ASSESSMENT OF TB & HIV SERVICES IN PAKISTAN THROUGH A GENDER LENS

REPORT

UNAIDS

NACP

TOGETHER

UN WOMEN

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Report reviewed by UNAIDS team

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FOREWORD

Ministry of National Health Services, Regulations and Coordination Pakistan is committed to helping the people of Pakistan in maintaining and improving their health, and making our population among the healthiest in the region. It is the Ministry's key and most crucial aim to provide efficient, equitable, accessible, scientifically sound and, affordable health services to each and every person in need.

Gender is a social construct embedded in a society and has many crosscutting determinants. With regard to HIV/AIDs Gender discrimination and other forms of social exclusion increase vulnerability to HIV and other sexually-transmitted infections, particularly amongst younger girls, women and spouses of people who inject drugs. Gender barriers limit women's use of services and ability to adopt healthy reproductive behavior. That is why gender mainstreaming depends on multi-sectorial interventions and involvement of diverse stakeholders, which may be within or outside health sector.

The health-related services' seeking and treatment behavior of men and women living with HIV, TB-HIV co-infection or suffering from TB, requires a systematic assessment from a gender perspective to inform national planning and budgeting for gender-responsive and gender-transformative TB and HIV responses. This gender assessment is a significant step and will help us identify gaps in TB and HIV services, and it will result in shaping policy level gender perspective integration into overall health framework and health vision of Pakistan. This will assist both national programs of TB and HIV to formulate their responses in a gender responsive manner by using gender lens to reduce the dual burden of HIV and TB infection.

The management of National AIDS Control Program, National TB Control Program along with UNAIDS has played a pivotal role in being harbinger of change in policy-making and the improvement in the tools used for the elimination of the infection in key populations of the region. Likewise, The Government of Pakistan is committed to ensure gender equality and Pakistan is a signatory to many international treaties to promote gender equality and empowerment of women. Ministry will assist implementation of all the valid recommendations to ensure gender transformative HIV and TB care in Pakistan.

Mr. Muhammad Ayub Shaikh
Secretary
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Islamabad, Pakistan

EXECUTIVE SUMMARY

BACKGROUND

The number of women in reproductive ages (15-49 year) in Pakistan was 31.7 millions in 1998 and it is estimated at 55 million in 2015, which is estimated to reach at 64.5 millions in 2030. Indicators related to women health care such as antenatal consultation, skilled birth attendance, pregnancy and birth related ailments, malnutrition and micro-nutrient deficiencies are posing enormous challenge for women health in Pakistan. Women are the poorest among the poor and are most vulnerable among their communities. The link between gender and poverty is evident all over the world. Out of 1.3 billion people living in poverty, 70% are women. Among poorer households, incidence of chronic malnutrition is higher among female children. Although proportion of population living below poverty line in Pakistan fell between 2001 and 2010, women did not benefit from economic growth to the same extent as men. Low social indicators coupled with limited access to income-generating opportunities have left women considerably more vulnerable to poverty than men.

With reference to the TB and HIV diseases, women are also more prone to a number of risk factors and problems globally. Across all regions of the world, women accounted for approximately 50% of all adults living with HIV; with 46% of all AIDS-related deaths in 2013 were women. Women of key populations are disproportionately affected worldwide. Female sex workers are 13.5 times more likely to be living with HIV than are other women. About 19% transgender women are living with HIV, globally, and chances of them acquiring HIV is 49 times higher than all adults of reproductive age. Gender differences exist in rates of compliance with treatment with more fear and stigma in women. In 2012, UNESCO stated that Pakistan showed least progress in the region for educating low-income girls. Women in Pakistani society have lower social, economic, and cultural standing, a sub-ordinate position with little or no decision making power.

Objective of Gender Assessment: The gender assessment was planned to identify gaps in TB and HIV services, which will be shared with relevant stakeholders for further policy level integration into overall health framework and vision. This will assist both programs to assess HIV and TB care context and response from a gender perspective, and help in shaping response from gender lens to reduce the dual burden of HIV and TB infection.

METHODOLOGY

The gender assessment was conducted using mixed methods approach with both quantitative and qualitative data collection. After an inception meeting with the officials from NACP, NTP, GFATM, UN-Women and UNAIDS the data was be retrieved from program offices of NACP and NTP in Islamabad and also from UN Women and UNAIDS. Focal persons from all the concerned departments and development partners were identified and approached for data collection. Three research associates were hired to collect all the data from national offices of TB (NTP) and HIV program (NACP) in Islamabad. In order to collect provincial and district level data, the provincial offices were approached through NACP and NTP Islamabad. This was followed by district level visits to Karachi, Larkana, Lahore, Quetta, and Peshawar. The Gender

Assessment Tool developed by UNAIDS for integrated assessment of TB and HIV services was used for this assessment. The qualitative aspect was achieved through in depth interviews of key informants, government officials, civil society representatives, representatives of relevant donor and development partners, and relevant public health officials.

FINDINGS

The assessment findings showed that in Pakistan gender desegregated data is lacking at facility level but overall statistics report that male to female ratio is 50:50 for TB but it is 70:30 for HIV&AIDS. However for TB cases, proportion of female is higher than male in regions of Azad Jammu Kashmir, Balochistan, FATA, Gilgit Baltistan and Khyber Pakhtunkhwa. While proportion for female and male in Punjab, Islamabad capital territory and Sindh is same. Gender dynamics in TB enrolment, treatment and cure rates are not uniform. Knowledge of TB and HIV&AIDS symptoms is available in most of Surveys in Pakistan but national level gender de-segregated data of knowledge of key populations is not available. The national level estimate of population proportion that has an accurate understanding of relationship between TB and HIV is not available in Pakistan. Stigma and discrimination in general population against PLHIV is shown in various surveys. National level estimates of stigma and discrimination towards TB patients is not available in Pakistan. Though HIV response in Pakistan advocates against stigma and discrimination of PLHIV at multiple levels, there is no formal redress or legal services available to PLHIV. Although there are no HIV specific laws, Pakistan's constitution articulates equality and non-discrimination as fundamental rights. The monitoring and evaluation (M&E) systems of NACP is trying to capture gender disaggregated information as well as other important demographics information related to risk, such as place of work, incarceration, pregnancy status, etc. for HIV and AIDS is not available for TB at national level. There are no specific programmes for people with disabilities in TB and HIV&AIDS response. Although the national TB response includes older people, in particular older women as key populations, there are no exclusive programmes to address their needs.

In order to ensure meaningful participation of all stakeholders, a Country Coordination Mechanism (CCM) Pakistan has been established in response to Global Fund requirements. Other than CCM there are no additional coordination mechanisms in different government sectors (e.g. gender, health or human rights) and levels for joint action on gender equality in the national TB and HIV response. There are plan provisions available for capacity building and allocation of resources to support the participation of key affected population (KAP) in the TB and HIV response. TB response is ensuring participation through LHWs program and HIV & AIDS response is linkage community support through CHBCs. There is a significant and excellent role of APLHIV in Pakistan in establishing a positive women network that has been established under this association. In Pakistan gender is not limited to only women but includes feminised males and hijra whose vulnerability is driven by underlying gender inequality and social marginalization. For these populations, stigmatization (including the condoning of violence) occurs in large part because society perceives their behaviour as violating the accepted norms of what women or men should do. Stigmatization in turn, makes task of reaching key populations HIV prevention, care and treatment services difficult.

Availability of female staff plays a vital role in the provision of health services to the women and children. In Pakistan, there are problems of female staff in both urban as well as rural areas, but the conditions in rural and remote areas are very poor. Even within the available staff, there are no specific pre-service sensitivity trainings in gender, human rights, stigma and discrimination in Pakistan.

Social and familial control over women's sexuality and commoditization of women is the one of the key determinants of gender-based violence (GBV). There are currently no partnerships between NTP and NACP on GBV; for representing women's rights, patients' rights, TB and HIV affected communities, and key affected populations—to develop and implement programs and initiatives that address GBV and violence against women.

In humanitarian crisis situation, the Gender Task Force (GTF) tries to address gender-based violence and violence against women and girls. The GTF is co-led by UN-WOMEN and UNFPA; and is reporting to the Humanitarian Country Team (HCT) and functions as an overarching institutional mechanism that has a policy and advocacy (interagency and multi-sector) role for gender mainstreaming into the clusters.

In Pakistan HIV/AIDS and STIs appear to be main issue of concern of young female and males in Pakistan. Researches in Pakistan show adolescents (both young girls and boys) unaware of their sexual and reproductive health rights and they are most vulnerable during puberty. This suggests that in order to bring a change there is a need to focus on HIV/AIDS prevention among youth and therefore the project aims to work with all stakeholders including youth, caretakers, gatekeepers and government ministries to enhance their knowledge, capacity, services and policies.

RECOMMENDATIONS

Based on findings of review, various recommendations were presented for discussion in the consultative meeting. The final set of recommendations coming out of the review and consultative meeting have been categorized into Short-term, Medium and Long-term actions on the basis of time needed for implementation, as below:

IMMEDIATE ACTIONS

- Establishment of a “Gender Task Force for TB and HIV Services” in Pakistan. There is a need of strengthening institutional response through a multi-sectoral coordinating body to lead the gender and human rights work in TB and HIV services in Pakistan. The Secretariat can be based either in UNAIDS or UN-Women and it can suggest various task, roles, responsibilities and proper implementation modalities for recommendations. It can assign responsibilities to each GTF partner for ensuring transparency and accountability.
- Advocacy and communication plan to help implementation of a four-prong strategy for a gender transformative HIV and gender responsive TB response. These four prongs include Advocacy and policy monitoring for gender mainstreaming in TB and HIV services; Gender sensitive TB and HIV service delivery and access; Training and capacity building of health

providers involved in TB and HIV services; and Stimulating research on utilizing gender lens for assessment of care.

- Establishment and strengthen Gender-responsive information systems and data management in TB and HIV&AIDS programs and it must be linked with existing HMIS/DHIS systems.
- Integrating gender perspective in National Health Policies and Provincial level Strategies and also in TB and HIV program strategies

MEDIUM TERM ACTIONS

- Deployment of properly trained female healthcare providers at all TB and HIV care centres wherever needed.
- Funding and Grants for Gender Equality Interventions for TB and HIV in Pakistan. GEEW interventions, that it should be considered under GRB. There is a need of strengthening evidence base on gender equality, especially with reference to TB and HIV dimensions in Pakistan
- Gender responsiveness in challenging operating environments. This will require a Gender Based Rights Complaint Procedure in TB and HIV care services
- Strengthening partnerships and collaboration for TB and HIV Response. There is a need for greater cooperation and coordination between the gender machinery and program machinery to strengthen collaboration on gender equality, women's empowerment in context of TB and HIV response in Pakistan.

LONG TERM ACTIONS

- Integrated Program for TB and HIV Care at functional level or integration at the point of care. It is essential that there is a functional or point of service level integration of HIV, TB, gender-based violence, and reproductive and sexual health services in Pakistan alongwith the provision of comprehensive care services including psychosocial and legal support. This integration can take up any shape in the long term; which may be a system of iintegrated TB and HIV services; One-stop health services for women (integrated TB, HIV, PMTCT, SRH, MNCH and Family planning) and Integrated or linked health services with TB, HIV and GBV services. It will require the partners under one umbrella, including the members of the GTF for TB and HIV.
- Empowerment of girls and women has immediate health results, ensures long-term impact. It is important working with communities to address harmful gender norms. Various interventions can enable empowerment of girls and women, including;
- Ensure meaningful participation and representation of women living with HIV and women and girls from key population in the national TB and HIV planning, implementation and monitoring processes

- Ensure dedicated funding to support capacity development and advocacy efforts of community organizations, especially those are led by and for women living with HIV and other women at higher risk of TB and HIV
- Ensure empowerment of women and girls and addressing gender based discrimination and inequality is integrated and funded in the national HIV and TB response, including through various GF mechanisms.
- Interventions to Eliminate Gender-based Violence: Although improvements in female education, employment and health will make them strong physically and socially and will provide them with knowledge and skills to protect themselves against violence. However, focussed interventions are also required to give them legal rights and focussed knowledge and skills to better protect themselves.
- Scaling up human rights services for women and girls TB/HIV Aids programs should take into account the HR framework and address issues of stigma, discrimination and GBV. Scaling up human rights services for women and girls, must include legal rights literacy, access to justice, ending violence against women and community systems strengthening
- Strengthening Community Participation to reduce vulnerability and to improve access for women and girls. Involving women and girls in designing, implementing and reporting on TB and HIV responses

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ART	Antiretroviral Therapy
ARV	Antiretroviral (drug)
BCG	Bacille-Calmette-Guérin
CDR	Case Detection Ratio
CPT	Co-Trimoxazole Preventive Therapy
DR-TB	Drug- Resistant TB
DST	Drug Susceptibility Testing
FDA	US Food and Drug Administration
GDP	Gross Domestic Product
GHE	Government Health Expenditures
GTF	Gender Task Force
HBC	High-Burden Country
HIV	Human Immune-Deficiency Virus
IPT	Isoniazid Preventive Therapy
LTBI	Latent TB Infection
MDGs	Millennium Development Goals
MDR-TB	Multidrug-Resistant
NHA	National Health Accounts
NRL	National Reference Laboratory
NTP	National TB Control Programme
OOP	Out-Of-Pocket
PPM	Public-Private Mix
RR-TB	Rifampicin-Resistant TB
SDGs	Sustainable Development Goals
TB	Tuberculosis
TST	Tuberculin Skin Test
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	US Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization
XDR-TB	Extensively Drug-Resistant TB

1 INTRODUCTION

Health care delivery have multiple determinants leading to inefficient care, which include insufficient funding for health, lack of preventive care, poor rural and outreach services, suboptimal human resources of health, little attention on health education, rising burden of communicable and emerging burden of non-communicable diseases. Alma Ata declaration, equated adequate primary health care as extending coverage and involving all components of society at affordable costs and continuum of care. Intersectoral coordination and contribution from all components of society is important component of health services. Pakistan has exhibited a modest improvement in maternal and child health indicators with infant and child mortality declining from 91 and 117 deaths per 1000 live births in 1990-91 to 76 and 92 deaths per 1000 live births in 2013, respectively in Pakistan. But neonatal mortality (deaths within first month) has virtually remained unchanged since 1990s, which now constitute 70% of all infant deaths.

