

Global AIDS Response Progress Report 2014

COUNTRY PROGRESS REPORT PAKISTAN

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Ministry of National Health Services Regulation and Coordination

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TABLE OF CONTENTS

ACRONYMS

FOREWORD

I. STATUS AT A GLANCE

- a. Description of the report-writing process
- b. Status of the HIV epidemic
- c. Policy and programmatic response
- d. Summary table of Core Indicators

II. OVERVIEW OF THE AIDS EPIDEMIC

- a. Background
- b. Current situation

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

IV. BEST PRACTICES

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

- a. Progress on key challenges reported on in UNGASS 2012 report
- b. Major challenges faced in 2012-2013
- c. Proposed remedial strategies

VI. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

VII. MONITORING AND EVALUATION ENVIRONMENT

- a. Overview of the current M&E system
- b. Challenges faced in implementation of M&E system
- c. Remedial actions
- d. Need for M&E technical assistance and capacity-building

ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV and AIDS

ANNEX 2: National Commitments and Policy Instrument (NCPI)

ACRONYMS

ACP	AIDS Control Programmes
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
APLHIV	Association of People Living with HIV
ART	Antiretroviral Therapy
ARV/s	Antiretroviral/s (medication)
BISP	Benazir Income Support Program
CBO	Community-Based Organization
CCM	Country Coordination Mechanism
CHBC	Community and Home-Based Care
CIDA	Canadian International Development Agency
CoPC	Continuum of Prevention and Care
CSO	Civil Society Organization
DHS	Demographic Health Survey
DoC	Declaration of Commitment
EHACP	Enhanced HIV/AIDS Control Programme
EID	Early Infant Diagnosis
FATA	Federally Administered Tribal Areas
FSW	Female Sex Worker
GARP	Global AIDS Response Progress
GARPR	Global AIDS Response Progress Report
GIPA	Greater Involvement of People living with AIDS
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoP	Government of Pakistan
HASP	HIV/AIDS Surveillance Project
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSW	<i>Hijra</i> Sex Worker
HTC	HIV Testing and Counselling
IBBS	Integrated Biological and Behavioral Surveillance
IDP	Internally Displaced Person
IDU	Injecting Drug User
IPC	Inter- Provincial Coordination
KP	Key Population
KPK	Khyber Pakhtunkhwa

M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MICS	Multi Index Cluster Survey
MIS	Management Information System
MoE	Ministry of Education
MoH	Ministry of Health
MoIPC	Ministry of Inter-Provincial Coordination
MoLJ	Ministry of Law, Justice and Human Rights
MSM	Men who have Sex with Men
MSW	Male Sex Worker
MTCT	Mother to child Transmission
MTR	Mid-Term Review
NACP	National AIDS Control Program
NCPI	National Commitment and Policy Instruments
NCSW	National Commission on the status of Women
NEP	Needle Exchange Program
NGO	Non-Governmental Organization
NMHA	Naz Male Health Alliance
NPM	National Program Manager
NSEP	Needle Syringe Exchange Program
NSF	National Strategic Framework
NTP	National Tuberculosis Program
NZ	Nai Zindagi
OST	Opiate Substitution Therapy
P&D	Planning and Development
PACP/s	Provincial AIDS Control Programme/s
PAS	Pakistan AIDS Strategy
PC	Planning Commission
PC-1	Planning Commission Proforma - one (Project Document)
PCSW	Provincial Commission on the status of Women
PITC	Provider Initiated Testing and Counselling
PLHIV	People living with HIV
PPM	Provincial Program Manager
PMTCT	Prevention of Mother-to-Child Transmission
PPTCT	Prevention of Parent-to-Child Transmission
PR	Principal Recipient/s - GFATM
PWID	People who Inject Drugs

RST	Regional Support Team - UNAIDS
SDP	Service Delivery Package
SGS	Second Generation Surveillance
SOP	Standard Operating Procedure
SPO	Senior Program Officer
SR	Sub-Recipients - GFATM
SRA	Situation Response Analysis
STI	Sexually Transmitted Infection
SWD	Social Welfare Department
TG	Transgendered person
TOR	Terms of Reference
TWG	Technical Working Group
UN	United Nations
UNAIDS	United Nations Joint Program on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCCT	Voluntary Confidential Counselling and Testing
VCT	Voluntary Counselling and Testing
WB	World Bank
WDD	Women Development Departments (WDD)
WHO	World Health Organization

FOREWORD

Pakistan committed to respond to its national HIV epidemic by endorsing the Declaration of Commitment (DoC) of the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS of 2001 and to achieve the 6th Millennium Development Goal (MDG) of *'halting and beginning to reverse the HIV/AIDS epidemic by 2015'*. In 2002, the UNAIDS Secretariat and Co-sponsors developed a series of core indicators for all countries to provide consolidated progress made on specific areas of the DoC and bring uniformity to reports encompassing diverse epidemics across the globe. Pakistan has already submitted five progress reports in 2003, 2005, 2008, 2010 and 2012 as per the UNGASS and Global AIDS Response Progress Report requirements. This 2014 report represents the sixth such progress report.

The GARPR reporting period from January 2012 to December 2013 has been prepared through consolidation and analysis of Second Generation Surveillance (SGS) data, service utilization reports - from HIV testing and counselling (HTC), treatment, prevention, care and support centres; monitoring and evaluation (M&E) data of the National and Provincial AIDS Control Programmes (N/P/ACP) and interviews with key informants from Government, multilateral, civil society and community-based organizations (CBOs), including the Association of People living with HIV (APLHIV). In the present report, 21 out of 32 indicators (including 6.1 Funding Matrix and 9.1 Travel Restrictions) have been validated. These indicators comprehensively describe various facets of the epidemic in Pakistan as well as progress of the national response to date. The remaining indicators, although relevant, have not been reported on due to non-availability of data.

Pakistan's epidemic continues to expand, concentrated among key populations and driven by injection drug use. HIV prevalence among people who inject drugs (PWID) is 27.2% across urban centres. Prevention remains the most funded programmatic area of the country's response. In 2010-2011, implementation of the 18th Amendment of the Constitution of Pakistan dictated the 'devolution' of the Ministry of Health (MoH) to the provincial level, giving the provinces more control over their epidemics. Today all provinces have their own AIDS strategies and comprehensive costed planning documents in the pipeline with Punjab's already approved.

STATUS AT A GLANCE

a. Description of report-writing process

Pakistan initiated the report-writing process for the Global AIDS Response Country Progress Report (GARPR) in early 2014. The NACP, in collaboration with UNAIDS and other members of the Joint UN Team on AIDS, started the process by constituting a Technical Working Group (TWG) which includes representatives from the NACP, Punjab AIDS Control Programme, UN agencies (UNICEF, UNODC, and WHO), and civil society organizations (CSOs): The Association of People Living with HIV (Sub-recipient [SR] for Global Fund [GF] regional Round 10 grant), Nai Zindagi (Principal-recipient [PR] for GF Round 9 grant), and Naz Male Health Alliance (SR for GF regional Round 9 MSM grant). The first meeting of the TWG took place beginning March in which TWG members agreed upon the relevant indicators to report on, the timeline and process of data collection, analysis, validation and report-writing. A consultant was hired for collecting information on the National Commitment and Policy Index (NCPI) indicator and the writing of the narrative report receiving assistance from the NACP and UNAIDS when needed. The task of NCPI was taken-up first and prepared through a process of desk review, consultations, key informant interviews, and self-administered questionnaires. A total of 5 key respondents for part A and 7 respondents for part B were identified by the TWG and each respondent was requested to address sections relevant to them. Data collection was accomplished through face-to-face interviews conducted at the convenience of the respondents and electronic submission of self-administered questionnaires. Following the first meeting consultations, in person and electronically, on the process, methodology and information-exchange between the consultant and the TWG, the first draft of the narrative and other indicators of the report were shared electronically and inputs incorporated till a final version was prepared.

The indicators, narrative, and the results of the NCPI were shared with national and provincial stakeholders representing the Government, UN agencies, CSOs and Non-Governmental Organizations (NGOs) in a National Consultation held 21st March 2014. Inputs received during the meeting were incorporated. Validation and consensus were reached in this meeting. A final meeting of the TWG was held virtually on 29th March following the national consultation to review the final draft, ensure inputs from the consultation were incorporated and to sign off on the final draft before submission.

b. Status of the HIV epidemic

Like other Asian countries, Pakistan is following a comparable HIV epidemic trend having moved from 'low prevalence, high risk' to 'concentrated' epidemic in the early to mid-2000s among key populations. The trend of concentrated HIV epidemic among key populations (KP) in Pakistan continues to be driven by people who inject drugs (PWID), with HIV prevalence at 27.2% in 2011. After PWID, prevalence was highest among *hijra*, or transgendered sex workers (HSW) at 5.2%, and then 1.6%

among male sex workers (MSW). Among the key populations identified in the country, female sex workers (FSW) exhibit the lowest HIV prevalence of 0.6%. The geographic trend of the epidemic began with surveillance and programming beginning in major urban cities and provincial capitals and expanding over time to smaller cities and towns.¹

Key Population Estimates in Pakistan 2009:	
• People who Inject Drugs (PWID):	91,000
• <i>Hijra</i> /transgendered Sex Workers (HSW):	42,877
• Male Sex Workers (MSW):	62,636
• Female Sex Workers (FSW):	136,300

In Pakistan, as elsewhere, contextual and structural changes are occurring in sex work. Recent improvements in communication technology, especially the easy and wide availability of cell phones, has diminished street-based sex work as sex workers and clients can now directly interact without the need of going through a third person. This has dispersed female sex workers and made them more difficult to access. In contrast, Naz Male Health Alliance working in the community with MSM has noted a growing phenomenon of boys in college and university selling sex to earn money for tuition often either renting a room together or working out of *hijra deras*.

Other than the key populations, including adolescent and young, evidence also suggests certain populations are at increased vulnerability and have started to become infected. These populations include spouses/intimate partners of PWID, MSW and HSW, imprisoned populations, street-associated adolescents and persons in certain occupational settings, including in some cases through nosocomial infection. Migrant workers and their spouses are also at increased vulnerability and were among the first HIV cases detected in Pakistan and continue to be the largest infected population in Khyber Paktunkhwa province. While evidence overwhelmingly calls for a focus on key populations, it is essential that prevention strategies and ‘low-threshold’ programs also be sustained for these larger segments of the population.

Pakistan had an estimated 83 468 people living with HIV by the end of 2013², with 7568 PLHIV registered in 18 HIV centres by end of 2013. Out of these, 3211 adult PLHIV and 70 children were on ART. Looking at recent trends there has been a slight decrease in the number of PLHIV registered at HIV treatment centres and on ART. On average, in 2012-2013 there were 33 PLHIV initiated on ART per month from 40-45 reported in the 2012 GARPR. Relative to the estimated number of PLHIV in the

¹ There are no population estimations for MSM but the AEM modeling done in 2013 suggests that .3% of the population (Sindh and Punjab) are MSM. In 2011 the number of males in Pakistan was estimated by the Pakistan Bureau of Statics to be 91.59 million (Pakistan Statistical Year Book 2011). In 2012 adolescents were around 22% of the population (United Nations Population Division). Excluding adolescent boys, a conservative estimate of MSM in Pakistan would be nearly 215,000.

² Spectrum, March 11th 2013.

country, the number of registered PLHIV within the health care system remains low. HIV treatment, care and support facilities are available through 18 HIV treatment centres, 5 paediatric AIDS centres, 16 VCCT and 11 prevention of parent to child transmission (PPTCT/PMTCT³) sites. Under Global Fund Round 9 till now 11 CHBC sites have been established. Majority of the treatment, care and support facilities are confined to key cities⁴.

c. Policy and programmatic response

Although there have been considerable efforts to implement a multi-sectoral response to Pakistan's epidemic, they have been complicated over the last five years due to conflict, insecurity, natural disasters, capacity, competing priorities and funding gaps. Currently the response is led by the health sector, and encompasses HIV prevention, treatment, care and support, with a priority focus on reaching key populations. The National Strategic Framework-II (NSF-II) completed its five-year time-frame in December 2011. Currently Pakistan's programming response, including policy advocacy, is rooted in the provincial strategic frameworks, or AIDS strategies. As a consequence of devolution, all Provinces developed their own AIDS strategies tailored to their specific context with costed action plans (*see section III National Response for more detail*).

At a national level Pakistan's policy and programming response has been complicated by Devolution, which was carried out in 2011. Devolution shifted mandates pertaining to national vertical programs, including the NACP, to the provinces with complete autonomy and authority for direct implementation. As Provincial AIDS Control Programmes had been established already for over 6 years with their own costed and funded plans (PC-1s) at the time of devolution, negative impacts of this shift were mitigated. At the same time, as AIDS, Tuberculosis and Malaria programmes were recipients of Global Fund grants, they were exceptionally maintained at a national level with specific Terms of Reference (ToRs). These include: (1) To act as the Principal Recipients for all Global Fund-supported health initiatives; (2) To prepare proposals and liaise with international agencies for securing support of such partner agencies; and (3) To provide technical and material resources to the provinces for successful implementation of disease control strategies and disease surveillance. The NACP currently sits under the National Health Services Regulation and Coordination, established in 2013.

Global Fund

Pakistan was awarded a Global Fund grant in round 9 focused on 'Continuum of Prevention and Care' (CoPC) for PWID, spouses and children as well as 'Community and Home-Based Care' (CHBC) for people living with and affected by HIV. In 2013 the grant was re-phased. Lessons learned from what worked

³ Although both terms – PMTCT and PPTCT - are globally acceptable, Pakistan primarily uses PPTCT.

⁴http://www.nacp.gov.pk/programme_components/hiv_prevention/hiv_care/

and what did not in phase 1 were incorporated into phase 2 through the following three adjustments: 1) increase coverage of PWID and PLHIV with prevention, treatment and care services within the amount of resources available; 2) adopt more effective linkages between services for prevention, treatment and care for meeting the set targets; and 3) modify certain planned activities with little measurable impact in favour of those that respond to the needs of the population (*see section III. National Response for more detail*).

Two regional grants came to Pakistan under Global Fund since 2011: a R9 grant implemented by Naz Male Health Alliance (PR: UNDP) focused on HIV prevention and social justice among men who have sex with men (MSM) and transgendered persons; and a R10 grant implemented by the Association of People Living with HIV (PR: APN+) aiming to document, monitor, and advocate issues related to treatment access for PLHIV across 7 countries in Asia and the Pacific region, including Pakistan.

D. Summary table of Core Indicators

Of the total now 32 indicators under the seven targets in the 2012 report, Pakistan is reporting on 19 indicators that reflect key features of the HIV epidemic and response in Pakistan. The ones not reported on include indicators that were either not relevant to the country context or those for which data was not available. Data for sex workers and people who inject drugs are from the last round of IBBS in 2011.

No. Indicator		2012 GARPR	2014 GARPR
Target 1: Reduce sexual transmission of HIV by 50 per cent by 2015			
General Population	1.1 (MDG)	Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Indicator is relevant, but there is limited data from DHS on married women 15-24 years: 28% knew about sexual mode of transmission and 17% knew about condom protection against HIV
	1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Indicator relevant, but data is not available
			DHS 2012-13: 4.3% of ever-married 15-24 years with comprehensive knowledge about AIDS. ⁵ 4.2% of ever-married women 15-24 (0.6% 15-19; 5.2% 20-24); and 5.2% of ever-married men 15-24 (5.4% 15-19; 5.2% 20-24)

⁵ In Pakistan DHS comprehensive knowledge is collected on 3 variables: 1) knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus; 2) knowing that a healthy-looking person can have the AIDS virus; and 3) rejecting the two most common local misconceptions about AIDS transmission or prevention.

	1.3	Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	Indicator is relevant, but data is not available	Indicator is relevant, but data is not available
	1.4	Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	Indicator is relevant, but data is not available	Indicator is relevant, but data is not available
	1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their result	Indicator is relevant, but data is not available	Indicator is relevant, but data is not available
	1.6 (MDG)	Percentage of young people aged 15-24 who are living with HIV	All young people= 0.04% (15-19= 0%; 20-24= 0.05%)	All young people= 0.04% (15-19= 0%; 20-24= 0.05%)
SW ⁶	1.7	Percentage of sex workers reached with HIV prevention programs ⁷	All sex workers = 8.7% (<25= 7.5%, +25 = 9.9%) FSW= 8.1% M/HSW= 9.1%	All FSW: 10.8% (15-19: 0.9%; 20-24: 2.1%; 25+: 7.8%) All HSW: 19.8% (15-19: 1.1%; 20-24: 4.7%; 25+: 14%) All MSW: 9.7% (13-19: 2.8%; 20-24: 4.9%; 25+: 2%)
	1.8	Percentage of sex workers reporting the use of a condom with their most recent client	All sex workers= 35.4% (<25= 33.3%; +25= 37.2%) FSW= 41.5% M/HSW= 32%	All FSW: 41.5% vaginal: (vaginal: 15-19: 4.4%; 20-24: 10.7%; 25+: 26.4%); 31.5% anal: (15-19: 2.7%; 20-24: 7.8%; 25+: 20.9%) All HSW: 36.6% (15-19: 1.8%; 20-24: 9.3%; 25+: 25.4%) All MSW: 27.4% (13-19: 9.1%; 20-24: 11.1%; 25+: 7.2%)
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	All sex workers 8.1% (<25= 6.2%, +25= 7.4%) FSW= 5.7% M/HSW= 9.4%	All FSW: 5.7% (15-19: 5.0%; 20-24: 5.6%; 25+: 5.8%) All HSW: 13.9% (15-19: 10.4%; 20-24: 12.8%; 25+: 14.6%)

⁶ IBBS Round IV age ranges were: 13+ MSW; 15+ FSW; 15+ HSW.

