming recommendations to guide interventions there. In September 2003, FHI, under its USAID-funded Implementing AIDS Prevention and Care (IMPACT) Project, initiated a program of activities to strengthen the Pakistan Ministry of Health's National AIDS Control Program (NACP). IMPACT's program strategy complemented Pakistan's national program, with its emphasis on reducing risk behaviors and supporting people living with HIV/AIDS (PLHA) with appropriate care. To implement its activities, IMPACT developed partnerships with eight organizations for an integrated response to the prevention of HIV and other sexually transmitted infections (STIs). IMPACT provided capacity building to the partner organizations, as well as technical assistance to the NACP to monitor the epidemic and the effectiveness of prevention and care programming.

IMPACT used subagreements to support projects for strategic behavioral change, care, and support through a variety of community-based organizations, including nongovernmental organizations (NGOs), youth groups, and PLHA organizations. Within a short time, IMPACT had become a recognized and respected partner among donors and NGOs working in Pakistan, in large part because of the range of expertise within its staff.

IMPACT's work with The New Lights AIDS Control Society, a PLHA organization, has evolved from informal activities that identified PLHA and provided them with some social/psychological support to a more formal home-based care program. The home-based care program has provided services to 78 HIV-positive individuals and their 276 family members. IMPACT published seven case studies (*Voices of People Living with HIV/AIDS*), which has made a meaningful contribution to reducing stigma and discrimination and provided a forum for PLHA self-expression for the first time in Pakistan.

Starting as a peer education project that would lead to greater involvement of the most-at-risk populations (MARP), IMPACT's program in Pakistan grew to include five partners, including the Organization for Social Development; Pakistan Lions Youth Council; Awareness on Social, Economic, Education Right; Pakistan Voluntary Health and Nutrition Association; and the Mehran Welfare Trust.

Taken together, IMPACT projects have reached more than 120,000 individuals from MARP. In addition to peer education training, IMPACT's technical assistance in the area of strategic behavioral communication (SBC) and SBC interventions has included the development of strategies, proposals and process-monitoring tools, project and financial management, SBC training for peer educators (PEs) and outreach workers (ORWs), financial management and strategic planning, and materials development.

In 2004, IMPACT supported the development of targeted materials such as the Peer Education Toolkit, which other development partners—including Marie Stopes Society, Interact Worldwide, and the Pakistan National AIDS Consortium—have used widely. IMPACT also supported youth-focused programs that have been implemented by two NGOs. These programs, which have reached an estimated 27,000 in-school and college youth, incorporated peer education through the youth advocacy network, trained young leaders as PEs, and supported

inputs to the Pakistan youth policy. The program started teacher-training about HIV and included parental education in its activities.

Over time, IMPACT expanded its activities with the NACP to include an assessment of the national blood transfusion situation, followed by a workshop on the development of safe blood transfusion and quality assurance systems for national and provincial blood transfusion managers. IMPACT also facilitated a workshop on STI strategy development to benefit national and provincial programs and provided technical assistance on developing a strategic paper for HIV interventions in Pakistan. In addition, IMPACT conducted a baseline evaluation survey in 2005 and spearheaded national consultative and participatory meetings to help provide a greater voice for people living with HIV/AIDS in Pakistan, in collaboration with the NACP, provincial AIDS control programs, UNAIDS, and PLHA organizations.

PROGRAM STRATEGIES, IMPLEMENTATION, AND RESULTS

Introduction

In September 1997, USAID awarded FHI and its partners a five-year cooperative agreement for the IMPACT Project, whose mission is to help countries expand and improve HIV prevention and care.

In 2002, an assessment was designed to provide an overview of the HIV epidemic in Pakistan, existing and planned responses, and short-term programming recommendations for USAID funds through the IMPACT Project. Additionally, recommendations for longer-term programming were provided, based on foreseen gaps in the national response.

In September 2003, FHI initiated the country program in Pakistan to strengthen the NACP through a grants program for private-sector, mid-level NGOs on SBC and interventions. IMPACT's program strategy complemented Pakistan's National Strategic Framework for HIV/AIDS prevention and control, with its emphasis on reducing risk-behaviors for MARP, initiating care and support for PLHA, integrating STI services, and increasing access to HIV-preventive education for in-school youth.

Based on the 2002 assessment, IMPACT's activities were designed to contribute to an important strategic objective (SO) of USAID/Pakistan:

SO7. Improved health of vulnerable populations in Pakistan, through Intermediate Result (IR) 7.3: Increased use of proven interventions to prevent major infectious diseases

Country Context

Pakistan covers an area of about 796,000 square kilometers, and comprises the provinces of Balochistan, North West Frontier Province (NWFP), Punjab, Sindh, the Federally Administered Tribal Areas (FATA), and the Federally Administered Northern Areas (FANA).

The country's population is estimated at more than 153 million, with a growth rate of 1.9 percent, according to the Ministry of Population Welfare.¹ The contraceptive prevalence rate is 36 percent,² while the condom-use rate (for birth spacing) is under 8 percent. Punjab, the most densely populated province, has 56 percent of the total population, followed by Sindh (23 percent), NWFP including FATA (16 percent), and Balochistan (5 percent).

Islamabad Capital Territory has less than 1 percent of the country's population, and the overall urban-rural population ratio is 33 : 67.³ Extensive rural to urban movement is occurring, and a large number of men have relocated to urban areas and live away from their natal or marital homes.

¹National Institute of Population Studies, September, 2005, *Population Growth and its Implications*, Islamabad www.mopw.gov.pk/nips/popgrowth.pdf

² Ibid.

³ Population and Housing Census, 1998

Pakistan is predominantly an agrarian country, with about 50 percent of the work force employed in agricultural occupations. The average per-capita income is US\$420.⁴ The and the average rural monthly income per household is about one-third lower than the a comparable urban income. The adult literacy rate is 44 percent.⁵ The low literacy level has implications for the programming of interventions, as does the frequent rural-urban movement of men.

Pakistan still has a window of opportunity to act decisively to prevent the spread of HIV. Although the estimated HIV prevalence is still low (about 0.1 percent of the adult population), there has been an outbreak of HIV among injecting drug users (IDUs) in Sindh province. Without vigorous and sustained action, Pakistan runs the risk of experiencing the rapid increase in HIV among vulnerable groups seen elsewhere in the region.

State of the Epidemic, Risk Factors, and Response

HIV and AIDS

According to UNAIDS estimates, some 70,000–150,000 persons (0.1 percent of Pakistan’s adult population) are infected with HIV. The number of officially reported cases is much lower. As of June 2005, the NACP had identified 2,622 HIV-positive cases, including 321 with AIDS.⁶ As in many countries, under-reporting is due mainly to the social stigma attached to the infection, limited surveillance and voluntary counseling and testing (VCT) services, as well as to ignorance about HIV among the general population and health practitioners.

Until recently, Pakistan was classified as a low-prevalence country with many risk factors that could lead to the development of an epidemic. However, recent evidence indicates that the situation might be changing rapidly. In 2004, a concentrated outbreak⁷ of HIV was found among IDUs in Karachi, where over 23 percent of those tested were found to be infected. High levels of HIV infection—4 percent—were also found among men who have sex with men (MSM) in that city, and the infection rate among Hijras (transgenders) was 2 percent. Nonetheless, HIV prevalence among other high-risk groups in Karachi and all vulnerable populations in Lahore is still low—below 1 percent.

Risk Factors

These findings underline the risk of an escalating epidemic. They point to the presence of significant risk factors, such as the very low rate of condom use among vulnerable populations, including female sex workers (FSWs), MSM, truckers, and Hijras; as well as risky injection and sexual behaviors among IDUs. There is also an alarmingly high prevalence of syphilis among Hijras (60 percent in Karachi and 33 percent in Lahore), which also increases the risk of HIV infection.

Serious risk factors that put Pakistan in danger of facing a rapid spread of the epidemic if immediate and vigorous action is not taken are listed below.

⁴ World Bank 2003c, Human Development in South Asia 2003

⁵ UNDP 2003, Human Development in South Asia 2003

⁶ NACP Sentinel Data report, June 2005

⁷ National Study of RTI and STI – survey of high-risk groups in Lahore and Karachi 2005 - DFID/NACP/FHI

Outbreaks among IDUs: The number of drug-dependent people in Pakistan is currently estimated to be about 500,000, of whom an estimated 60,000 inject drugs.⁸ An outbreak of HIV was discovered among IDUs in Larkana, Sindh, where, out of 170 people tested, more than 20 were found to be HIV-positive. In Karachi, a 2004 survey of STIs among high-risk groups found that more than one in five IDUs had been infected with HIV. These are the first documented epidemics of HIV in well-defined, vulnerable populations in Pakistan. The data confirm the threat that HIV poses and validate the premise of Pakistan's recently enhanced HIV program.

*HIV infection among MSM:*⁹ MSM groups are heterogeneous: they include Hijras (biological transgendered males who are usually fully castrated), Zenanas (transvestites who usually dress as women), and masseurs. Many MSM sell sex and have multiple sexual partners. The 2004 STI survey found that 4 percent of MSM in Karachi were infected with HIV, as were 2 percent of the Hijras in the city. Syphilis rates were also high, with 38 percent of MSM and 60 percent of Hijras in Karachi infected with the disease.

Unsafe practices among sex workers: Commercial sex is prevalent in major cities and on truck routes. Behavioral and mapping studies in three large Pakistan cities found a sex worker population of 100,000 who have limited understanding of safe sexual practices. Furthermore, sex workers often lack the power to negotiate safe sex or seek treatment for STIs. Recent findings indicate that female sex workers (FSWs) and their clients report low condom use. Less than half the FSWs in Lahore and about a quarter of them in Karachi had used condoms with their last regular client.

*Inadequate blood transfusion screening and a high level of professional donors:*¹⁰ It is estimated that 40 percent of the 1.5 million annual blood transfusions in Pakistan are not screened for HIV. In 1998, the AIDS Surveillance Center in Karachi conducted a study of professional blood donors—people who sell blood for money—who, typically, are very poor and often drug users. The study found that 20 percent of them were infected with hepatitis C, 10 percent with hepatitis B, and 1 percent with HIV. About 20 percent of the blood transfused comes from professional donors.

*Unsafe medical injection practices:*¹¹ Pakistan has a high rate of medical injections—around 4.5 per capita per year. Studies indicate that 94 percent of injections are administered with used injection equipment. Use of unsterilized needles at medical facilities is also widespread. According to WHO estimates, unsafe injections account for 62 percent of hepatitis B, 84 percent of hepatitis C, and 3 percent of new HIV cases.

Large numbers of migrants: Large numbers of workers leave their villages to seek work, whether in larger cities, the armed forces, or industrial sites. A significant number (around 4 million) are employed overseas. Away from their homes for extended periods of time, these migrants become exposed to unprotected sex and are at risk for HIV.

⁸ UNDCP

⁹ Social Assessment and Mapping of Men who have Sex with Men in Lahore - Naz Foundation International

¹⁰ National Blood Transfusion Services, Pakistan

¹¹ World Health Organization

Low levels of literacy and education: Efforts to increase awareness about HIV among the general population are hampered by low literacy levels, as well as cultural influences. In 2001, the illiteracy rate of Pakistani women over age 15 was 71 percent.¹²

Vulnerability due to social and economic disadvantages: Restrictions on the mobility of women and girls limit their access to information and preventive and support services. Young people are vulnerable to influence by peers, unemployment frustrations, and the availability of drugs. In addition, some groups of young men are especially vulnerable because of the sexual services they provide, notably within the transport sector. Men and women from impoverished households may work (or be forced to work) in the sex industry to obtain income.

Response by the Government, NGOs, and Other Donors

Government: Pakistan's Ministry of Health initiated a National AIDS Prevention and Control Program (NACP) in 1987. In its early stages, the program centered on the diagnosis of people infected with HIV who came to hospitals, but it progressively shifted toward a community focus. The program's objectives are the prevention of HIV transmission, safe blood transfusions, reduction of STI transmission, establishment of surveillance, training of health staff, and development of research and behavioral studies and program management. The NACP has been included as part of the government's general health program, with support from external donors.

As the government has indicated by the recent scaling up of its response to HIV, more needs to be done. A special focus on reducing the exposure of high-risk groups is urgently required. Improving skills, building capacity, strengthening advocacy, and increasing participation is needed—not only in the area of health, but in several sectors, including education, labor, and law and order. In early 2001, the Government of Pakistan, through a broad consultative process, developed a national HIV/AIDS Strategic Framework that sets out the strategies and priorities for effective control of the epidemic.

NGOs: More than 36 NGOs are involved in increasing public awareness of HIV and in the care and support of PLHA.¹³ These NGOs also work on education and prevention interventions that target sex workers, truck drivers, and other high-risk groups. NGOs serve as members of the Provincial HIV/AIDS Consortium, which has been set up in all four of Pakistan's provinces to coordinate HIV prevention and control activities. Although NGOs are active in HIV prevention activities, it is believed that they are reaching less than 5 percent of the vulnerable population.