Indicators related to women health in Pakistan, including antenatal coverage, skilled birth attendance, postnatal care, show gradual but sub-optimal progress in Pakistan. Similarly there are problems of acute and chronic malnutrition, progressive micro-nutrient deficiencies in women has been grave challenge for women health in Pakistan. The women health status also indicate multiple risk factors in the form of repeated pregnancies, high reproductive health morbidity, high maternal mortality, unsafe abortions, and poor health care seeking practices in Pakistan.

Across all regions of the world, HIV continues to affect women and girls. By end of 2013, women accounted for approximately 50% of all adults living with HIV globally. Approximately 9% of all women having with HIV live in South Asia. AIDS-related complications are a leading cause of death in women of reproductive age globally. 46% of all AIDS-related deaths in 2013 were among women. Women of key populations are disproportionately affected worldwide. Female sex workers are 13.5 times more likely to be living with HIV than are other women. An estimated 19% of transgender women are living with HIV, globally, and chances of them acquiring HIV is 49 times higher than all adults of reproductive age.

A number of studies suggest that barriers to early detection and treatment of TB vary; and are greater for women than for men. Gender differences also exist in rates of compliance with treatment; fear and stigma associated with TB seems to have a greater impact on women than on men, often placing them in an economically or socially precarious position. Because health and welfare of children is closely linked with their mothers, TB in women can have serious repercussions for families and households. Women have less access to health services due to cultural, social and economic reasons. Sometimes they are stigmatized by discriminatory behaviours of health care providers. Most of the public sector health facilities also lack proper places of examination for privacy purposes and consultation room lack of confidentiality of communications.

1.1 POPULATION PROJECTIONS OF FEMALES AND YOUTH IN PAKISTAN:

According to projections, the female of reproductive ages (15-49 year) in Pakistan was 31.7 million in 1998 and currently it is estimated at 55 million in 2015. It has been estimated to reach at 64.5 million in 2030. Pakistan has high population growth with reference to other developing countries. The population structure shows a higher proportion of youth, within age group of 10-24 years. It means that population growth will remain a problem for Pakistan for some time in future given this youth bulge. It indicates population momentum in future with more demand on public services including health and education services, as well as other basic amenities of life.

Table 1: Population Projection Female 15-49 (Millions)

Population Projection for Females (15-49),Youth (0-24), 1998-2030 (in million)						
Year	**1998**	**2007**	**2010**	**2015**	**2020**	**2030**
Females (15-49)	31.7	43.8	49.8	55	60	64.6
Youth (10-24)	32.3	57.3	60	61.3	63.4	66.3

Source: NIPS, 2014

Table 2: Population Projections By Province (Millions)

Population Projections by Province, 1998-2030						
	1998	**2007**	**2010**	**2015**	**2020**	**2030**
Pakistan	**132.4**	**162.9**	**173.5**	**191.7**	**210.1**	**242.1**
Punjab	73.6	89.4	94.7	103.8	112.9	128.3
Sindh	30.4	38.5	41.3	46	50.8	59.1
KPK	17.9	21.8	23.3	25.8	28.5	33
Balochistan	6.6	8.2	8.8	9.9	11.1	13.3
FATA	3.2	3.8	4.1	4.6	5.2	6.3
Islamabad	0.8	1.2	1.3	1.5	1.7	2

Source: NIPS, 2014

1.2 INCOME INEQUALITY IN PAKISTAN

The income inequality, shown by rising Gini coefficient and share of income of highest to bottom quintiles in Pakistan has increased and income inequality has worsened in last 5 years. In rural areas, Gini coefficient declined from 0.25 in 2004-05 to 0.24 in 2005-06 and again increased to 0.25 in the year 2012; whereas in urban areas, inequality increased from 0.32 in 2001-02 to 0.33 during the year 2004-05; and further increased to 0.34 during the year 2012.

2 HEALTH EXPENDITURE IN PAKISTAN

There has been low health expenditure by government in Pakistan, averaging 0.5% of GDP till 2010 and then further decline post devolution. Public sector health expenditure is one of the lowest in health in the world. Most health expenditure in Pakistan is by the private households, out-of-pocket and there is large private sector expenditure born by majority of population itself. The utilization rate of public versus private providers also show that majority (70%) of Pakistan population visits private provider as compared to only 20% visiting public sector.

Table 5: Public Sector Health Expenditure 2000 to 2015 (Rs. Billion)

Fiscal Year	Total Expend	Develop. Expenditure	Non-develop Expenditure	Percentage Change	Health Exp. As % of GDP
2000-01	24.28	5.94	18.34	9.9	0.72
2001-02	25.41	6.69	18.72	4.7	0.59
2002-03	28.81	6.61	22.21	13.4	0.58
2003-04	32.81	8.50	24.31	13.8	0.57
2004-05	38.00	11.00	27.00	15.8	0.57
2005-06	40.00	16.00	24.00	5.3	0.51
2006-07	50.00	20.00	30.00	25.0	0.57
2007-08	60.00	27.22	32.67	20.0	0.57
2008-09	74.00	33.00	41.10	23.0	0.56
2009-10	79.00	38.00	41.00	7.0	0.54
2010-11	42.00	19.00	23.00	-47	0.23
2011-12	55.12	26.25	28.87	30.97	0.27
2012-13	79.46	17.34	62.12	44.16	0.35
2013-14	102.33	27.84	74.50	28.78	0.40
2014-15	114.20	31.90	82.30	12.11	0.42

Source: Planning Commission, 2016

3 HEALTH SERVICES INPUTS IN PAKISTAN

There have been some improvements in certain input indicators of health sector, over the years. When the human resources for health is analysed, in the year 2015, there are 164,930 physicians, 11568 dentists, 78,244 nurses, and 29.053 midwives. Besides, there are 987 hospitals in the country with total of 104,137 hospital beds, 4,962 dispensaries and 5343 basic health units (BHUs), and 1135 MCH Centers. According to the available heath data, there are 1222 person per doctor; there is availability of one dentist for 16,854 people and one hospital bed for 1701 people in Pakistan. The number of health professionals is different in various provinces; Sindh and Punjab having more general and specialist doctors than other Provinces. The distribution of health facilities in different provinces is also unequal, with Sindh having highest facilities in terms of hospitals and dispensaries (mostly urban Sindh); but less primary health facilities like MCH Centres and first aid posts; and Balochistan is having the least of all facilities, although its geographical span is largest among all provinces (Table).

Table 6: Health Facilities By Province

Province	Hosp.	Disp.	MCH Centre	RHC	BHU	T.B Clinic	ART Centre	Total
Punjab	304	1504	515	296	2455	54	11	5137
Sindh	334	2093	151	103	768	186	5	3640
KPK	202	562	141	100	942	28	2	1977
Balochistan	98	555	92	70	506	22	2	1344
AJK	17	100	177	33	194	67	-	588
GB	25	107	55	2	18	17	-	224
ICT	7	41	4	3	14	2	1	72
Total	987	4962	1135	607	4897	374	21	12980

Source: NHIRC, 2015

4 LINKAGE BETWEEN POVERTY AND GENDER ISSUES

The constructs of gender and poverty are interlinked across the globe. If the estimated poor population of 1.3 billion people is desegregated by gender, it is evident that 70% of this poor population is women. Women are poorest among the poor in most underdeveloped societies of the world. Women are also classified among the most vulnerable components of the communities. Poverty in Pakistan has a “woman's face.” Analysis of food distribution and investment of resources between male and female members of the household in Pakistan have shown gross inequalities.

Similarly the incidence of chronic malnutrition is higher among female children in the poorer households. Although proportion of population living below poverty line have been declining in Pakistan between last decade, a benefit incidence analysis showed that women did not benefit from economic growth to the same extent as men. Deprivation showed by social, demographic and health indicators, is compounded by the fact that there are limited livelihood opportunities for women in Pakistan thus making them more vulnerable to poverty than men. There are also socio-cultural constraints on the movements of girls and women thus limiting access to development opportunities.

5 GENDER

Gender refers to socially constructed roles, behaviors and responsibilities assigned to males and females because of their sex. Gender is not just being male or female; it is the social and cultural differences rather than biological ones. It also refers to the attitudes, feelings, and behaviors that a given culture associates with a person's biological sex. Gender defines what is expected, allowed and valued in a women or a man in any given context. In most societies of the world, there are differences and inequalities between women and men. These include decision space, life skills opportunities, routine or special responsibilities which are assigned to men and women, intra household or outreach activities undertaken, as well as access to and control of economic resources.

5.1 GENDER MAPPING

Gender mapping is carrying out analysis to find out gender issues in a society. It includes a 'gender check', which makes sure that gender dimensions are taken care of from the start of any analysis. The main aim is to look at the impact of gender on people's opportunities, social roles and interactions. For any project, plan or program, it is pertinent to seek gender perspective for successful implementation and ensuring gender impact for optimal social development. Gender should be taken as integral part economic, social, daily and private lives of individuals and societies. It must be assessed to understand different roles, attributed by the society to men and women.

The UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) adopted in 1979. However it did not contain any provision on gender based violence (GBV) against women. In 1992, the CEDAW Committee adopted General Recommendation No. 19 on violence against women. Committee stated that GBV against women is a form of discrimination so it must be covered by CEDAW.

GBV is defined as “violence that is directed against a woman because she is a woman or that affects women disproportionately”. It is important to appreciate that gender based violence to women doe not occur randomly. It is a systematic and chronic issue, and it is because of their gender. GBV constitutes a violation, as the right to life, the right to equal protection under the law; the right to equality in the family; or the right to the highest standard attainable of physical and mental health.

The UN Declaration on the Elimination of Violence against Women (DEVAW) adopted by the UN General Assembly in 1993 further defines VAW as: “Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life”.

DEVAW declaration incorporates all forms of gender-based violence against women, whether it is physical, sexual and psychological. It may occur,

- In the family (such as battery, marital rape; sexual abuse of female children; dowry-related violence, female genital mutilation/cutting and other traditional practices.
- In the general community (such as rape, sexual harassment and intimidation at work, in school and elsewhere; trafficking in women; and forced prostitution).
- Violence perpetrated or condoned by the state, wherever it occurs (Article 2).

The Beijing Platform for Action was adopted in 1995. It has further expanded on the definition of DEVAW and now includes violations of the rights of women in situations of armed conflict, including systematic rape, sexual slavery and forced pregnancy; forced sterilization, forced abortion, coerced or forced use of contraceptives; prenatal sex selection; and, female infanticide. It further recognized the particular vulnerabilities of women belonging to minorities; the elderly and the displaced; indigenous, refugee and migrant communities; women living in impoverished rural or remote areas, or in detention.

5.2 GENDER RELATED INDICATORS OF PAKISTAN

Pakistan ranks 120 in the 146 countries in terms of Gender-related Development Index while it stands at 92 in the Gender Empowerment Measurement rankings of 94 countries. In 2013, Gender Development Index (GDI) for Pakistan was 0.532, placing Pakistani women's status low from last in the world. Gender gap in all key social sectors is increasing in Pakistan. Although socially driven gender barriers may change over time but there are differences in various social constraints being practiced across different zones and regions of Pakistan. The gender parity indexes for primary and secondary education improved over years, from 0.73 for primary education in 1991 to 0.85 in 2010. This may indicate that attitudes toward education of girls have changed. Households headed by females are also increasing but these households are among the impoverished, which may be due to comparatively lower earning of women than men. It is also evidenced by the fact that average monthly income of female-headed households is one fourth of male-headed households. In Pakistan, 40% of girls get married before the age of 18 and by the age of 19, 30% of married women of reproductive age are either pregnant or already

mothers. The World Economic Forum ranks Pakistan least gender equitable in Asia and Pacific region. In 2012, UNESCO stated that Pakistan showed least progress in the region educating low-income girls. A global report shows that Pakistani women face the world's worst inequality in access to health care, education and work. It reports that 13% increase in violence against women in the year 2010. Rape, gang-rape, domestic violence, forced/child marriages, honour killing (Karo Kari) and Vani (exchange of women in settling the disputes), and are some examples of women's rights violations that have occurred in Pakistan. The annual Gender Gap Index by the Geneva-based World Economic Forum recently released has showed that Pakistan ranked 141 out of 142, second to last in global gender equality. Patriarchal values embedded in local traditions and culture determines gender roles that set societal norms. As per these gender roles men are put in productive while women in reproductive roles. Women in Pakistani society have lower social, economic, and cultural standing meaning a sub-ordinate position with little or no decision making power; hence a lower status. This can be evidenced by low ranks country occupies in most gender related human development indicators and gender empowerment measurements.

Women in Decision Making	% Seats in Parliament Held by Women	% Female Legislators, Senior Officials and managers	% Female professional andtechnical workers	Ratio of estimated Female or Male Earned Income
82	20.4	2	20.6	0.29

Source: Pakistan: Country Gender Profile Study; SDPI, 2010

5.3 GENDER DISPARITY ACROSS EDUCATION

Despite efforts from Pakistani government for enhancement of female literacy, only 44 percent females as compared to 69 percent of their male counterparts are literate. It is interesting to note that same proportions of boys (59%) and girls (52%) are enrolled in grade one, yet more girls (6.4%) than boys (3.9%) drop out when they reach class four. The exclusion of women from activities, in education, in particular, has an effect on all spheres of national development. Global researches have repeatedly demonstrated that women's participation in education and other social activities, including various economic activities, can play a significant role to reduce child malnutrition and poverty.

5.4 GENDER DISPARITY ACROSS LAND OWNERSHIP

Women seldom, if at all, own land in Pakistani society. This is basically because the traditional norms deprive them from to own property. The situation worsens since women are unaware of state and its laws with regard to land ownership as these are not easily accessible to them because of illiteracy and restricted mobility. Inheritance in Pakistan is governed by Islamic Sharia as codified in the Family Laws Ordinance 1961, even those women who can access these state laws, perceived them abstract.

5.5 GENDER AND POLITICAL PARTICIPATION

As a result of women's continuous and exhaustive struggle they were provided 33% of seats at national, provincial, and local government levels, which should be filled through direct election by joint electorate (in 2001 local govt. devolution plan).