⁷ Know where to get an HIV test; and free condom in last 12 months.

				All MSW: 4.8% (13-19: 2.7%; 20-24: 5.5%; 25+: 7.3 %)
	1.10	Percentage of sex workers who are living with HIV	All sex workers= 2.4% (<25= 2.2%, +25= 2.6%) FSW= 0.6%	All MSW: 1.6% [95% CI: 1.3%, 2.1%] (13-19: 0.7%; 20-24: 0.5%; 25+: 0.4%) All HSW: 5.2% [95% CI: 4.5%, 5.9%] (15-19: 0.3%; 20-24: 1.3%; 25+: 3.5%) All FSW: 0.6% [95% CI: 0.4%, 0.9%] (15-19: 0.1%; 20-24: 0.1%; 25+: 0.4%)
MSM	1.11	Percentage of men who have sex with men reached with HIV prevention programs	Indicator is relevant, but data is not available	Indicator is relevant, but data is not available
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Indicator is relevant, but data is not available	Indicator is relevant, but data is not available
	1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	Indicator is relevant, but data is not available	Indicator is relevant, but data is not available
	1.14	Percentage of men who have sex with men who are living with HIV	Indicator is relevant, but data is not available	Indicator is relevant, but data is not available

Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015

PWID ⁸	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programs	42 syringes per PWID per year	131.1 syringes per PWID per year
	2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse ⁹	All PWID= 22.6% (<25=21.9%, +25= 22.7%) Male PWID=22.3% Female PWID=45.0%	All PWID: 22.6% (<20: 0.3%; 20-24: 3.2; 25+: 19.1%) Male PWID: 22.3% Female PWID: 45.0%
	2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected ¹⁰	All PWID= 66% (<25= 63.5%, +25= 66.8%) Male PWID= 65.9% Female PWID= 84.6%	All PWID: 66% (<20: 1.9%, 20-24: 12.3%; 25+: 51.9%) Male PWID: 65.9% Female PWID: 84.6%
	2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	All PWID= 9.1% (<25= 7.8%, +25= 9.4%) Male PWID= 8.8% Female PWID	All PWID: 9.1% (<19: 12.4% [11]; 20-24: 7.3% [50]; +25: 9.5% [271]) Male PWID: 8.9% Female PWID: 35.4%

⁸ Age range for PWID was 18+.

⁹ IBBS variable: The last time you had sexual intercourse with your regular (female/male) partner, did you use a condom?

¹⁰ IBBS variable: The last time you injected did you inject with a used syringe/needle? (Optional answers: yes, no, don't know, no response)

			48.8%	
	2.5	Percentage of people who inject drugs who are living with HIV	All PWID= 27.2% (<25= 33.9%, +25= 25.3%) Male PWID= 27.3% Female PWID= 17.9%	All PWID: 27.2% (<20: 1%; 20-24: 6.6%; +25: 25.3%) Male PWID: 27.3% Female PWID: 17.9%

Population No.	Indicator	2012 GARPR	2014 GARPR
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Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal death

HIV positive pregnant women	3.1	Percentage of HIV-positive pregnant women who receive antiretroviral drugs to reduce the risk of mother-to-child transmission	1.66% (n=57/3418 HIV positive pregnant mothers)	8.1% (n=126/1554 HIV positive pregnant mothers) - all on 3-drug regimen
	3.1a	Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding	Was not an indicator previously	100% (n=44/44 exclusively breastfeeding)
	3.2	Percentage of infants born to HIV positive women receiving a virological test for HIV within 2 months of birth ¹¹	19.5% (n=8/41)	1.9% (n=30/1554)
	3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	36.2% (n=1239/3418)	34.4% (n=534/1554)

Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2011

PLHIV	4.1 (MDG)	Percentage of eligible adults and children currently receiving antiretroviral therapy ¹²	8.7% (2,491 adults and children out of 28,554 estimated eligible adults and children)	ART coverage of eligible adults 15+: 8.9% (9.3% for males [inclusive of TG], 7.8% coverage for females); all HIV positive adults 15+: 5.3%
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Indicator is relevant, but data is not available	ART coverage of eligible children 0-14: 4.9%; all HIV positive children 0-14 years: 3.7% (see indicator 4.1 for more explanation of figures).

¹¹ In 2012 reporting, the denominator used was number of infants born to women receiving services; in 2014 Mothers needing PMTCT was used as a proxy for denominator.

¹² These figures for adults are different than coverage rate rates generated for adults 15+ on the online reporting tool.

Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2011

TB	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Indicator is relevant, but data is not available	Indicator is relevant, but data is not available
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Target 6: Reach a significant level of annual global expenditure (US\$22-24 billion) in low- and middle-income countries

\$/PKR	6.1	Domestic and international AIDS spending by categories and financing sources	Complete Matrix Submitted	<i>Matrix submitted</i>
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Population	No.	Indicator	2012 GARPR	2014 GARPR
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Target 7: Eliminating gender inequalities

	7.1	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Indicator is relevant, but data is not available.	Only physical violence - DHS 2012-13: 27.3% (15-19: 22.2%; 20-24: 29.2%; 25-49: 20.7%.
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Target 8: Eliminating stigma and discrimination

	8.1	Discriminatory attitudes towards people living with HIV ¹³	-	All: 46.7 Women: 15-19: 45.6%; 20-24: 46.5%; 25-49: 46.4% Men: 15-19: (not significant); 20-24: 55.1%; 25-49: 50.5%;
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Target 9: Eliminate travel restrictions

	9.1	<i>Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed</i>	-	No travel restrictions.
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Target 10: Strengthening HIV integration

¹³ Pakistan reports on the indicator "Would buy fresh vegetables from shopkeeper who has the AIDS virus?" from 2012-13 DHS.

	10.1 (MDG)	Current school attendance among orphans and non-orphans aged 10-14 ¹⁴	Indicator is relevant, but data is not available.	Orphans: 56.8%; non-orphans: 71.5% (male orphans: [69.5%], non-orphans: 76.9%; female orphans: [27.5%], non-orphans: 65.2%)
	10.2	Proportion of the poorest households who received external economic support in the last 3 months	58.33% (3.5/6 million)	66.6% (4.8/7.2 million) ¹⁵
		National Commitments and Policy Instruments (NCPI)	Submitted	<i>NCPI submitted</i>

¹⁴ Pakistan DHS 2012-13. Under "School attendance by survivorship of parents," orphan is defined as "both parents deceased" and non-orphan as "both parents alive and living with at least one parent." Figures in parentheses [] are based on 25-49 unweighted cases.

¹⁵ World Bank Group - Pakistan Partnership: Country Program Snapshot, Pg. 25, As of October 2, 2013.

OVERVIEW OF THE HIV EPIDEMIC

a. Background

The population of Pakistan was estimated at approximately 185.4 million in 2012-13 making it the sixth most populous nation in the world with an average annual growth rate of 2%¹⁶ (modelled Spectrum data based on population of 182 million).

The country consists of four main Provinces: Punjab, Sindh, Baluchistan, and Khyber Pakhtunkhwa (KPK); two autonomous states: Azad Jammu Kashmir (AJK), Gilgit-Baltistan, the 'Federally Administered Tribal Areas' (FATA) and the Islamabad Capital Territory (ICT).

Figure 1: Map of Pakistan



Quick Stats: Pakistan Estimates

Reside in urban areas: 36.5%
Infant mortality rate: 85.9 per 1000 live births
Life expectancy at birth: 65.7 years
Human Development Index: 0.515
Gender Inequality Index: 0.567
Mean years of schooling (of adults/years): 4.9
Population living below \$1.25 PPP per day (%): 21
Internet users (per 100 people): 10

Sources: UNDP Human Development Reports (<http://hdr.undp.org/en/countries/profiles/PAK>) and the World Bank World DataBank, World Development

Each province or region features its own socio-demographic characteristics. Punjab and Sindh are the most populous provinces, with the largest cities reporting the highest HIV prevalence among key populations. It is also important to note that in some locations, clusters of HIV positive cases were identified in semi-urban communities due to a mix of unsafe injecting practices in informal health care settings as well as other risks such as unsafe sex and injecting

drug use.

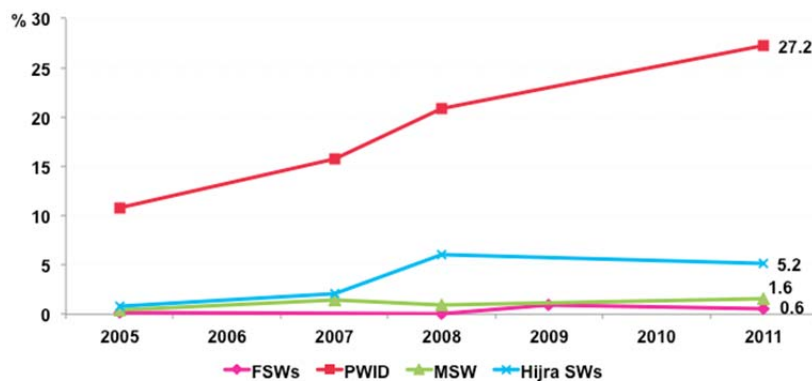
b. Current situation

The 2011 IBBS conducted in 19 cities by the Government of Pakistan's HIV/AIDS Surveillance Project (HASP) supported through the Canadian International Development Agency (CIDA) and technical partners such as the University of Manitoba, confirmed that HIV prevalence among key populations rose from 20.8% in 2008 to 27.2% in 2011 among PWID; 1.6% among MSW in 2011 compared to 0.9% in 2008; and 0.6% among FSW in 2011 compared to 0.2% in 2007. An additional round of IBBS conducted with

¹⁶ National Institute of Population Studies NIPS, Planning and Development Division, Government of Pakistan (2013) in DHS 2012-13.

FSW in 2009 found the prevalence to be 0.97%. Amongst *hijra* or transgendered sex workers prevalence was at 5.2% in 2011 lower than 6.1% in 2008. Figure 1 below shows these trends in graphical form suggesting a clear rise in prevalence among PWID, a moderate rise in MSW and FSW with a mild drop in HSW.

Figure 2: HIV prevalence among key populations, 2005-2011



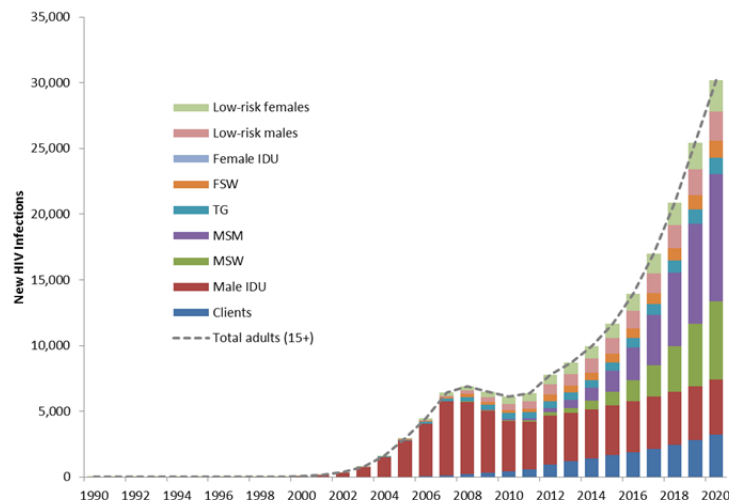
Source: Data Hub, <http://www.aidsdatahub.org>, accessed 1st March 2014.

Although prevalence is still relatively low among sex workers, it was close to zero until recently suggesting that HIV may have recently been introduced to sex work networks, especially female and male networks. Considering the behavioural risks and large size of sex worker populations, there is significant potential for rapid transmission of HIV within these networks as recent AIDS Epidemic Modelling (AEM) suggests below for Punjab in figure 3.^{17, 18}

Figure 3: Punjab Baseline Model Project HIV New Infections

¹⁷ AIDS Epidemic Modeling in Pakistan: Country Case Study Report for UNAIDS, January 2014.

¹⁸ Emmanuel F, Thompson, LH, Blanchard JF. The size and distribution of key populations at greater risk of HIV in Pakistan: implications for resource allocation for scaling up HIV prevention programmes. Sex Transm Infect. 2013 September; 89(Suppl 2): ii11–ii17. Accessed 21st February 2014 at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3756450/>.



If the model outputs are assumed to be correct, programs in Punjab need to prioritise programming for the MSM and MSW populations in addition to PWID. While the bulk of new infections currently are among PWID, projections show this number will remain fairly static over time as contributions from FSW, and especially MSM and MSW populations start increasing.¹⁹

Characteristics of injection drug use

Estimated to be 91,000 in 2009, people who inject drugs are now found across the country with large concentrations in cities such as Karachi, Faisalabad and Lahore, the largest metropolitan areas. Based on the 2011 data, PWID are overwhelmingly male (98.4%) with an average age between 25-40 years old, 57.1% have no formal education, 81.2% live with their families or friends, and 33.8% are married.

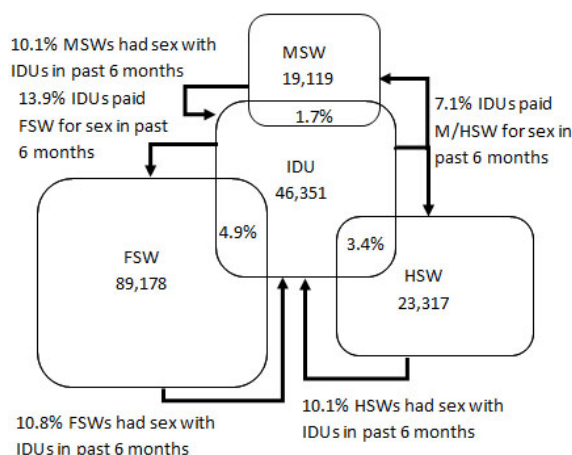
The high HIV prevalence among PWID is consistent with their frequent and risky injection practices: 71.5% report 2-3 injections per day; another 21% report more than 3 injections a day; and only 39% report always using a new syringe. Gaps in knowledge and access to preventive services add a further dimension of risk. Although 86% of PWID knew HIV can be sexually transmitted, only half of them knew that condoms can prevent HIV transmission and only 32.8% were aware of where they could undergo testing for HIV. Only 44% were aware of the existence of specific service delivery programs in their cities. However, of those who were aware of services, 76% said they visit them frequently and 92% accessed them to obtain new syringes.

An additional important aspect of transmission dynamics is the interaction between injecting practices and unprotected sexual contacts. Linkages with sex workers exist with around 14% and 7.1% reporting paying for sex with FSW and M/HSW respectively in the past six months, but only around 16% used a condom in their last sexual act. Figure 2 below shows the interactions between different key

¹⁹ AIDS Epidemic Modeling in Pakistan: Country Case Study Report for UNAIDS, January 2014.

populations as reported in Round IV.

Figure 4: Interactions between PWID, MSW, HSW and FSW populations (Source: HASP 2011)



Characteristics of sex work

Sex workers in Pakistan are categorized distinctly as male, female and *hijra* in Pakistan.

Female Sex Workers: With an estimated population of over 136,000 in 2009, the majority of FSW are located in large cities. Their average age in 2011 was 26.9 years with 64.3% of FSW reporting being married. For 43.1% their mode of selling sex with through a brothel, *kotikhana*²⁰ or home-based mostly operating through a *madam*, while 22.3% were street-based and 24.7% used cell phones for accessing clients.

FSW reported an average of three clients a day. Condom use with clients was generally low as only 33.2% reported that they always used a condom with their client in the last month, and 20.6% reported consistent condom use with non-paying partners. Brothel-based FSW reported substantially more condom use than the other types of sex workers. Overall, condom use during anal sex was lower than that reported during vaginal sex (35.1% reported having engaged in anal sex in the last month). Condom use was highest in the 15-19 age cohort, generally reducing through 35 years and then increasing slightly again. The longer number of years in school also had a positive association with condom use.

Use of alcohol and drugs during sexual encounters was reported by 39% of FSW. The highest proportion of injecting drug use among FSW was reported at 16.8% in Multan, Punjab. Both injecting drugs and having sex with a PWID were highest among brothel-based FSW at 7.2% and 15.8%, respectively.

²⁰ Refers to a rented house in a residential neighborhood providing sex work services. Reference: Mapping Networks of Female Sex Workers in KothiKanas and Private Homes, NACP, Canada-Pakistan HIV/AIDS Surveillance Project, 2007.