Donors: UNAIDS has established a theme group and a technical working group on HIV/AIDS to coordinate the response of United Nations agencies and provide assistance to the government in the strategic development of activities. The theme group includes UNAIDS, WHO, UNICEF, UNFPA, UNDP, UNDCP, UNESCO, the International Labor Organization, the World Bank, national and provincial program managers, and representatives of NGOs.

USAID Support for the Response

With funding from USAID/Pakistan through the IMPACT cooperative agreement, FHI has implemented targeted interventions with its eight partner agencies in six cities, including Islamabad, Multan, Lahore, Rawalpindi, Karachi, and Larkana. More than 120,000 people were

¹² The World Bank

¹³ Assessment of NGOs active in HIV/AIDS prevention in Pakistan

reached through these projects, and the technical capacities of partner organizations and the national and provincial HIV control programs have been strengthened.

USAID's overall objective was to develop programs that reduced or eliminated HIV and STI risk-behaviors among MARP and high-risk youth. The many achievements of the existing project have been described elsewhere, but the latest Performance Monitoring Plan (PMP) data are noteworthy.¹⁴ These show that 52 percent of MSM exposed to IMPACT interventions in the last year could correctly identify two or more methods of preventing HIV transmission, compared to 34 percent of those who had not been exposed to FHI interventions. Similarly, condom use at last anal commercial sex was 21 percent among MSM exposed to interventions, versus only 9 percent among the non-exposed. Differences were statistically significant for both parameters, indicating that the interventions are having a positive impact by improving HIV-related knowledge and reducing risk behaviors.

USAID and the IMPACT team have a unique opportunity to strategically develop model programs that can influence and leverage larger and more effective responses in Pakistan. Given the early stage and concentrated nature of the epidemic, the limited funding for this project, and lessons learned during implementation of IMPACT, Pakistan can now consolidate high-quality, well-documented models of service delivery. These models can be replicated nationally, by other agencies with alternative funding, to make significant strides toward the objective of expanded coverage with quality programming.

Issues and Challenges: Priority Areas

Interventions sought to improve the lives and decrease the vulnerability of people in high-risk groups, promote behavioral change and increase general awareness, improve the safety of blood and blood products, increase surveillance, contribute to research on HIV and other STIs, and build management capacity.

High-risk groups: For vulnerable and high-risk groups, particularly those in large cities, IMPACT aimed to assist governmental and NGO efforts to expand the knowledge of, access to, and coverage of high-risk groups by a package of high-impact services. The project also sought to make effective and affordable STI services generally available, and to encourage safe-sex practices among sex workers. Behavioral change communications among high-risk groups aimed to promote condoms use with non-regular sexual partners, as well as the use of STI services when symptoms are present, with knowledge of the link between STIs and HIV.

Awareness and behavioral change: IMPACT sought to increase interventions to promote awareness and behavioral change among youth, police, and migrant laborers. Interventions were also planned to encourage tolerant and caring behaviors toward PLHA and members of vulnerable populations.

Safety of blood and blood products: To improve the safety of blood and blood products, interventions needed to promote the use of blood for transfusion only if it had been screened for HIV, as well as the use of sterile syringes for all injections and a reduction in the number of injections an individual received. Educational campaigns also aimed at encouraging voluntary blood donation, particularly among those ages 18–30. IMPACT also advocated to ensure mandatory screening of blood and blood products for all major blood-borne infections. In addition, the project aimed to develop quality assurance systems to ensure that proper screening of all blood for HIV and hepatitis B by public and private blood banks.

¹⁴ RAASTA Development Associates, 2005

Surveillance: In addition to strengthening and expanding the surveillance and monitoring system, IMPACT participated in consultations to design a second-generation, HIV-surveillance system that tracks seroprevalence and changes in HIV-related behaviors, including those that spread STIs and HIV. The project, implemented by another group, also sought to track sexual attitudes and behaviors, including healthcare-seeking behaviors related to STIs.

Management capacity: IMPACT also sought to identify gaps in existing programs and continue to build management capacity within provincial programs and local NGOs to ensure evidence-based program implementation and continue phased expansion of interventions.

Implementation and Management

Implementation

IMPACT was one of the key USAID instruments for funding HIV programs in support of the Government of Pakistan and NGO partners. Within a short time, IMPACT became a recognized and respected partner among donors and partners working in HIV, not in small part because of the range of expertise that the project brought to the country. IMPACT country office staff served on many committees, including the NACP Technical Advisory Committee for AIDS, the UNAIDS Technical Working Group, and the Monitoring, Evaluation, and Research Subcommittee.

Most of the support for IMPACT's implementing partners was channeled through subagreements with partner agencies and by providing technical assistance to help them establish SBC and other interventions for HIV prevention and care. Other subgrant mechanisms included firm fixed-price and cost-reimbursable contracts for material development and a baseline evaluation survey.

Management

In September 2003, FHI hired a country director to manage IMPACT, and an office was opened in December. That same year, a program officer, finance officer, an administrative and human resource officer, administrative assistant, and an office assistant joined the country office team. Later, a finance assistant and an additional program officer and a driver were hired, bringing the total IMPACT staff to nine.

The country office was responsible for the day-to-day coordination of technical assistance and programmatic support to the implementing partners. It was also responsible for collaboration with national-level institutions (such as the NACP), liaison with USAID/Pakistan, and the achievement of program objectives. The country office worked with the FHI's Asia and Pacific Department team responsible for backstopping the IMPACT program.

Coordination with USAID and Stakeholders

IMPACT enjoyed the full support of USAID/Pakistan. The mission's health office was easily accessible to the country office team for meetings with consultants, and its staff frequently participated in IMPACT activities, such as training and capacity building and program launches. IMPACT participated in regular quarterly meetings of all USAID partners and in quarterly meetings of the SO7 partners.

IMPACT established excellent relationships with multiple local agencies and the Government of Pakistan and strengthened coordination effectiveness by engaging in a number of activities.

These included

- contributing actively to national meetings with stakeholders and sharing experiences, research findings, and lessons learned from monitoring and evaluation (M&E)
- supporting the “Three Ones”¹⁵ by providing inputs to development of a national M&E system and participating in national consultations and review missions on responses to HIV, including the Technical Advisory Committee on AIDS
- participating in dissemination meetings relating to best-practice models
- collaborating with Population Services International/Greenstar Social Marketing by starting a revolving credit facility to allow IMPACT partners to access condoms
- joining with UNAIDS in facilitating the formation of the PLHA network
- participating in a workshop on second-generation surveillance funded by the Canadian International Development Agency

¹⁵ The “Three Ones” refer to one national plan, one national coordinating authority, and one national M&E system.

Pakistan Program Timeline

The table below provides an overview of significant activities during the life of the project.

| Activities and Interventions | FY 04–05 | | | | FY 06 | |
|---|----------|----|----|----|-------|----|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 |
| IMPACT/Pakistan office set up | X | | | | | |
| Orientation for staff | X | | | | | |
| Development of site-specific strategies | X | | | | | |
| Workshop on selection of implementing agencies (IAs) | | X | | | | |
| Workshop on project design and proposal writing | | X | | | | |
| Development and implementation of seven subagreements and technical assistance in implementation | | X | X | | | |
| Workshop for master trainers on SBC strategies and developing an action plan | | | X | | | |
| Workshop on competency-based SBC for PEs and ORWs | | | X | | | |
| Workshop on process monitoring | | | X | | | |
| Workshop on management of targeted interventions | | | X | | | |
| Exposure trip to Bangladesh | | | | X | | |
| Exposure trip to Indonesia | | | | X | | |
| Support for partners and IPs to attend the XV International AIDS Conference in Bangkok | | | X | | | |
| Support for partners and IAs to attend three training courses related to surveillance in Bangkok | | | X | X | | |
| Technical assistance to partners on surveillance | | | | X | | |
| Technical assistance to partners on reviewing guidelines for STI case management | | | | X | | |
| Technical assistance to partners on analysis and use of data for advocacy and decision-making | | | | X | | |
| Urdu translations of selected FHI publications | | | | X | | |
| | FY 04–05 | | | | FY 06 | |
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 |
| Training on care and support; publication of case studies | | | | X | | |
| Implementation of SBC interventions for vulnerable populations in six strategic geographic areas | | | | | X | |
| Implementation of home-based care; control of opportunistic infections; SBC for reducing stigma and discrimination against PLHA | | | | | X | |
| Dissemination of findings of baseline evaluation survey | | | | | X | |
| World AIDS Day—IQC contract | | | | | X | |
| Program and field monitoring | | | X | X | X | X |
| IMPACT close-out | | | | | | X |

Program Objectives, Strategies, and Activities

Program Objectives

Under the Strategic Objective Grant Agreement between the US Government and the Islamic Republic of Pakistan, FHI developed strategies to complement the NACP's efforts to promote awareness and healthy behaviors among MARP and in-school youth, through information, education, and communication (IEC) programs on the risk factors for HIV.

This was the fourth focus area of the US Government’s Health and Population Program in Pakistan. IMPACT has developed projects that reduce the transmission of HIV and other STIs among MARP and in-school youth in Rawalpindi, Islamabad, Lahore, Multan, Karachi, and Larkana, in Punjab and Sindh provinces, as well as support PLHA with appropriate care and provide technical assistance to the NACP. IMPACT/Pakistan partnered with eight NGOs to initiate SBC and other prevention interventions in response to the HIV epidemic in the country.

IMPACT’s goal and objective was to support the Government of Pakistan in maintaining low HIV prevalence through provision of effective HIV prevention and care activities for MARP and high-risk youth. To achieve the strategic objective, IMPACT/Pakistan worked in collaboration with the NACP and a number of key partners to attain the following IRs:

- *IR 1:* Increase the involvement of NGOs and other institutions in the provision of targeted HIV-prevention interventions among the most vulnerable populations.
- *IR 2:* Increase the capacity of NGOs and the NACP in implementing quality HIV/AIDS programming.
- *IR 3:* Strengthen the quality and availability of HIV/AIDS/STI surveillance data for decision-making.

Implementation Sites and Geographic Coverage

The table lists project sites for MARP, in-school youth, and PLHA in six major cities of Pakistan. IMPACT supported the efforts of eight partner organizations from the private sector to render HIV/STI preventive services and care at nine field sites.

| Implementing Agencies | Activity Summary | City | Populations Reached |
|-----------------------|--|---|---|
| SACHET | SBC strategies and interventions, abstinence and be faithful | Rawalpindi and Islamabad | In-school, college youth, associated populations |
| CSC | SBC strategies and interventions, abstinence and be faithful | Multan | In-school, college youth, associated populations |
| OSD | SBC strategies and interventions, STI service delivery | Rawalpindi | FSWs, MSM, working and street youth, associated populations |
| PLYC | SBC strategies and interventions, STI service delivery | Multan | Truck/bus drivers, FSWs, MSM, working youth, associated populations |
| ASEER | SBC strategies and interventions, STI service delivery | Multan | MSM, associated populations |
| PAVHNA/MWT | SBC strategies and interventions, STI service delivery | Larkana | FSWs, MSM, working and street youth, associated populations |
| NLACS | Home-based care and SBC strategies and interventions | Lahore, Multan, Rawalpindi, and Karachi | PLHA and associated populations |

Key: SACHET: Society for the Advancement of Community Health, Education, and Training; CSC: Community Support Concern; OSD: Organization for Social Development; PLYC: Pakistan Lions Youth Council; ASEER: Awareness on Social, Economic, Education Rights; PAVHNA: Pakistan Voluntary Health and Nutrition Association; MWT: Mehran Welfare Trust; NLACS: New Lights AIDS Control Society.

Project Design, Strategies, and Activities

Project design and implementation started simultaneously, engaging implementing agencies (IAs) in a series of participatory activities relating to the planning process and capacity building. As part of the program start-up, implementing agencies conducted needs assessments and related formative research.

The strategies implemented for HIV prevention through the NGOs included assessment and planning for implementation, peer education and a youth advocacy network, home-based care, edutainment, and continuing capacity building

Strategic Behavioral Communication and Interventions

To effectively allocate resources, IMPACT targeted intensive strategic behavioral programming for populations most vulnerable and central to the HIV epidemic. The work supported objectives already set by the NACP. IMPACT also assisted implementing agencies by building technical capacity in the design and implementation of SBC and interventions.

To reach MARP, IMPACT used the SBC model as a crosscutting tool for HIV prevention and developed SBC in the context of a prevention, care, and support program. IMPACT advocated integrating many different interventions, products, and channels into a comprehensive approach, and worked to contribute to national program goals and collaborate with national, regional, and international partners.