5.6 GENDER DISPARITY ACROSS LIFE SKILL OPPORTUNITIES IN PAKISTAN

Gender disparities in various sectors result into difference in opportunities and sufferings for men and women in different spheres of their life. Women, having lesser opportunities and more sufferings, become powerless and vulnerable group in the population prone to extensive violence including domestic violence.

5.7 GENDER DISPARITY ACROSS LABOR FORCE

In Pakistan, labor force participation rate is 16% for women and 71% for men. The terms and conditions of employment for women are different and mostly inferior than the terms and conditions for men. There is a quota of 10% for women in government service, but as far as its implementation progress is analysed, it is not uniform across different regions, especially in the senior level positions. There are a higher number of unemployed women with a degree certificate compared to their male counterparts in same age groups. Whatever increase has been witnessed in the female labor force it has been almost entirely of the illiterate populations. Similarly there are huge urban rural differentials for years of schooling among male and females. Moreover, there is high attrition rates in women due to multiple determinants for example sever discrimination at workplace, physical insecurity faced by most of the women .

6 OBJECTIVE OF GENDER ASSESSMENT OF TB AND HIV SERVICES

The gender assessment findings were needed to identify gaps in available and accessibility of services and strategies for reaching priority and key sub-populations and the findings to be integrated into activity implementation of NTP and NACP, which will be shared with relevant stakeholders at national level and Provincial level for further policy level integration into overall health framework and vision. This study will assist programs to assess HIV and TB epidemic context and response from gender perspective, help in shaping their responses from gender lens and reduce the dual burden of HIV and TB infection.

The assessment is an important step in assessing how the national programs on TB and HIV address and respond to gender related barriers, dynamics and inequalities from socio-economic and legal perspectives in technical programming, policies and practices specifically in terms of prevention, access, treatment services. It is supposed to highlight programme coverage, successes and gaps in programming, key strengths, weaknesses, opportunities, and threats to implementing a gender inclusiveness services. The assessment also ensures that gender related dynamics are considered during work planning, implementation, budgeting, monitoring and evaluation.

7 METHODOLOGY

The gender assessment was conducted using mixed methods approach; involving both quantitative and qualitative data collection. The assessment provides benchmarking for output and outcome indicators and explores influencing and predictive factors related to gender aspects of TB and HIV care services, general health seeking attitudes and behaviours/practices.

Comprehensive literature review was conducted for existing situation regarding TB and HIV services in Pakistan. The online resource repositories including Google scholar, PubMed, Elsevier etc. were explored along with the websites of national and international organizations i.e. UNAIDS, UN-Women, UNFPA, UNICEF, Rutgers WPF, USAID, DFID, Pathfinder, Population Council, and Rahnuma FPAP etc.

An inception meeting was arranged in office of Program Manager, NACP. The Participants in the meeting included officials from NACP, NTP, GFATM, UN-Women, Health Services Academy and UNAIDS. Inception report was generated on the basis of discussion in the meeting. It was decided that all the data would be retrieved from program offices of NACP and NTP in Islamabad and also information will be retrieved from UN Women and UNAIDS. Focal persons from all the concerned departments and development partners were identified and approached for data collection. Three research associates were hired to collect all the data from program offices and districts. Data was collected from national offices of TB (NTP) and HIV program (NACP) in Islamabad. In order to collect provincial and district level data, the provincial offices were approached through NACP and NTP Islamabad. This was followed by district level visits to Karachi, Larkana, Lahore, Quetta, and Peshawar.

The tools for quantitative part of assessment were the Gender Assessment Tool developed by UNAIDS for integrated assessment of TB and HIV services. The qualitative aspect was

achieved through in depth interviews of key informants, government officials, civil society representatives, representatives of relevant donor and development partners, and relevant public health officials. The Interview guide for qualitative assessment was developed from Gender assessment Tool to identify gaps and issues to be addressed within ambit of study.

8 FINDINGS OF ASSESSMENT

8.1 EPIDEMIOLOGY OF HIV & AIDS AND TB IN PAKISTAN

Table 9: Epidemiology of TB and HIV in Pakistan

INDICATOR	TUBERCULOSIS	HIV & AIDS
INCIDENCE PER 100,000	270 per 100,000	
PREVALENCE PER 100, 000	341 per 100,000 (0.341%)	0.9 per 100,000 (0.09%)
PREVALENCE: MALE: FEMALE RATIO	50:50	70:30
MORTALITY RATE PER 100,000	26 per 100,000	124 per 100,000
MORTALITY RATIO: MALE TO FEMALE	(SAME)NO DATA	1.25 : 2.61

8.2 INCIDENCE AND PREVALENCE OF HIV & AIDS

Pakistan is currently classified as having a concentrated epidemic among high risk groups particularly injecting drug users. In Pakistan First cases reported in 1984-85 and current estimate are 98000 cases (UN estimation model). Pakistan does not have a generalized HIV epidemic; however, during the past few years situation is changing rapidly. Pakistan has low levels of human immunodeficiency virus (HIV) infection; and the overall HIV prevalence rate is less than 0.1 percent in general population. However, the country is considered to be at high potential risk for an HIV epidemic for a number of reasons. Within the major cities of Pakistan many individuals are engaging in behaviors, which make them vulnerable to HIV. The bridging population defined as “individuals who have contact both with high-risk groups and the general population” also makes risk of spreading HIV &AIDS.

Currently, Pakistan has an estimated 113,113 People Living with HIV (PLHIV) living in the four main provinces of Punjab, Sindh, Khyber Pakhtunkhwa and Balochistan and two autonomous states: Azad Jammu Kashmir (AJK) and Gilgit-Baltistan, as well as the Federally Administered Tribal Areas (FATA) and the Islamabad Capital Territory (ICT). Of those estimated, 70% are male (65,747) and 30% female (28,178); 2.5% children <14 years (1.3% male children and 1.2% female children – of the total number); and 1770 women in need of Prevention of Mother/Parent to Child Transmission services'.

UNAIDS employs Spectrum / EPP and AIDS Epidemic Modelling (AEM) to estimate Incidence of HIV, in Pakistan. Spectrum data towards the end of 2013 indicated a rise of new HIV cases by 16 percent on average from 2005 through the end of 2014.

Table 5.2: Prevalence of AIDS by Region

Region	Adult Prevalence %	Estimated cases	cases Reported	Total deaths	FSW %	MSW %	IDUs%
Global	1%	39.5M	_	2.9M	_	_	_
Pakistan	0.1%	85, 000	2,718	309	<0.1	0.04	5-10
India	0.4-1.3%	2M - 7.6M	124,995	8097	8.44	8.74	10.2

Source: NACP, 2015

Table 5.3: Integrated Behavioural & Biological Surveillance (IBBS)

	IBBS Round-I (8 Cities)	IBBS Round-II (12 Cities)	IBBS Round-III (8 Cities)
IDUs	Concentrated epidemic in 5/8 cities-9%	Concentrated epidemic in 8/12 cities-15.8%	Concentrated epidemic in all 8 cities-20.3%
MSWs	Sporadic	1.5% (95% CI: 1.0, 2.0)	0.9% (95% CI: 1.0, 2.0)
HSWs	Sporadic	1.8% (95% CI: 1.3, 2.5)	6.1% (95% CI: 1.3, 2.5)
FSWs	Nil	Occasional	Not included

Source: IBBS, NACP, 2015

Table 5.4: HIV Prevalence in Pakistan by city (2013)

City	IDUs	MSWs	HSWs	FSWs
Karachi	23%	3.1%	3.5%	0.0%
Hyderabad	30%	0.0%	0%	0.25%
Larkana	28%	0.5%	27%	0.0%
Faisalabad	12%	-	2.5%	0.0%
Sargodha	23%	-	-	0.0%
Lahore	15%	01%	2.5%	0.0%
DG Khan	19%	-	-	0.0%
Peshawar	13%	-	1.2%	0.0%
Total	**20.3%**	**0.9%**	**6.1%**	**0.02%**

Source: NACP, 2013

National AIDS Control Programme (NACP) was established in 1986-87 with a focus on diagnosis of cases coming to hospitals, but progressively moved towards community focus. Its objectives are prevention of HIV transmission, safe blood transfusions, reduction of STD transmission, establishment of surveillance, training of health staff, research and behavioral studies, and development of programme management. In 1999 - 2000, GoP with the assistance of UNAIDS and other development partners undertook a strategic planning exercise with input from all stakeholders. The framework envisages multi-sectoral response and development of partnerships and collective action, essential for decreasing the vulnerability of Pakistan's population. As a result of consultations and provincial level discussion, in 2014-2015, Pakistan AIDS Strategy III 2015-2020 was also developed after through consultation that took place after mid-term review of all 04 provincial AIDS strategies.

Pakistan was considered to a low prevalence country, but now it is in group of "Countries in Transition" with a concentrated epidemic among high risk groups, where the AIDS problem is increasing since last five years. The number of infected persons might be running in millions if proper screening is carried out. Behaviour conducive to spread of HIV infection to young people is curiosity about sex, drugs, negative peer pressure, and lack of knowledge and information on safe sex. HIV is most prevalent in Sindh province while least prevalent in AJK.

8.3 INCIDENCE AND PREVALENCE OF TB

Through the years the Incidence of TB in Pakistan is almost static at 270/100,000 per year among all ages and both sexes. It is estimated to be the same in both sexes. The Case notification rate for all forms during year 2015 has been 174/100,000 and it is equal in both sexes.

Figure 1: Incidence of TB in Pakistan (Trend)

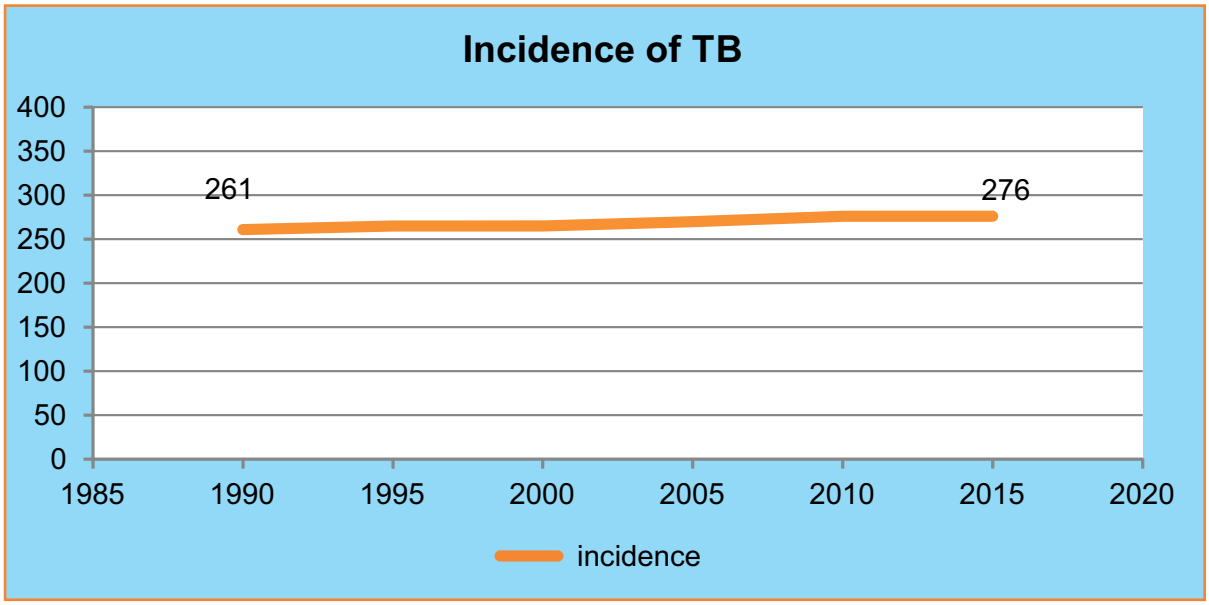
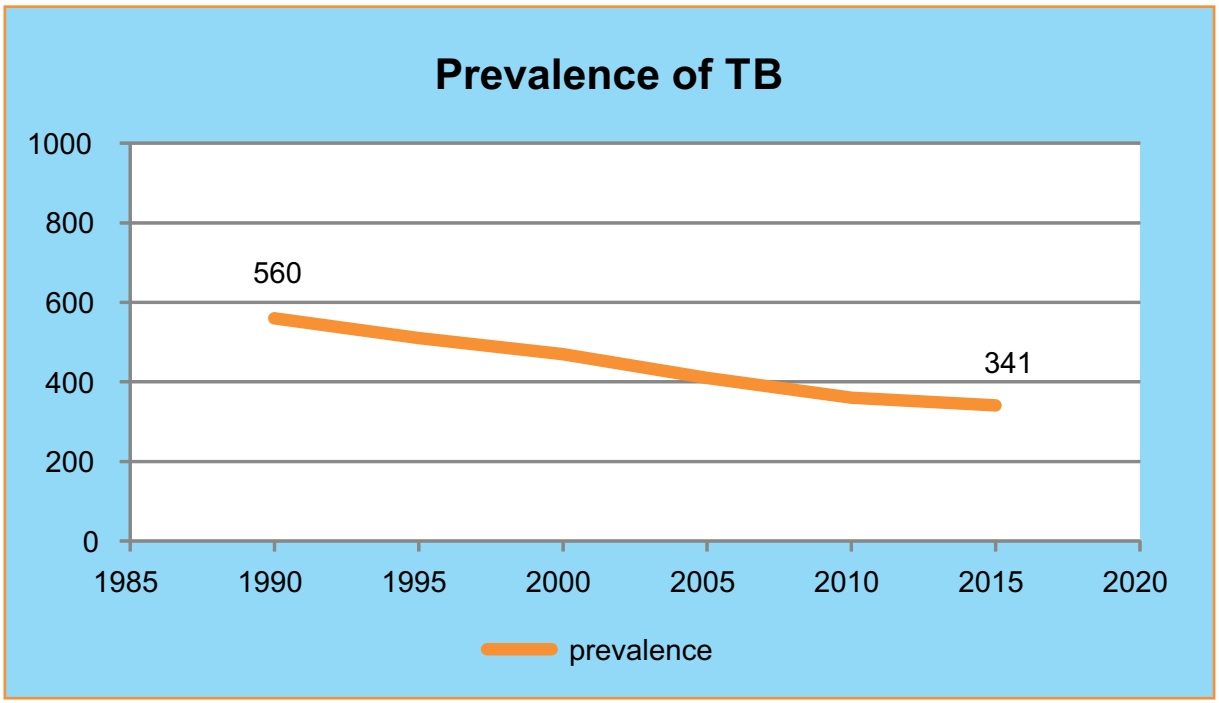
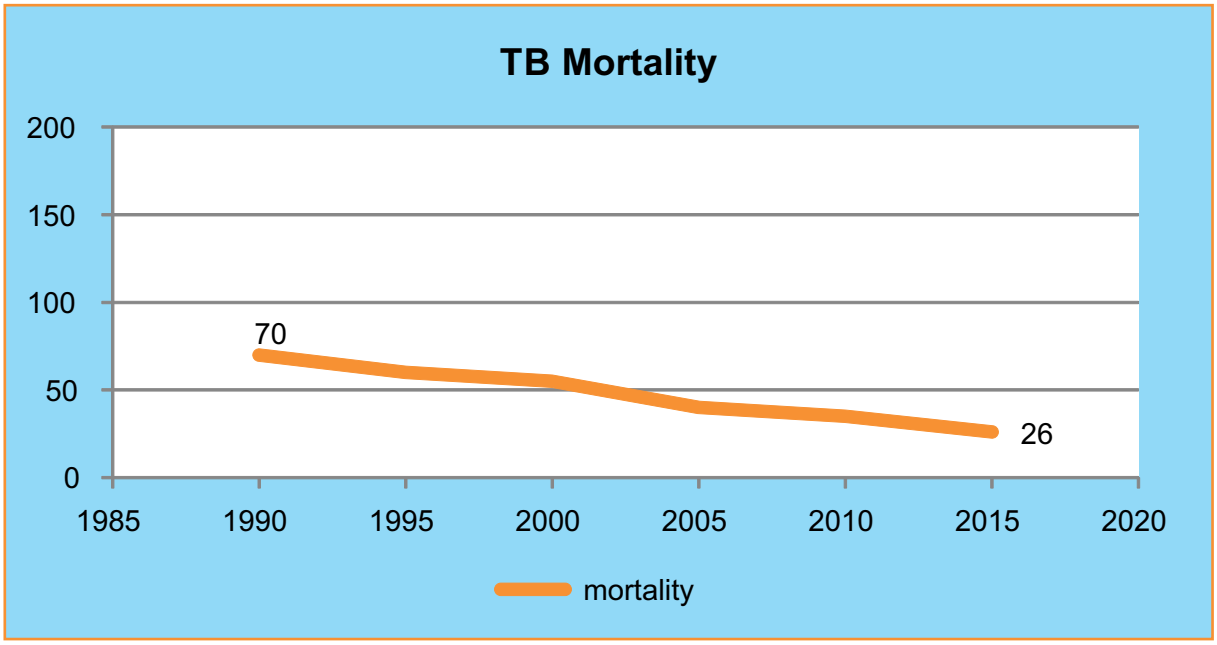