Assessment of HIV-related knowledge revealed that approximately 80.4% had ever heard of HIV or AIDS, with brothel-based sex workers reporting the highest level of awareness (91.2%). Of the total number who had heard about HIV, 94.3% knew that HIV can be transmitted by sexual intercourse, but less than one-third (32.6%) knew that HIV can be transmitted through needles/syringes and only 13.4% knew about mother-to-child transmission. An estimated 18.9% of FSW were aware of HIV prevention programs in their city. Among those, 36.6% used the services once a month. Knowledge of and participation in programs was much higher among brothel-based FSW than any other category: approximately 89.1% of the former had received a free condom in the past month. Of the total population of FSW, 22.5% knew where to get tested and 15.7% had an HIV test at least once.

Male Sex Workers: The estimated total number of MSW in 2009 was almost 63,000 with the majority also found in larger cities. The average age of MSW was less than 30 years, the majority was unmarried, approximately 40.2% had received no formal education, and more than 80% lived at home with their families. More than one half (57.6%) solicited clients by roaming around in public places; however, an important proportion (30.4%) used cell phones to access clients. On average, MSW entertained 2 clients per day, averaging a number of clients per month of 40.4. Bisexual behaviour was reported by approximately 39.5%. Only approximately 16% had ever been married but this is coherent with the low ages of mapped MSW.

MSW Age concern:

The youngest cohort of MSW in the 2008 IBBS cohort was 15-19 years. At the time this cohort was 41.5% of the total MSW mapped; 20-24 was 34.1% and the rest >24 years. The population proportion of the lowest cohort prompted the HASP to advocate to bring the age of the lowest cohort down to 13 in 2011. They were successful. In 2011 the 13-19 cohort was 42.1%; the 20-24 was 36.1% and the rest >24 years. Of all MSW mapped in the country 78.2% were under 24 years of age. Since 2008 the mean age of initiation went

Consistent condom use was generally very low: overall, only 13% reported regular condom use with paying partners. The proportion was lower (10.9%) with non-paying sex partners. Consistent condom use during the past month varied significantly by age with younger less likely to use condoms when compared to older age groups, however, the vast majority of MSW are young: Only 9.5% under 20 years (over 42% of the mapped MSW) consistently used a condom with clients and 13.8% among 20-24 year olds (over 36% of the mapped MSW). Consistent condom use increased as education level increased.

Overall, only 1.7% of MSW reported having injected drugs in the previous six months, but 52.5% reported using alcohol or drugs while having sex in the past six months. Approximately 10.1% reported having had sex with a PWID in the past six months. Knowledge of sexual transmission as a mode of HIV

transmission was reported by 94.5%, whereas only 46.2% knew that HIV could be transmitted through syringes. Approximately 69.8% of those who had heard of HIV knew that transmission could be prevented by using a condom during sex.

Only 22% of MSW interviewed had ever been tested for HIV and 12.7% were aware of an HIV prevention program in their city. Among those who utilized these services, over one-half (57.8%) used them less than once a month. Service utilization varied considerably across cities.

Hijra Sex Workers: It was estimated that there are a total of almost 43,000 HSW in 2009. In 2011, approximately 22.7% of HSW had moved from other cities: Rawalpindi, followed by Karachi, Quetta, and Peshawar were the most commonly reported destination points. Although the age of initiation is similar to MSW (average 16 years all cities), the proportion of younger HSW is considerably less than MSW: 7.1% were 15-19 years, 23.9% were 20-24 years and a little over one-third (34.7%) were between 25-29 years old, more than two-thirds (85.1%) were unmarried, almost one-half were illiterate (42.4%), and 70.6% lived in *deras* (*hijra* communal residence). The most commonly used means to solicit clients were public places (38%) and/or cell phones (44.4%), with only 10.7% of HSW relying on *gurus* for clients, reflecting the decreasing dependency on them for sexual partnering (*gurus* have a comparable role to *madams* among FSW).

On an average, HSW entertained two clients per day or approximately 40 clients per month. Reported consistent use of condoms was low, with only 23.6% of HSW reporting that they always used a condom with clients in the past month. This proportion was even lower with respect to regular condom use with non-paying partners at 18.1%. The main reason reported for low condom use was partner objection (42.5%). For transgender in Pakistan and elsewhere, condom negotiation is more difficult given their female gender based identity and socially constructed deferent role in society (including anal receptive sexual role).²¹ One study showed among *hijras* (transgendered people) in Pakistan, median 24 years, 83% had never asked a client to use condoms.²²

More than half (55.1%) HSW reported using alcohol and/drugs during sexual intercourse in the past six months. Overall, 10.1% of HSW reported to have had sex with PWID in the past six months, whereas 3.4% HSW reported that they had been injecting drugs in the same time period. A high proportion (90.9%) had knowledge of HIV/AIDS and means of prevention. Around 32.6% had ever been tested for HIV and 35.8% knew where to go for HIV testing.

²¹ Collumbien M, Qureshi AA, Mayhew SH, et al. *Understanding the context of male and transgender sex work using peer ethnography*. Sex Transm Infect. 2009 Apr;85 Suppl 2:ii3-7.

²² Khan AA, Rehan N, Qayyum K. *Correlates and prevalence of HIV and sexually transmitted infections among Hijras (male transgenders) in Pakistan*. Int J STD AIDS. 2008 Dec;19(12):817-20.

Approximately 31.6% of HSW were aware of HIV prevention programs in their city. Among those aware of services, 7.8% said they never utilized them but almost one-half of HSW (47.9%) used the services less than once a month. Obtaining condoms was the most utilized service (85%) followed by requests for lubricants (39%), obtaining medications (26%), and HIV testing (20%).

Vulnerable Populations

Other vulnerable populations in Pakistan include clients of sex workers, spouses of key populations (especially PWID), street-associated adolescents, prisoners, persons working in specific occupational settings, migrants, and refugees and internally displaced persons (IDPs). While these populations have not been sufficiently researched, prevalence in the general population remains low equivalent to or less than <0.1%. A national study conducted in 2011 among 26,500 women in antenatal clinics found prevalence to be at 0.04% (see details under the section *National Response, Target 3*).²³

Evidence of vulnerability of specific populations:

- *Spouses of PWID*: A research study conducted in Punjab by the NGO Nai Zindagi found up to 15% HIV prevalence among spouses and female partners of male PWID. Transmission of HIV from PWID to their wives is enhanced by the fact that around 80% of the former engage in unprotected sex²⁴ (see section IV *National Response, Target 2* for more information on spouses of PWID).
- *Urban Men*: A study conducted by the Population Council of Pakistan in 2008 focused on urban men in an effort to further characterize vulnerability to HIV. According to this study, which sampled 2,400 men (mean age of 29 years) in six cities, almost 29% of men reported ever having non-marital sex of which 37% reported having ever used a condom. Of the 29%, 16% had premarital sex while the rest (11%) engaged in both pre and extra-marital sex. However, non-marital sex was most commonly reported with females who were not sex workers. This population had relatively high awareness regarding HIV (90% had heard of HIV or AIDS), but many had misconceptions about the modes of transmission. Of the 2,396 subjects who agreed to be tested, 4.4% were found positive for at least one of the five of the sexually transmitted infections (STIs). The individual prevalence of HIV, Syphilis, HSV-2, Gonorrhea and Chlamydia was 0.1%, 1.3%, 3.4%, 0.8% and 0%, respectively.²⁵
- *Coal Miners*: A 2011 survey of coal miners in Baluchistan revealed that almost 90% of the sampled subjects had had sexual intercourse, with the mean number of sexual partners being 4.2 in the past one year. The mean number of paid female sex partners in this population was

²³ Antenatal Sero-surveillance for HIV/AIDS in Pakistan, NACP, HASP, 2012.

²⁴ The Hidden Truth' Report by Nai Zindagi and PACP, Punjab 2008

²⁵ Study of Sexually Transmitted Infections Among Urban Men in Pakistan: Identifying the Bridging Population. Population Council, May 2008.

6.1 in the last one year. Alarming, condom use was very low, with only 2% always using a condom. This population has interactions with both female and *hijra* sex workers. While awareness of STI was relatively high (79%), more than half reported experiencing STI symptoms.²⁶

- *Migrant Workers*: As in other countries of South Asia, a number of HIV cases reported to the health care services across the four Provinces have been and continue to be among returning migrants deported from the Gulf States when found to be HIV positive.²⁷ The risks of onward HIV transmission to spouses and to children have been documented upon the return of migrant workers from abroad. In KPK, for example, among the 1257 PLHIV ever-registered (includes dead and missing) 41.8% (526) are migrants. Among the 819 on ART at the end of 2013, 28.9% were migrants (237). The spouses of 248 migrants are still non-reactive.

Migration & HIV

There has been significant migration from rural areas of all Provinces to the Gulf States. The net outward migration rate from Pakistan is estimated at 3.3 per 1000 inhabitants. To obtain a work and residence visa, Gulf States and other receiving countries require prospective visitors from Pakistan and other countries to undergo mandatory testing for HIV and other health conditions, without HTC/VCCT being provided at the designated Gulf Cooperation Council GCC Approved Medical Center's Associations (GAMCA). And most deportees do not receive counselling, proper educational information about their status and/or ensuring access to treatment, care and support services upon return to their countries of origin. In line with the World Health Assembly resolution on health of migrants in 2008, member states were called upon to promote migrant-inclusive health policies and equitable access to information and support for migrants.

Source: Mapping of HIV Risk and Vulnerabilities of Temporary Contractual Workers from Pakistan to

- *Internal Displaced Persons*: The military operations launched by the Government against militants in 2009-2010 in Khyber Pakthunkhwa and FATA resulted in over 2 million IDPs and led to some disruption of preventive and treatment care and support services to vulnerable populations as well as to PLHIV. At the end of July 2013, over 1 million internally displaced individuals (170,000 families) were estimated to be affected by the on-going security operations in the FATA and KP.²⁸ The challenge of ensuring continuity of services for PLHIV and key populations, assessing HIV-related vulnerabilities for the displaced populations and providing HIV-related information, services and programs for those in need among the displaced remains a challenge for the Government and UN agencies.

²⁶ Bio-Behavioral Survey among Mine workers in Balochistan, Pakistan. January 2012.

²⁷ At the end of 2013, Of the 526 migrants registered at Hayatabad Medical Complex in Peshawar, 60% were from UAE and 23% from Saudi Arabia.

²⁸ 2014 UNHCR country operations profile – Pakistan. Accessed at: <http://www.unhcr.org/pages/49e487016.html>.

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

The Government of Pakistan (GoP) has maintained a sustained response to the HIV epidemic since 1987 through a close collaboration between the National AIDS Control Programme (NACP), Provincial and AJK AIDS Control Programmes, UN agencies, bilateral and multilateral donors, and a consortium of NGOs and CSOs, including PLHIV representative organizations, operating at national, provincial and grass-root levels. Since 2005 under the EHACP Pakistan has been following an investment approach, programming strategically according to its concentrated epidemic. Excluding HIV treatment, services to PLHIV and key populations are provide through 2 primary mechanisms: Global Fund through public-private partnerships between Government and NGOs and CSOs.

The Government's response till date can be divided into four phases:

- I. 1987-2003: The response shifted from identification of cases through laboratory services and awareness among the general populations to inclusion of key vulnerable populations.
- II. 2003-2007: Following the Declaration of Commitment (DoC) in the 2001 UNGASS session, and in line with the NSF-I, the GoP approved the 'Enhanced HIV/AIDS Control Project' (EHACP) for 2003-8 funded by the World Bank, DFID and Government itself. The strategy of EHACP partially decentralized the program to five provincial (PACP) bodies and addressed four principal components: 1) Interventions for most-at-risk populations; 2) Establishment of a Second Generation Surveillance System; 3) Preventing HIV transmission to the General Public through Blood and Blood Products; and 4) Treatment, Care and Support services for PLHIV and Capacity-Building.
- III. 2008-2010: A continuation of the EHACP originally to be reported over a five-year time frame, revised following the devolution of the Federal MoH in 2011 to provincial levels.
- IV. Post Devolution 2011 - Present: Provincial AIDS Control Programmes are following their own provincial strategies, which will be consolidated with a new National AIDS Control Programme strategy into one document in 2014. The NACP was placed initially under the newly established Ministry of Inter-Provincial Coordination and then moved under the Ministry National Health Services Regulation and Coordination, established in 2013.

Surveillance History:

Under the EHACP, The HIV/AIDS Surveillance Project (HASP) was launched in 2004 with the support of the Canadian International Development Agency (CIDA), and technically supported by the University of Manitoba. After the initial pilot surveillance round, the 2nd round was conducted 2006-07, the 3rd 2008 and the 4th and final round of the project in 2011. Surveillance is now included in the provincial AIDS strategies. In 2014 Naz Male Health Alliance through its

regional GF grant and with the support of UNDP. plans

The NSF-II completed its five-year timeframe in December 2011. Provincial AIDS strategies are now in place for all 4 provinces, tailored to their specific context with costed action plans. In 2014 a final document will consolidate the four provincial documents under one overarching framework entitled the Pakistan AIDS Strategy-III (PAS-III). The context of the PAS-III will be in line with the overall health and development strategies as well with international commitments and MDGs. Given that the epidemic is concentrated in every province, individual provincial AIDS strategies share the same 3 goals/outcomes and 10 outputs, although strategies for Punjab and Khyber Pakhtunkhwa include an output on increased uptake of PPTCT services.

Figure 5: Outcomes and Outputs of Provincial AIDS Strategies

Outcome I	Outcome II	Outcome III
HIV prevalence is reduced among key affected populations and maintained at less than 1% in the general population.	HIV-related morbidity and mortality is reduced, and the quality of life of People Living with HIV is improved.	Policy environment and the AIDS response is enhanced for HIV prevention, treatment, care, and support.
Scaled up coverage of prevention services to reach 80% of PWID (Sindh and Balochistan targets 60-80% and includes sexual partners).	Increased coverage and quality of VCCT (Sindh and Balochistan include PITC).	Enabling policy environment ensured (Sindh includes enabling environment is for scale-up of services).
Scaled up coverage of prevention services to progressively reach 60% of TG and other KAP	Scaled up coverage of ART and improved quality of medical management for people living with HIV (Sindh and Balochistan include improve quality)	Multi-sectoral coordination enhanced
Improved access to HIV prevention among selected Vulnerable Populations (Sindh includes reduced risks of HIV transmission among vulnerable populations through mainstreaming into health and social sectors and Balochistan only health sectors)	Increased coverage and quality care, support and social services for people living with HIV (Sindh and Balochistan includes improve quality and providing social services to families of PLHIV)	Strategic evidence generated for planning and tracking the response (Sindh and Balochistan include evaluation, coverage, quality and impact)
<i>Punjab and KP: Increased uptake of PPTCT services</i>		Resources mobilized for sustainability of the response (Sindh and Balochistan do not mention resources)

All strategies share the same Guiding Principles, namely: a) Prioritization based on needs and availability of resources; b) Evidence-based informed by epidemiological, public health and social

research; c) Results-based including specific, measurable and realistic targets; d) Efficiency and sustainability - reduce reliance on external funding and seek integration of AIDS-responses into existing health and social welfare systems; e) Participatory - strategies are developed with all relevant stakeholders; and f) Gender sensitive - across prevention, treatment, care, and support.

Global Fund Single Stream Funding (SSF) March 2013 – February 2016 (Round 9 phase 2)

Pakistan was awarded a GF grant for HIV for Round 9 (R9). Implementation began in 2012. In 2013 phase 2 of the grant was awarded through 28th February 2016. Pakistan has two PRs for this grant, Nai Zindagi, a national NGO for PWID, for objective 1 and the NACP for objective 2. The grant was designed to assist Pakistan's transition towards more comprehensive coverage of HIV services. The goal is to reduce HIV-related morbidity and mortality -- i.e. reduce burden of HIV. The expected outcome of the grant is improved access to the Continuum of Prevention and Care (CoPC+) sites for PWID and their spouses (*see Section IV Best practices*) and Community and Home Based Care (CHBC) sites for PLHIV and associated populations. It also links exiting services such as treatment, PPTCT and paediatric AIDS care.

Under Objective 1 of the grant continuation, services for PWID will increase to 34,000 (37% of the estimated total need), and to 3,229 spouses and partners of PWID across 4 provinces. The package for PWID is largely community-based and is delivered by seven Sub-Recipients (SRs) to cover unmet needs in 29 districts.

The Objective 2 of the grant proposal offers means to access HIV care and support to PLHIV (target: 24,000) and associated populations (i.e. Care and support for 6,000 PLHIV and 18,000 family members and ARV treatment for 2,000 PLHIV). This is provided through CHBC and HIV treatment centres, which now number 18. The existing 11 CHBC sites, either operated by or involving considerable participation of PLHIV, and planned opening of an additional 10 in phase 2 in underserved districts, serve as entry-points to gender sensitive care and support, including psycho-social support; VCCT; nutritional support; referrals to ART, PPTCT and paediatric care; and linkages to social services.