Care and Support

At the request of USAID/Pakistan, IMPACT also supported home-based care activities for PLHA through its partner, New Lights AIDS Control Society. The care and support strategy undertook these activities and improved networking among PLHA organizations and wider coverage in Pakistan's cities, including Lahore, Multan, Rawalpindi, and Karachi. IMPACT initiated and spearheaded national consultative meetings for PLHA, in collaboration with UNAIDS, the NACP, provincial AIDS control programs (PACPs), and community support organizations (CSOs) of PLHA.

STI Service Delivery

Peer education has been the main behavioral strategy since the inception of the program. Over the past few years, IMPACT has delivered solid preventive education to MARP at various geographic locations and created a demand for information and services.

Realizing that information needs to be integrated with tangible services and provide a meaningful contribution to HIV/STI prevention, IMPACT implemented amendments to four of the operating projects to deliver community-based STI services. By that time, the SBC program was mature enough to direct and refer clients to STI health outlets. ORWs and PEs played a key role in bringing clients from the field. Special considerations guided positioning of clinics so that stigma would not jeopardize prevention efforts. Trained medical staff provided syndromic management to STI patients in the catchment area.

Technical Assistance

At the core of IMPACT's programs was provision of timely technical assistance to partners for key activities. Most of this assistance was provided by FHI technical experts outside Pakistan.

The technical assistance provided the opportunity to demonstrate a formal response to HIV disease-prevention by IMPACT partner agencies. The technical assistance included an assessment of the national blood transfusion situation, followed by workshop on leadership development for safe blood transfusion and a quality assurance system for national and provincial blood transfusion managers.

Technical assistance was also provided in a workshop on STI strategy and protocol development for national and provincial programs, and in the development of a strategic paper relating to HIV interventions in Pakistan. In addition, IMPACT was invited to join a team to review the situation of HIV in IDU populations and recommend immediate and long-term intervention for control of HIV.

Capacity Building

IMPACT planned a series of capacity building activities for both the Government of Pakistan and local NGOs to implement HIV-prevention interventions among target groups. The project also established a grants program for eight NGOs in two provinces.

The key thrust of the IMPACT program has been supporting the capacity building of partner organizations and the implementation of targeted interventions in Pakistan. Over the life of the program, The IMPACT program organized workshops for IAs on SBC strategies and interventions, project design, M&E, management of targeted interventions, competency-based SBC for ORWs and PEs, pre-testing of SBC materials, integration and management of STI services, SBC for STIs, and financial management.

IMPACT supported NACP attendance at and participation in a workshop on behavioral surveillance and the participation of three government provincial staff at the XV International AIDS Conference in Bangkok in 2004. That year, IAs had an opportunity to observe and learn from HIV prevention and treatment interventions during two study tours of IMPACT programs in Bangladesh and Indonesia. IMPACT further supported NACP participation in the AIDS Conference held in Kobe, Japan, in 2005. In addition, IMPACT/Pakistan's director participated in country directors' meetings and global management meetings organized by FHI.

Monitoring and Evaluation

One weakness within the country program was the lack of an effective M&E system to track program implementation. With technical assistance from FHI's Asia and Pacific Department, IMPACT/Pakistan developed an M&E framework and tools. Implementing partners received training in M&E, and reporting tools (appendix F) were designed and implemented for process-monitoring at various levels of project management. Relevant global spreadsheet indicators relating to home-based care were published in *Training for Positive Living*, a manual developed in the local language to build PLHA capacity, and these indicators were accordingly reported by IAs.

IEC Materials and Products

IMPACT developed policy and protocols for material development and produced various materials and publications.

IMPACT/Pakistan homepage: With support from FHI Arlington, IMPACT developed an IMPACT/Pakistan homepage at the beginning of program implementation. The homepage details the last two years of IMPACT operations and features its quarterly reports.¹⁶

SBC and peer education toolkit: IMPACT developed targeted communication materials for improving HIV/STI understanding by MARP. The materials were designed as a SBC kit, and developed exclusively for interpersonal communication with at-risk populations. The toolkit was used successfully by IAs, ORWs, and PEs for HIV/STI prevention and care programs at nine field sites in six cities. It aimed to communicate complex and sensitive HIV/STI messages for predominantly illiterate audiences in simple, entertaining, and understandable ways, using interpersonal communication and small group settings in the field. The kit contained seven types of material, including a training manual designed for use by ORWs and PEs.

Baseline evaluation survey: A baseline evaluation survey was developed as a sequel to consultative meetings with USAID/Pakistan on SO7's Performance Monitoring Plan-Performance Indicator Reference (PMP-PIR) Sheet. After preparing the research design and questionnaire, with technical assistance from FHI's Asia and Pacific Department, IMPACT awarded a contract to RAASTA Development Consultants in January 2005 for execution. The results of the survey (see attachments) provided baseline data for the PMP-PIR sheet.

Publication of case studies: With its PLHA partner, IMPACT developed and published seven case studies, *Voices of People Living with HIV/AIDS* (see attachments), to bring PLHA into public view, improve advocacy, and reduce the stigma and discrimination that they face.

Urdu-language publications on SBC: IMPACT adapted and published "How to Design an Effective Communication Project" and "Assessment and Monitoring of Strategic Behavioral Interventions" in the national Urdu language. The adapted versions made a meaningful contribution toward improved understanding on HIV program design and monitoring for NGOs and CSOs.

One-page flyer: IMPACT produced a flyer on its operations in Pakistan that provided a summary of the two-year performance of the SBC and care projects.

Program Results

Program and Service Outputs

Prevention: Ongoing capacity building in prevention for IAs has focused on enhancing interpersonal communication for delivery of HIV and STI services, designing activities around a behavior-change model to promote and support adoption of safe practices, and increasing access to STI services for MARP. The SBC program has reached almost 120,000 beneficiaries. Among them were almost 27,000 in-school youth, who were informed about lifeskills, abstinence, and faithfulness. This increased outreach has been possible through the work of 60 ORWs and more than 1,000 trained PEs. SBC tools, including puppet and theater shows, were used for edutainment.

¹⁶ <http://www.fhi.org/en/hivaids/country/pakistan/index.htm>

Peer education toolkit: IMPACT spearheaded development of a peer education toolkit for field staff that communicates complex and sensitive HIV/STI messages in simple ways.

Care and support: IMPACT's home-based care program has reached 276 HIV-affected family members and 72 PLHA from all over Pakistan. Responding to a recent, concentrated HIV epidemic in Sindh province, IMPACT expanded its home-based care operations to Karachi. IMPACT also spearheaded two national consultative workshops on PLHA, in collaboration with UNAIDS, NACP, PACPs, Catholic Relief Services, and PLHA organizations. In addition, *Voices of People Living with HIV/AIDS*, published by IMPACT and its partner PLHA organization, has been a meaningful vehicle toward reducing stigma and discrimination.

STI counseling and treatment: IMPACT recently started providing community-based STI services to MARP. Trained medical staff provided syndromic STI management for 340 clients as well as counseling to more than 1,400. Female medical assistants were hired to meet the cultural needs of female clients from the target areas.

Technical assistance: IMPACT provided technical assistance to NACP with an assessment of the national blood transfusion situation, followed by a workshop on the development of safe blood transfusion and quality assurance systems for national and provincial blood transfusion managers. IMPACT also held a workshop on STI strategy and protocol development for national and provincial programs and developed a strategic paper for USAID to inform HIV interventions in Pakistan.

Capacity building for partner organizations: Based on the capacity building needs of partner organizations, IMPACT organized a series of workshops for IAs on SBC strategies and interventions, project design, M&E, management of targeted interventions, competency-based SBC for ORWs and PEs, pretesting of SBC material, integration and management of STI services, SBC for STIs, and financial management.

Capacity Building Workshops During the Life of the Project

| Workshop Title | Dates | Audience | Technical support | # of people trained |
|--|-----------------------------|--|---|---------------------|
| Project designing and proposal writing, SBC | Feb. 17–21, 2004 | Project management team | Local staff/consultant | 14 |
| HIV/AIDS SBC strategies and developing an action plan | May 4–8, 2004 | Project management team | FHI SBC specialist/local staff | 14 |
| Leadership development on process monitoring and quality assurance | June 21–23, 2004 | Project management and monitoring staff | FHI M&E specialist/local staff | 7 |
| Leadership development on process management | Aug. 2–6, 2004 | Project managers and coordinators | FHI SBC specialist/local staff | 19 |
| Competency-based SBC for ORWs and PEs | Nov. 23–26, 2004 | PE supervisors, ORWs, and PEs | FHI SBC specialist/local staff | 40 |
| Leadership development on integrating the STI service delivery component | March 15–18, 2005 | STI management staff | FHI SBC and Management Services for Health specialist/local staff | 08 |
| Progress review meeting | Jan. 17–18, 2005 | IAs management staff | IMPACT local staff | 22 |
| PLHA consultative meeting, 1 | Aug. 7, 2004 | UNAIDS, NACP, PACP, PLHA, NGOs | IMPACT/UNAIDS Pakistan | 16 |
| PLHA consultative meeting, 2 | Feb. 3, 2005 | UNAIDS, NACP, PACP, PLHA, NGOs | IMPACT/UNAIDS Pakistan | 28 |
| Development on safe blood transfusion and quality assurance systems in Pakistan: how to design and implement a sustainable quality blood supply system | Feb. 17–18, 2005 | Managers of national and provincial blood transfusion services, NGOs | NACP, FHI local staff | 34 |
| Consultative workshop to develop national STI strategy for prevention and control of STIs in Pakistan | March 29–30, 2005 | NACP, PACP, NGOs | IMPACT/Egypt and local staff | 28 |
| Training workshop on clinical management and SBC for STIs | Aug. 31, 2005–Sept. 1, 2005 | IA clinical staff and PE supervisors | IMPACT local staff | 16 |
| Pretesting of SBC materials | Oct. 7–9, 2004 | PE supervisors, PEs, and ORWs | Arjumand and Associates | 20 |

Baseline evaluation survey: IMPACT's baseline evaluation survey in early 2005 assessed the knowledge and behaviors of MARP in Multan, Larkana, and Rawalpindi. The study carried out by RAASTA Development Consultants (Karachi), described sexual behaviors among male sex workers (MSWs), Hijras, and FSWs in targeted sites and measured the frequency of risk behaviors among these subpopulations. The study also obtained baseline behavioral indicators for monitoring and evaluating IMPACT-supported interventions in the three cities.

Program Outcomes

MARP-focused Activities and Results

Reaching MARP, especially FSWs, MSWs, Hijras, and non-commercial MSM, is a complex and strategic issue in Pakistan. Until recently, no consistent mapping studies have estimated the size and locations of MARP. After discussions with the NACP and USAID—and to minimize duplication of effort—IMPACT identified strategic cities for interventions.

The experience of observing vulnerable communities and potential sites in Pakistan suggests that most MARP subgroups live in close proximity to each other, except for non-commercial MSM. It is not easy to address only one MARP subgroup. Rather, the need is to address HIV/STI in the demographic context of the special situation and location in which MARP find themselves. Thus, one of the implementation strategies was to address all subgroups associated with a specific target population. For example, an intervention for truckers at a terminal required addressing associated populations, such as FSWs, MSWs, Hijras, and migrants. The small grants also limited the scope of interventions to one or two sites in a city, which also limited coverage.

While initiating a grants program, IMPACT invited selected NGOs to a series of workshops on project-proposal planning and development. The first activity began with an assessment and the development of a plan for implementation with MARP. IMPACT requested specific information from potential partners on the subtypes of MARP—their behaviors, population sizes, and an inventory of secondary populations affecting the primary populations' ability to access SBC and interventions (e.g., those who would influence MARP, such as workshop owners or employers of drivers).

Program Activities and Results for MARP

| # | Measurable Indicators | # |
|-----------|---|--------|
| 1 | Individuals reached through peer education programs and community outreach | |
| | FSWs | 1,376 |
| | MSM (including commercial and non-commercial MSM) | 15,009 |
| | Hijras | 2,646 |
| | Mechanics/workers (potential clients of sex workers) | 12,153 |
| | Truckers | 9,999 |
| | Migrants | 1,794 |
| | Street youth | 3,556 |
| | IDUs | 418 |
| | General population | 496 |
| 2 | Individuals reached through advocacy activities | |
| | Religious leaders | 1,396 |
| | Media staff | 47 |
| | NGO/CSO representatives | 792 |
| 3 | # of contacts made one-on-one by peer education | 40,774 |
| 4 | # of condoms distributed through the intervention | 31,276 |
| 5 | # of IEC distributed through the intervention | 85,005 |
| 6 | # of events conducted through the intervention | 819 |
| 7 | # of assessments conducted | 8 |
| 8 | # of STI clinics | 4 |
| 9 | # of patients treated for STI symptoms | 340 |
| 10 | # of clients counseled for STI services | 1,400 |

ASEER Activities

ASEER partnered with IMPACT to develop and implement SBC strategies and interventions for adolescents and youth from vulnerable high-risk groups in Nawan Shehar, an area of Multan in the southern Punjab. Based on anecdotal evidence, Nawan Shehar is a strategic location for prevention and care interventions. Its population has low socio-economic status, and a number of risk factors are present, including covert male-to-male sex and street youth who work at mini hotels, carpenter shops, and snooker clubs, putting them at risk of sexual exploitation and sex at an early age.