Figure 2: Prevalence Trend of TB in Pakistan



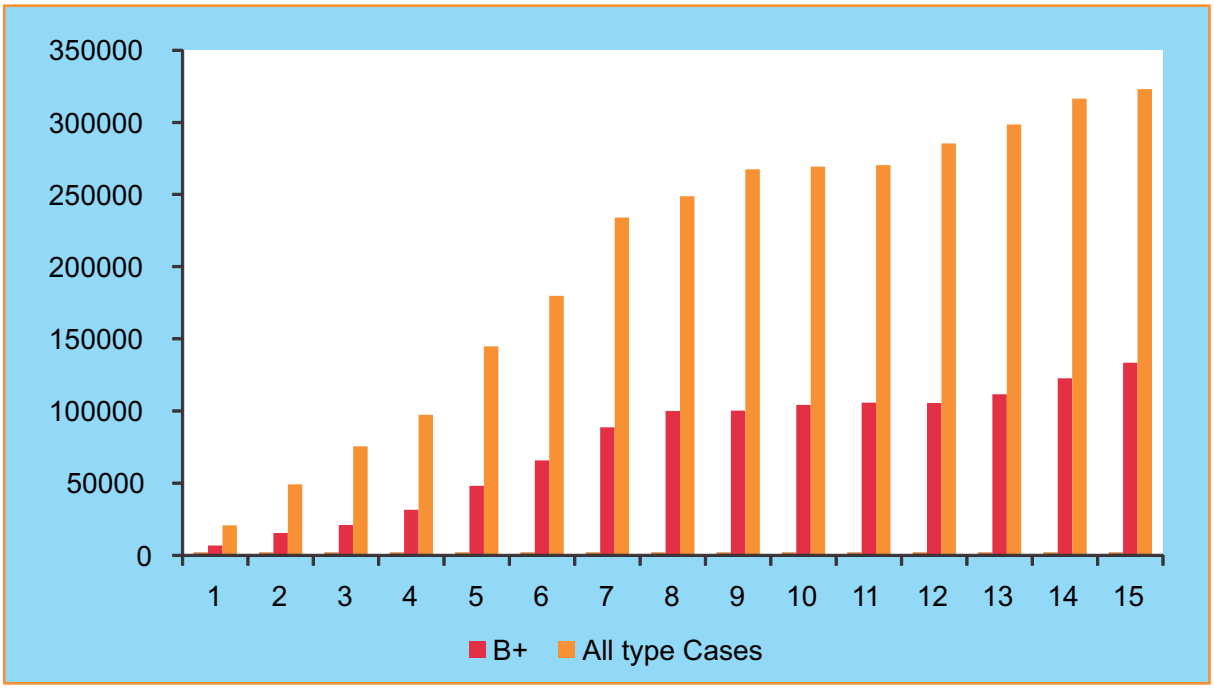
There has been an observed decrease from 560 to 341 per 100,000, which is a decrease of roughly 39% since the 1990. The target has not been achieved but is set on track.

Figure 2: Trend in TB Mortality



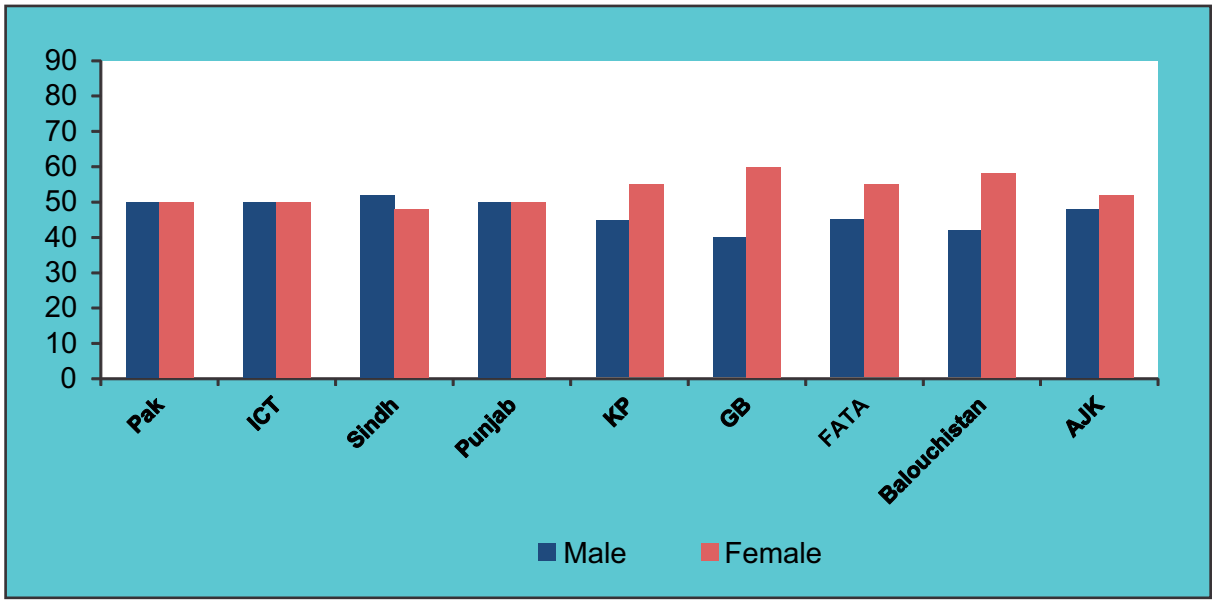
According to WHO Global TB report 2015, the Mortality Rate at country level is 26/100,000 during 2014 however the disaggregated data by sex is not available as per WHO reporting format. The motallities have fallen from 70/100,000 to 26/100,000 which is an estimated decline of 63% and Achieved target.

Table : Number of B+ and All Type TB Cases in Pakistan



The graph represents no. of B+ cases and all type cases from the year 2001 to 2015 and it has been observed that there has been an increase in number of cases through years.

Figure : Percentage of TB Cases By Gender



The proportion of the female is higher than male in the regions of Azad Jammu Kashmir, Balochistan, FATA, Gilgit Baltistan and Khyber Pakhtunkhwa. While the proportion for female and male in Punjab, Islamabad capital territory and Sindh is same. On the whole there is 50-50 proportion of male and female.

Table 12: TB Case Notification Rates in Pakistan

Region	Case Notification rate B+ (both sexes)	Case Notification rate All forms (both sexes)
AJK	44	124
Balochistan	38	87
FATA	30	84
GB	16	130
KP	62	174
Punjab	86	208
Sindh	63	133
ICT	35	137
Pakistan	72	174

Key affected population in TB are elderly (>65) and childhood TB cases (<15). The prevalence rate among these population is not separately calculated and is same as that for all ages i.e; 341/100,000

Estimates of TB burden in Pakistan (2015)		
	NUMBER (thousands)	**RATE per 100 000**
Mortality (excludes HIV+TB)	**48 (11-110)**	26 (6-61)
Mortality (HIV+TB only)	1.3 (0.76-1.9)	0.68 (0.41-1)
Prevalence (includes HIV+TB)	630 (530-740)	341 (285-402)
Incidence (includes HIV+TB)	500 (370-650)	270 (201-350)
Incidence (HIV+TB only)	6.4 (4.4-8.7)	3.4 (2.4-4.7)
Case detection, all forms (%)	62 (48-83)	

Estimates of MDR-TB burden (2015)		
	NEW	**RETREATMENT**
% of TB cases with MDR-TB	3.7 (2.5-5)	18 (13-23)
MDR-TB cases among notified pulmonary TB cases	9 000 (6 100-12 000)	2 900 (2 100-3 700)

TB case notifications 2015

	NEW	RELAPSE
Pulmonary, bacteriologically confirmed	122 537 7 420	122 537 7 420
Pulmonary, clinically diagnosed	120 350 426	120 350 426

Reported cases of RR-/MDR-TB 2014

	NEW	RETREATMENT	TOTAL
Cases tested for RR-/MDR-TB	361 (<1%)	11 685 (72%)	20 143
Laboratory-confirmed RR-/MDR-TB		3 243	
Patients started on MDR-TB treatment		2 662	

Treatment success rate and cohort size

	(%)	COHORT
New and relapse cases registered in 2013	(93)	289 376
Previously treated cases, excluding relapse, registered in 2014	(80)	7217
HIV-positive TB cases, all types, registered in 2014	(81)	37
RR/-MDR-TB cases started on second-line treatment	(71)	858
XDR-TB cases started on second-line treatment	(32)	41

TB Laboratories 2014	
Smear (per 100 000 population)	0.8
Culture (per 5 million population)	0.3
Drug susceptibility testing (per 5 million population)	0.1
Sites performing Xpert MTB/RIF	42
Is second-line drug susceptibility testing available?	Yes, in country

Financing TB control 2015	
National TB programme budget	US$ 50 millions
% Funded domestically	17%
% Funded internationally	60%
% Unfunded	23%

8.4 CO-MORBIDITY OF TB AND HIV

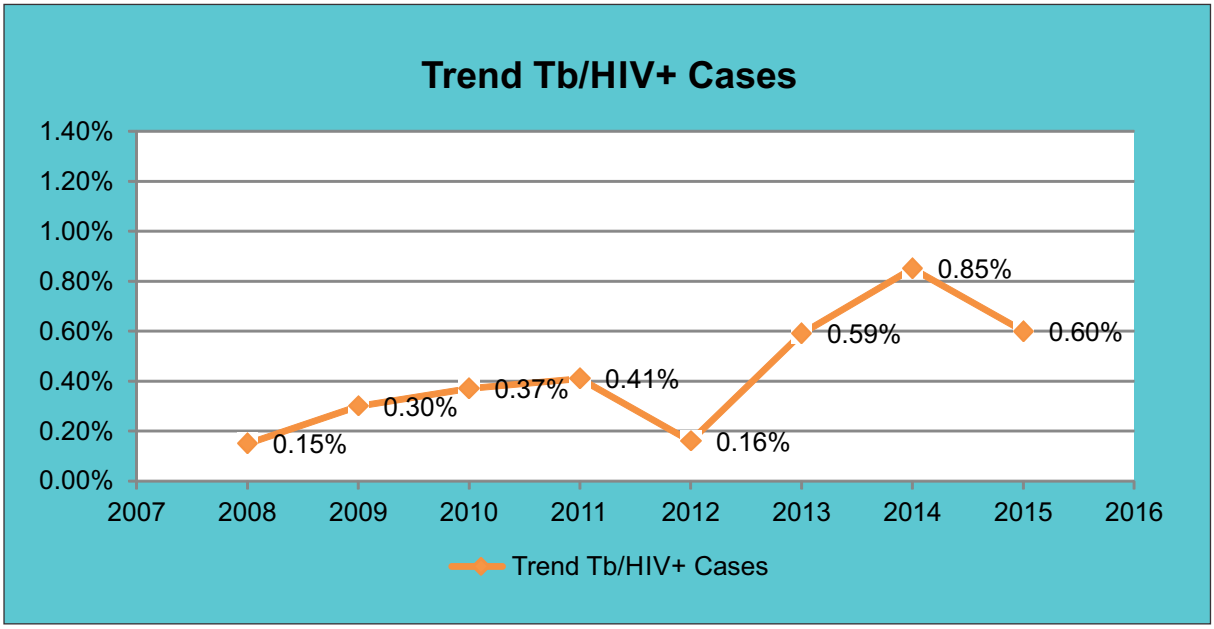
According to WHO, people living with HIV are around 29 times more likely to develop TB than persons without HIV. TB is the most common presenting illness among people living with HIV, including those taking antiretroviral treatment and is the major cause of HIV-related death. Most TB cases and deaths occur among men, but TB remains among the top three causes of death of women worldwide. There were an estimated 510 000 TB deaths among women in 2013, more than one third of whom were HIV-positive women. In a study done to assess the gender variations in delay from symptom onset to help seeking, diagnosis and treatment of TB it is evident that compared with men, women experienced longer delays at various stages of the clinical process of help seeking for TB which warrants appropriate measures to improve the situation. Gender dynamics in TB enrolment, treatment and cure rates are not uniform. In most low and middle-income countries about two-thirds of reported TB cases are men and only one

third women, and it is not well known whether this is due to a higher risk of developing TB among men or under-notification of TB among women with the evidence that women are less likely to be diagnosed with tuberculosis and successfully treated. It is evident that the health seeking and treatment behaviour of men and women living with HIV, TB-HIV co-infection or suffering from TB, requires a systematic assessment from a gender perspective to inform national planning and budgeting for gender-responsive and gender-transformative.