The Objective 3 of the grant proposal aims at strengthening of the National and Provincial AIDS Control Programs, as well as NGOs and PLHIV organizations towards effective implementation of Global Fund R9.

The main changes from R9 to its continuation grant is the scale up of PWID reached, and the shift of care for PWID from CHBC sites to CoPC sites now enhanced to CoPC+, providing HIV testing and CD4 at point of care for both PWID and spouses and family of HIV positive PLHIV and referring eligible PLHIV

directly to the HIV treatment centres. Improved coordination with the PACPs and establishment of District AIDS council to seek an enabling and supporting environment at the District level are among other significant changes on the project design. In addition, CHBC sites now provide PITC as part of the package of services.

Role of NGOs and CSOs

Since the beginning of the coordinated response to the HIV epidemic in Pakistan, service-delivery interventions have been implemented largely by NGOs and CSOs operating in a public-private partnership with Government. While GF funds NGOs directly, coordination with Government is still critical for an effective HIV response. The crucial and integral role of NGOs and CSOs is based on their comparative advantage of accessing and providing services to marginalized populations, most of the latter having have a quasi- legal status. The success of their service-delivery implementation hinges on establishing close contacts with concerned community members starting at the grass root level and extending to district, provincial and in some cases, national levels.

The number of dedicated AIDS-organizations, or those with a focus on HIV or specific populations across the country in the area of HIV prevention, treatment, care and support has increased substantially from initially a handful to currently over 50.²⁹

A number of CSOs providing care and support services in collaboration with NACP under GF are founded and headed by PLHIV themselves. The National Association of PLHIV (APLHIV) was founded in 2006 and operationalised in 2008. The APLHIV has evolved rapidly, from one national chapter to include 4 provincial chapters, and today plays a more important role in the national and provincial AIDS responses: it is a sub-recipient of both the GF R9 national grant and a regional Global Fund R10. The key role of the APLHIV includes advocacy for access to preventive, treatment, care and support services for PLHIV, and ensuring Greater Involvement of PLHIV (GIPA) in all policy and decision- making processes. Significant efforts have gone into lobbying, networking, and establishing public private partnerships with government, facilitating a bridge between community and government. The APLHIV also provides HIV related information to whoever needs it through their helpline.

HIV Helpline

Hello+ is a HIV helpline established and managed by the Association of People Living with HIV (APLHIV). It began providing four services at national level in August 2013: 1) basic information on HIV; 2) referral information; 3) counseling; and 4) receiving and recording grievances, complaints, suggestions and feedback of the callers about the service and services provided. Hello+ is the only helpline providing services

²⁹ UNAIDS.

Other CBOs and NGOs directly funded through GF support include the PR for R9 for PWID; the SR for the R9 regional grant for transgender and men who have sex with me. Additional CBOs and NGOs are being supported either through international NGOs and/or the UN system. Coordination among and between CBOs and NGOs and Government remained a key challenge 2012-2013.

Mid-term review of the 2011 Political Declaration on HIV & AIDS

A mid-term review of Pakistan's progress made on the 10 global targets of the 2011 Political Declaration on HIV & AIDS was held in 2013. While progress has been made on most targets since 2011, especially those concerning key populations and even those not prioritised by the country, critical targets for PPTCT and treatment are not on track.

PREVENTION / KNOWLEDGE & BEHAVIOUR CHANGE



Target 1: Reduce sexual transmission of HIV by 50 per cent by 2015

As of the mid-term review of the 2011 Political Declaration on HIV & AIDS at the end of 2013, Pakistan reported they were not on track to reach this target.

Indicator 1.1: Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission³⁰

This indicator is relevant, but data in Pakistan is only partially available, limited to ever-married women and men collected through the Demographic Health Survey. The percentage of ever-married men women age 15-49 who said in the 2012-13 DHS that a healthy-looking person can have the AIDS virus and who, in response to prompted questions, correctly reject local misconceptions about transmission or prevention of the AIDS virus, and the percentage with comprehensive knowledge about AIDS, was extremely low: 4.7% of ever-married 15-24 years; 4.2% of ever-married women 15-24 years (0.6% 15-19; 5.2% 20-24) and 5.2% of ever-married men 15-24 years (5.4% 15-19; 5.2% 20-24). Knowledge was positively associated with wealth quintile, education, and urban areas, especially the

³⁰ The language "AIDS virus" used here under indicator 1.1 is the language used in the DHS 2012-13.

Islamabad Capital Territory. While the information collected was more comprehensive in the 2012-13 DHS as opposed to the 2006, as this survey is at the household level among married persons, it is unclear to what extent young and adult key populations, those not affected by the epidemic in Pakistan are captured.

The Multiple Indicator Cluster Surveys conducted by provinces also have information on comprehensive knowledge. Punjab reported in 2011 that 3.9% of ever-married women aged 15-24 had comprehensive knowledge about HIV prevention.³¹ The last MICS in Khyber Pakhtunkhwa (2008) reported 0.4% of married women had knowledge of preventing HIV (all three ways), and 16.9% knew that HIV could be transmitted by sharing needles.³²

There is no data collected in Pakistan on the following indicators:

- 1.2: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15;
- 1.3: Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months;
- 1.4: Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse; or
- 1.5: Percentage of women and men aged 15-49 who received an HIV test in the

Indicator 1.6: Percentage of young people aged 15-24 who are living with HIV

This indicator is relevant but data is not available in Pakistan as the country is classified as being in a 'concentrated' phase of the HIV epidemic and no population-based demographic or other national surveys include this question. However, modelled projections estimate prevalence among 15-24 year olds at 0.03% in both 2012 and 2013 (incidence 0.01% both years).³³ The prevalence burden for this cohort was estimated at 13.7% of the total estimated PLHIV population in 2012 (n=9642/70 536) and 13.4% in 2013 (n=11 155/83 468).

As Pakistan is in a concentrated epidemic, routine ANC surveillance is not conducted. However, during IBBS Round IV, HASP, NACP, and the Provincial AIDS Programmes in collaboration with UNICEF conducted a survey on antenatal clinic attendees in 9 districts in all four provinces of the country to understand the HIV status among the general population. The districts included 5 'high' and 4 'low' HIV prevalence districts, with a total sample

Limitations of ANC Study:

The overall HIV prevalence of the study was 0.045% - i.e. 12 confirmed positive cases among 26,510 women. There are potential biases, however, in using ANC surveillance to determine general population prevalence in a concentrated epidemic driven by PWID, nearly all of whom are men, and sex workers, many of whom are male. Although 73.1% of women in Pakistan attend at least one ANC visit (DHS 2012-13), women most at risk for HIV are already living with it may have partners, or be themselves, part of criminalized populations and may be less likely to use public sector services due to real or perceived stigma and discrimination (see below Target 8: Eliminating stigma and

³¹ <http://www.bos.gop.pk/?q=provincialreport>.

³² Children and Women: Khyber Pakhtunkhwa Multiple Cluster Indicator Survey, 2008.

³³ Pakistan 2012 & 2013 EPP Projections, Spectrum Modelling, GoP/UNAIDS/HIV/AIDS.

size of 26,510 antenatal clinic attendees from 41 antenatal clinics at health facilities. Any pregnant woman between 15-49 years of age attending regular antenatal services in one of the selected ANC clinics and having her first haematological screening at the ANC facility during the study period was selected for participation in the study. The HIV tests were carried out on blood from pregnant women coming for routine antenatal tests, with additional socio-demographic data obtained from ANC cards used by the health facility. Out of the total 26,510, 34.3% (9,095) women were in the age bracket of 15-24 years and had an HIV prevalence of 0.044% (4/9095 confirmed sero-positive).

Indicators 1.7 - 1.10 Sex Workers

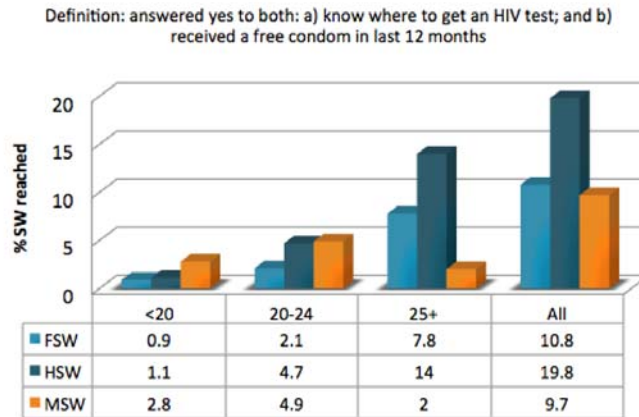
Pakistan's epidemic is driven mainly by PWID. However, the data from all IBBS rounds and other studies indicates a risk overlap of PWID with SW and other clients, making prevention of sexual transmission a priority intervention in all the Provincial AIDS Strategies developed for 2012-16, with a target to reach 60% of MSW, FSW and HSW with HIV prevention services. Although the provision of specifically tailored HIV prevention and control service delivery for sex workers remains a key feature of the overall national response, the current level of coverage of services required to prevent the sexual transmission remains low. Capacity, programmatic challenges and depleting financial resources at all levels have restricted the national response to attain the optimum level of coverage of services to these key populations at risk of HIV.

Indicator 1.7: Percentage of sex workers reached with HIV prevention programs³⁴

Data was captured in the 2011 IBBS on both the questions required for this indicator - i.e. *"Do you know where you can go if you wish to receive an HIV test and in the last twelve months?"* and *"In the last month, have you been given condoms?"* Data on this indicator (percentage of sex workers who answered "Yes" to both questions) clearly indicates that the overall coverage for sex workers is low - for FSW, it is around 5.2%, MSW= 9.7%, and for HSW= 19.8%. The rate of SW reached with HIV prevention programming was lowest in the youngest cohorts, often the most vulnerable. For MSW only 2.8% were reached and 4.9% of 20-24 years. This is especially troubling as >78% of MSW mapped are 13-19 years old. Last reported awareness rates of service delivery programs in their area (IBBS 2011) were 12.7% for male sex workers, 31.6% for *hijra* sex workers and 18.9% for female sex workers.

Figure 6: Percentage of sex workers reached with HIV prevention programmes

³⁴ Figures for FSW differ slightly from those reported in 2012, as data analysis was refined for this population since GARPR 2012.

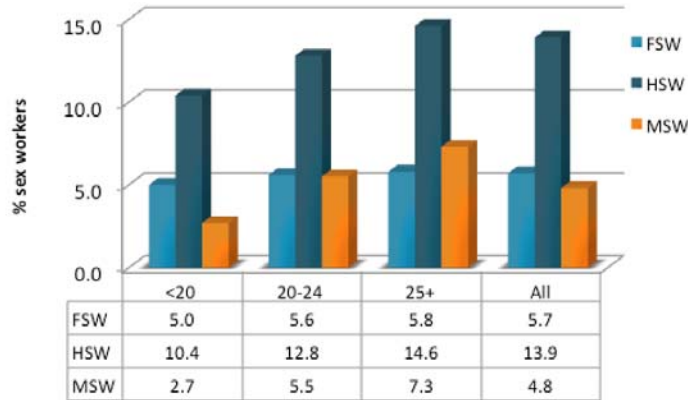


Indicator 1.8: Percentage of sex workers reporting the use of a condom with their most recent client The IBBS 2011 mapped sex workers in 17 major cities of the country. Around 41.5% of FSW reported condom use in vaginal sex with their most recent client, and 31.5% in anal sex. However, only 33.2% FSW reported that they always used a condom with their clients in the last month, with brothel-based FSW reporting substantially higher condom use than all other categories of FSW. It was also observed that the overall condom use declined with age (vaginal: 15-19: 4.4%; 20-24: 10.7%; 25+: 26.4%; anal: 15-19: 2.7%; 20-24: 7.8%; 25+: 20.9%) and was positively associated with education: the longer the number of years in school, the more consistent condom use. Condom use by MSW with most recent clients was lower (27.4%) compared to HSW (36.6%). Again, condom use increased among MSW with age (13-19: 9.1%; 20-24: 11.1%; 25+: 7.2%), but decreased with *hijras* >25 (15-19: 1.8%; 20-24: 9.3%; 25+: 25.4%).

Indicator 1.9: Percentage of sex workers who have received an HIV test in the past 12 months and know their results

The results on this indicator clearly demonstrate that uptake of PITC/VCCT offered through community SDPs and other methods for sex workers in Pakistan is low: overall 5.7% among FSW, 13.9% among HSW and 4.8% among MSW reported receiving an HIV test in the past 12 months and knew their results. Looking at age breakdown there was not much difference among age cohorts in FSW (15-19: 5%; 20-24: 5.6%; 25+: 5.8%) and HSW (15-19: 10.4%; 20-24: 12.8%; 25+: 14.6%), however the rate of MSW tested 13-19 years was significantly lower than other cohorts (13-19: 2.7%; 20-24: 5.5%; 25+: 7.3 %). The results also indicate the highest rate of SW tested and knowing their results was among *hijra*. The trend analysis of this indicator depicts that there has been a decline in KP tested after the closure of EHACP service-delivery projects for sex workers across Pakistan in 2010.

Figure 7: Percentage of sex workers who have received an HIV test in the past 12 months and know their results



Indicator 1.10: Percentage of sex workers who are living with HIV

Unlike the classical AIDS Epidemic Model in Asia where HIV, after taking root among PWID, spreads to FSW, in Pakistan it is ‘bridging’ also to HSW and MSW. IBSS 2011 round reported only 0.6% HIV prevalence among FSW with more cases detected in the Province of Sindh compared to other provinces; 1.6% among MSW and 5.1% among HSW. Prevalence increased among HSW (15-19: 0.3%; 20-24: 1.3%; 25+: 3.5%) and HSW (15-19: 0.1%; 20-24: 0.1%; 25+: 0.4%), however decreased among MSW (13-19: 0.7%; 20-24: 0.5%; 25+: 0.4%) reflecting a regional trend that MSM are getting infected at an earlier age rather than later.

Indicators 1.11 - 1.14 Men Who Have Sex With Men

While overall incidence in MSM in Asia Pacific is rising more quickly than any other key population, we have no information on prevalence among MSM in Pakistan as no sentinel surveillance is conducted among this population. Given cultural sensitivities and the fact that most MSM are hidden within the general population, representative sampling for surveillance among this population would be difficult to obtain. However, since 2011 Naz Male Health Alliance (NMHA) has been implementing the DIVA project in Punjab and Sindh under a regional GFATM MSM grant (procured under R9). The DIVA project currently provides technical, financial and institutional support to MSM networks, groups and organisations across Pakistan providing services STI diagnosis and PITC/VCCT services for MSM and transgendered persons. Through May 2013 (last quarter reported) a total of 28 698 MSM and 6139 transgendered persons were registered in 6 service centres in 5 cities of Punjab and Sindh (4 locations for MSM and 2 for *hijra*); 34 837 benefitted from community-based behaviour change communication outreach prevention programs; 361 338 male condoms (with lubricant doses) were distributed free of charge through community-based outreach activities; 2531 cases of STIs among MSM and transgendered persons were treated by CBOs; 4503 HIV tests were conducted among MSM; with 114 (2.53%) confirmed sero-positive. Among transgendered persons 1119 HIV tests were conducted and 66 (5.89%) were

confirmed sero-positive. The prevalence found for transgendered persons is similar to the (unweighted) prevalence of 5.2% found among HSW in the 2011 IBBS (indicating a potential frequency of transgendered persons selling sex). UNDP and APCOM estimate the number of MSM in Pakistan to be 2 285 500.³⁵ If NMHA's MSM programme prevalence data is in any way indicative of (unweighted) national MSM prevalence estimates then there is potentially a significant number of undetected HIV positive MSM in Pakistan.

³⁵ Asia Pacific Coalition on Male Sexual Health and United Nations Development Program, Country Snapshots: Pakistan, December 2012. Accessed at: www.apcom.org/tl_files/2012_resources/12_12_Resources/MSMSnapshots-Pakistan.pdf.



Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015

As of the mid-term review of the 2011 Political Declaration on HIV & AIDS at the end of 2013, Pakistan reported they were on track to reach this target.

There are an estimated 91,000 PWID in Pakistan.³⁶ The results from all survey IBBS rounds show that poly-drug use is common in Pakistan and different types of opiates, anti-histamines, narcotic analgesics, psychotropic drugs and heroin are injected. After the closure of the EHACP in 2010, availability and coverage of services for PWID declined dramatically, as indicated by 2011 IBBS knowledge, behaviour and prevalence results compared to the 2008 IBBS data. Prevalence was 27.2% unweighted when last measured (2011 IBBS) and 37% weighted. Service provision was maintained at lower levels through province's own budgets and increased again with Objective 1 (PWID) under the GF, which began

Coverage Recovery: Punjab

During the implementation of the public sector funded NSF I and II, PWID coverage had reached 28% by early 2010, with the support of donors and development partners. This coverage dropped to less than 5% by late 2010 due to lack of resources and non-availability of services for PWID and other KPs. However, through a PACP Interim Action Plan 2011-12 funded by Government of Punjab and some development partners, the coverage rose again to 24% for PWID as of early 2012. From May 2012 to June 2013, 14,200 PWID were provided services through service delivery projects (approximately. 65% of the total estimated PWID in Punjab); while Global Fund Round 9 covered an additional 7,000 PWID in 10 districts. Finally the actual coverage remained 21,200 PWID, against the target of 22,000 PWID. The overall achievement remained 96.3%, against the planned target of the interim Action Plan¹.