ASEER started with a project planning and assessment exercise through qualitative assessment and mapping, and communication strategies were recommended from the findings. The project began a peer education program, including recruitment and training of ORWs, and identified potential PEs from the target group. One of the strategies was to establish sports groups (such as cricket or snooker teams), since these provided PEs with good opportunities to interact with their high-risk peers. Advocacy activities included involvement of religious leaders and influential local administration officials. Later, IMPACT helped the project integrate a STI service-delivery component, and a referral system for potential clients was established through thematic peer education on STIs.

In Nawan Shehar, ASEER and IMPACT

- recruited 13 ORWs from target sub-segments
- conducted 30 training sessions for PEs and ORWs and 6 refresher courses
- selected and trained 200 PEs
- conducted six graduation ceremonies for peer educators
- trained 40 PEs in sports activities and organized four sports competition or edutainment events
- educated 10,000 peers on STI/HIV through outreach activities
- produced promotional T-shirts and caps for the ORWs and PEs
- made agreements with condom suppliers and made 10 condom outlets active
- formed five community committees (each comprising five members) and trained their members
- trained 10 local healthcare providers acceptable to the target groups to provide quality STI services
- set up STI clinic according to IMPACT guidelines and provided services to potential clients

Pakistan Lions Youth Council Activities

The Pakistan Lions Youth Council (PLYC) partnered with IMPACT to develop and implement SBC strategies and interventions for adolescent and youth from vulnerable high-risk groups at the general bus stand in Multan city. The site was strategic because a small number of MARP was concentrated at one place. They comprised truck and bus drivers and their assistants, FSWs disguised as beggar women, street youth, MSM, drug users, and Hijras covertly involved in high-risk practices.

PLYC started with a project-planning and assessment exercise that entailed qualitative assessment and mapping. Communication strategies were derived from the findings. The assessment team recommended interventions with influential local leaders and imams in the area, including establishment of a primary healthcare facility to provide routine services. Trained PEs provided one-to-one and group education to MARP in the area. Later, IMPACT helped the project integrate an STI service-delivery component and a referral system for VCT and drug rehabilitation services.

In Multan, the PLYC and IMPACT

- held meetings with community and religious leaders, forwarding agents, and healthcare providers
- maintained relationships with 50 local stakeholders over the LOP
- provided two four-day trainings and five refreshers for ORWs
- conducted 10 PE trainings and identified and trained 200 PEs, including training on appropriate use of condoms
- established one resource center
- produced one brochure
- produced and distributed promotional items, which included water coolers, wall clocks, ID bags, T-shirts, caps, or key chains
- signed an MOU for provision of condoms with Greenstar Social Marketing

- Ten condom outlets were established to ensure visibility and availability.
- Set up one STI clinic according to IMPACT guidelines and provided services to potential clients
- developed a referral card and STI recording sheet with local healthcare providers

Organization for Social Development Activities

At the busy bus terminal in Rawalpindi are many homeless children who are highly vulnerable to sexual exploitation. IMPACT implemented a program for supporting street children, designing interventions to reduce their social vulnerability, providing health services for common ailments, and assisting reintegration with their families. The program provided training on desired lifeskills for the children, along with social services to improve their environment. To this end, the Organization for Social Development (OSD), an IMPACT local partner, provided the children with personal hygiene kits with toothbrushes, toothpaste, soap, anti-lice shampoo, and combs. OSD also provided them with seasonal clothing, boots, and sleepers. In the project area to date, OSD has distributed 336 kits to street children, along with fortnightly hair-cutting services. The program further integrated SBC and interventions for other MARP, including FSWs, MSWs, and Hijras.

The project performed an informal assessment and planning exercise to quantify the numbers of MARP and ascertain their behaviors and risk factors toward contracting STIs, including HIV. Peer education was the main strategy; the project also mobilized local stakeholders to help develop an enabling environment, with the involvement of police and local unions.

In Rawalpindi, OSD and IMPACT

- developed and adapted a basic five-day curriculum to meet needs of different groups
- implemented the training program for peer education
- trained 13 field and technical staff members and 13 ORWs
- conducted 30 peer outreach trainings for ORWs
- conducted six refresher courses for outreach workers
- established a drop-in center
- conducted eight graduation ceremonies
- conducted nine meetings with stakeholders to increase sensitization on the issue of vulnerable, homeless children
- set up one STI clinic according to IMPACT guidelines and provided STI services
- produced promotional T-shirts and caps for ORWs and PEs
- conducted nine special events, including World AIDS Day commemoration and advocacy events
- reached at least 450 street youths through incentive schemes.
- helped reunite 15 runaway children with their families
- signed one MOU for providing condoms and activated 10 condom outlets
- commemorated World AIDS Day

PAVHNA and Mehran Welfare Trust Activities

IMPACT identified PAVHNA and Mehran Welfare Trust as the two NGOs to implement SBC for MARP in Larkana, Sindh province. The city is strategic for this purpose, as it harbors many risk factors, along with recent incidence of a concentrated HIV epidemic among IDUs. Target

populations included MSM, Hijras, brothel-based FSWs, and associated populations, as well as high-risk occupations, such as bus and truck drivers, special rickshaw drivers, and street youth.

The project conducted an informal assessment and planning exercise to quantify members of various MARP and discover their behavior and risk factors for contracting STIs, including HIV. Peer education was the main strategy, and the project mobilized local area stakeholders who helped create an enabling environment.

In Larkana, IMPACT and the two NGOs

- held 15 meetings with local stakeholders to seek their support for the SBC interventions
- conducted a five-day training workshop with stakeholders and partner organizations
- recruited 13 ORWs from target populations and trained them in peer education, each of whom identified 10–15 peers per month and recruited them for training
- identified 50 PEs (who will be gradually selected over time)
- conducted two four-day trainings for 50 PEs on SBC interventions
- conducted three refresher trainings for ORWs and PEs
- facilitated weekly meetings of ORWs and PEs that discussed issues and support needs and developed records or reports of activities, progress, and problems.
- supported supervisory meetings with ORWs to mentor and monitor peer education and outreach activities
- conducted edutainment activities, including theater, group meetings with MARP, and a rickshaw race
- set up one STI clinic according to IMPACT guidelines and provided services.
- established drop-in centers at two sites

PLHA-focused Activities and Results

Anecdotally, many ordinary Pakistanis seem to feel that HIV infection is a curse from Allah (God) and thus judge PLHA negatively. Stigma has increased because of poor reporting in the media and the behavior of some healthcare providers, who isolated PLHA and breached confidentiality. HIV-positive people have sometimes been shunned by their family members. The scarcity of HIV counseling, testing, and treatment has further marginalized PLHA in Pakistan. The National Strategic Framework offers guidelines on care and support, but unfortunately does not provide adequate financial support for such interventions and services.

Realizing the need to address care and support as an integral component of HIV programming, IMPACT designed a small-scale, modified response.

PLHA-focused Program Activities and Results

| Provide care to PLHA and their families through psychosocial/medical support in four cities | | | |
|--|-------------------|-------------------|----------|
| Name of activity | # training | # trainees | # |
| Training of field workers on home-based care | 4 | 10 | |
| Trainings for positive living | 5 | 50 | |
| Identification of new PLHA (those not previously known) | | | 10 |
| Publication and dissemination of <i>Voices of People Living with HIV/AIDS</i> | | | 7,000 |
| Trainings for religious people | 10 | 90 | |
| Trainings for street doctors | 3 | 30 | |
| Trainings for traditional healthcare providers | 3 | 30 | |
| Social gathering for PLHA and affected families | 20 | 276 | |
| Social gathering for HIV-affected families | | | 276 |
| # of PLHA served/reached | | | 78 |
| # of clients who received antiretroviral therapy (self-supported) | | | 50 |
| # of clients who received HIV clinical care | | | 50 |
| # of healthcare providers | | | 127 |
| # of religious leaders (pastors and imams) | | | 400 |

In-school, Youth-focused Activities and Results

The youth subprojects were implemented in Multan city by two NGOs—the Advancement of Community Health, Education, and Training (SACHET) and Community Support Concern (CSC).

The program reached 50 public and private schools in Multan and Islamabad and informed 27,000 students ages 13–25 about basic lifeskills and the ABC approach to abstinence and faithfulness. The key roles played by school management, teachers, and parents reflected IMPACT’s growing realization of the need for education about basic lifeskills as well as HIV prevention. The program started a quarterly newsletter and electronic magazine (e-zine) to inform a larger youth network about its interventions. It also organized youth advocacy networks of proactive young leaders who organized activities in their schools, including funfairs, art and sports competitions, summer camps, and peer education.

In-school Youth Program Activities and Results

| Activity | # meetings | # trainings | # trainees | # activities |
|---|-------------------|--------------------|-------------------|---------------------|
| Obtain support of heads of partner educational institutions for HIV interventions in their institutions | 50 | | | |
| Draft recommendations on HIV for national youth policy | | 2 | | |
| Form youth advocacy networks at partner institutions | 50 | | 250 | |
| Involve media professionals in the dissemination of information on HIV | 4 | 4 | 50 | |
| Train master trainers to become HIV educators | | 4 | 8 | |
| Provide training to young PEs | | | 5,000 | |
| Train teachers and students counselors on HIV | | 4 | 60 | |
| Train leaders of youth advocacy networks on HIV through edutainment (theater performances) | 4 | 3 | 50 | |
| Organize extracurricular activities at educational institutions | 50 | | | |
| Promote student creativity through publications | | | | 4 |
| Develop a knowledge-based system for field data to generate reports and learn from findings | | | | 1 |
| Other indicators | # reached | | | |
| In-school youth reached through peer education | 27,000 | | | |
| Parents reached | 1,583 | | | |
| Teachers reached | 1,127 | | | |
| Policymakers reached | 27 | | | |

LESSONS LEARNED AND RECOMMENDATIONS

The IMPACT Project in Pakistan gained many insights into comprehensive HIV programming and made significant contributions to the country's national response, despite operating in an environment of massive collateral funding from the World Bank, the UK Department for International Development, and the European Union.

The National Strategic Framework provides further guidelines and opportunities for the international community to invest in HIV prevention and care strategically. One of the most important elements of a successful intervention is ongoing coordination and collaboration with the now enhanced HIV-control program efforts. Peer education and home-based care are effective tools for strategic behavior communication activities, as are training and capacity building efforts.

Overall Program Management

Improving networking and collaboration with development partners: Efforts are needed toward improved networking with other development partners and collaborating on the mobilization of resources so as to strengthen the comprehensive response to HIV prevention and care.

Developing program-oriented monitoring tools at the outset: It seems imperative to develop project-oriented, process-monitoring tools at the outset of program implementation. The participatory planning process of an early workshop helped get partners to buy into reporting requirements and the development of appropriate tools for effective implementation.

Improving service quality, affordability, and uptake: Quality assurance mechanisms should be institutionalized, including clinical review meetings, counselors' meetings, monitoring of adherence, and client exit interviews.. Linkages between implementing agencies and PLHA groups, as well as with NACP-Global Fund-supported VCT and antiretroviral treatment centers, should be actively pursued to improve care of PLHA and the quality of community-based follow-up services. The mix of staff skills can be improved by involving sociologists, psychologists, religious leaders, and public health practitioners.

MARP-focused Interventions

Starting interventions early: Sex work is illegal and highly stigmatized in Pakistan, and it takes time to gain the trust of sex workers. Once that trust is achieved, sex workers can become very active in prevention programs. STI and VCT services may thus have slow initial uptake among stigmatized populations and take a long time to achieve full patronage.

Gaining access to MARP: It is often difficult to initiate and maintain access to sex workers. Periodic police harassment and the closure of brothels where some sex work takes place contribute to the difficulty in maintaining contact. To overcome these barriers, community ORWs often had to work late at night.

Using peer education to reach MSM: PEs are particularly skilled at reaching hard-to-reach MSM populations because they are trusted and know where their counterparts operate. That trust is particularly important in overcoming competitiveness among MSM, which can make it difficult to bring them together for peer education activities. Peer education sessions also helped make the program widely known to the target group.

Promoting condoms: To maximize condom promotion and sales among sex workers, program implementers should make condoms and lubricating gels available, accessible, and affordable. Issues such as condom availability, training for correct usage, and distribution recordkeeping are very important components of sex worker interventions.

Benefiting from partnerships: All partners felt that collaboration with other agencies (such as social marketing agencies) ensured wider availability of condoms in the target areas. Moreover, quarterly review meetings among partners and NACP and PACPs offered invaluable opportunities to learn from each other's field experiences and to share challenges.