Table 13: Trend in TB + HIV Cases in Pakistan

Year	Trend TB/HIV+ Cases
2008	0.15%
2009	0.30%
2010	0.37%
2011	0.41%
2012	0.16%
2013	0.59%
2014	0.85%
2015	0.60%

Table 1: Trend in TB+ HIV Cases in Pakistan



TB/HIV 2014		
	NUMBER	**(%)**
TB patients with known HIV status	10715	(3)
HIV-positive TB patients)	90	(<1)
HIV-positive TB patients on co-trimoxazole preventive therapy (CPT)	90	(100)
HIV-positive TB patients on ART	90	(100)
HIV-positive people screened for TB	NA	NA
HIV-positive people provided with IPT	NA	NA

The trend for TB/HIV cases indicates that there is a steady increase in cases from 2008-2011, and then there is a sudden decline in the number of cases in the year 2012. While after that the number of cases increase exponentially for 2013-2014 with a decrease observed for the year 2015.

8.5 MODE OF TRANSMISSION OF TB & HIV IN PAKISTAN

AEM Modelling conducted at the end of 2013 for Punjab and Sindh, PWID were reported producing the bulk of new infections. While, model predicted an elevating prevalence of HIV in all key population groups, including transgender persons and especially Men who have Sex with Men (MSM). The crucial steps, in HIV Care & Treatment pathway, have been described as HIV testing, assessment of eligibility for ART, pre-ART care, initiation of ART and long-term retention on ART. The significance of linking diagnostic facilities with the ART clinics, and keeping the PLHIV's retained in care, has gained considerable attention, in particularly settings, where resources are much constrained and resulted in improved health outcomes for PLHIVs and overall reduced health care costs. While the situation in Pakistan, is even more challenging, where PLHIV, in need of life-long treatment can't access the healthcare systems, which at the same time, are less well developed.

National level mode of transmission study for TB has not been undertaken to identify the modes of TB transmission for women, girls, men, boys and transgender people.

8.6 KEY POPULATIONS FOR TB AND HIV&AIDS IN PAKISTAN

The key affected populations (KAPs) for TB are classified under following three distinct groups:

1. People who have increased exposure to TB bacilli (due to where they live or work – overcrowding, poor ventilation) like healthcare workers, household contacts of TB patients, workplace or educational facilities contacts, people living in urban slums and shared living facilities like orphanages, slums, old people homes, etc. are at risk of increased exposure to TB bacilli for a range of reasons including poor living and sanitary conditions, poor ventilation, overcrowding, malnourishment etc. Overcrowding in healthcare facilities, congregate settings especially prison and mining increases exposure – outpatient facilities and hospital wards.

2. People who have limited access to health services (due to gender, geography, limited mobility, limited financial capacity, legal status, stigma) like elderly and the mentally or physically disabled with limited mobility and support, remote population due to occupation like fishermen, miners, etc., the homeless, migrants, refugees, internally displaced, ethnic minorities and indigenous people who suffer stigma and discrimination. Also included are incarcerated people who may have limited access to health services.

3. People at increased risk of TB because of biological and behavioural factors that compromise immune function like people living with HIV, people with diabetes, people suffering from silicosis and lung disorders, those on long term therapeutic steroids, those on immune suppressant treatment and people who are malnourished are vulnerable to TB

because their compromised immune system are less able to fight infections. Certain lifestyle activities like smoking and harmful use of alcohol and drugs increase their risk of TB infection.

The proportion of key populations for TB at national level is not known in Pakistan.

Key affected population of HIV and AIDS include, People who Inject Drugs (PWID) Male and female Sex Workers, which are driving the epidemic in Pakistan. According to Integrated Behavioural and Biological Surveillance (IBBS) PWID has a national prevalence of 27.2% (weighted prevalence of 37.8%); followed by Hijra (Transgender) Sex Worker (HSW) standing at 5.2% and then 1.6% among Male Sex Worker (MSW). While, HIV prevalence among Female Sex Workers (FSWs) remained low at 0.6%. The HIV prevalence, among general population, still remained, as 0.09 percent as per the latest UNAIDS/NACP Spectrum/Epidemic Projection Package (EPP) estimates. The most at risk population (key populations) in various cities of Pakistan is given in Table 5.5

Table 5.5: Key Populations of HIV&AIDS- Estimates – 12 cities (2012)

City	IDUs	MSWs	HSWs	FSWs
Karachi	9000	4550	6350	13150
Hyderabad	2600	1350	1100	2300
Sukkhur	1350	900	250	2550
Larkana	800	900	600	375
Multan	900	1750	750	2725
Faisalabad	8030	4045	1400	6500
Sargodha	2450	1050	600	1237
Lahore	3350	1550	2600	14525
Gujranwala	2650	750	600	1725
Peshawar	150	1000	100	1200
Bannu	125	175	25	250
Quetta	150	1300	350	2500
Total	**31555**	**19320**	**14725**	**49037**

8.7 PROPORTION OF PEOPLE RECOGNIZING SYMPTOMS OF TB AND HIV&AIDS

Knowledge of TB and HIV&AIDS symptoms are available in most of Surveys in Pakistan but the national level de-segregated data of knowledge of key populations knowledge is not available. Almost 89% population have heard of TB and 76% of them recognize at-least three symptoms of TB. For HIV & AIDS while more than four in 10 ever-married women (42%) and seven in 10 ever-married men (69%) in Pakistan have heard about AIDS, only one in five ever-married women (20%) and two in five ever-married men (40%) says that consistent use of condoms is a means of preventing the transmission of HIV. Having heard of AIDS was low among 20-24 year old women (37.4%), an age by which nearly half (49.1%) of young women are already married.

8.8 PROPORTION OF POPULATION UNDERSTANING ASSOCIATION OF TB WITH HIV&AIDS

The national level estimate of population proportion that has an accurate understanding of relationship between TB and HIV is not available in Pakistan.

8.9 DISCRIMINATION AND STIGMA TOWARDS TB AND HIV&AIDS PATIENTS

Stigma and discrimination in general population against PLHIV is shown in various surveys. The Demographics and Health Survey (PDHS) 2012-13 reported overall, 17% of women and 15% of men expressed accepting attitudes of PLHIV.

The Stigma Index assessment was carried out in 2010 by APLHIV. In this assessment, a sample of 833 PLHIV was interviewed. Results of stigma index assessment showed that majority of patients were poor, without any employment opportunities resulting due to

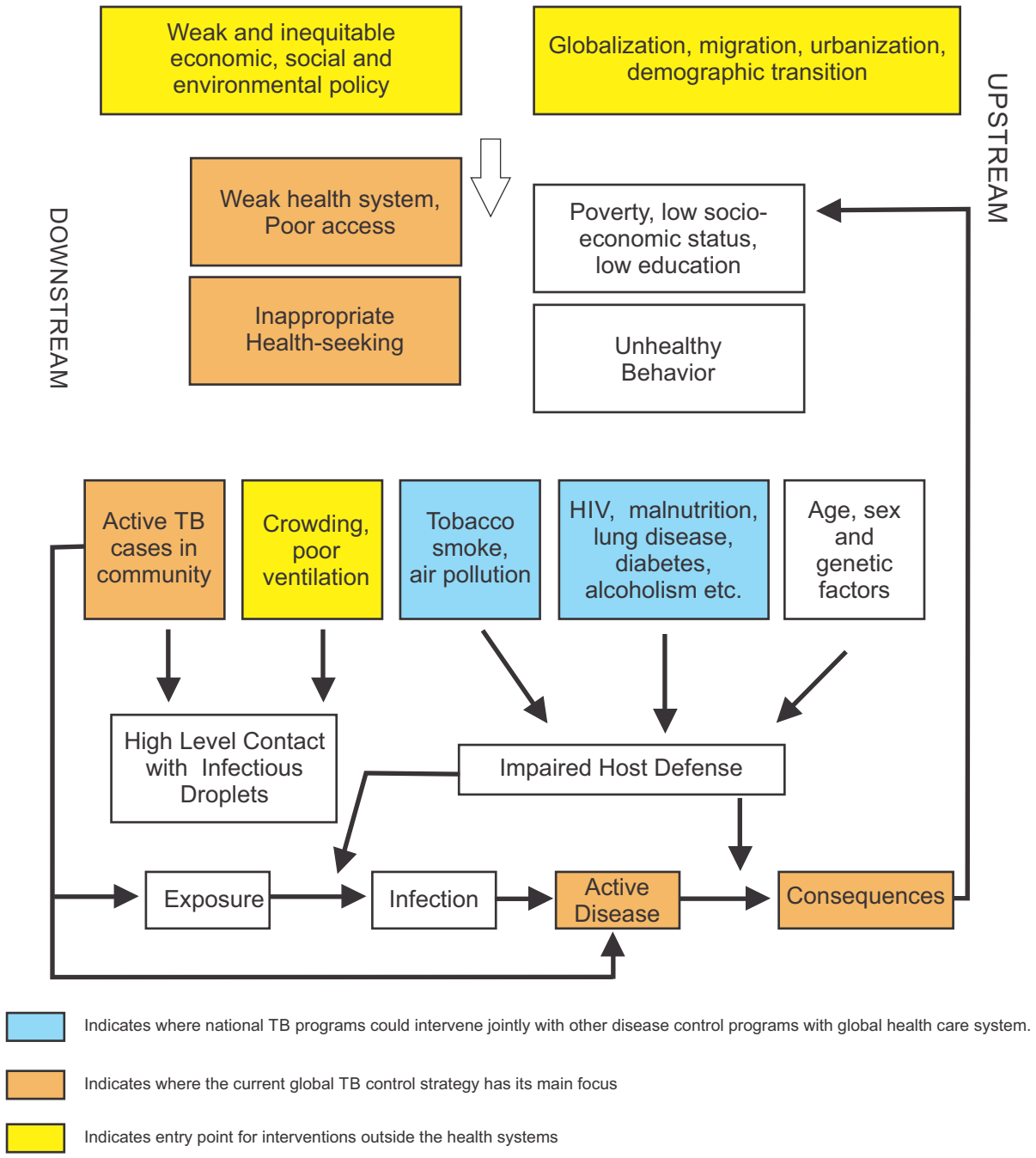
discrimination against their HIV status. The APN+ regional study undertaken in 2013, was also done by APLHIV. It looked at the access, initiation and adherence of ART. Results showed that 49.2% of respondents (n=525) reported to have denied medical services due to their HIV status; another 40% experienced some type of housing instability (forced to change place of residence or unable to rent accommodation because of their HIV status) and 25% reported their children were prevented, dismissed, or suspended from attending school in last 12 months. Although HIV response in Pakistan advocates against stigma and discrimination of PLHIV at multiple levels, there is no formal redress or legal services available to PLHIV. Although there are no HIV specific laws, Pakistan's constitution articulates equality and non-discrimination as fundamental rights. Articles 3 and 25 obligate the State to eliminate all kinds of exploitation, and to guarantee that all citizens of the country shall be equal before law and shall be entitled to equal protection of law. National level estimates of stigma and discrimination towards TB patients is not available in Pakistan.

8.10 INFORMATION ON GENDER AND DEMOGRAPHIC DESEGREGATED RISK OF TB & HIV

The monitoring and evaluation (M&E) systems of NACP is trying to capture gender disaggregated information as well as other important demographics related to risk, such as place of work, incarceration, pregnancy status, etc. for HIV and AIDS but this information is not available for TB at national level. Determinants of HIV & AIDS in Pakistan include the following:

- Untreated Sexually transmitted infections (STI) increases risk of HIV transmission and infection many fold. Women are more susceptible to HIV-1 infection due to hormonal changes, vaginal microbial ecology and physiology
- Poverty leads to limitations in healthcare, education, employment. Pakistan 36 million people (6 million households) fall below the poverty line. Due to poverty many men and women are driven to commercial sex to earn a livelihood
- Low literacy levels, religious and cultural influences hamper awareness about HIV, and talking about HIV and AIDS is still felt unethical here.
- Gender inequalities: restrictions on women's mobility & decision making power limits their information and knowledge seeking and reproductive health rights
- Migration for employment to foreign countries and from rural to urban.
- Social taboos and high stigma related to AIDS, sex and sexuality marginalize those most in need of health services and support systems.

8.11 SOCIO-CULTURAL NORMS AND PRACTICES CONTRIUTING RISK OF TB AND HIV&AIDS



For HIV & AIDS, 86% of reported HIV positive cases are found to be men. Furthermore 51.88% of the HIV infected men fall within the age group of 20-40 years. 24.59% of the reported cases are of unknown origin, 13.20% are females, and 45.10% of the total HIV carriers acquired the disease through sexual contact. In Pakistan the various risk factors and vulnerabilities for HIV & AIDS can be summarized as below:

- Concentrated epidemic among IDUs is a great risk
- Emerging epidemic among MSMs & HSWs;
- A very large percentage of youth; more than 63% of population less than 25 year; it is of great risk and concern due to their potential risky sexual behaviours.
- Well-established sex industry in many parts of the country
- Inadequate blood screening & professional donors whole over Pakistan
- Unsafe injection practices, mostly in private sector, which is uncontrolled and difficult to monitor as limited data about private sector is there in Pakistan
- Large number of migrants and refugees; internal as well as international migration has been continuous source of disease spread and Pakistan is one high risk country with huge population internally displaced as well.
- Low income levels and income inequalities; pushing people into unsafe sex and illegitimate sexual practices
- Low levels of literacy and education; with limited ability to develop healthy lifestyle and safe practices.
- Unemployed youth, out-of-school youth and street children; due to high number of these population groups, it is a great risk
- Silence, denial, stigma and discrimination; waiting for something to happen and causing problems for those who raise voice for this problem
- Gender inequalities: putting women on higher risk and less access to information and knowledge
- Youth seems to be the most vulnerable group in terms of HIV/AIDS and other infectious diseases.