Source: Third Party Evaluation (End Project Evaluation) of Enhanced HIV/AIDS Control Program

implementation beginning 2012. The recent Provincial AIDS Strategies rank the scaled-up provision of services to PWID to achieve coverage of 80% by 2015 as the highest priority.

Opioid substitution treatment

One of the main challenges to providing comprehensive harm reduction services to PWID in Pakistan is the initiation and gradual scale up of Opioid Substitution Therapy (OST). In 2013 implementation of an OST pilot project began at the Institute of Psychiatry (IOP), Benazir Bhutto Shaheed Hospital (WHO Collaborating Centre) with support from UNODC in collaboration with the Narcotics Control Division,

³⁶ IBBS 2011. According to a national survey on drug use in Pakistan conducted by the Pakistan Bureau of Statistics and the Ministry of Interior and Narcotics Control, supported by UNODC, in 2012 there were an estimated 423 000 people in Pakistan who had injected drugs in the last 12 months (190 000 – 657 000).³⁶ The GoP defines a PWID as a person who has injected drugs regularly, for non-therapeutic purposes in the last six months.

the National HIV/AIDS Control Programme, WHO and UNAIDS. This pilot is a starting point for the initiation of OST in the country. The pilot began with an advocacy workshop for key national stakeholders in collaboration with the GF on the importance of OST for treatment of opioid dependence and prevention of HIV among opioid dependent individuals. A two week training course on OST management followed, organized for 16 staff involved in the pilot OST programme at the IOP. Since the beginning of 2013, a total of 120 opioid dependent individuals were enrolled in the pilot programme, of whom 80 were availing OST and related services on a daily basis as of December 2013. Controlling and reversing current trends of expanding HIV prevalence among PWID will not be feasible unless OST programme is made available to at least 40% of the estimated number of people who inject drugs in Pakistan. Scale-up of OST programming in Pakistan is critical, however significant challenges remain (*see Section IV: Major Challenges and Remedial Actions*).

Indicator 2.1: Number of syringes distributed per person who injects drugs per year by needle and syringe programs

Injecting drug use is the main driver of the HIV epidemic in the country. Under the EHACP, harm reduction service-delivery projects were implemented for PWID in all 4 provinces. At present, harm reduction programs are implemented through Punjab and Sindh provincial budgets and through GFATM. Data collected from CSOs from across the country implementing NSEP, including GF, indicates that in 2012 6 393 485 syringes were distributed among 17 107 PWID³⁷ (373.7 syringes pp/yr), and in 2013, 11 932 572 syringes among 34 133 PWID (349.6 syringes pp/yr).³⁸ Using 91,000 as the estimated number of PWID in the country as a denominator, 70.3 syringes were distributed per person in 2012 and 131.1 in 2013.

Indicator 2.2: Percentage of people who inject drugs who report the use of a condom at last sexual intercourse

The IBBS 2011 reported 22.6% PWID used a condom during last sexual intercourse (<20: 0.3%; 20-24: 3.2; 25+: 19.1%). The reported condom use was much higher in female PWID - i.e. 45% compared to male PWID - i.e. 22.3%, however, the study included a very small number of female PWID (N=39). Looking at trends from the 2008 to the 2011 IBBS, there was a decline in the reported condom use during last sex among PWID (29.2% <25 years and 31.2% >25 years among male only PWID), most likely related to interruption of services due to closure of World Bank funded programming (2005 to 2010) under the EHACP. Under the GF Objective 1 managed by Nai Zindagi for the 2012-2013 reporting

³⁷ 2012: GFATM Objective 1 MIS: 2012: 1 835 692 syringes distributed/10 776 registered clients (170.3 pp/yr/project); Sindh ACP report: 2012: 636,792 syringes distributed/1981 PWID reached (321.4 pp/yr/project); Punjab ACP report: 3921001 syringes distributed/PWID reached May – Sept 2013= 4350 (901 pp/yr/project).

³⁸ 2013: GFATM Objective 1: 2013: 4 303 423 needles distributed/19728 registered clients (218.1 pp/yr/project); Sindh ACP report: 2013: 1 094 149 syringes distributed/4255 PWID reached (257.1 pp/yr/project); Punjab ACP report: 6 535 000 syringes distributed/cumulative PWID reached May – Sept 2013= 10 150 (643.8 pp/yr/project).

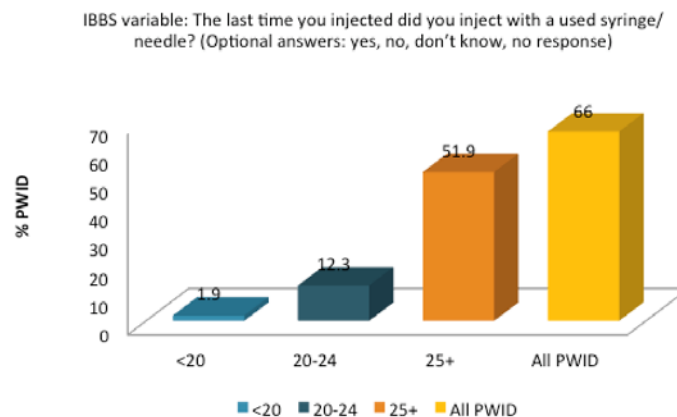
period, at the time of registration 15% of registered clients (16 829) reported to have had sex reported use of condom at last sexual intercourse.

Indicator 2.3: Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected

Almost three quarters (71.5%) of PWID reported injecting between two to three times a day in the past month, while 21.1% reported injecting more than three times a day in 2011. The mean number of injections per day ranged from 1.5 to 3.3 injections across cities. Help for injecting by ‘*professional injectors/street doctors*,’ who inject multiple clients with the same needle, was reported by two-thirds of all PWID. Of those 24.1% said they always received their injections from such professional injectors.

Overall, 38.6% of PWID reported that they always used a new syringe in past month with substantial variation across cities. Despite harm reduction services being implemented at a lower scale across the country in 2011, 66% PWID reported using sterile injecting equipment the last time they injected. This proportion was higher among females 84.6% (33/39) as compared to male PWID (3,239/4,917). This rate went up sharply with age (<20: 1.9%, 20-24: 12.3%; 25+: 51.9%).

Figure 8: Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected



Looking at trends, these figures are lower than the 2008 IBBS reporting and also reflect the decreased coverage and availability of harm reduction services across the country after the withdrawal of donor funding. Registration information under the GF Objective 1 managed by Nai Zindagi for the 2012-2013 reporting period, shows 50% of the registered clients (n=19 560) reported using sterile injecting equipment the last time they injected.

Indicator 2.4: Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results

IBBS 2011 indicates that around 86.7% of PWID had heard of HIV/AIDS. Among them, 87.2% knew that HIV can be transmitted by sharp instruments/needles (syringes) and 83.3% were aware of sexual intercourse as a mode of transmission. Results also indicate that around 64% believed that they were at risk of acquiring HIV, but only 32.8% knew of a place where they could be tested for HIV. Among PWID surveyed in IBBS Round IV, 6.7% had received an HIV test in the past 12 months and knew their status whether positive or negative. This varied among age cohorts (<19= 7.6%; 20-24: 5.2%; +25: 7%). As part of Objective 1 GF under the management of Nai Zindagi, from the beginning of 2012 through the end of 2013 62.2% of registered PWID received PITC/VCCT services (12 282/19 728).

PITC/VCCT for Spouses of PWID

As part of Objective 1 of GF R9 managed by Nai Zindagi, VCCT was provided initially for wives of PWID, and then later for wives of HIV positive PWID. From the beginning of the grant through December 2013, 772 wives were registered, 605 tested and 33 were found to be reactive (5.4%)

Indicator 2.5: Percentage of people who inject drugs who are living with HIV

PWID are driving the epidemic in Pakistan. Since 2003, a number of studies have indicated considerable on-going transmission among this group. Recent studies indicate a growing geographical spread as well with more cities emerging with significant PWID populations. Pakistan is one of three expanding epidemics in the Asia Pacific region along with Indonesia and the Philippines.³⁹ The results of the 2011 IBBS also indicate significant network interactions among PWID and sex workers, among whom prevalence is rising. The overall prevalence of HIV among PWID was 27.2% (weighted= 37.8%). Among male PWID, it was 27.3% (1,341/4,914) and among female PWID it was 17.9% (7/39). As expected, prevalence increased with age (<20: 1%; 20-24: 6.6%; +25: 19.6%)

Prevalence among PWID are also reported under Objective 1 of the GF grant, managed by Nai Zindagi, Principal Recipient. From the inception of VCCT under Objective 1 beginning 2012 through December 2013, 12,282 PWID went through VCCT and 3,286 were found reactive (26.7%). - 700 CD4s were completed by the end of 2013 to ascertain the treatment eligibility.

³⁹ HIV in Asia and the Pacific, UNAIDS



Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal death

As of the mid-term review of the 2011 High Level Meeting Targets at the end of 2013, Pakistan reported they were not on track to reach this target.

Pakistan's programme for the prevention of mother to child transmission of HIV (also referred to as prevention of parent to child transmission) was initiated in early 2007. Currently there are a total of 11 PPTCT centres in major cities across the country.⁴⁰ The first National PPTCT Guidelines were developed in 2006 and revised in October 2011.

Like other low and concentrated epidemics in Asia (region with one of the lowest PPTCT coverage rates in the world), Pakistan has faced obstacles in finding the most effective approach to reach HIV positive pregnant women, therefore the total number of registered mothers is low as compared to the national estimates. Current Provincial AIDS Strategies recognize that though a number of PPTCT centres that have been established in the country, primarily in the public sector, their access and utilization by HIV positive pregnant women, often belonging to or associated with marginalized or criminalized populations, remains low.

UNICEF, the technical lead on PPTCT, is working with National and Provincial AIDS Control Programmes to increase PPTCT uptake. Increasing uptake requires increasing testing among spouses and intimate partners of male key populations, as well as geographical prioritization through a targeted and district model approach. PPTCT and HTC uptake will continue to be scaled up with special focus on districts having significant HIV prevalence among key populations. Provincial departments of health have integrated PPTCT services into MNCH and other relevant programming and services such as the LHW program. Community-level models reaching FSW, migrants, and spouses of key populations including spouses and children of PWID are in the process of being planned and implemented. Under GF, spouses of positive PWID are being reached and tested through an outreach approach (see above) and referred to PPTCT. Referral linkages to PPTCT and paediatric care have also been developed under GF Objective 1 from CHBC sites.

⁴⁰ ICT: 1) Pakistan Institute of Medical Sciences - Islamabad; Punjab: 2) Lady Willingdon Hospital - Lahore, 3) Services Hospital - Lahore, 4) DHQ Hospital – Sargodha, 5) DHQ Hospital - DG Khan; 6) DHQ Hospital - Gujrat; 7) Allied Hospital – Faisalabad; Sindh: 8) Civil Hospital - Karachi; 9) Sheikh Zayed (Women's) Hospital – Larkana, Khyber Pakhtunkhwa: 10) Hayatabad Medical Complex – Peshawar; Balochistan: 11) Bolan Medical Complex Hospital - Quetta (*established in 2013*).

Indicator 3.1: Percentage of HIV positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission⁴¹

Recent data from 11 PPTCT centres across the country indicate coverage of PPTCT services increased from 2012⁴², where 55 out of an estimated 1329 HIV positive pregnant women (4.1%) were registered and availed prophylaxis or treatment for their own health to 2013, where 126 HIV positive pregnant women out of an estimated 1554 (8.1%) HIV positive mothers were registered and availed or are still availing prophylaxis or treatment for their own health. In the revision of their PPTCT Guidelines in 2011, Pakistan stipulated Option B as their national prophylactic regimen. Option B has been in place since beginning 2012.

Indicator 3.1a: Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding

Out of the 126 HIV positive pregnant women registered with the PPTCT centres, 21 opted for replacement feeding and 44 opted to exclusively breastfeed. For the rest of the 126 women, records were not kept. Therefore, for 2013, 100% (n=44) women were receiving antiretroviral medicines for themselves or their infants during breastfeeding.

Indicator 3.2: Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth

The national PPTCT guideline calls for early infant diagnosis at 6-8 weeks. The data for this indicator has been obtained from 11 PPTCT centres established across the country. In 2012, 7 infants born to an estimated 1329 HIV positive women (0.5%) received a virological test for HIV within 2 months of birth. Of those infants born to women receiving PPTCT services in 2012 (n=43), 16.3% received a virological test for HIV. In 2013 the rate of early infant diagnosis increases. Of infants born to estimated HIV positive women, 1.9% (30) received EID (denominator equal to HIV positive women) and of infants born to women receiving PPTCT services, 23.8% (n=126) received EID. A small number of infants born to HIV positive mothers at the end of 2013 have yet to avail EID.

Indicator 3.3: Mother-to-child transmission of HIV (modelled)⁴³

PPTCT centres have been established in both public and private sector hospitals and are closely linked to the 18 HIV treatment centres providing free HIV-related services to PLHIV. Challenges in reaching HIV positive pregnant women in a concentrated epidemic require coordinated efforts with key population prevention programmes to bring these figures closer to the estimated need. In 2012 the rate

⁴¹ Population estimates of HIV positive pregnant women come from Pakistan EPP Projections, Spectrum Modelling, GoP/UNAIDS, 11th March 2013.

⁴² Pakistan EPP Projections, Spectrum Modelling, GoP/UNAIDS, 11th March 2013.

⁴³ Pakistan EPP Projections, Spectrum Modelling, GoP/UNAIDS, 11th March 2013.

of mother to child transmission in Pakistan was 34.6% (460/1329). The generated estimated percentage of child HIV infections from HIV-positive women delivering in 2013 decreased from 2012 to 34.4% (534/1554) (modelled data = child new infections 0-14 years).

CARE, TREATMENT & SUPPORT



Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2011

As of the mid-term review of the 2011 Political Declaration on HIV & AIDS at the end of 2013, Pakistan reported they were not on track to reach this target.

Provision of ART to PLHIV through public sector HIV treatment centres was initiated in 2005 in the public sector in Pakistan as one of the key components of the EHACP and with the support of the GFTAM R2. At present, PLHIV eligible for ART are registered and receiving ART and all other related diagnostic and treatment related services free of cost in 18 public and private sector HIV treatment centres across the country. Under the existing Global Fund 11 CHBC sites have been developed providing psycho-social support to PLHIV and families; food and nutrition support; medical and emergency referral support; referral to HIV treatment centres; clinical investigation support and advocacy with the local community. However coverage by these CHBC sites is low. According to an APLHIV study, only 33.5% of study participants confirmed availability of such services in the past 3 months.⁴⁴ Phase 2 of GF R9 grant will establish another 10 CHBC sites.

The NACP is responsible for procuring and distributing ARVs to all HIV treatment centres across the country. Since 2005 ARVs have been mainly procured through Global Fund R2 and R9, DfID funding and some funding from the 'One UN' in gap periods. USAID supported the provision of kits for HIV testing, CD4 and viral load testing for 2012 and 2013. All four Provincial AIDS Control Programmes are financing the provision of specific key diagnostic and treatment related services e.g. basic laboratory tests and drugs for opportunistic infections. GF provides ARV and other treatment care and support services through already established and scaled-up HIV treatment centres and CHBCs across the country.

⁴⁴ Final draft: Determinants to Improve Antiretroviral (ARTs) Access, Initiation and Adherence among People Living with HIV/AIDS in Pakistan, Asia Pacific Network of People Living with HIV/AIDS (APN+), 2013. Available through the Pakistan Association of People Living with HIV.

Pakistan has one of the lowest coverage overall ART coverage rates in the region. Limited HTC/VCCT provision and uptake remains a major barrier to an effective national response. This has been addressed in part by new National VCCT Guidelines. Provincial AIDS Strategies recognize acute need to bridge the gap between estimated and actually registered numbers of PLHIV and to prioritize the provision of ART services to all those eligible. Accordingly the provincial PC-1s have also earmarked substantial financial resources for treatment through public sector funds. In addition, the strategies also focus on reducing the barriers to ART access for PWID, transgendered persons and other key populations with improved referral linkages within the continuum of treatment and care, including for TB diagnosis and treatment. A draft Continuum of Care Model was finalized by the NACP, WHO and UNICEF⁴⁵ in February 2012 after consultations with key stakeholders and in response to gaps and constraints identified in the assessment of the National Treatment and Care program in 2010.⁴⁶ Finally, mechanisms to strengthen the current ART M&E and ART related procurement and supply chain management systems have been planned to ensure the quality and timely provision of ART in line with international standards to achieve national and HLM targets.