Using puppet shows and theater as educational tools: Puppet shows and theater proved to be powerful tools that furthered HIV education with MARP.

Preparing promotional and educational materials: PEs need to be equipped with ample SBC materials. IMPACT developed a peer education toolkit for one-to-one and group education. More targeted material should be developed that takes account of the distinct needs of subgroups within MARP, a heterogeneous grouping.

Choosing and training PEs: The criteria for selecting PEs include good communication skills, competence, desire to do the work, and positive attitudes about HIV-related issues. Some involved in the program feel that training for PEs should offer multiple refresher courses. Sessions on stigma reduction should be included.

PLHA-focused Interventions

Advocating through PLHA case studies: Published PLHA case studies have proved to be one of the most important tools in promoting greater voice for PLHA. IMPACT used this approach with its partner, New Lights AIDS Control Society, and seven members of the society consented to offer insights about themselves. The resulting publication, *Voices of People Living with HIV/AIDS*, provided wide exposure and acknowledgement of their issues.

Holding consultative meetings at national levels: Dialogues on PLHA, in collaboration with national and international PLHA organizations, were also used by IMPACT as an instrument to de-stigmatize HIV. Such meetings, held at the outset of the project, yielded good support from stakeholders.

Building strong management: Active program management committees have proved invaluable for implementing well-managed HIV prevention and clinical care programs. It has been observed that PLHA programs should have a strong management team and structure, which allow for innovation, quality assurance, and leadership.

Ensuring service quality and increasing uptake: Some of the critical factors for a successful HIV clinical-care program are availability of antiretroviral drugs, the provision of services at affordable costs, dedicated and well-trained staff, a well-functioning laboratory, a good referral system, an effective quality assurance system, and good leadership. Quality assurance mechanisms, including clinical review meetings, counselors' meetings, monitoring of adherence, and client exit interviews, should be implemented. In addition to antiretroviral therapy services, the management of opportunistic infections effectively reduces HIV-related morbidity and

improves quality of life for PLHA. All these services should be accessible and promoted through VCT services and mass media.

Providing occupational training and entrepreneurship development: A sustained response to positive living requires PLHA to be trained and provided with opportunities for economic activities, based on their previous experience and skills. There is a need to establish and strengthen coordination with other development partners engaged in such activities.

Enlarging home-based care services: Home-based care services should serve to establish PLHA groups, based on the geographic distribution of PLHA within or among different cities. Other supporting factors such as provision of nutritional supplements for those in need should be ensured.

Youth-focused Interventions

Getting early approval and buy-in from the Ministry of Education and local educational agencies, teachers, and parents: For youth-centered activities, it has been found essential to seek approval from the Ministry of Education and relevant local school authorities before the program starts. This approval helped secure early support, cooperation, and involvement of educators and administrators. Additionally, sensitizing teachers, parents, and students before programs begin ensures their sustained interest in reproductive health and HIV-related activities.

Enlisting teachers to lead activities: Teachers in training workshops showed enthusiastic interest in establishing a health council, while using tutorials for education on pertinent health issues, including HIV.

Helping youth understand HIV issues by exposing them to PLHA: Implementing agencies found that young people learn better when they can see firsthand what they're learning about—in this case, the reality of HIV disease. Interactive sessions and interviews with PLHA made a strong impression on the youth and helped draw them in to the program's activities. Additionally, young people enjoyed activities such as school quiz competitions, summer camps, and contributions in the e-zine and quarterly newsletter, which proved successful in sustaining their interest.

HIGHLIGHTS OF IMPLEMENTING PARTNER ACTIVITIES

Implementing Partner Matrix

Subagreements and contracts: IMPACT, Award Number HRN-A-00-97-00017-00

| ORG. TYPE | ORG. NAME | LOCATION | TARGET POPULATION | LOP BUDGET (US\$) | ACTIVITY | PROJECT DATES |
|----------------------|-------------------------|-------------------------------------|-------------------|-------------------|------------------------|---------------|
| Subagreements | | | | | | |
| NGO | ASEER | Multan | MARP | \$80,450 | SBC/STI | 05/04–02/06 |
| NGO | CSC | Multan | In-school youth | \$65,249 | SBC | 06/04–12/05 |
| NGO | NLACS | Lahore, Rawalpindi, Multan, Karachi | PLHA | \$79,227 | Home-based care | 05/04–02/06 |
| NGO | OSD | Rawalpindi | MARP | \$92,059 | SBC/STI | 04/04–02/06 |
| NGO | PAVHNA/MWT | Larkana | MARP | \$86,732 | SBC/STI | 06/04–02/06 |
| NGO | PLYC | Multan | MARP | \$81,377 | SBC/STI | 04/04–12/05 |
| NGO | SACHET | Islamabad, Rawalpindi | In-school youth | \$65,876 | SBC | 06/04–12/05 |
| Contracts | | | | | | |
| Consultancy firm | Arjumand and Associates | Islamabad | MARP | \$27,586 | Peer education toolkit | 08/04–11/04 |
| Consultancy firm | RAASTA | Karachi | MARP | \$45,969 | Baseline survey | 02/05–05/05 |

ATTACHMENTS

Country Program Financial Summary

| IMPACT Obligation Amount By Year (US\$) | |
|--|--------------------|
| FY 2002 | \$200,000 |
| FY 2003 | \$300,000 |
| FY 2004 | \$900,000 |
| FY 2005 | \$660,000 |
| Total | \$2,060,000 |

Process-monitoring and Reporting Tools for M&E

M&E Tools for SBC Programs

Activity Performance Report—Field-based Reporting

Monthly Report Format for Master Trainers

Monthly Report Format for Counselors

Monthly Report Format for Project Coordinator

ORW/PE Monthly Report

ORW/PE Weekly Diary

Implementing Agency's Quarterly Report

M&E Tools for STI Programs

Male Health Record Form for STI Physician

Female Health Record Form for STI Physician and Female Medical Attendant

Monthly and Quarterly Clinical Record Formats for STI Physician

Condom Distribution Record Form for STI Physician/Counselor

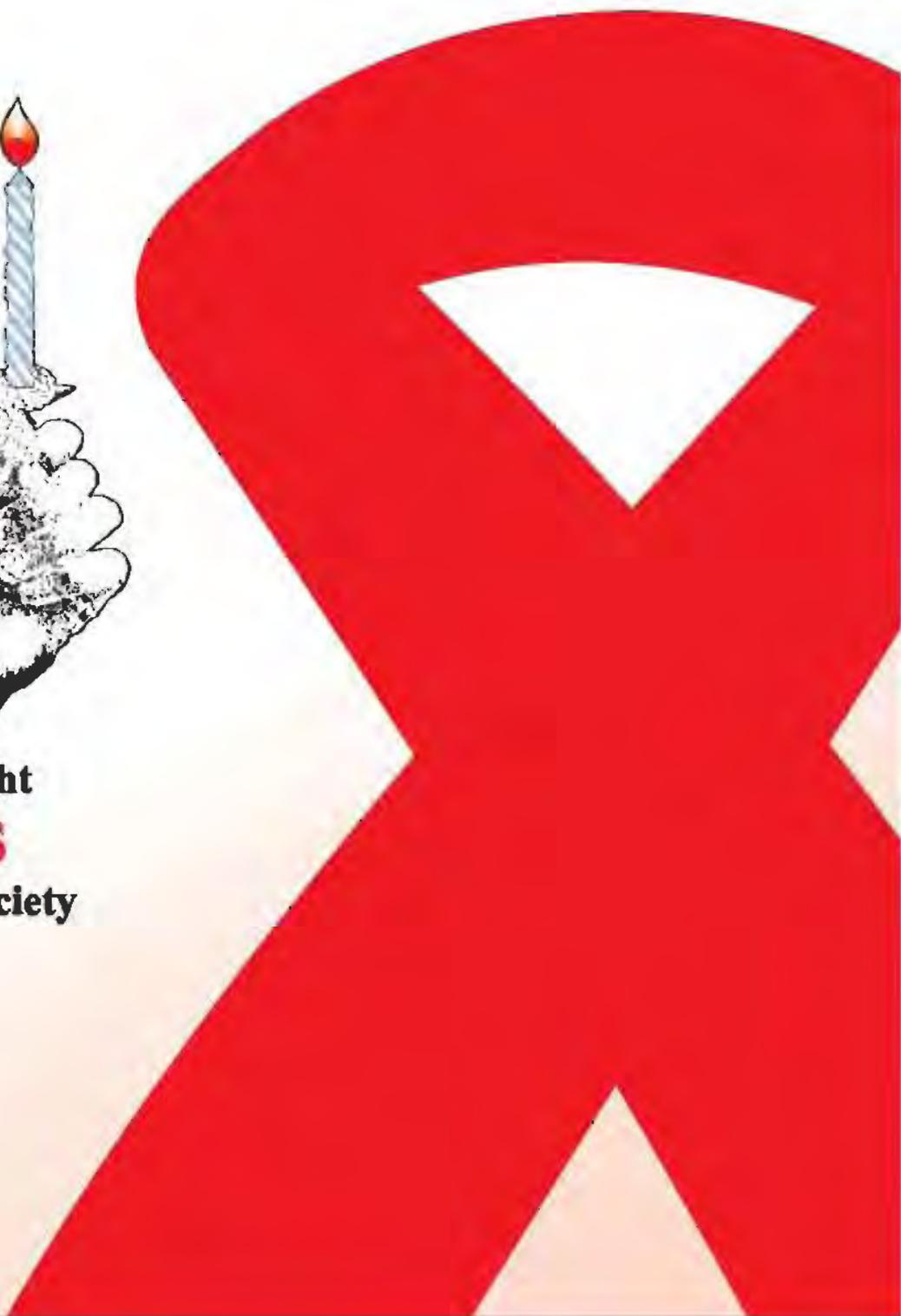
Client Referral Card for ORW/PE

Financial Flow Format

Voices of People Living With **HIV/AIDS**



New Light
AIDS
Control Society



Acknowledgement

We are very thankful to all those who contributed to complete these case studies (Voices of People Living With HIV/AIDS) successfully. Especially mentioning USAID, NACP, PACP, Drs. Naseer Muhammad Nizamani and Muhammad Tariq of Family Health International; their guidance helped to accomplish our task.

Mr. Nazir Masih, whose tireless effort and dedication for work, (which is a role model for all of us) made it possible to finish the work well in time. Staff members, Mr. Asher, Mr. Samuel Nazir, Ms. Kiran, Mr. Robin, Mr. Michael, Mr. Mohammad Asim, Mr. Shehzad, Ms. Mahreen and Dr. Syed Abdul Rasheed of New Light; they all worked hard to achieve the target.

Dr. Saeed-ur-Rahman, the Project Consultant responsible for preparing Training Manuals and these Case Studies. Special thanks to all those members who courageously and boldly expressed their views and allowed us to print their stories.



Voices of People Living With HIV/AIDS

"All of you sit on the floor. Do not dare to sit on the seats", scolded the ambulance driver, to the handcuffed family of Nazir Masih, while taking them to health department for mandatory testing for HIV. The government ambulance and the police came with screaming sirens and screeching brakes to the front door of Nazir's house. The whole street shook up. The year was 1992. It marked the beginning of a long nightmare. "Despite having been deported from UAE in 1990 because of my HIV status, and worrying everyday about what will happen to my family after I am no more, that was the worst day of my life", recalls Nazir. Humiliated and overwhelmed by the guilt of dragging his family into this situation, he felt helpless as a father who could not reassure his children huddled together on the floor of the ambulance, looking at him for answers.

Living in a house arrest of sorts, Nazir welcomed into his home four months later, two gentlemen from a national newspaper posing as government health officers. The family was interviewed, photographed and the next morning, papers all across the country carried the news and information on the whereabouts of Nazir and his family. The whole world knew what Nazir had been desperately trying to keep to his family, until that day.

Then in the same year, he met Professor Dr. Rasheed, an angel in disguise, handling HIV testing at the Institute of Public Health, Lahore. He was very supportive and friendly to Nazir.

Angel and Phoenix





Voices of People Living With HIV/AIDS

One day he said, "Nazir, you should declare your HIV status to the public. The cat is already out of the bag, by daring to reveal yourself you will conquer your own fears." That is what Nazir did. He was the first one in Pakistan to openly declare his HIV status. He felt he was a free man. A heavy load was off his shoulders. "Now you have to help other 'positive' people", said Dr. Rasheed plainly, putting the burden back on Nazir. "What? I cannot write and I can barely read," replied the bewildered Nazir, "All I know is how to fix broken down bicycles, so that people can ride again". Professor Rasheed smiled back, "Exactly".