8.12 LEGAL FRAMEWORKS TO PROTECT RIGHTS OF KEY AFFECTED POPULATIONS IN PAKISTAN

There is an enormous role of legal framework that might directly impact women and girls, men and boys, transgender people and key affected populations in relation to TB and HIV services. Extent to which legal frameworks that specifically protect the rights of people living with TB, HIV-TB, DR-TB, HIV, women and girls, and other key affected populations in the countryIn Pakistan

The Penal Code, Section 377, criminalizes male-to-male sex as “carnal intercourse against the order of nature” with the punishment of imprisonment with the possibility of fines. The Sharia law carries heavy penalties for homosexuality; for an imprisonment for 2-10 years or for life; or of 100 lashes or stoning to death (depending on whether the person is married or not). Sex work is also illegal and Section 9 of Control of Narcotics Substances Act (CSNA), 1997 allow for death penalty for drug offences depending on the quantity of the narcotic drug, psychotropic substance or controlled substance.

Progress in responding to the prevention, treatment and care needs of criminalised populations depends on mitigating punitive actions through engaging in public health and rights-based discourses with legislators and law enforcement agencies. However within these legal frameworks, Pakistan has shown some progress in increasing the accessibility of vulnerable population groups for getting TB and HIV treatments. The TB and HIV response makes special provision for provision of care to the key populations. There are international standards of TB care (ISTC), approved and endorsed by WHO for people with TB infection including universal access to TB care. The legislation over mandatory notification of TB cases act is in progress and the province of Sindh has got it approved from the legislative assembly. However country specific legal framework is not available.

8.13 ACCESS OF SERVICES TO PEOPLE LIVING WITH DISABILTIES (PLWD)

There are no specific programmes for people with disabilities in the TB and HIV&AIDS response. Although the national TB response includes older people, in particular older women

as key populations, there are no exclusive programmes to address their needs e.g. chronic care packages, including cervical cancer screening. However for women with restricted mobility, preventive and therapeutic care through community health workers such as Community workers is required which has been proved to be effective,,

8.14 MEANINGFUL PARTICIPATION OF CIVIL SOCIETY AND KEY POPULATIONS

In order to ensure meaningful participation of all stakeholders, a Country Coordination Mechanism (CCM) Pakistan has been established in response to Global Fund requirements. The CCM has five major functions according to the guidelines established by the Global Fund. These include:

- Managing the proposal development process, including the selection of one or more principal recipients
- Harmonization with other program support activities
- Organizing and managing the CCM activities
- Monitoring, oversight and evaluation of GF project implementation under Global Fund grants,
- Creation and distribution of minutes and information on GF activities

In line with the GF guidelines, CCM members have been selected from five main sector groupings with the following representation:

Public sector	12
Private sector	2
NGOs/CBOs	4
Faith Based Organizations	2
People Living with / or Effected by Disease	1
Private Academic and Research institutions	2
Multilateral/Bilateral agencies	5
Key Affected Communities	1
Total CCM Members	**29**

The Civil society organizations working on TB and HIV, representatives of identified key affected populations, and groups working on gender equality and women's rights issues are officially involved in CCM. Civil Society is significantly represented on CCM Pakistan and there has been four seats allocated for Civil Society. Civil society member inputs to CCM are very

frequent. Civil society sector is mostly the part of every CCM sub committee governing any aspects related to GF grants implementation. Civil society organizations represented on CCM are elected by their constituency.

This constituency consists of large number of members therefore, any matter related to GF grants is shared with large number of organizations and similarly the members representing civil society share the concerns and opinions of a larger group with CCM. In addition to this, Civil Society play a major role in GF grant implementation as the implementing partners. Civil society organizations are the sub recipient and the Principal Recipient for GF grants implementation. Civil society organization are also involved in Oversight role over the GF grants. Civil Society is heavily involved in the GF grants implementation, decision making and for oversight over GF grants in Pakistan.

Other than CCM there are no additional coordination mechanisms in different government sectors (e.g. gender, health or human rights) and levels for joint action on gender equality in the national TB and HIV response.

8.15 CAPACITY BUILDING OF KEY POPULATIONS OF TB & HIV

There are plan provisions available for capacity building and allocation of resources to support the participation of key affected population (KAP) in the TB and HIV response. TB response is ensuring participation through LHWs program and HIV & AIDS response is linkage community support through CHBCs. There is a significant and excellent role of APLHIV in Pakistan in establishing a positive women network that has been established under this association.

8.16 GENDER EQUALITY AND AWARENESS ABOUT TB AND HIV&AIDS IN PAKISTAN

Although Pakistan has shown some improvement in the status of women, still women and girls have lower socio economic status. Importantly, significant gap remain in social sector indicators like education and health, which may increase their vulnerability to HIV. There are many social restrictions to mobility and access to services so it is difficult for them to adopt sexual and reproductive health behaviour. There are many problems for women in health seeking, there are other problems in treatment services with many owmen reporting such problems. Another reason may be less autonomy of decision making for women who do not have any say in decisions regarding their health care.

The HIV epidemic in Pakistan is driven in norms around acceptable and unacceptable knowledge/behaviour such as women's awareness about condoms and negotiating condom use with spouses/intimate partners, or the cultural barriers to discussing SRH with adolescent girls and boys. In Pakistan gender is not limited to women only. This includes feminised males and hijra. These are also facing problems of gender inequality and social marginalization and stigmatization. This is mostly due to fact that society perceives their behaviour as against the norms of what women or men should do. Stigmatization results in their drop out form mainstream, which in turn makes the goal of reaching to this key populations for HIV prevention

and control very difficult. There is also a lack of operational and applied research to understand nexus between gender based violence (GBV) and HIV, which limits the formulation of a strategy to address this issue.

8.17 SENSITIZATION TRAINING IN GENDER, HUMAN RIGHTS, STIGMAAND DISCRIMINATION IN PRE-SERVICE CURRICULM

There are no specific pre-service sensitivity trainings in gender, human rights, stigma and discrimination in Pakistan. However medical and nursing graduates are taught ethics, which covers part of sensitivity training on gender and human rights.

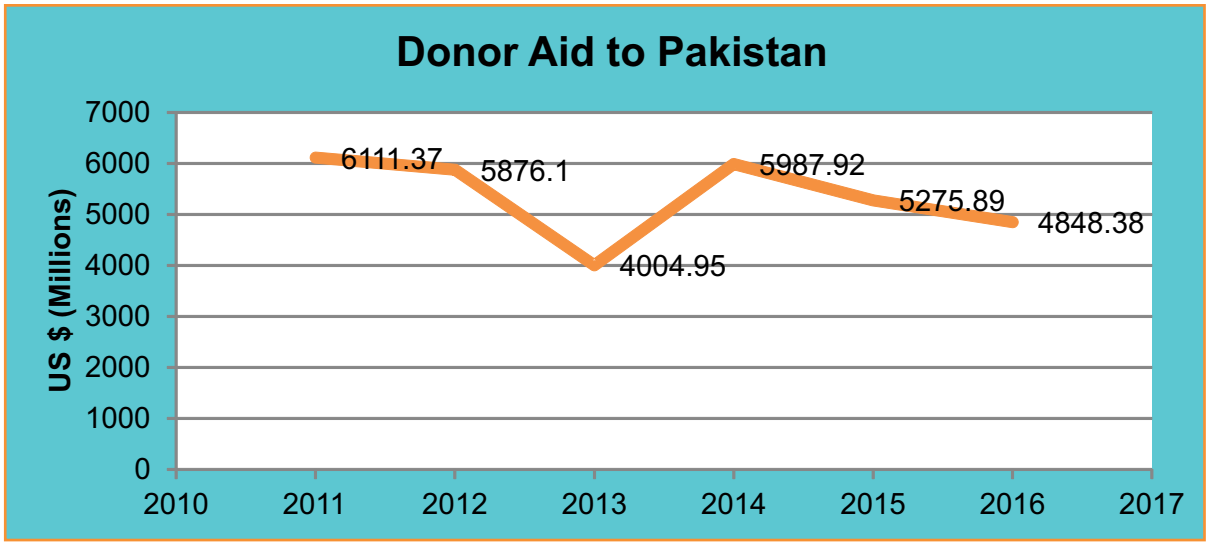
8.18 HEALTH EXPENDITURE TRACKING IN PAKISTAN

Pakistan has system of tracking National Health Accounts (NHA) for estimating the total healthcare expenditures (both public and private) at national level. NHA methodology actually tracks flow of funds through healthcare sector by compiling following four selected dimensions (i) Financing sources (ii) Financing agents (iii) Health care providers & (iv) Health care functions. NHA is a standard set of matrices, or tables, that presents various aspects of a nation's health expenditures and deals with the questions like, (i) who is financing health care in a particular country?; (ii) how much do they spend? and (iii) on what type of services? This globally accepted tool based upon the expenditure review approach, highlights the “financial health” of national health systems in respective country. NHA has developed the above three dimensions by including actual results of Out of Pocket health expenditures survey of private health care providers for 2009-10 and secondary data collected from various sources.

However TB and HIV specific financial information at national level is not available other than public sector financing of TB and HIV sector. NTP is estimated to have an outlay of Rs. 50 Billion and NACP has an outlay of Rs. 8 Billion.

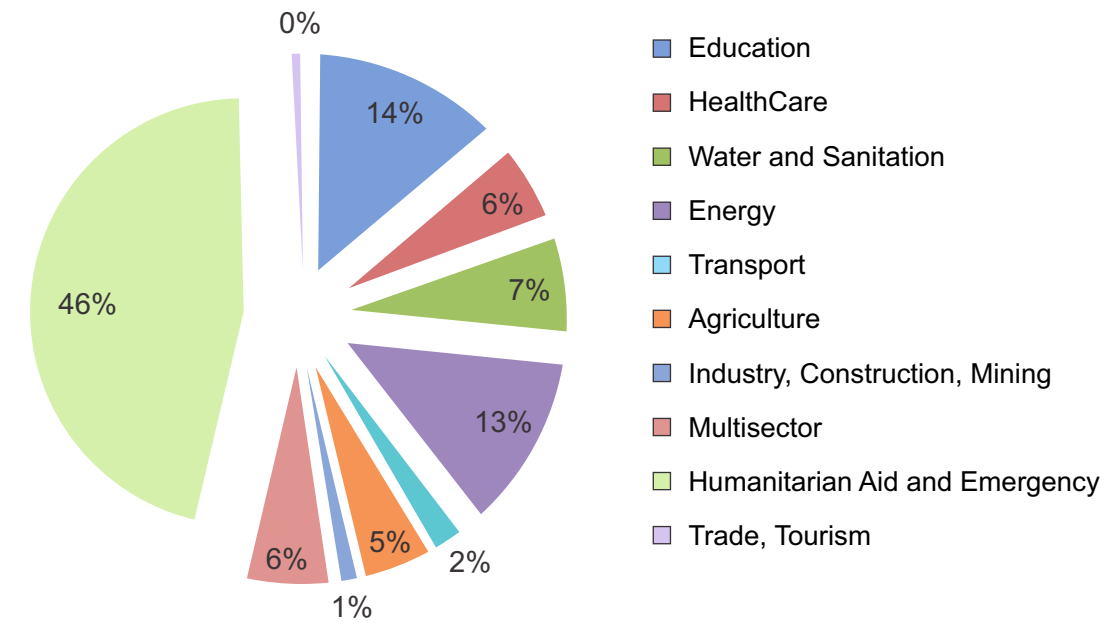
8.19 DONOR FUNDING IN PAKISTAN

The role of donors in health and social sector can be analysed in the following information:

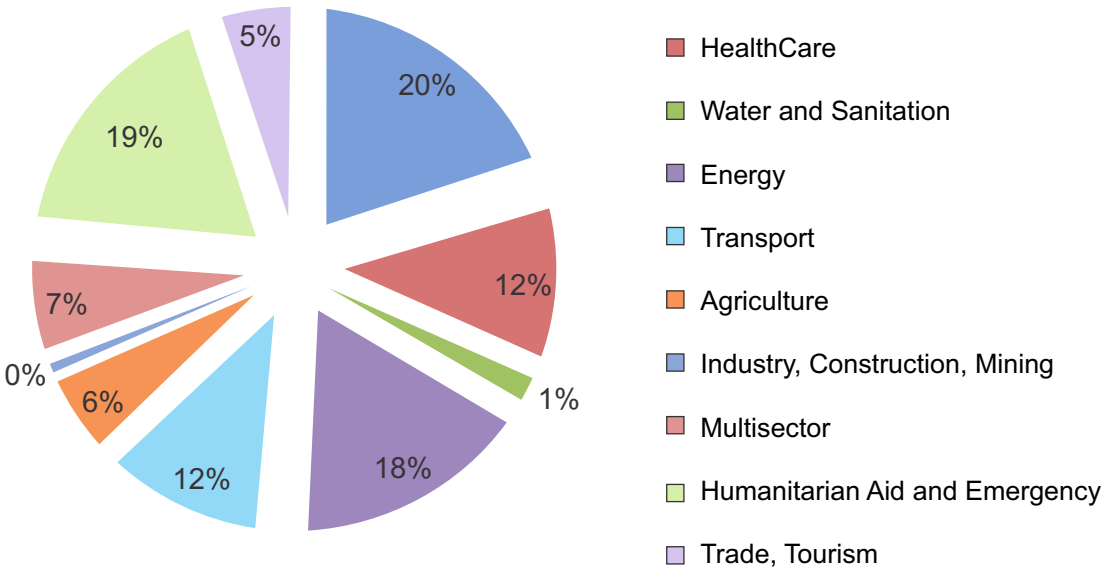


Above $300 Mil/Year	Below $300 Mil/Year
World Bank	European Commission
Asian Development Bank	JICA
USAID	DFAT – Australia
DFID	GiZ
US State	DFAT - Canada
Islamic Development Bank	

Donor Funding to Pakistan by Sector (2010)



Donor Funding to Pakistan by Sector (2013)



8.20 COMPREHENSIVE TB AND HIV RESPONSE INFORMATION TO POPULATIONS

The TB and HIV &AIDS response include the following services in Pakistan:

- Access to information about TB and HIV
- BCG vaccination
- INH prophylaxis for people living with latent TB infection
- TB contact tracing and treatment
- TB counselling and treatment adherence support
- Voluntary testing and counselling services for HIV &AIDS

The following services are not included and not in the preview of NTP or NACP:

- access to justice and benefit of the law
- addressing violence in all cases (including from, family, community)
- gender identity: protection against harmful gender norms and practices.