Low cotrimoxazole coverage among children

WHO recommends cotrimoxazole for all children both exposed (until the risk of HIV transmission ends or is excluded) and infected (all <1, those in stage 2, 3 or 4 regardless of CD4%, and for 5 years and above those with CD4 <350 or stage 3 or 4).^{*} Despite this and the general availability and low cost of the drug, coverage rates in Pakistan are very low. In 2012, an estimated 3212 children 0-14 years needed cotrimoxazole but only 64 received, a coverage rate of only 2%. The coverage rate rose slightly in 2013 to 4% with 139 children receiving out of an estimated 3765 needing the drug (Spectrum data 31st March 2014).

**Consolidated Guidelines on the Use of Antiretroviral Drugs for*

Indicator 4: Percentage of eligible adults and children currently receiving antiretroviral therapy:⁴⁷ At the end of December 2013, there were 7568 PLHIV registered with 18 HIV treatment centres. The total need for ART 15 and above (National guidelines stipulate ART should be initiated at 350 CD4) was estimated at 48 778 (males: 34 518; females: 14 260) at the end of 2013. A total of 4391 clients were on ART including 3182 males, 1110 females, 29 transgendered persons, and 70 children 0-14 years. Coverage of adults 15+ years eligible for/needing ART were 8.9% (9.3% for males [inclusive of TG], 7.8% coverage for females).⁴⁸ Coverage rates of children eligible for treatment were 4.9 (n=70/1437 children needing ART)%. Of all those living with HIV, ART coverage rates were 5.3% for adults,⁴⁹ and 3.7% of

⁴⁵ A Continuum of Care Model for Pakistan: HIV Treatment, Care and Support Services, February 2012 National AIDS Control Programme, World Health Organization and UNICEF.

⁴⁶ Assessment of the Treatment and Care Program by WHO and NACP 2010.

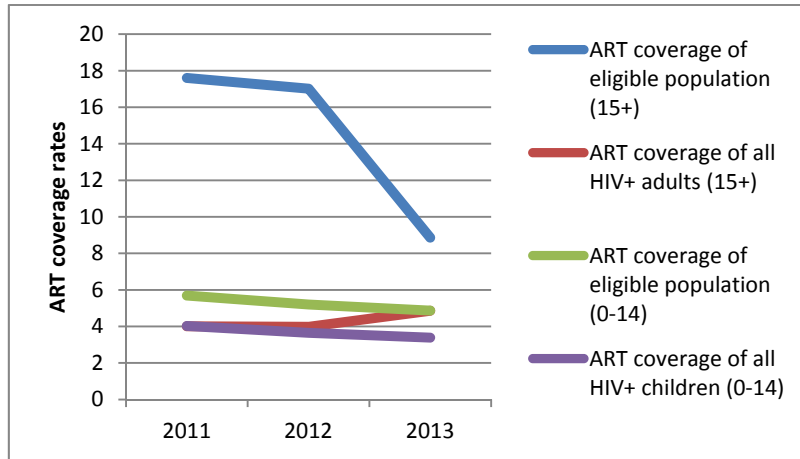
⁴⁷ Spectrum does not disaggregate by transgender, officially recognized as a third gender in Pakistan.

⁴⁸ Pakistan EPP Projections, Spectrum Modelling, GoP/UNAIDS, 11th March 2013.

⁴⁹ There is a discrepancy between this figure (calculated using Spectrum denominator of HIV positive of estimated adults 15+ living with HIV and coherent with the GARPR online reporting tool) and the Spectrum generated calculation, which is 4.9% (5.0% for males, 4.4% for females)

children.⁵⁰ Coverage rates fell from 2012 to 2103 as the total estimated need for ART rose from over 17,500 persons in 2012 to over 48,700 in 2013.

Figure 9: EPP generated ART coverage



Looking at trends there was a gradual increase in the number of PLHIV who were both registered at HIV treatment centres and who were initiated on ART from the last reporting period. Registrations went from 5256 at the end of 2011 to 7568 at the end of 2013, an average of 96 persons registered per month over the 24-month period. New numbers initiated on ART declined over this reporting period from an average of 40-45 in the last reported period to 33 month on average for 2102 and 2013.

⁵⁰ There is a discrepancy between this figure (calculated using Spectrum denominator of HIV positive children and coherent with the GARPR online reporting tool) and the Spectrum generated calculation, which is 3.4%.



Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015

As of the mid-term review of the 2011 Political Declaration on HIV & AIDS at the end of 2013, Pakistan reported they were on track to reach this target.

Prevention and control of TB in Pakistan is one of the priorities in health sector. Pakistan ranks fifth amongst TB high-burden countries worldwide. It accounts for 61% of the TB burden in the WHO Eastern Mediterranean Region.⁵¹ Approximately 420 000 new TB cases emerge every year, half of which are sputum smear positive. Pakistan is also estimated to have the fourth highest prevalence of multidrug-resistant TB (MDR-TB) globally. National and provincial TB control programs work at respective levels through GoP financing as well as Global Fund support through various rounds. Recently the National TB Control Program (NTP) has merged all these grants into single stream funding model and is proceeding ahead to implement the program with provincial TB programs taking the lead, as per the 18th Constitutional amendment and devolution.

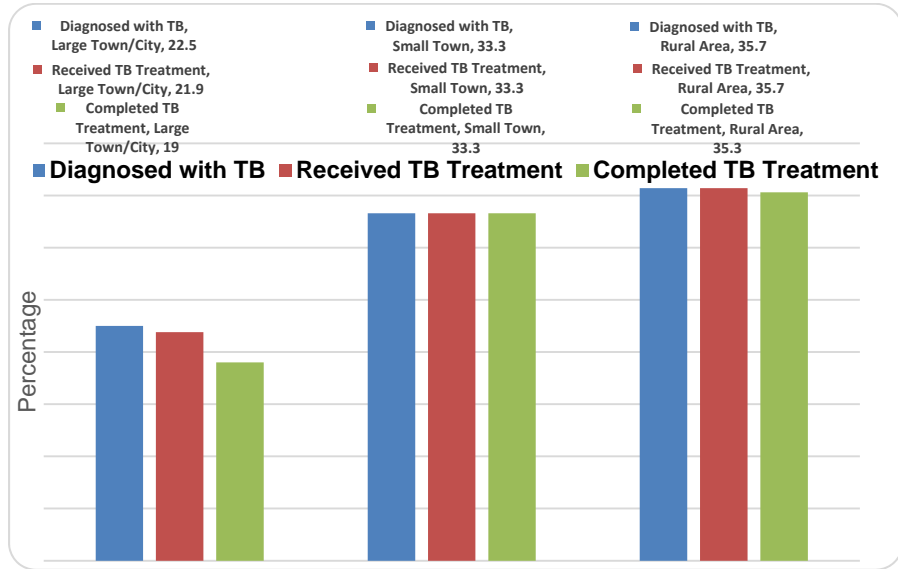
Pakistan observes the WHO/UNAIDS policy on collaborative TB/HIV activities and the national guidelines have been developed taking into account the concentrated nature of the HIV epidemic in the country. Collaborative and referral linkages between TB, and HIV control programs have been established, including staff trained to provide VCCT services at 17 TB sentinel sites; routine TB screening of all HIV registered patients with testing for TB conducted at HIV testing lab instead of the previous strategy of referring PLHIV to TB Centres for testing; and lastly, access to TB treatment is free for PLHIV who need treatment.

Collaboration between the NACP and NTP started in 2003 after the launch of EHACP. Provincial AIDS Strategic plans identify this as a priority area and envisage 100% TB treatment for all PLHIV with TB through improving referral linkages within the continuum of care, including for TB as an important outcome and interventions for other vulnerable groups such as prison inmates. The strategies at provincial level proposes building capacities of health care and NGOs sector services providers at provincial levels including CBOs on referral mechanisms especially for early TB diagnosis and treatment as per the national guidelines.

⁵¹ World Health Organization, 2014.

The APLHIV ART study in 2013 reported on PLHIV receiving TB treatment. Rates of receiving and completing treatment were similar (>50%), however, it is not stated whether the PLHIV were receiving ART or not.

Figure 10. Prevalence of TB-HIV co infection and its treatment among surveyed PLHIV by living area, in Pakistan – CAT study



IMPACT ALLEVIATION

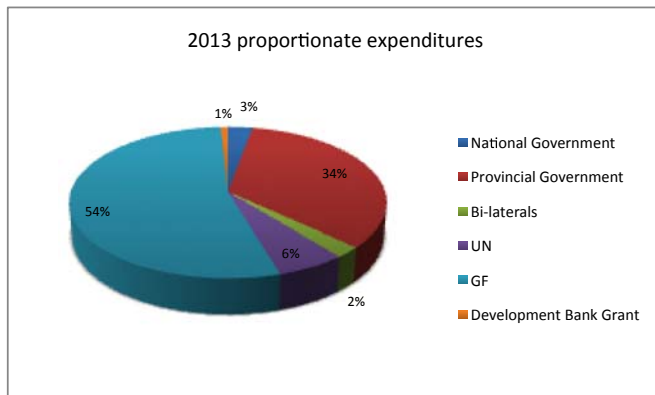


Target 6: Reach a significant level of annual global expenditure (US\$22-24 billion) in low- and middle-income countries

As of the mid-term review of the 2011 Political Declaration on HIV & AIDS at the end of 2013, Pakistan reported they were not on track to reach this target.

Pakistan conducted its first National AIDS Spending Assessment (NASA) in 2011. The assessment found that annually, Pakistan spent around 8 US Dollars on HIV activities in per capita terms. Since the NASA exercise external funding in grants or loans has decreased considerably, despite Global Fund Round 9. In 2013 GF (including regional grants) accounts for approximately 50% of the total HIV response, Provincial Government 37%, the UN 7%, other external donors 3% and National Government 3%.

Figure 11: Proportionate expenditure by donor 2013

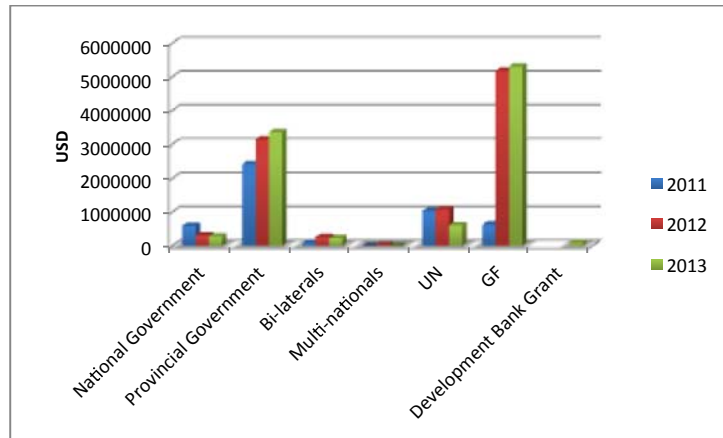


decreased considerably, despite Global Fund Round 9. In 2013 GF (including regional grants) accounts for approximately 50% of the total HIV response, Provincial Government 37%, the UN 7%, other external donors 3% and National Government 3%.

From 2011 through 2013, expenditures by provincial governments and Global Fund increased while expenditures by the National

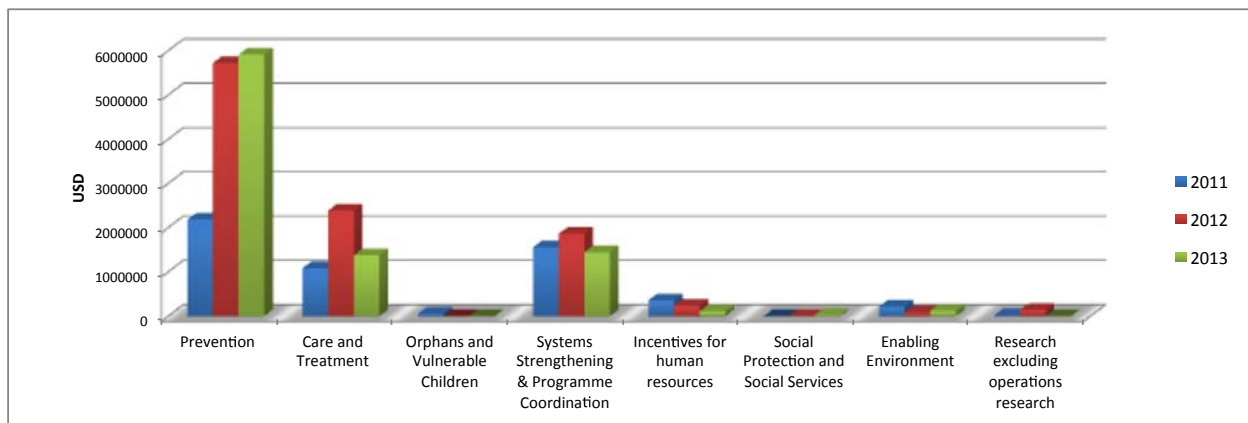
Government decreased given Devolution. World Bank, although finishing support (loan and grant) to EHACP, they supported Naz Male Health Alliance in 2013. The Dutch Government through MAINLINE supported Nai Zindagi all three years with allocations to the NGO increasing every year (2012 reflects additional bi-lateral contributions).

Figure 12: Financing sources of the HIV response in Pakistan for 2011-13



Looking at the eight areas of expenditure outlined by the Global AIDS Reporting system, expenditures in prevention have gone over the 3 years. Expenditures in both care and treatment and systems strengthening have come down, in part due to UN support decreasing but also because Governments report half-calendar year to half-calendar year so 2013 expenditures do not reflect the entire year. An increase in expenditure in these high impact programme areas is logical given Pakistan's expanding epidemic. Given the low ART coverage rates, expenditures need to be strengthened in care and treatment, however this is dependent on PLHIV being identified for care (PITC/VCCT), which comes under prevention and needs to continue to be strengthened. There is little or expenditure for an enabled environment, key for a successful HIV response in a concentrated epidemic, or development synergies e.g. social protection and services.

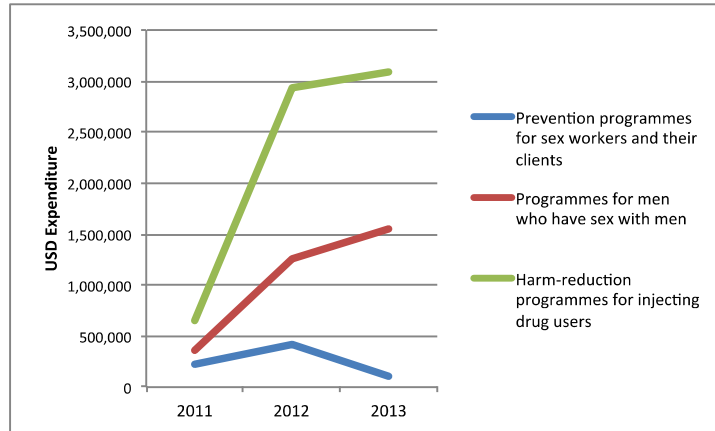
Figure 13: Eight areas of programme expenditure 2011 through 2013



Lastly, if we look at specific expenditure within Prevention among key populations, we see that while PWID and MSM expenditures have gone up, expenditures for FSW and their clients have declined dramatically. While the prevalence rate among FSW is still low, it has increased sharply since 2005 and

the number of sex workers in the country remains high.

Figure 14: Expenditure by key populations 2011 through 2013





Target 7: Eliminate Gender Inequalities

For the mid-term review of the 2011 Political Declaration on HIV & AIDS at the end of 2013, Pakistan did not report this target as a priority for the country in terms of the HIV response, and consequently reported they were not on track to reach this target. However, reflecting an overall national concern with gender, the DHS 2012-2103 included a chapter on Domestic Violence.

Pakistan is a member state of the Commission on the Status of Women, which works toward the elimination and prevention of all forms of violence against women and girls and recognizes the linkages between violence against women and girls and HIV. Most recently at the Sixth Asian and Pacific Population Conference held in Bangkok, 16-20 September 2013, Pakistan voted without reservation to adopt the Asian and Pacific Ministerial Declaration on Population and Development which resolves to promote the right of women and girls to enjoy the highest attainable standard of physical and mental health in order to achieve gender equality (article 79); to respect, protect and fulfil the human rights of all women and girls and to create an enabling environment, including national rules and regulations, enactment of laws, as appropriate, for the exercise of those rights and the right to access to justice, as well as the right to equal and full participation in parliamentary and policymaking processes (article 80); and to take all possible preventive and remedial measures, by all relevant stakeholders at all levels, to end all forms of violence and discrimination against women and girls, and importantly, raising public awareness of women's and girls' rights and of the existing penalties for violating those rights (article 81).⁵² As part of their addressing gender issues, Pakistan legally acknowledges transgendered persons as a third gender, giving them equal citizenship, and opening the way for seven TG to run for Federal and Provincial elections in 2013.