In March 1999, New Light AIDS Control Society had a humble beginning in a bicycle repair shop. Slowly but surely people living with HIV started flocking to this little cycle workshop, for 'repairs'. Nazir's family backed him up wholeheartedly. Caring for PLWHA was a family business. 'Customers' shed their pains, shared their problems and got love in exchange. Nazir and his family faced and braced all kinds of attitudes from healthcare authorities, professionals, media and society, yet they remained steadfast in their mission. International NGOs noticed New Light's efforts and assisted with funds and guidance. Nazir represented PLWHA of Pakistan in several international conferences. He became the voice of the marginalized. Today, New Light has five satellite offices all over Pakistan, aiding people living with the HIV disease. New Light continues to struggle to get ARV medicines from across the border while it tries to ensure care without prejudice in the home country. New Light has restored dignity and self-esteem of the 'positive' people, inspiring them to become advocates for their own rights.

"We must speak out. There are thousands of 'positive' people out there walking among us, with their hearts in self-imposed exile. We have to make them feel at home again. We have to end this deportation of souls", says Nazir passionately.

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Voices of People Living With HIV/AIDS

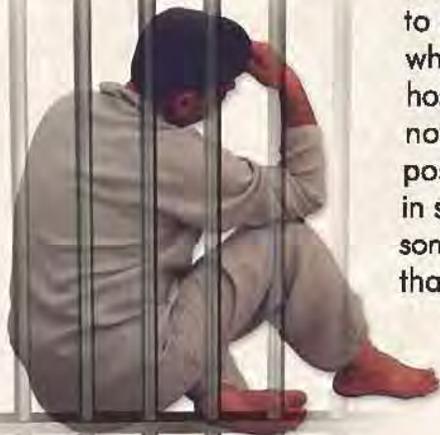
CHAINS

"They put me in shackles at the hospital. Those chains left marks on my ankles and my soul", says Qamar emotionally, when he talks about his last four days in Kuwait. A hardworking family man, Qamar, had been toiling in Kuwait for the last fifteen years. After many years of doing odd jobs for others, he finally started a business of his own last year; a computer repair shop in partnership with a friend. Life was in a groove and things were looking upbeat. Qamar used to have some difference of opinion with his partner from time to time. One day these differences escalated into a quarrel and they ended up in jail. If one knows Qamar one can tell that he is a mild mannered person, who does have the courage to stand up for his rights. In detention, the authorities took routine blood samples and then Qamar was released. He settled his differences with his partner and it was business as usual.

A week later Qamar received a call from the local hospital telling him that his blood samples from jail have gone missing and he needs to visit the hospital for a redraw. Unaware of what lay ahead, Qamar went to the hospital. To his shock and disbelief he was immediately arrested, handcuffed and later bound in shackles to a hospital bed, incarcerated in a separate room. "It was a very humiliating experience", remembers Qamar. Not knowing why it was happening to him, he got frustrated and argumentative with the hospital staff.

It was later explained to him that his tests came back positive for HIV and he will not be allowed to stay in Kuwait, any longer. "Go back to where you came from", he was told at the hospital. Four agonizing days, bound in chains, not knowing well what it means to be HIV positive, Qamar dreaded going back home in shame, dreaded that he had to tell his wife, somehow and feared the enormity of the disease that started off by taking away his freedom.

Sent to Pakistan on a one-way ticket, Qamar was not welcome in Kuwait anymore, his home away from home, where he had invested a lifetime.





Voices of People Living With HIV/AIDS

For the next year Qamar tried to learn about HIV and AIDS, knocked at many healthcare doors, in search of answers, help and support. His wife urged him to keep on going, but without a job and without guidance on HIV disease, pressures were mounting. Then Qamar reached New Light, a local NGO, for the people, by the people and of the people living with HIV/AIDS. Now he knows a lot about HIV. He figured out how the virus got into him. For the last 23 years Qamar has been going to barber shops for getting a close shave. New Light helped him understand the risks of exposure to HIV. "After joining New Light, my life has changed completely. My self-esteem and self-respect is restored. I know that I can lead a healthy life. I am not ashamed of my HIV status, anymore. My heart is at peace, and I feel I have been set free", Qamar explains. He says that he has learned a lot from the public speaking workshop that he attended at New Light. Qamar has helped in preparation of the declaration to abolish discrimination faced by the HIV positive expatriates in the Middle East and to establish a referral system between countries for post-deportation continuity of care. "I am free from the chains that bound me. I intend to help other positive people break their chains, to declare their status and have a taste of freedom. Freedom from the shackles of discrimination, fear, prejudice and ignorance."



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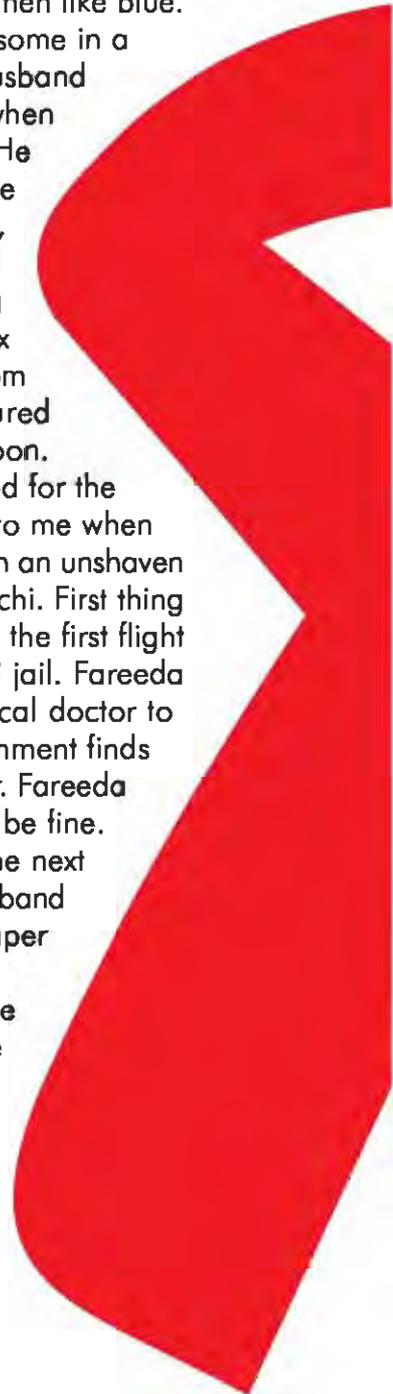
Voices of People Living With HIV/AIDS

RED

"Do you know any man, who loves wearing a red shirt? Most men like blue. I knew such a man. He was my husband and he looked handsome in a red shirt." Fareeda talks of her soul mate. Fareeda and her husband have nine children. Their baby girl was only eleven days old when her husband left for Dubai for the last time, seven years ago. He worked there as an electrician. His visit visa had expired and he was overstaying there illegally. He was getting work and earning, so it seemed okay to stay low. One day when the youngest girl was eighteen months old, he called Fareeda long distance, saying that he was sick and his fever was not going away. Then six months later, almost five years ago, Fareeda received a call from her husband's friend, who said that the police had captured her husband and he is in jail, but not to worry, he will be out soon.

"My husband had many friends, he was full of life, and he lived for the moment. He was a kid with kids and gave his heart and soul to me when he was with me", Fareeda blushes. He was still in jail clothes, with an unshaven face and burning with a fever of 104F, when deported to Karachi. First thing he did was to call her when he got back to Pakistan. She took the first flight to Karachi. He told her, he had AIDS. He was tested in Dubai jail. Fareeda and her husband returned to their hometown and asked a local doctor to make a house call. "Think of yourself as a widow. If the government finds out they would give him a poison injection", warned the doctor. Fareeda lied to her husband saying that the doctor said that he would be fine. "We both cried separately in private", remembers Fareeda. The next day that doctor announced in a national newspaper, that her husband has brought AIDS to the city and gave their address in the paper as well.

Everyone knew now. His brothers and sisters left him, and the neighbors shunned them. But there was a blessing in disguise with that news because positive people of New Light also read the paper and contacted the family, offering help. For the rest of his life, New Light supported the family. They brought ARV medicines and helped with many hospitalizations of her husband. "New Light is now my extended family", says Fareeda passionately.





Voices of People Living With HIV/AIDS

"I never asked my husband how he got infected. I pray for his soul. We slept on the same bed, right till his end." Fareeda sighs looking up in the distance. It was her husband's desire to see his eldest daughter in a bridal dress. Fareeda's sister secretly gave jewelry and money for the wedding. With tears of joy in her eyes, Fareeda, talks about how her daughter is living like a princess, happily married to her sister's son. Her husband died peacefully in his sleep, although he was bedridden for many months. These days, her daughter would often call long distance and ask what her mother has cooked for dinner, "I lie every time, saying we are having a lavish dinner, but she knows I am lying, so she sobs on the phone". New Light is still helping Fareeda, with food rations and school fees for her children. "When my sons grow up, I will make sure that they dedicate their lives to the cause of people living with HIV and AIDS", Fareeda says proudly. "It was New Light people who gave the last bath to my husband's body before burial, when his own brothers would not do it. I dry up my tears for my children. I live on for my children. I miss my husband a lot. I want him to be remembered by the way he lived. I love wearing the red ribbon. It reminds me of him. Red is my favorite color now."



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Voices of People Living With HIV/AIDS



"No woman should be in a situation where she is forced to sell her body to buy food for her children," says Zahida. Youngest of her siblings, she was only sixteen when her aging father decided to marry her off. Zahida's beau-to-be was a handsome young man. She agreed to the marriage, but when the wedding vows were being taken Zahida realized that she was being married off to someone else. She protested but her father strangely forced her into marrying this person, whom she later found out had some psychiatric problems. Zahida's new husband did not work. He would beat her and go away for weeks to live with his sisters. Time went by. Zahida scrounged for money by doing housekeeping and cleaning jobs. Making ends meet seemed impossible. Months turned into years and Zahida became a mother of four children.

When her in-laws joined her husband in abusing her mentally and physically, she decided that enough is enough and left for her father's place, taking her kids with her. Her father became very upset. He sent her elder two children back and tried to beat some sense into her. When she refused to go back, he threw her out with her two young ones, a toddler and a breastfeeding baby. With no place to go, Zahida wandered with her children. A taxi driver gave them refuge in his house and then helped them rent a roof over their heads. Zahida searched for work and found a cleaning job but they would not allow her to bring her children to work. She was out of work very quickly. With her children hungry and her own milk drying up, she started selling her body.

SPIRAL





Voices of People Living With HIV/AIDS

She did this for over a year and then settled down with one customer who asked her to become his mistress. He was paying her enough to get by, so she was content. Two years later this widower asked for her hand in marriage. She was in her mid-twenties and he was in his mid-fifties. She did not have to sell her body to put food on the table for her children, anymore. She was happy.

A friend from her past, who had developed symptoms of HIV disease, advised Zahida to get tested also, as she had similar symptoms. She was brought to New Light, a local NGO working for people living with HIV/AIDS. She tested positive. Zahida is very pragmatic about her illness, "I accept what I have, and I understand that I have to be careful". Her second husband is yet to be tested for HIV. After having attended the public speaking training workshop at New Light, Zahida addressed a gathering of three hundred students at a local college. She spoke on behalf of all the women who end up becoming commercial sex-workers because their families and communities have turned their backs on them.

To earn bread by selling their bodies, these women are extremely vulnerable to HIV and sexually transmitted diseases, and are less likely to seek medical advice due to fear of stigma. These shunned, ignored and marginalized women of society are prone to develop complications of stigmatizing diseases, trapped in a vicious spiral of silence, vulnerability and spreading of illnesses. "This cycle of sex-for-food can only be halted by first breaking the silence about the plight of such women," reminds Zahida.

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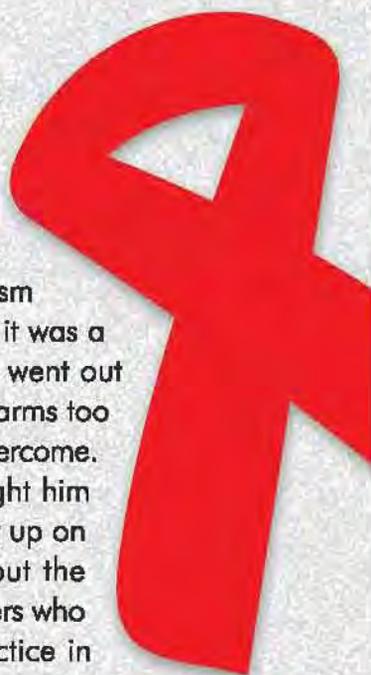


INNINGS OF LIFE

"I have been playing cricket as far back as I can remember", says Nasir, a fifty years old tailor-master. Every Sunday, Nasir would get up at dawn and play cricket with the local boys. The teenagers would let him in the team because not only was he good but he also played with vigor and enthusiasm of a youngster. Nasir recalls that three years ago, it was a beautiful sunrise and it was his turn to bat. As he went out to the pitch and took position, he suddenly felt his arms too weak to even lift the bat. A strange weakness had overcome. He did not pass out but felt dizzy. The boys brought him home. At first he thought that age had finally crept up on him. In his heart though, he was still youthful but the weakness was overwhelming. He went to local healers who gave him injections for strength, a common practice in Pakistan. These 'strength-shots' of vitamin B12 were not helping much, and Nasir was getting weaker and weaker by the day. He could not walk over to his shop and could not even pick up tailoring scissors now, let alone a cricket bat.