8.21 GENDER PARITY ACROSS PROVIDER OF CARE; AVAILABILITY OF FEMALE STAFF

Availability of female staff plays a vital role in the provision of health services to the women and children. In health care setting, it has been observed that availability of female provider tends to increase the service utilization rate in the periphery and hence is one good input indicator. In Pakistan, there are problems of female staff in both urban as well as rural areas, but the conditions in rural and remote areas are very poor. Sindh and Balochistan are having less number of LHVs, which makes provision of women friendly services in these provinces more challenging (Table 7).

Table 15: Female Staff By Province

S. No	Provinces	Female Staff				Total
		Reg. Nurses	Midwives	LHWs	LHVs	
1	Punjab	4282	4113	46720	2704	57819
2	Sindh	3226	465	19987	400	24078
3	NWFP	874	924	13044	8921	24363
4	Balochistan	154	1283	5710	544	7691
5	FATA	94	647	1706	280	2727
6	AJK	131	345	2656	204	3336
	Pakistan	**8761**	**7827**	**90423**	**13053**	**120014**

8.22 GENDER-BASED VIOLENCE (GBV) IN PAKISTAN

In Pakistan, more women are discriminately subjected to violence due to a multiple plethora of orthodox cultural norms. All kinds of violence are being used including: physical, sexual, emotional, economic and social. Victims of domestic violence may face a dual dilemma; they get abused at homes and there is also no protection outside homes. A study revealed that verbal abuse is 97 percent while physical abuse is 80 percent in the country. 34% reported ever being physically abused, 15% ever being physically abused. Women are even victimized during pregnancy; of the women interviewed, 44% reported abuse during the index pregnancy; and of these, 43% experienced emotional abuse and 12.6% reported physical abuse. This physical and sexual abuse especially during pregnancy causes anxiousness and depression among pregnant women.

Social and familial control over women's sexuality and commoditization of women is the one of the key determinants of gender-based violence. Government, though, affirms reproductive rights for every woman living in the country, practically women still lack control over their bodies. Awareness needs to be created among women about their 'Sexual and Reproductive Rights', this however needs improvement in female education and employment. Making women aware of the reproductive rights alone might not work, behavior and attitude change at individual, family and community level is vital to accept women as human being having rights and needs.

This will change gender norms and will have positive effect on women's status. Low status of women is not simply because of discrimination in one sector, but the underlying fact is the low value attached in general to women in Pakistani society. A single intervention therefore would not be adequate, wide range of effective multi- sectoral strategies (legal, economic, education, health, etc.) suggested are the need to eliminate injustice and inequality faced by women.

8.23 TB AND HIV RESPONSE FOR GBV

There are currently no partnerships between NTP and NACP on GBV; for representing women's rights, patients' rights, TB and HIV affected communities, and key affected populations to develop and implement programs and initiatives that address GBV and violence against women.

8.24 GENDER-BASED VIOLENCE (GBV) IN HUMANITARIAN CRISIS

In humanitarian crisis situation there is a specific program, the Gender Task Force (GTF) which tries to address gender-based violence and violence against women and girls. The GTF is co-led by UN-WOMEN and UNFPA; and is reporting to the Humanitarian Country Team (HCT) and functions as an overarching institutional mechanism that has a policy and advocacy (interagency and multi-sector) role for gender mainstreaming into the clusters. It identifies specific gender equality issues related to humanitarian action, and response. Gender analysis and disaggregation of data by sex and age are critical elements of strategic planning informing humanitarian appeals processes (including flash appeals and strategic response plans. This however needs to be combined with community support and advocacy groups that can promote use of such services by those in need during disasters. There is need to train and deploy community-based health workers, partner with private sector providers, incentivize healthcare providers for provision of TB and HIV services in remote and underserved communities during humanitarian crisis.

8.25 SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR)

According to traditions, girls are married early to start reproducing children, preferably sons. The average age of women for marriage has increased in the last fifty years from 17.9 in 1951 to 20.1years in 2012, however, about 20% females between ages of 15 and 19 are married, compared with 5% of males in the same age group. Women continue bearing children, since their status in the family and society at large is determined by number of children they reproduce. Cultural norms do not permit them to use contraceptives resulting into low contraceptive use (36%) and high fertility (3.9 per woman). Repeated pregnancies therefore make them prone to complications during pregnancy, delivery and immediately after birth. This is evidenced by high proportion of pregnancy and delivery complications (20%) in women in age group of 15-49; largest single contributor of death, disease and disability in women during their reproductive life. Vulnerabilities resulting from high fertility are compounded by inadequate care during pregnancy and delivery; only 49% of deliveries assisted by skilled healthcare provider. Moreover, lack of autonomy to seek further decreases the possibility of seeking timely healthcare as also evidence in other studies. In addition, woman's ability to exercise her right to

reproductive health and to negotiate her access to health services, when needed, is directly affected by gender, social, cultural and economic inequities they face.

In Pakistan HIV/AIDS and STIs appear to be main issue of concern of young female and males in Pakistan. Women are most affected as their knowledge and understanding of HIV/AIDS and STIs prevention is limited. Four in 10 ever married women age 15-49 have heard of AIDS according to the latest Pakistan and Health Demographic Survey 2012-2013. Researches in Pakistan show adolescents (both young girls and boys) to be acutely unaware of their sexual and reproductive health rights. They lack decision-making power and are most vulnerable during puberty. There are no formal mechanisms for adolescents to ensure provision of comprehensive education related to sexual and reproductive health. Issues around acceptability and mainstreaming of sexual minority groups are key component needed for interventions in Pakistan.

Pakistan does not have a sexual and reproductive health and rights (SRHR) policy. In the absence of such policy document, there are no established linkages between TB/HIV services and women's reproductive role demands.

8.26 SPECIFIC VULNERABILITIES OF YOUTH IN PAKISTAN

In Pakistan, a National HIV Prevention Strategy has been formulated, which classifies Pakistani youth into three categories (i) most at risk young people (young people living on the streets, sex workers, Injecting Drug Users (IDUs); (ii) vulnerable young people, adolescent labourers and out of school youth; and (iii) the general population of young people at home and in school. There has been very little documentation on the extent to which young people of these categories engage in risky behaviours. The evidence available in Pakistan shows, young Pakistanis have limited knowledge about reproductive, sexual health and HIV and AIDS. Additionally, myths and misconceptions exists about the determinants of sexuality, STIs, and reproductive health among these youth. It is a norm that parents and teachers do not want to or are unprepared to talk with young people about key issues related to sexual and reproductive health. Against this backdrop, the youth in Pakistan rely on information from mainstream media or from other youth peers, which may not be providing potent and reliable information. There are no ASRH services which may be readily available. This suggests that in order to bring a change there is a need to focus on HIV/AIDS prevention among youth and therefore the project aims to work with all stakeholders including youth, caretakers, gatekeepers and government ministries to enhance their knowledge, capacity, services and policies.

Pakistan does not have a country level children's TB policy. Similarly there is no children specific policy within the TB control that address specific vulnerabilities of children under age 15. So there are no separate framework for access to TB screening for children less than 15 years or access to free TB diagnostic services and treatment for children less than 15 years. However there is access to paediatric formulations of anti-TB drugs and Paediatric TB Guidelines in Pakistan.

8.27 BARRIERS TO ACCESS FOR GIRLS, YOUNG WOMEN

There are multiple issues of access to health services in Pakistan for girls, young women, including those from key affected populations. There is bias in food distribution between genders, with less calorie intake and high proportion of anemia among women. This results into poor health and infirmity, yet girl's illness is a social taboo that causes under reporting of illness by girls due to shame and guilt. Differentials exist in parent's practices to prevent son and daughters against major childhood killer diseases. Moreover, fewer amounts is spent on girl's healthcare as compared to boys, and lesser proportions of girls than boys are taken to health facility by parents in case of illness and receive medicines when prescribed. As a result, despite the existence of same number of health facilities for both genders, access to healthcare is far less by girls than boys,, ', even half in some cases. Throughout life women always rely on male family member's decisions for seeking health care because of their economic dependence and restricted mobility.

Pakistani women do not seek care appropriately because of lack of awareness of the health problem resulting from lack of education; low perceived worth due to low status given by society; and misconceptions about modern care due to cultural practices. What is more concerning is institutionalized gender bias within the health service delivery system resulting in severe scarcity of female healthcare providers. Although cultural norms in Pakistan underscore the need for reproductive health service providers to be females; yet there are extreme inadequacies in terms of number of female service providers resulting from inadequate sanctioned posts, inability to fill vacant posts, high attrition rate of female workers and neglect of women's basic and reproductive health needs, intensify women's disadvantaged health status. Health indicators of women in Pakistan are among the worst in the world.

8.28 GENDER RELATED POLICIES AND PRACTICES

Article 25 of 1973 Constitution of Pakistan guarantees equality of rights to all citizens irrespective of sex, race, and class and empowers the Government to take affirmative action to protect and promote women's rights. The Constitution upholds the equality and pledges protection of women in Pakistan.

8.29 WOMEN RIGHT LEGISLATION IN PAKISTAN

On March 8, 2002, on International Women's Day, National Commission for Women “for the protection of women's rights, and later in 2004, the Ministry of Women Development was established. In order to remove the misconception and improve the national image, following measures were undertaken:-

- Criminal Law (Amendment) Act of 2004 known as “honor killing law” was passed.
- Gender based Violence bills passed by Punjab, Balochistan, Sindh and AJK
- A quota for women in government services was increased to 5% (now 10 %).
- 17% seats were reserved for women in National and Provincial parliaments, and 33 %for women in most tiers of local government.
- It formalized the National Commission on the Status of Women, sought national consensus on a National Policy on Women, and set in motion a series of reforms to promote women's rights consistent with the global norms articulated in the CEDAW Convention.

- In order to end the social, political, and religious injustices against women, another significant initiative on women's rights was the Prevention of Anti-Women Practices (Criminal Law Amendment) Bill 2006 which banned the practices such as forced marriages, marriage in exchange for vengeance, and deprivation of women's inheritance.
- Another initiative, unanimously passed in the national assembly on January 21, 2010, and signed into law eight days later, was the Protection against Harassment for Women at the Workplace Act 2009.
- Acid-Throwing Legislation, titled as Acid Control and Acid Crimes Prevention 2011, bill was passed on 12th December 2012. It specifically cites penalties for causing harm or disfigurement by using a "corrosive substance," punishable by long imprisonment and fines of up to a million rupees.
- Elevation of National Commission on Status of Women (NCSW) in February 2012 is considered an important step for protection of women rights in Pakistan. The NCSW has been granted greater administrative autonomy to review laws, make recommendations, liaise with provincial governments, and overall gain greater scope, funding, and effect in redressing violations of women's rights.
- Pakistan has developed some policies and initiatives to advance the work of women's rights and gender equality. The Gender Reform Action Plan (GRAP) of 2005 at federal and provincial levels has been one of the projects demonstrating the government's commitment to gender equality, GRAP is mandated to undertake a coherent gender reform agenda, but after 18th amendments, there are no more exits available for these and need provincial level actions.
- Women Development Department was established on April 4, 2012 under "Punjab Women Empowerment Package 2012 (PWEP)". This policy document comprises multiple reforms in legal, administrative and institutional spheres while providing new initiatives to safeguard women's rights and is expected to transform the socio-economic status of women by expanding opportunities available to them. The newest self-contained administrative unit in the Punjab Secretariat, Women Development Department is mandated to lead the province towards Women Empowerment and Gender Equity following PWEP. Legislation undertaken by the Punjab Government includes Women Development Department (WDD) Bill 2012, The Punjab Commission on the Status of Women (PCSW) Bill 2013 and Punjab Protection against Harassment of Women at Workplace (Amend Bill) 2012 to establish a Women Ombudsperson.
- In Punjab, "The Protection of Women against Violence Bill 2015" became a law in February 2016. The law declares physical violence, abusive language, stalking, cybercrimes, sexual violence, psychological and emotional abuse against women a crime in Punjab. The bill, passed by the Punjab Assembly, features redress for female victims of violence, criminalizes all forms of violence against women and provides them with special centers, which remove the bureaucratic hurdles that complicate a woman's access to justice.

8.30 ELDERLY AND SENIOR CITIZEN PROBLEMS IN TB &HIV

Physically, socially and economically elderly population is a vulnerable group and due to emerging changes in our social set up they are mostly deprived of care. Old aged people need care, however it needs evaluation that in a resource limited country like that of ours, how much we can spend for this purpose. In our social set up where care of elderly is primarily a responsibility of children, poverty has augmented the dilemma. Pakistan lacks comprehensive data on prevalence of various diseases in elderly population. Studies have shown extreme deficiency of health and social care services for the elderly in Pakistan. Old age people are usually dependent on others for their medical care both physically and economically. The health facilities lack well-trained doctors in geriatrics and are not well equipped. Government representatives from 159 countries gathered for the Second UN World Assembly on Ageing and adopted the Madrid International Plan of Action on Ageing on April 2002 in Madrid, Spain. Advancing Health and Well being into Old Age is one of three critical priority areas highlighted in the Plan. WHO launched its Policy Framework on Active Ageing, which stresses the need that elderly must be enabled as active contributors and participants of society. The Policy Framework defines Active Ageing as the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. In addition to building on these two documents, i.e. the International Plan of Action on Ageing and the WHO Policy Framework, this brochure brings together two important areas of WHO work relating to the importance of primary health care, and how to adapt such care to the specific needs of different population groups. There is however no exclusive mechanism of provision of TB and HIV services to elderly in Pakistan.