Pakistan is also a signatory to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). CEDAW can be central towards our collective journey to end AIDS. Addressing the gender related determinants of vulnerability to HIV and ensuring the protection of the rights of women and girls is critical to responding effectively to the HIV epidemic in Pakistan. The majority of HIV infections in women are sexually acquired by intimate partners or spouses, and exacerbated by the presence of certain sexually transmitted infections (STIs). CEDAW obligates States through Article 12 to take appropriate measures to eliminate discrimination against women in the field of health care on the

⁵² Asian and Pacific Ministerial Declaration on Population and Development, Report of the Sixth Asian and Pacific Population Conference, Bangkok, 16-20 September 2013, Economic and Social Commission for Asia and the Pacific, E/ESCAP/APPC(6)/3, 18 November 2013, pg. 11. Accessed at: <http://www.unescapdd.org/files/documents/Report%20of%20the%20Sixth%20APPC.pdf>.

basis of equality with men; which include access to health care services, including those related to sexual reproductive health and family planning. However, the Committee on the Elimination of All Forms of Discrimination against Women raised critical reservations with the fourth periodic report of Pakistan to this committee in early 2013 (*for more information see section 4, Major challenges and remedial actions*).

Although this target has been determined to be “not a priority”, gender equity has been addressed in the provincial HIV strategies where spouses and intimate partners of PWID have been identified as a key vulnerable population. While an enhanced policy environment including multi-sectoral coordination is a key outcome of the provincial AIDS strategies, at an implementation, or even consultative level, there are few linkages between the National and Provincial AIDS Control Programmes and the various women machineries (MoLJ&HR, NCSW, PCSWSs, SWD, and WDDs). In the current post devolution scenario, strengthened linkages, including consistent advocacy and sensitization of policy and decision makers are critical to effectively analyse the gender elements in the epidemic and response including interventions design and monitoring and evaluation.

7.1 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months: Data on sexual violence is not reported on in Pakistan. The percentage of ever-married women 15-49 years who have experienced physical violence by any husband in the past 12 months was reported as 18% in the 2012-13 DHS (age disaggregation: 15-19: 21.8%; 20-24: 17.3%; 25-29: 19.9%; 30-39: 18.7%; 40-49: 15.5%).⁵³ Experience of physical violence decreased with age and increased with number of children, ranging from 10 per cent among women with no children to 23 per cent among women with five or more children; and with women who are employed for cash.

⁵³ Pakistan Demographic and Health Survey 2012-13, National Institute of Population Studies, MEASURE DHS, ICF International, December 2013, pg. 221.

HIV services for women who inject drugs and female prisoners

During 2012-2013 over 2,700 females who use/inject drug and spouses of males who inject drugs were registered and provided with harm reduction services regularly in Karachi, Hyderabad, Sukkur, Lahore, Faisalabad, Okara, DG Khan, Chitral and Peshawar. In addition to the new registered cases, more than 5,000 females enlisted earlier (since 2010) with the NGOs at these sites also availed these services during 2012-2013.

With funding support from the Government of Norway, HIV services were also provided to more than 4000 female prisoners, out of whom 373 were injection drug users and 1512 were using drugs in nine prisons and female barracks. To obtain a baseline for service delivery rapid behavioural assessments were carried out. In addition, policy makers, prison authorities and staff were sensitized on the need to address HIV vulnerability of women who use drugs and female prisoners, and to provide harm reduction, drug use prevention and HIV information. Physical infrastructure was upgraded and mobile units for provision of VCCT, primary health care, and distribution of hygiene kits were made available at seven sites. Over 300 female medical practitioners and service providers from governmental and civil society organizations were trained to provide gender-sensitive services for women who inject drugs and spouses of men who inject drugs.

Information briefs on gender responsive harm reduction services were developed and disseminated with stakeholders and implementing partners, and information toolkits were developed for NGOs and prison staff for effective implementation of services. The project also included a component of empowerment of women who use drugs through a skills building programme and NGOs provided vocational skills to eligible, registered and rehabilitated female drug users and female prisoners. The vocational trainers at each site established linkages with government operated skill centres, which issued diplomas and certificates. An integral part of the project is a job placement programme, supported by NGOs working in collaboration with UNODC, through which several women and former prisoners who have undergone rehabilitation have been employed in a variety of jobs.



Target 8: Eliminate stigma and discrimination

As of the mid-term review of the 2011 Political Declaration on HIV & AIDS at the end of 2013, Pakistan reported they were not on track to reach this target.

Stigma and discrimination in the general population against PLHIV is measured through the DHS. The 2012-13 DHS reported similar proportions of women and men willing to take care of a family member with HIV at home (92% and 90%, respectively) and would buy fresh vegetables from a shopkeeper who has HIV (47% each).⁵⁴ Overall, 17 % of women and 15 % of men express accepting attitudes. Among both women and men, accepting attitudes toward those living with HIV or AIDS increase with increasing education and wealth. Except for women in Balochistan and men in Balochistan and Sindh, accepting attitudes toward people with HIV and AIDS are more or less similar in all regions.⁵⁵

The Multiple Indicator Cluster Surveys conducted by province also have information on stigmatizing attitudes. Balochistan reported in 2010 18.9% ever-married women with accepting attitude towards people with HIV.⁵⁶ Khyber Pakhtunkhwa reported in 2008 that 22.2% of ever-married women thought that a healthy man can be infected with HIV, and that 34.4% had stigmatizing attitudes towards people living with HIV or AIDS.⁵⁷

Though the 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 (*see NCPI for more details on non-discriminatory laws*). Under these articles the National and Provincial AIDS Control Programmes are legally bound to provide ways and means to prevent HIV transmission through implementation of Universal Precautions including education, training, personal protective equipment and by employing safe working practices, including the distribution of condoms, provision of clean syringes etc.

⁵⁴ DHS 2012-13, pg. 192.

⁵⁵ DHS 2012-13, pg. 193.

⁵⁶ http://www.childinfo.org/files/MICS4_Balochistan_2010_FinalReport.pdf

⁵⁷ Children and Women: Khyber Pakhtunkhwa Multiple Cluster Indicator Survey, 2008.

In addition, key civil society stakeholders in the HIV response have been able to mitigate stigmatizing and discriminatory practices and policies. PLHIV at individual and organizational levels have been involved in HIV program and policy formulation and at all levels of the CCM, the primary coordinating mechanism for the response. Under the Global Fund Round 9 grant objective 1 implemented by Nai Zindagi, advocacy in around 20 districts increased contact with police and district level public administration resulted in reduced law enforcement related harassment. Sensitization trainings of healthcare providers in private and public settings by CBOs resulted in easier access of PLHIV to HIV treatment centres and other diagnostic facilities within large hospital settings. This initiative is being sustained and scaled up to further reduce stigma and discrimination.

The Stigma Index assessment was carried out September 2009 - July 2010 by the APLHIV, in which 833 PLHIV were interviewed by 33 peer data collectors. Findings revealed that HIV positive widows faced the worst stigma in family and communities, often expelled out of the house by in-laws and natal families to fend for themselves. Denial of SRH services in healthcare settings was experienced by 15% PLHIV and although most of them were aware of CBOs working with PLHIV, most did not opt to access them. A major challenge faced by most PLHIV was poverty and lack of employment opportunities due to discrimination against their positive status.⁵⁸ In 2013 The APN+ regional study undertaken by the APLHIV looking at ART access, initiation and adherence, found that 49.2% of the total respondents (n=525) reported being denied medical services due to their HIV status; another 40% experienced some type of housing instability (forced to change place of residence or been unable to rent accommodation because of HIV status) and 25% reported that their children were prevented, dismissed, or suspended from attending school in last 12 months.⁵⁹ There is a need to compile evidence from the PLHIV Stigma Index Survey and the regional ART study to create a “national index” so that country progress can be measured periodically and advocacy can be undertaken for law reform. This process has the potential to build a redress mechanism for people living with HIV in Pakistan

Although Pakistan is not on track on achieving this target, steps in the right direction have started. Future priorities include the need to develop and disseminate low cost but effective evidence based knowledge among the general community related to HIV and AIDS, and to key populations about their specific risks; and improve coordination in a sustained manner to advocate for rights of PLHIV through involvement of associations of PLHIV, key populations, media, and the human rights commission. Lastly, more qualitative research is needed on the dynamics of lives of PLHIV and key populations within the Pakistani socio-cultural context.

⁵⁸ The People Living with HIV Stigma Index: An Index to measure the Stigma and Discrimination experienced by People Living with HIV in Pakistan, 2009-10.

⁵⁹ Final draft: Determinants to Improve Antiretroviral (ARTs) Access, Initiation and Adherence among People Living with HIV/AIDS in Pakistan, Asia Pacific Network of People Living with HIV/AIDS (APN+), 2013. Available through the Pakistan Association of People Living with HIV.



Target 9: Eliminate travel restrictions

For the mid-term review of the 2011 Political Declaration on HIV & AIDS at the end of 2013, Pakistan did not report this target as a priority for the country, however, they reported they are on track to reach this target.

There are no existing HIV related restrictions on entry, stay and residence in the country.



Target 10: Strengthening HIV integration

As of the mid-term review of the 2011 Political Declaration on HIV & AIDS at the end of 2013, Pakistan reported this indicator as a priority for the country and that they were on track to reach this target.

Strengthening HIV integration is a priority for the Pakistan AIDS response and is addressed in provincial AIDS strategies, in continuation of the multi-sectoral approach adopted in the NSF-II. Given the concentrated nature of the epidemic, implementation of prevention services for key populations will remain through GF and public-private partnerships between Government and CBOs. However, PITC and treatment related service delivery is foreseen to move out of vertical HIV delivery systems into the general health system and care and support merged into the social sector. In general, integration initiatives are very limited as the epidemic is not generalized, however, linkages between AIDS Control and other programmes have been forged, primarily from the HIV sector side, including budgets, to the other sectors.

Linkages between the HIV/AIDS Control Programmes and Ministry of Education, Trainings & Standards in Higher Education have been established as well. By the end of 2013 a draft Policy Framework on HIV/AIDS Prevention Education was prepared and disseminated to all Education Departments for finalization. It is now up to provincial governments to adopt it officially and to integrate it into curricula and textbooks. Concurrently, HIV prevention education is being introduced in teachers' training programs, advocacy meetings and seminars with education policy makers and managers. A public awareness and education policy makers' sensitization campaign was run in collaboration with public sector electronic media. A series of radio programs and public service messages were run across Pakistan as to sensitize community, civil society and policy makers on the importance of HIV Prevention Education.

Indicator 10.1 Current school attendance among orphans and non-orphans aged 10-14: The 2012-13 DHS reported that about 4 percent of children younger than age 15 have one or both parent dead.⁶⁰ The percentage of orphans attending school (both parents dead) was reported as 56.8% compared to non-orphans at 71.5%. Gender breakdown was as follows: male orphans (69.5%); male non-orphans (76.9%); female orphans (27.5%); and non-orphans (65.2%).

⁶⁰ Pakistan Demographic Health Survey 2012-13, pg. 23.

Spectrum estimates the number of AIDS orphans in 2012 at 20,000 out of a total of 4,050,000 orphans in the country (0.5%) and in 2013 AIDS orphans remaining static at 20,000 out of a total 4,020,000 orphans in the country (0.5%).⁶¹

Indicator 10.2: Proportion of the poorest households who received external economic support in the last 3 months: 66.6%: 4.8 million reached by the Benazir Income Support Program (BISP) out of 7.2 million eligible households across all provinces of the country.⁶² The BISP, implemented primarily through a loan from the World Bank, was initiated in 2009 for poverty alleviation and women's empowerment (disbursing cash only to a female beneficiary of eligible households) among the under privileged segments of Pakistan society. It is currently the national safety net platform. A Proxy Means Test (PMT)-based Poverty Scorecard (PSC) was rolled-out nationally through a door-to-door census and then a National Poverty Registry was created, the first in the South Asia region, comprising information on more than 27 million households (approx. 165 million people). Through the PSC 7.2 million families (approx. 35 million people) were identified as eligible for support through a cut-off score, and more than 4.8 million families received payments through modern technology-based payments 1st quarter FY 2013. Coverage was hindered as many female beneficiaries did not have a computerised national identification card issued by the National Database and Registration Authority (a criteria), and a policy decision to disburse only through a technology based disbursement mechanism. Through the female beneficiary, eligible households receive a monthly cash transfer of Rs 1,200, is paid per household on a quarterly basis, adding an estimated 20 per cent increase to household incomes.

While BISP is the largest cash transfer programme in Pakistan, the criteria for inclusion presents obstacles for key populations to access it. Criterion include there should be one female beneficiary per household. This necessarily excludes *hijra* living in a *dera* or heading household. It also excludes most MSW as most are not married given the young age of this population and almost 20% live outside the home. Criterion also requires the female beneficiary to hold a computerised national identification card issued by the National Database and Registration Authority (NADRA). Key populations are some of the most marginalized citizens of Pakistan, and it is likely that many do not have ID cards.

Annex II: National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination and monitoring and evaluation)

⁶¹ Spectrum data 11th March 2013.

⁶² World Bank Group - Pakistan Partnership: Country Program Snapshot, Pg. 25, As of October 2, 2013.

IV. BEST PRACTICES

The HIV epidemic in Pakistan has evolved in the past decade to one concentrated among key populations. As the epidemic has evolved, so too has the response with good programming examples being developed and implemented. Although no formal evaluations have been conducted on them, the following best practice programming examples for 2012-2013 were chosen due to their innovative approaches and programmatic evidence:

I. Comprehensive programming for PWID and their families: While harm reduction was mentioned as a best practice in the 2012 GARP report, Pakistan's programming approach for PWID has evolved since then under Government funded service delivery programmes working in Punjab and Sindh, and under the GF R9 phase 2 managed by Nai Zindagi in coordination with GoP. Following the epidemiological trail, Pakistan has expanded its coverage of services for PWID from large urban cities, to smaller cities where prevalence remains high. Distribution of needles has increased from 2102 from 42 per PWID/yr per year 131 per PWID/yr in 2013; XX% an increasing number of PWID registered under GF have access to detox; and access to OST will be provided once the GoP approves the use of bupenophrine for PWID.

Testing coverage has expanded through GF to street-based PoC testing with 2 rapid tests (WHO testing algorithm with the population prevalence found in PWID in Pakistan), streamlining the testing process for PWID. A bottleneck still remains in the system, however, as HIV treatment centres still re-test all clients registering with them. Spouses of HIV positive PWID are now being tested at their homes through female outreach workers under GF and provided a package of specific needs based services (living support package). This ensures improved access and inclusion to generic public sector services for women/spouses and children related health services including access to Prevention of Parent To Child Transmission (PPTCT) services. Children of HIV positive spouses/mothers are also then referred for testing, including paediatric testing (PCR) if below 18 months. From 2014 HTC access for spouses of PWID will start in select districts of Punjab.

PoC CD4 is also being offered to HIV positive PWID and their spouses under GF and has resulted in a rapid scale up of PWID registered at HIV treatment centres, although barriers remain to access to ART. The original grant provided referrals for PWID who tested HIV positive with NZ to public sector HIV treatment centres to be registered for CD4 and initiation of ART if needed, however delays in obtaining CD4s existed both at a facility level and in terms of PWID's ability access the centres. In 2013 NZ began providing mobile PoC CD4 diagnostics to their clients testing positive for HIV and increased the uptake of registration and treatment 4-fold. Between February 2012 and June 2013, 1762 HIV positive clients were referred by NZ to public sector HIV treatment centres for CD4 and ART initiation if needed. By

August 2013 8 NZ clients had initiated ART. With the GF and Government of Pakistan's agreement, in September 2013 NZ began mobile PoC CD4 in 23 districts. By the end of 2013 700 mobile CD4 counts were completed, 39% of which were <350, the current Government initiation protocol. Of those, 115 have been registered in ART clinics. PoC CD4 is an efficient way to determine ART eligibility and can close the gap between those needing ART, and those receiving ART if centres are prepared to register and initiate treatment.

To support the comprehensive programming for PWID and their spouses under GF, district level AIDS Councils were planned and in the process of being formed at the end of 2013. By end 2014 they will be established in 29 districts. The primary objective of these AIDS Councils is to address challenges facing PWID and their families related to health and social care, legal support, human rights, etc. in their respective district. This will result in access to district level services, increased inclusion for clients and their families and reduced stigma and discrimination associated with drug use, HIV and AIDS.