After hopping from doctor to doctor and a whole battery of laboratory tests in search of answers, he came to Newlight, courtesy of a friendly neighbor. Nasir was tested for HIV and it turned out positive. With prompt treatment, he soon regained his strength and gained back his weight.

"I still do not know how I got the HIV. I have always been true to my wife and my kids are all grown up. Doctors tell me that I might have gotten it from unhygienic, injection sharing practices of local quacks. I also had jaundice six years ago", says Nasir, still trying to grapple





Voices of People Living With HIV/AIDS

with the mystery of how he got infected. He had heard little about AIDS before he tested positive for HIV. On hearing that HIV is the germ that causes AIDS, he was in disbelief and became extremely depressed. "I thought it was a death sentence", remembers Nasir.

Being a diabetic he was very careful about his diet and played cricket for exercise with religious passion. These days Nasir teaches other positive people at Newlight, on how they can protect themselves from opportunistic infections, by taking a few hygienic precautions in everyday life. "One should be meticulous in caring for one's body, just as a tailor master is very careful when cutting out a suit from a piece of cloth", advises Nasir. He has very quickly become an eloquent advocate for people living with HIV disease. He speaks with youthful enthusiasm, "You must start at home, taking your family into confidence. Once you have your family on your side, then you can tell anyone about your HIV status".

Nasir believes that prejudice against the PLWHA can be reduced in our society by spreading the word on HIV disease. "Cricket is no different from the game of life. Cricket is a team game and I intend to play a long innings of solid defense for my PLWHA team", says a defiant Nasir, who can be seen playing cricket on Sunday mornings in the park near his home. You can be on his team, if you get up early.



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Voices of People Living With HIV/AIDS

Love & Faith

"God and Love of family gets me through", Shahida's eyes tell it all. The rough storms that she has endured in her life can be seen in her eyes. She talks about her two years old daughter with a twinkle in her eye and a smile that expresses nothing but a mother's pure love, brimming with hope. "They said I would live for a year. Look at me. I am still alive. I trust in God and I know God is on my side", Shahida expresses her faith.

Almost a decade ago, Shahida got married to a decorated Pakistani soldier in the UN peacekeeping force, returning from war zones of Somalia. Little did she know that her husband had the AIDS virus in his body when she married him. In no more than nine months, Shahida gave birth to a beautiful baby girl but the newborn could not thrive beyond infancy. By this time her husband had left the military service and was staying sick off and on. Shahida was expecting again. She became a mother to a healthy, cute baby boy. She made sure that her son grows into a strong boy, feeding him with the milk from her bosom. Shahida did not fully understand why her husband had started going to meetings in a local church. He took her along on one of these meetings. She learned a little about AIDS that day. Her husband was getting sicker and sicker by the day. Just when their son started walking on his own, her husband could barely walk anymore.

One Sunday he collapsed on the steps of the church. He was awfully quiet that day. "My husband was an excellent marksman", she says proudly, "He could hit a flying bird in a single shot". He kept his sidearm after leaving the Pakistan army. That fateful night Shahida woke up startled by noise, but her husband was next to her, so she went back to sleep feeling secure. The next morning the world had changed for Shahida, forever. She woke up in a pool of blood. Her husband had taken his life with the gun that saved his life many times in Somalia.





Voices of People Living With HIV/AIDS

Her in-laws filed a police report against Shahida and her ordeal began with the justice system in Pakistan. Shahida moved back to her parents' house. After several court hearings she was acquitted but another tragedy was soon to follow, as her son who was staying ill, died.

Shahida lived a life in utter loneliness. It seemed that her fate was sealed for the rest of her life, as is for most widows, in Pakistan. Life becomes a long arduous dragging wait till the end. But God had other plans for her. Some people from a local NGO, New Light, visited her at home. They invited her over and insisted that she should get tested for HIV herself. She agreed. The test came back positive. "I was not devastated by the news, I have faith in God", she says. It had been over three years since her husband died. Shahida started attending regular meetings at New Light, carrying the burden of her tragedies, alone. When Tahir saw her in the meetings, it was love at first sight. He was swept off his feet. It was clear to him that he could not live with anyone else. Everyone forbade Tahir not to marry her, she is HIV positive, but it was ordained. At first Shahida did not agree but she gave in eventually. She was taken over by love. Somehow her clouds did have a silver lining. It was her destiny to live happily ever after. "My new family gives me so much love that my sisters-in-law snatch food away from my hands and eat it, to show that they don't care if I am HIV positive; we love you just the same, they say", Shahida tells others cheerfully.



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New Light AIDS Control Society

New Light AIDS Control Society (NLACS) is a non-profit, non-political and non-religious organization. It is a pioneer group of HIV positive people in Pakistan working with more than 50 persons (females and males) and their families affected with HIV. The purpose to establish this group was to bring into light, the issues of HIV + ve people and to help them stop the dissemination of epidemic. Besides this, NLACS empowers HIV + ve people to face the challenges of life, and enhance the skills to meet the needs of the time. NLACS accommodate every infected person without any religious, social, racial and linguistic discrimination. NLACS also provide medical and psychological treatment to its HIV + ve members. NLACS is registered with the government under the Society Act 1960. New Light is also the member of Punjab AIDS Consortium, which is a collaboration of Government and Non-Government Organizations.

Family Health International

Family Health International is dedicated to improving lives, knowledge, and understanding of health worldwide. We pursue our mission through a highly diversified program of research, education, and services in family health and HIV/AIDS prevention and care. Under the Strategic Objective Grant Agreement between US Government (USG) and Islamic Republic of Pakistan, USAID is complementing the National AIDS Control Program to promote awareness and healthy behaviors in vulnerable groups, through information, education and communication (IEC) programs regarding the risk factors for HIV/AIDS. This is the fourth focus area of the USG Health and Population Program in Pakistan.

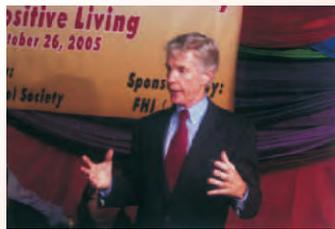
USAID assists HIV/AIDS control interventions using support of Family Health International as management agency under IMPACT Cooperative Agreement. The IMPACT Cooperative Agreement with USAID and its interventions in Pakistan is in accordance with the successful management of USG resources on HIV/STI research, programming, monitoring and evaluation in more than 70 countries of the world by Family Health International.

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New Light AIDS Control Society

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“The U.S. government is the world leader in responding to the global pandemic of AIDS and currently has HIV/AIDS programs in nearly 100 countries worldwide. The U.S. government has made the fight against HIV/AIDS a top priority, not only for humanitarian reasons, but because the HIV/AIDS crisis threatens the prosperity, stability, and development of nations around the world. As part of a U.S. social and economic assistance package for Pakistan totaling more than \$1.5 billion for the next five years, USAID funding has helped get important preventive messages to 120,000 people at risk for getting HIV and has also helped 72 HIV positive individuals and their 276 family members to obtain care, including home-based services.”

Background

Pakistan stands at a crossroads and has entered in a situation of concentrated HIV epidemic. The country has enormous potential from private sector to restrain the epidemic and offers a unique window of opportunity to control and prevent a widespread epidemic. As of June 2005, the National AIDS Control Program (NACP) had identified 2,622 HIV positive cases including 321 with AIDS. The estimated number of HIV cases is thought to be nearly 80,000. Since 2003, Family Health International (FHI) with support from United States Agency for International Development (USAID) has closely worked with National AIDS Control Program, local non-governmental organizations and community groups to develop and strengthen HIV prevention and care activities.



Strategies and Program Areas



Under the Strategic Objective Grant Agreement between US Government and Islamic Republic of Pakistan, FHI is complimenting the National AIDS Control Program to promote awareness and healthy behaviors among vulnerable groups, through information, education and communication programs regarding the risk factors for HIV/STIs. This is the fourth focus area of the US Government Health and Population Program in Pakistan. The program has developed projects that reduce the transmission of HIV/STIs among most at-risk populations (MARP) and in-school youth in Rawalpindi, Islamabad,

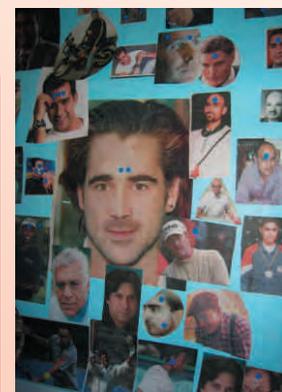


Lahore, Multan, Karachi and Larkana of Punjab and Sindh provinces; support people living with HIV and AIDS (PLHA) with appropriate care; support technical assistance to NACP to monitor the dynamics of the epidemic and the effectiveness of prevention and care programming. FHI Pakistan is working with eight partner organizations for and integrated response to HIV/STI disease prevention.



Implementation Strategy: In order to effectively allocate resources, FHI targets intensive strategic behavioral communication programming for populations most vulnerable and central to the HIV epidemic. This work supports objectives already set by the NACP. FHI will increase the capacity of both the Government of Pakistan and local non-governmental organizations (NGOs) to implement HIV and AIDS prevention interventions among target groups.

Development and Implementation of Strategic Behavioral Communication (SBC) and Interventions: To reach most at-risk populations, FHI uses SBC as the most important tool for HIV/AIDS prevention at this stage of epidemic. FHI: 1) develops SBC in the context of prevention, care and support program, 2) advocates integrating many different interventions, products and channels into a comprehensive approach, 3) works to contribute to the national program goals and collaborate with national, regional and international partners and 4) will assist implementing agencies (IAs) build technical capacity in design and implementation of Strategic Behavioral Communication and Interventions.



Together We Achieve Prevention

Capacity building of partner organizations has been ongoing and focused on enhancing capacity on inter-personal communication for HIV/AIDS and Sexually Transmitted Infections' (STI) service delivery and to design activities around a behavior change model to promote and supporting adoption of safe practices and increasing access to STI services to most at-risk populations. The program has reached almost 120,000 beneficiaries of SBC program. Out of these almost 27,000 in-school youth were informed about life skills, abstinence and faithfulness. The increasing outreach has been made possible through 60 outreach workers and more than 1,000 trained peer educators (PEs). SBC tools including puppet and theater shows are being used for edutainment.

Peer Education Kit: FHI spearheaded development of Peer Education Tool Kit for projects' field staff. The kit communicates complex and sensitive HIV/STI messages in simple ways.



Care and Support

FHI with partner PLHA organization published 07 case studies on "Voices of People Living with HIV and AIDS"; it is a meaningful medium to reducing stigma and discrimination. Responding to recent HIV concentrated epidemic in Sindh; FHI expanded its HBC operations to Karachi. Home Based Care has reached 276 HIV/AIDS affected family members and 72 PLHA from all over Pakistan. FHI also spearheaded two national consultative workshops on people living with HIV and AIDS in collaboration with UNAIDS and NACP.



Treatment

The program has recently started providing community based STI services to MARP. Trained medical staff provided syndromic treatment to 340 clients suffering from sexually transmitted infections and counseling to more than 1400 individuals. Female medical assistants are hired to cater female clients.

Technical Assistance to NACP, Ministry of Health

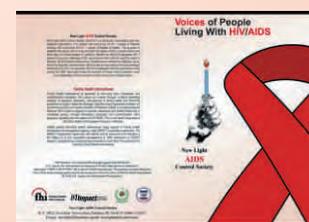
Assessment of national blood transfusion situation followed by workshop on leadership development for Safe Blood Transfusion; Quality Assurance system for the national and provincial blood transfusion managers; organized a workshop for national and provincial programs on STI strategy and protocol development and; Technical Assistance on developing strategic paper for HIV/AIDS interventions in Pakistan.

Challenges

- Assuring the level of capacity building necessary to help implementing agencies develop, design and implement Strategic Behavioral Communication and interventions for various high-risk groups that meet the country's needs.
- Solving the programmatic and management challenges faced by partner NGOs.
- Guaranteeing that these groups have access to standardized, accurate information and quality communication materials.
- Meeting the increasing need for home based care and involving people living with HIV and AIDS as partners.