9 RECOMMENDATIONS

Based on the findings of this review, various recommendations were presented for discussion in the consultative meeting. These have been categorized into Short-term, Medium and Long-term actions on the basis of time needed for implementation.

IMMEDIATE ACTIONS

9.1 **Establishment of "Gender Task Force for TB and HIV" in Pakistan**. There is a need of strengthening institutional response through a multi-sectoral coordinating body to lead the gender and human rights work in TB and HIV services in Pakistan. This can be based either in UNAIDS or UN-Women and it can suggest various task, roles, responsibilities and proper implementation modalities for recommendations. It can assign responsibilities to each GTF partner for ensuring transparency and accountability.

9.2 **Advocacy and communication plan** to help implementation of a four-prong strategy for a gender transformative HIV and gender responsive TB response. These four prongs include Advocacy and policy monitoring for gender mainstreaming in TB and HIV services; Gender sensitive TB and HIV service delivery and access; Training and capacity building of health providers involved in TB and HIV services; and Stimulating research on utilizing gender lens for assessment of care.

9.3 **Establishment and strengthen Gender-responsive information systems** and data management in TB and HIV&AIDS programs and it must be linked with existing HMIS/DHIS systems.

9.4 Integrating gender perspective in National Health Policies and Provincial level Strategies and also in TB and HIV program strategies

MEDIUM TERM ACTIONS

9.5 **Deployment of properly trained female healthcare providers** at all TB and HIV care centres wherever needed.

9.6 **Funding and Grants** for Gender Equality Interventions for TB and HIV in Pakistan. GEEW interventions, that it should be considered under GRB. There is a need of strengthening evidence base on gender equality, especially with reference to TB and HIV dimensions in Pakistan

9.7 **Gender responsiveness in challenging operating environments**. This will require a Gender Based Rights Complaint Procedure in TB and HIV care services

9.8 **Strengthening partnerships and collaboration for TB and HIV Response**. There is a need for greater cooperation and coordination between the gender machinery and program machinery to strengthen collaboration on gender equality, women's empowerment in context of TB and HIV response in Pakistan.

LONG TERM ACTIONS

9.9 **Integrated Program for TB and HIV Care at functional level or integration at the point of care**. It is essential that there is a functional or point of service level integration of HIV, TB, gender-based violence, and reproductive and sexual health services in Pakistan along with the provision of comprehensive care services including psychosocial and legal support. This integration can take up any shape in the long term; which may be a system of iintegrated TB and HIV services; One-stop health services for women (integrated TB, HIV, PMTCT, SRH, MNCH and Family planning) and Integrated or linked health services with TB, HIV and GBV services. It will require the partners under one umbrella, including the members of the GTF for TB and HIV.

9.10 **Empowerment of girls and women has immediate health results, ensures long-term impact**. It is important working with communities to address harmful gender norms. Various interventions can enable empowerment of girls and women, including;

- Ensure meaningful participation and representation of women living with HIV and women and girls from key population in the national TB and HIV planning, implementation and monitoring processes
- Ensure dedicated funding to support capacity development and advocacy efforts of community organizations, especially those are led by and for women living with HIV and other women at higher risk of TB and HIV
- Ensure empowerment of women and girls and addressing gender based discrimination and inequality is integrated and funded in the national HIV and TB response, including through various GF mechanisms.

9.11 **Interventions to Eliminate Gender-based Violence:** Although improvements in female education, employment and health will make them strong physically and socially and will provide them with knowledge and skills to protect themselves against violence. However, focussed interventions are also required to give them legal rights and focussed knowledge and skills to better protect themselves.

9.12 **Scaling up human rights services for women and girls** TB/HIV Aids programs should take into account the HR framework and address issues of stigma, discrimination and GBV. Scaling up human rights services for women and girls, must include legal rights literacy, access to justice, ending violence against women and community systems strengthening

9.13 **Strengthening Community Participation** to reduce vulnerability and to improve access for women and girls. Involving women and girls in designing, implementing and reporting on TB and HIV responses.

ANNEXURE

ANNEX-1:

LIST OF TB & HIV DATA SOURCES REQUIRED

1. What is the prevalence rate of TB in key affected populations of TB
2. Information on case notification rates in key affected populations disaggregated by sex and age
3. What is the latest national HIV incidence and TB notification rate (all new TB cases and all new smear-positive cases), disaggregated by sex; age at national level and by regions
4. What is the ratio of the case notification rate in men and women to the estimated prevalence in men and women?
5. If available, what is the ratio of the case notification rate in men and women to the estimated prevalence in men and women
6. What are the modes of TB transmission for women, girls, men, boys and transgender people?
7. Are there any locations of higher prevalence/incidence of HIV (e.g. rural, urban or specific geographic locations)?
8. What proportion of the population correctly identifies symptoms of TB/HIV and where to go for help?
9. Provide information disaggregated by sex (female, male and transgender), age and geographical location.
10. What percentage of young women, men and transgender people have knowledge of whether a person can reduce the risk of getting HIV by using a condom every time they have sex?
11. What is the percentage of the population that has an accurate understanding of the relationship between TB and HIV? Provide information disaggregated by sex (female, male, transgender), age, and geographical area.(TB data required
12. What is the trend in knowledge and access to services (disaggregated by sex and age) over the past five to 10 years?
13. What is the percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months?
14. What percentage of women and men aged 15–49 who have had more than one partner in the past 12 months used a condom during their last incident of sexual intercourse?
15. What is the trend in knowledge and access (disaggregated by sex and age) over the past five to 10 years?
16. Country data on unwanted pregnancy among unmarried adolescents?
17. Link between country policies and programmes for prevention of unwanted pregnancies and HIV prevention?

18. What is data on intimate partner violence (IPV)? Is data available on non-partner? Sexual violence? Describe and include age disaggregated data

19. Country data on stigma and discrimination within the health care system against people living with HIV, with TB, TB/HIV, or DR-TB? Please include data disaggregated by sex and age.

20. HIV/AIDAs monitoring and evaluation (M&E) systems (route recording and reporting or prevalence surveys) capture gender disaggregated? (Information as well as other important demographics related to risk, such as place of work, incarceration, pregnancy status, etc.)

21. What socio-cultural norms and practices may contribute to increased risk of HIV and TB transmission among women and girls, men and boys, and/or transgender people?

22. Country level data on age-disparate sexual relationships between older men and younger women? Also add any data on age-disparate sexual relationships between older men and younger men.

23. Are there socio-cultural norms and practices that contribute to the risk of HIV and TB transmission among key affected populations that were not named in Question 1? If so, what are these norms and practices, and what populations do they affect? Magnitude;(High risk HIV transmission; High risk TB transmission;

24. What socio-cultural norms and practices may contribute to gender differences in any of the issues described in the answers you provided for above question (e.g. knowledge, condom use, stigma, discrimination, early or unwanted pregnancy)?

25. According to available data, what are the factors or social determinants—such as economic vulnerability, multiple sexual partners, or alcohol or chemical dependence—that contribute to the continuation of these practices and behaviors? How? Please identify factors for a) individual, b) community and c) society levels. (Especially for HIV)

26. Role of legal framework or policy, basic health policies and other general government policies that might directly impact women and girls, men and boys, transgender people and key affected populations in relation to HIV, TB, TB-HIV, or DR-TB? If so, what aspect of their lives may be affected?

27. Extent to which legal frameworks that specifically protect the rights of people living with TB, HIV-TB, DR-TB, HIV, women and girls, and other key affected populations in the country?

28. Are all key affected populations (HIV) protected equally? Please specify.

29. Extent to which existing laws and policies translate into equal access to services for women, girls, men, boys, transgender people and key affected populations (TB)?

30. Do both the executive and legislative branches of government work towards

implementing the international treaties and declarations on which the country is a signatory? Please give examples of laws approved and services provided according to the 2011 Political Declaration on HIV/AIDS, the Beijing Declaration and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). Also consider regional commitments by governments i.e. AU, Southern African Development Community (SADC)(For TB)

31. Is there any indication of discriminatory or coercive practices in health-care settings that may impact access and utilization of HIV and TB-related services by women living with HIV, including those from key and marginalized populations?

32. Is there any indication of discriminatory practices by the judiciary or law enforcement personnel (including the police) that may prevent women, girls or any other key or marginalized populations from accessing their rights? If so, please describe.

33. Which populations are addressed in the HIV and TB national response? Please disaggregate by age and gender. (TB data is required)

34. Does the national, TB response include people with disabilities? If yes, are there specific programmes for people with disabilities in the response?

35. Is there a difference between the way the needs of men/boys and women/girls are addressed by it? If yes, are there programmes to address their needs (e.g. chronic care packages, including cervical cancer screening)?

36. Does the TB response recognize, plan for and address gender issues related to any of the following?

- Early and forced marriage
- Access to health care services barriers to care-seeking based on religious or cultural beliefs and traditions
- Barriers to care-seeking based on religious or cultural beliefs and traditions
- Incarceration
- Forced displacement, internal or international migration for work
- Occupational risks (e.g. Mining)
- Disabilities
- Race, ethnicity, indigenous status
- Rural/urban specificities
- Socio-economic status
- Smoking and alcohol abuse

37. Role of a formal system of accountability for the HIV/TB response that allows civil society, UN agencies and citizens to monitor the spending on gender equality within the HIV and TB response? how should it work?

38. Are networks and organizations representing people living with TB, women's rights, sexual and reproductive health, gender equality, youth and key affected populations engaged in decision-making at different stages, levels and sectors of the country TB response (including design and implementation)?

39. What national gender equality policy/guideline provides guidance to the national HIV and national TB response?

40. Inequality between women/girls and men/boys and transgender people?

41. Stigma and discrimination toward people living with HIV and those who acquired TB, particularly women and girls living with HIV and who acquired TB (including transgender people)—in the provision of HIV and TB and other health services, as well as the social welfare and judiciary systems?

42. Stigma and discrimination against key affected populations?

43. Does the pre-service curriculum of health-care workers include sensitivity training in gender, human rights, stigma and discrimination?

44. Accessible system of information such as the National AIDS Spending Assessment— that documents expenditures (national and external) on gender and HIV in the country?

45. Accessible system of information that documents expenditures (national and external) on gender and TB in the country?

46. Based on the type of epidemic and the affected populations groups, are the specific needs of women, girls, men, boys and transgender people considered in the budget allocated to the national HIV/TB response?

47. Does the TB/HIV response disaggregate financial data collection and reporting by sex and age?

48. Are the HIV and TB prevention and supportive services generally available (TB Data)?

49. Identify gender-related impediments to accessing, using and/or adhering to prevention services for women, girls, men, boys, transgender people and key affected populations that should be considered and addressed.

50. Do prevention services respect, promote and protect the rights in a way that is independent of marital status, profession and age, or are there indications that these principles have been violated? (TB)

51. What is the percentage of coverage for services that prevent vertical transmission?

52. What is the percentage of girls and boys, aged 10 to 14, who received an HIV /TB test in the past 12 months and know their results?

53. What is the percentage of transgender people who received an HIV/TB test in the past 12 months and knows their results?

54. What is the percentage of people who use drugs who received an HIV test in the past 12 months and know their results?

55. What is the percentage of TB infected (women, men, transgender people) who received an HIV test in the past 12 months and know their results, disaggregated by sex?

56. What is the number of people (disaggregated by age and gender) diagnosed with HIV and started treatment in the past 12 months?

57. What is the number of people (disaggregated by age and gender) diagnosed with TB and started treatment in the past 12 months?

58. What is the number of people (disaggregated by age and gender) diagnosed with MDR-TB and started treatment in the past 12 months?

59. What is the current national average viral suppression rate, if available?

60. Are there gender factors for the use of—and adherence to the following services among women, girls, men, boys, transgender people and key affected populations that should be considered and addressed?

61. Do TB care and support services respect, promote and protect the rights of women, girls, men, boys, transgender people and key affected populations in a way that is independent of marital status, profession and age, or are there indications that these principles have been violated?

62. Is there gender parity among providers of care and support at the community level? Please describe.)

63. How (GBV) is addressed within HIV/TB programmes and services?

64. Do the national HIV and/or gender policy guide the HIV response in recognizing the link between gender-based violence and HIV, both in terms of increased risk of HIV transmission as a result of violence and persons living with HIV experiencing violence as a result of their HIV status?

65. Does the TB response address attitude of public service providers (such as health workers, uniformed services, teachers, etc.) about violence against women and gender-based violence?

66. What is the role of country humanitarian crisis situation, is there a specific program to address gender-based violence and violence against women and girls? If so, please describe its relation to HIV and to TB

67. Are SRHR services are equally accessible to young women, men, transgender people and other key affected population (e.g. special clinic timings, mobile units targeting specific groups, etc.)

68. What are the most common gender-related barriers and challenges to accessing integrated HIV, TB and SRHR services and commodities?

69. Does the gender policy guide the HIV and TB response in terms of recognizing and addressing both the gender aspects of the HIV and TB epidemic and the specific HIV and TB risks and vulnerabilities of women and girls (including those from key affected populations)? Please elaborate.

70. Effect national HIV and TB and/or gender policy guide the HIV and TB response to work with men and boys in addressing gender-related cultural norms (e.g. smoking and alcohol abuse) and expectations that may negatively impact both HIV and TB vulnerability and access/adherence to HIV and TB services?

71. Effect of HIV and TB policy guide programmes and initiatives for key affected populations? If yes, please indicate the activities by ticking the applicable box.

72. Relationship of country youth policy (either a stand-alone or as part of the HIV policy/TB policy)? If there is no youth-specific policy, are there regulations within the HIV and/or health framework that address the specific vulnerabilities of young people, in particular girls and young women? Please explain and describe.

73. Does the national HIV policy include programmes and services that specifically target the needs and rights of young key affected populations?

74. National elderly/ senior citizen policy? Does the gender policy (or senior citizen policy as referred above and their inter linkages guide the HIV and/or TB response in terms of recognizing and addressing both the gender aspects of the HIV and/or TB epidemic and the specific HIV and/or TB risks and vulnerabilities of elderly women?

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