Future Program Priorities

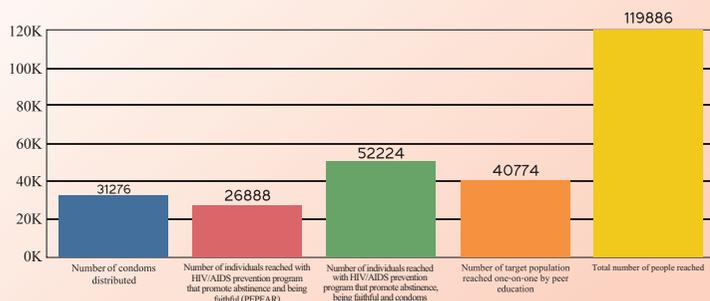
- Identify opportunities to mobilize additional resources for a comprehensive response to HIV/AIDS prevention and care.
- Expand FHI/Pakistan outreach to various other high-risk groups and add new strategic geographical sites.
- Ensure quality and coverage of programs addressing the most at-risk populations.



Out reach for HIV/STI disease prevention: Abstinence (A), Be Faithful and Use Condoms (C) remain backbone of the FHI SBC program FY 04/05

With the help of 08 partner organizations, FHI has established contacts with all most 120,000 people for improved understanding on HIV and AIDS. Out of these about 27,000 are young male and female students from Islamabad and Multan cities.

Condom distribution is picking up while Inter-personal communication of the ORWs and PEs has improved, the program distributed more than 31,000 units of condoms among Most At Risk Populations (MARP) at seven different geographic locations of Punjab and Sindh provinces.



Home Based Care (HBC) for PLHA and their families for Positive Living FY 04/05

The program has reached 276 family members of PLHA and provided HBC to 72 HIV+persons individuals from all over Pakistan. FHI/USAID has designed Care and Support project to meet physical and psycho-social needs of the PLHA and their families in Pakistan.



Partners: The National AIDS Control Program (NACP), Ministry of Health, Society for the Advancement of Community Health Education and Training (SACHET), Organization for Social Development (OSD), Pakistan Lions Youth Council (PLYC), Awareness of Social, Economic, Educational Rights (ASEER) Foundation, Pakistan Voluntary Health and Nutrition Association (PAVHNA) in collaboration with Mehran Welfare Trust and New Light AIDS Control Society (NLACS)



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Baseline Evaluation Survey among Male Sex Workers, Hijras, and Female Sex Workers in Rawalpindi, Multan, and Larkana, Pakistan

Executive Summary

Introduction

FHI through its programme in Pakistan is complementing the National and Provincial AIDS Control Programmes in maintaining low prevalence of HIV/AIDS in the country. A baseline evaluation was undertaken by FHI Pakistan Country Office in Rawalpindi, Multan and Larkana in May 2005. The main objective was to obtain baseline behavioral indicators for monitoring and evaluating the FHI supported interventions implemented in the 3 designated sites. The study was carried out by Raasta Development Consultants, Karachi assisted by a technical monitor from FHI Pakistan.

A total of 780 male sex workers (MSWs)/ Transgenders (TGs) and 240 female sex workers (FSWs), age of 16 years or more were recruited for the survey. The study used a Respondent-Driven Sampling (RDS) method for recruitment. The methodology did not work well for FSWs in Rawalpindi and the sampling methodology had to be switched to convenience sampling. Local NGOs facilitated the survey. Training for the study was conducted in 3 parts: 3-day training in RDS methodology, 3-day training for field investigators and research assistant and 3-day training of interviewers. A verbal informed consent was administered to each study participant prior to the interview and compensation provided for transportation.

All data was double entered, and data cleaning was carried out under the supervision of FHI's technical advisor.

Main Findings

Profile of MSW/TG

MSWs were generally young in the age bracket of 18-25 years while TGs were largely in the age bracket of 21 – 30 years. TGs, however, continue in the sex business longer. MSWs reported being in sex work from 1 – 15 years, with most concentrated in the 1 – 10 years group. TGs reported being in sex business from 1-20 years with most concentrated in the 1-15 years group. Similar trends were found in all three cities. The trend for selling sex in other cities is higher among TGs than MSWs.

A little more than one third of MSWs/TGs were able to read and write. A large majority had never attended school. Most MSWs and TGs were poor; earning up to Pakistan Rupee (PKR) 3,000 (USD 50) per month. Few earn more than PKR 5,000 (USD 83) per month. TGs generally have higher income from sex work than MSWs.

About half the MSWs and TGs in Rawalpindi and Larkana reported having clients (during sex business) 5-7 days in the week. In Multan a little over half the MSWs

reported clients 1-2 days in the week while about half the TGs reported 3-4 clients in the week.

The practice of drinking alcohol, especially every day, was generally low. Consumption of alcohol was more common and frequent among TGs than MSWs. Use of recreational drugs¹ was far more common than alcohol. *Charas* was the most popular followed by *Bhung* and *Afeem*². Forced sex, beatings, discrimination and blackmail were common forms of harassment. Generally more TGs than MSWs were targets.

MSWs overwhelmingly identified themselves as ‘man’ while a few identified themselves as ‘malishia’ or ‘chava’. TGs identify themselves as ‘zenana’, ‘hijra’ or ‘chava’, the numbers for each type varying across the 3 cities. Taking of hormones for a more feminine appearance was prevalent only among one third of TGs.

Partners & Sexual Behaviour

The practice of having live-in sex partners was far more prevalent than marriages. It was also noticeably higher among TGs. By and large the trend was to have male live-in partners although some MSWs also had female partners. Few hijras as live-in partners emerged. Findings varied from city to city. Generally MSWs and TGs have had their first sexual intercourse in their early teens. The first sexual partners were overwhelmingly male but some MSWs also had female partners. Use of condoms at the time of first sexual intercourse was minimal.

MSWs had a greater proclivity for being bisexual. TGs almost always had male sex clients/partners. An overwhelming majority of respondents only sold anal sex to one-time and/or regular male clients. Buying sex from men or hijras was found to be prevalent only among MSWs in Multan. The prevalent behaviour pattern was overwhelmingly commercial sex for both MSWs and TGs. Casual sex with male partners emerged strongly in Multan. Prevalence of commercial or casual sex with females was generally low, except among MSWs in Multan.

Consistent condom use during (commercial and casual) anal sex with male clients and partners was very low among both MSW and TG (past one month). In comparison condom use at last anal sex was reportedly higher; the reason being that besides the “always” condom users the ones reportedly using condoms “most” and “sometimes” showed a tendency to report condom use at last anal sex. Same trend of condom use was found with female clients and partners during (commercial and casual) vaginal/anal sex.

Unprotected anal sex with commercial male clients was widespread, far more with commercial than with casual partners. Only 18 percent MSWs and 8 percent TGs in Larkana reported always using condoms. In other cities barely 5 percent of respondents reported always using condoms. Prevalence of unprotected vaginal/anal sex with female sex partners was lower than that with male sex partners. It was also lower with casual

¹ Recreational drugs refer to the ones orally taken (question related to inject drug use was missed out)

² *Afeem*: Opium, *Bhung*: A local addictive derived from a shrub, *Charas*: Cannabis

female partners but the difference was not as startling as that between commercial and casual male partners.

All respondents could by and large identify condoms. Condoms were generally easily obtained, largely from shops, clients, pharmacies, friends and pimps. Few reported obtaining condoms from workers of NGOs while health facilities were hardly reported as a source across all 3 cities. Use of condoms together with a special lubricant (for condoms) was insignificant. Bursting of condoms, during the last month, was experienced by about one third of the respondents.

Sexually Transmitted Infections

Knowledge of all symptoms of sexually transmitted infections (STIs) in males was next to nil. Ability to read and write was found to have little bearing on this knowledge. STIs affected a fairly large number of MSWs and TGs. Reported experience of STIs was highest from Multan. Whether treatment for STIs from a medical staff was obtained varied considerably from city to city and between MSWs and TGs. In Multan and Rawalpindi there was higher reported trend for TGs to obtain medical help for STIs. Very few MSWs in Multan obtained medical treatment. In contrast a large number of MSWs in Larkana reportedly went for proper treatment compared to TGs. It seemed that this was more a consequence of attitude than availability for treatment. Generally treatment was sought the same day or within 2-3 days of the first appearance of symptoms. Treatment costs were found to vary between the 3 cities. In Rawalpindi most respondents reported obtaining treatment between PKR 100 (USD 1.7) or less and PKR 500 (USD 8.3). Larkana and Multan appear to be more expensive as a majority of respondents paid up to PKR 1,000 (USD 16.7).

HIV/AIDS Knowledge, Risk and Avoidance

Familiarity with the terms HIV/AIDS was fairly widespread. Knowledge about prevention of HIV/AIDS, however, was far less. Barely one third of the respondents 'knew enough' about prevention i.e. avoiding anal sex and using condoms correctly during anal sex. A large majority harbour misconceptions about HIV transmission. Findings varied from city to city. There was little knowledge about HIV/AIDS screening facilities. Barely 1 percent had gone for any tests or screening for HIV/AIDS; only 2 respondents (of a total sample size of 780) reported a voluntary test in the past year.

Exposure to Interventions

Few NGOs work with sex workers or on HIV/AIDS. Organization for Social Development (OSD) emerged in Rawalpindi, largely working with TGs. ASEER emerged in Multan and Mehran Welfare Trust (MWT) in Larkana, largely working with MSWs. Membership was reported by less than 1 percent; 37 respondents out of a total of 780. There was however, some exposure to interventions; much of which was in the nature of initial contact, IEC material, and educational session, condoms and referrals. Many who received IEC material were illiterate.

Profile of FSWs

Majority of FSWs were in the age bracket of 21-35 years. Only about 20 percent FSWs were able to read and write with a large majority never having received formal education. A very large majority were in sex work from 1-10 years with a larger concentration in the 1-5 years bracket. The trend of selling sex in other cities was fairly common as almost 40 percent reported going to other cities for sex work.

A large number of FSWs had clients anywhere between 3-4 days and 5-7 days a week. Earnings were largely between PKR 1,000 (USD 17) – PKR 5,000 (USD 83) per month with about half only earning up to PKR 3,000 (USD 50) per month. A majority of the FSWs did not drink alcohol at all. Use of recreational drugs was also not common. FSWs suffered from some kind of harassment with blackmailing at the top of the list. There were also incidents of forced sex, mostly by clients, regular partners and sometimes police and pimps. Beating and discrimination were other forms of abuse.

Partners & Sexual Behaviour

The trend for marriages in FSWs was high; the trend for a live-in sex partner was even higher. Among those who were not currently married, 49 percent reported to have a live-in partner. Generally FSWs reported having had their first sexual intercourse between the ages of 11 – 20 years with a large concentration in the 16-20 years age group. Use of condoms at the time of first sexual intercourse was minimal.

Almost all FSWs had vaginal sex with one-time or regular male clients. Then trend for casual sex partners was lower but substantial. FSWs were largely into commercial ‘vaginal’ sex with male clients. Anal sex with male clients was very low.

Less than a quarter FSWs were consistent condom users during (commercial and casual) vaginal /anal sex with males (past one month). In contrast condom use at last vaginal/anal sex was much higher; the reason being that besides the ‘always’ condom users, those reportedly using condoms “most” and “sometimes” largely show a tendency to report condom use at last vaginal/anal sex.

The trend of unprotected sex was very high whether it was practiced with male clients or non-commercial male partners. An overwhelming majority reportedly did not use condoms every time they had sex in the last month.

Almost all FSWs were able to identify a condom. Condoms were easily available from shops, through NGO workers, friends, clients and pharmacies. Bursting of condoms, during the last month, was experienced by about one third of the respondents.

Sexually Transmitted Infections

Knowledge of ALL symptoms of STIs was generally low. STIs appeared to be quite widespread as close to 60 percent reported experiencing painful / smelly discharge from vagina or pain in lower stomach area or warts, sores or ulcers in the genital area. Treatment from medical staff was sought to some extent only; a large number rely on medical store keepers, traditional healers, friends and self-medication. Generally treatment was sought within 1-2 days of the first appearance of symptoms. The cost of STI treatment mostly ranged between less than PKR 100 (USD 2) to PKR 500 (USD 8).

HIV/AIDS Knowledge, Risk and Avoidance

Familiarity with the term HIV/AIDS was fairly widespread but knowledge of HIV/AIDS prevention was low among FSWs. Only about 30 percent know enough while only 20 percent had correct knowledge on a range of HIV/AIDS preventive methods. However, it was apparent that FSWs even when they did associate low risk with correct condom usage during sexual intercourse as a means of HIV prevention generally did not practice it. A large number have misconceptions regarding transmission of HIV/AIDS. Only a fraction of FSWs had knowledge regarding services for conducting a confidential HIV/AIDS test; 5 FSWs from a total sample of 240 reported undergoing a voluntary test (VCT) in the past year.

Exposure to Interventions

FSWs in general appeared to have limited exposure to interventions. Only 4 percent FSWs had knowledge about MWT in Larkana, while a fraction had heard about ASEER in Multan. None had heard of OSD in Rawalpindi. None are members of these or any other organizations. There were however some referrals to STI clinics through local organizations, contact through outreach workers, attending of educational sessions receiving of IEC material or condoms/lubricants.



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