II. Community based monitoring and oversight support: The APLHIV opened provincial offices in September 2013 to monitor equity principles and community support and also to build cooperation with national and provincial leaders for community inclusion. Through the provincial offices and the helpline (see section 2 National Response, Target 4) the APLHIV has monitored and addressed 97 inquiries with appropriate actions taken against each including notifying GF PR Objective 2 twice in 2013. Two focus group discussions were held in each province the last quarter of 2013 and one per quarter is planned to be held from 2014 in each province, rotating between service delivery organizations. In addition, provincial APLHIV staff visited all CHBC sites and HIV treatment centres the last quarter of 2013 and plan one visit per quarter from 2014. Feedback from both the clients and the service providers is sought through a tool/questionnaire. The results of FGDs and visit reports are analysed at the Federal Secretariat of APLHIV and communicated to all stakeholders on a quarterly basis (once by end 2013), including identified issues and recommended remedial measures on quarterly basis. This system has given confidence to the community that a mechanism is in place and working to record their voices, giving a voice to the voiceless, leading to a sense of belonging and empowering the infected and affected community. Under the Global Fund grant (objective 1), the position of one provincial coordinator to be placed at each PACP has been budgeted in order to improve coordination. By the end of 2013, this post was endorsed by all provinces and ToRs were finalized by the Sindh, Balochistan and KP Governments. The provincial coordinator will liaise between the ART centres being administered by PACPs and the CoPc+ sites from where HIV positive PWID will be referred for ART to ensure timely and efficient ART uptake. The provincial coordinators will have access to information about the project activities in respective provinces through Nai Zindagi's Management Information System to regular update the PACPs about the progress in various districts where project is being implemented.

III. Community based services for MSM and transgendered persons: MSM, MSW and HSW together constitute the largest risk group in Pakistan. Given the hidden nature of MSM, the low condom use of *hijra*, the young age of MSW and the specific cultural determinants of risk behaviour for all, the most effective response is from the community itself. Under GF R9 the first and only men-who-have-sex-with-men (MSM) and transgender community based organization in Pakistan, Naz Male Health Alliance (NMHA).

The programming model develops and supports community-led health and social interventions for MSM and transgendered persons through the creation of CBO organizations rooted in the community. This fosters a sense of ownership, responsibility and trust among the community. The CBOs are strategically located close to “hotspots” and in areas where there is a large concentrate of *hijra* (transgender) *deras* (dwellings) in order to provide easy access, secure and relaxing atmosphere for the economically deprived low income community members who are the primary beneficiaries.

Currently there are 6 CBOs in 5 cities supported by NMHA. Service delivery includes HIV VCT, STI diagnoses and treatment, BCC, and condom/lubricant distribution, both via outreach as well as through the DIC/clinic. Each CBO is segregated into two portions. One portion of the office includes a drop-in centre where the community is provided with a secure and comfortable environment in hopes of strengthening the community while the second portion is used to provide clinical services.

Remaining invisible to get the work done

NMHA has a policy to operate in a minimal visibility mode due to the conservative religious culture, political volatility and security situation in Pakistan. The organisation has no public presence - no website or page on any social network sites. This policy has been developed to protect the identity of both clients and staff. As an Islamic Republic, Pakistan’s punitive laws against MSM behaviour remain the biggest barriers in the service delivery to the community. As per the Pakistan Penal Code - Section 377 and the *Hudood Ordinance*, the punishment for someone who is caught engaged in MSM behaviour may receive up to 100 lashes and can be imprisoned for up-to 10 years or sentenced to death via stoning.

Capacity building of various stake holders, networks, groups and organisations is a key component to not only scale up the capacity of the community to serve their own needs, but to create an enabling environment in which to do their work and serve the needs of their population.⁶³

IV. Optimizing Diagnostics through mobile CD4 and enhancement of general viral load services for HIV: Under the Enhanced HIV/AIDS Control Programme in Pakistan three CD4 (Becton Dickinson) and three viral load machines (ROCHE) were purchased and installed in Islamabad, Lahore and Karachi. As these machines were laboratory based, all PLHIV had to come to these three cities to get tested, leading to heavy financial and human cost through inevitable lost to follow up. The costs per tests were

⁶³ <http://www.apcom.org/spotlight-naz-male-health-alliance-pakistan#sthash.ToJcOuV8.dpuf>

very high and only increased with time. To overcome logistic challenges WHO introduced the concept of PoC CD4 machines to Pakistan through practical demonstration and consultations on new machines with Provincial and National Programme officials. WHO also suggested a model of three-tier treatment and testing centres under its Continuum of Care model, whereby PoC CD4 machines are to be introduced at secondary level of care while lab-based CD4 machines are to remain at tertiary level. To implement the model PoC CD4 machines were purchased for inpatient care programs for PWID and Punjab AIDS Control Programme purchased for secondary level facilities providing ART. Two PoC CD4 machines were donated by WHO to the Punjab Program.

WHO also piloted a program to optimize already available viral load machines in the country being used to conduct viral loads for diseases other than HIV. This pilot program ran successfully for a year paving the way to scale up optimization of already available machines all over the country. By the end of 2013, viral load testing was widely available all over the country. To support the optimization of diagnostics in the country USAID procured CD4 and viral load test kits for Provincial and National Programmes for 2012-2013. This support has greatly reduced the resource burden of diagnostics procurement on provincial programmes at a time when the devolution transition created financial constraints.

V. A Prioritised PPTCT approach: Since Pakistan's PPTCT programme launched in 2007, identifying HIV positive pregnant women and linking them to prevention services and needed ART to prevent the risk of mother to child transmission has proven extremely challenging. Following global guidance more suited for a generalised epidemic than a concentrated one, the programme was initially only rolled out through tertiary ANC sites in major cities. Women potentially at risk were identified through risk criteria, later proved to be non-associative with HIV after a 2009 evaluation. Low ANC rates, although improving, was a challenge (currently 24.3% have no ANC at last birth, 13.3% had one visit), especially for high risk, marginalised women less likely to access public services. In late 2010 after UNICEF technical support to assess PPTCT approaches in low and concentrated epidemics, focus was shifted to geographical prioritisation, a district model (outreach) approach to scale-up HTC and PPTCT coverage.

The district model approach, shifted focus from tertiary care facilities to specific districts with higher vulnerability factors including a concentration of a key population, namely PWID, or a concentration of PLHIV. The model was introduced in Punjab by developing programmatic linkages with the Programme for Primary Health Care and Family Planning (PHC & FP), more commonly known as the Lady Health Worker (LHW) Programme. It involves training of the healthcare staff in selected districts on HIV case identification, management and referral. Training of LHWs on basics of HIV, and to screen women based on a risk criteria, a tool while not working in general tertiary level ANC in large cities, was expected to work within the geographically prioritized districts. LHWs, on routine visits to households,

verbally screen women for their risk to HIV and refer/encourage women falling in the risk criteria to seek HIV Testing and Counselling (HTC). After HTC of women at specially arranged Family Health Days, HIV positive pregnant women are referred to the PPTCT centres for further management.

While PPTCT coverage rates remain far below the target in Pakistan, shifting the focus to a geographical prioritisation has had a marked impact on the programme. In 2013, 803 Lady Health Workers and 197 healthcare professionals were sensitized on HIV and trained to apply risk criteria to identify and refer at-risk women for HTC. As a result more than 4,000 women were screened/tested for HIV and 126 HIV positive pregnant women availed PPTCT services, a more than 200% increase in the coverage of HIV positive pregnant women receiving PPTCT as compared to 2012. Provinces continue to refine their PPTCT strategy with the support of UNICEF, and from 2014 will strengthen linkages with SDPs to reach FSW and female intimate partners of key populations.

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

a. Progress on key challenges reported on in UNGASS 2012 report

Several remedial strategies to expand the scope of services and scale up HIV and AIDS interventions, and improve access and quality of these services were proposed in the 2012 UNGASS report. Progress made in regard to the challenges mentioned in the previous report is described in the following points:

1. **Funding gaps:** This challenge remains a challenge (see below B. Major challenges faced in 2012-2013)
2. **Upward trend in prevalence among certain key populations:** It is difficult to measure whether there has been progress or not as there not been another round of surveillance since 2011. Provincial AIDS strategies follow an in investment approach prioritizing high-impact programming with key populations, however Government funded service delivery packages with key populations are limited and funds are currently not available to reach coverage targets set by the country.

PWID

Ensuring PWID are reached with prevention and treatment services is key as injecting drug use is driving the epidemic. While GF round 9 and its continuation have provided essential programming for PWID (*see section 3 National Response*), the grant's coverage does not come close to coverage targets set in provincial AIDS strategies, and the grant does not extend to the major cities of Sindh and Punjab where the majority of PWID reside. Recent evidence shows that ensuring HIV positive persons receive ART is the best prevention strategy. A national VCCT strategy endorsed by the provinces and expected to be disseminated in 2014 will promote more targeted and effective testing strategies to raise VCCT coverage targets among key and other vulnerable populations. A key issue hampering equitable access to ART, however, is the reluctance of providers to treat PWID despite no restrictions stated in the national treatment guidelines. Adherence is an important concern as Pakistan has only one medical institute able to conduct resistance testing and it is very expensive. And no 3rd line regimen is proposed in the national guidelines. Provision of OST is a critical programming component in the response for PWID and for HIV positive PWID to access ART. There are SoPs but so far only implementation of a small pilot project.

Transgendered persons

Currently the second highest prevalence is among transgendered persons. Under a regional GF grant transgendered persons (and MSM) are reached with services (*see section III National*

Response), but only 10% are tested for HIV.⁶⁴

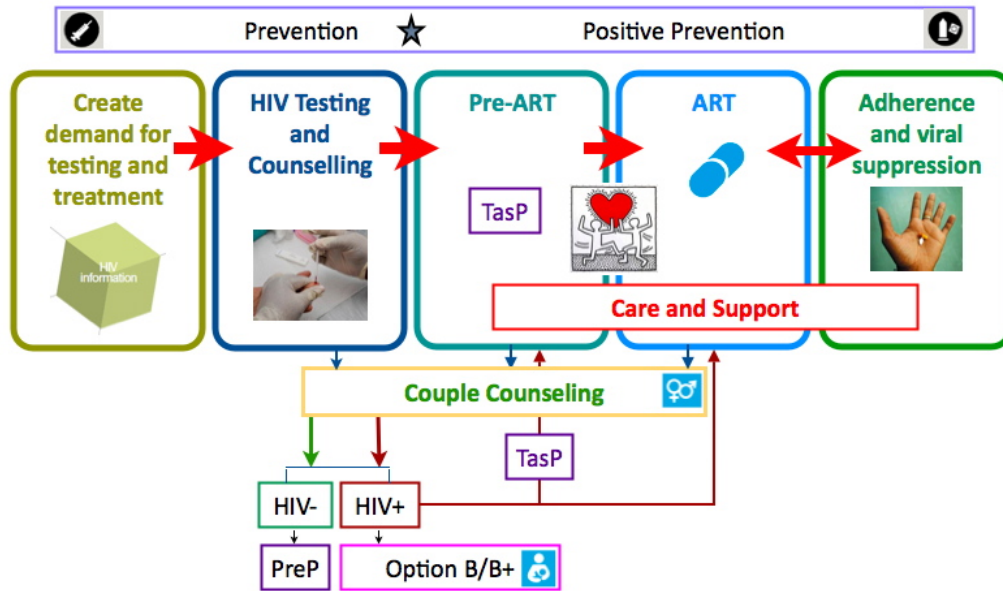
3. **Disaster response:** No tangible progress has been made to address this challenge. While Devolution in theory should strengthen the provinces ability to respond to disasters (more autonomy over coordination and resources), this theory has not really been tested as the number of disasters in the country have declined. In addition, the cluster system is the norm in disaster coordination. Often HIV falls through the cracks of both the health and the protection clusters. While the NACP and the PACP have made ad-hoc arrangements to ensure continuation of ART and emergency supply provision to mitigate physical vulnerability, prevention responses for key populations have been missed.
4. **Devolution:** Devolution remains a key challenge in the HIV response. It took time for the NACP to settle under its current ministry and for provinces to get their new PC-1s approved. Now provincial PC-1s are approved and provincial strategies are in place.

b. Major challenges faced in 2012-2013

1. **Funding:** Pakistan successfully secured phase 2 of the GF R9 grant addressing HIV and AIDS prevention, treatment and care services specifically and some health systems strengthening. The grant was continued in 2013. The total value of the original grant was over 28 million USD and an additional over 19 million USD was requested for the continuation phase including unspent funds from the first phase. By the end of 2013 only Punjab had an approved PC-1. The new fiscal period began July 2013 for Punjab, Balochistan and KPK. Of the 3, only Punjab's PC-1 has been approved. Sindh's PC-1 is through June 2014. The World Bank brought some funding back into the sector on a limited scale, including direct funding to MSM programming. USAID provided only supply goods, namely diagnostic kits. The Dutch and Norwegian Governments provided only small project based support. The UN continued to fund technical and financial assistance at strategic and operational levels, however availability of funding has decreased continually since 2010. While Devolution brought increased decentralization of policies, finances, planning and implementation to the Provinces, it has yet to bring together multiple Government stakeholders to address the HIV response beyond a planning level.
2. **A leaky test and treat cascade:** The cascade from testing through to treatment and viral suppression, now proven to be the most effective way to prevent HIV transmission, is very leaky in Pakistan, with large gaps between steps throughout.

⁶⁴ Source: NHMA.

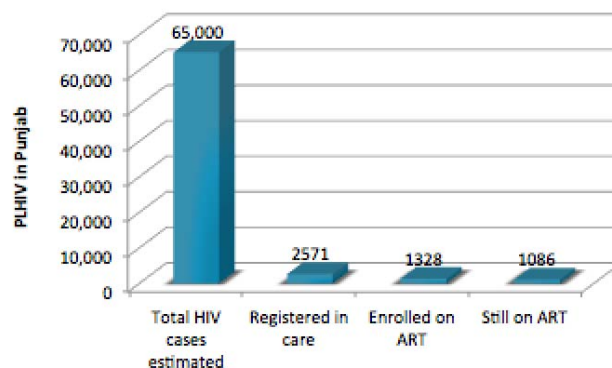
Figure 15. Test and Treat Cascade



Low coverage of service provision means a low demand for testing among key population. Coverage of HIV testing among key populations remains very low: 6.7% among PWID; 13.9% among HSW; 4.8% among MSW and 5.7% among FSW. Testing coverage rates among other highly vulnerable groups such as wives and intimate partners of key populations such as PWID, prisoners, etc., is not tracked, and testing among these groups rarely promoted (an exception being spouses of PWID under GFATM). While nearly all identified HIV positive pregnant women have received PPTCT services, the number identified is exceptionally low as compared to other countries in Asia and the Pacific. Figure 16 below shows the Punjab treatment cascade from 2013.⁶⁵ While the column “identified as HIV positive” is missing, it can be assumed it is far below “estimated” and not much higher than “registered”.

Figure 16: Punjab treatment cascade 2013

⁶⁵ Presentation, Stakeholders Consultative Workshop on Cascade Analysis of HIV Treatment in Punjab, 6th -7th February 2014, Lahore, Punjab, Punjab AIDS Control Programme.



At the end of 2013 it was estimated that there were an estimated 83 468 PLHIV in Pakistan.⁶⁶ Of those, only 7568 were registered at any of the HIV treatment centres. Typically the centres are viewed as a place to initiate and maintain treatment, not for regular clinical monitoring of PLHIV. While CD4 is not essential for initiating treatment, it is available in Pakistan, part of the national protocol for initiation, and almost all PLHIV initiating ART have their CD4 done. Of PLHIV registered with HIV treatment centres, it is unclear how many clients received CD4 as data is not aggregated to a national level given the lack of an MIS system. However, an estimated 51 033 persons 15+ years were eligible for treatment using a CD4 cut-off threshold of 350 cells/mm³. Of those eligible for ART only 4321 received it. In 2014 Pakistan will raise its CD4 threshold to 500, further widening the gap.

While decisions are taken by individuals moving along the test and treat cascade, gaps are primarily determined by factors including at the facility level, as well as logistical, financial, environmental, etc. As part of a regional study undertaken by the Asia Pacific Network of People Living with HIV and AIDS (APN+) in 2013 under GF R9, the Pakistan Association of People Living with HIV looked at determinants to improve ART access, initiation and adherence among PLHIV - the first study of its kind in Pakistan. The study results suggests that delay in seeking ART treatment and failure to follow medical advice once becoming eligible for ART treatment may be due to perceived decline in available health infrastructure, inadequate pre-ART care, high level of stigmatization of PLHIV, perceived lack of staff confidentiality, long distance to diagnostic and treatment sites, lack of health insurance schemes and community and home based care, and lack of ART treatment literacy. Factors affecting ART adherence included regimen complexity, medication side effects, therapeutic relationship between patient and provider, location of treatment sites, travel cost, availability of ARVs, lack of treatment

⁶⁶ Spectrum data, 11th March 2013.

literacy and socio-economic status of the clients.⁶⁷

3. **Opioid Substitution Therapy:** The unavailability of OST is a major barrier to HIV prevention and control among people who inject drugs. Pakistan is the only country in Asia with a large population of PWID where OST programmes are not available with the exception of a pilot project at the Institute of Psychiatry supported by UNODC and WHO that is currently reaching 80 individuals. Unavailability of OST to stabilize PWID who are in need of HIV treatment is a major barrier to scaling up coverage of ART for HIV positive PWID in Pakistan. Despite increasing understanding about the need to make available OST among many stakeholders, misunderstanding and significant ambivalence about the OST intervention remains among some concerned government agencies. Given this on-going ambivalence there is a need for discussion and a policy decision regarding introduction and expansion of OST taken at the highest Government level.
4. **Critical enablers:** While Pakistan has continued to evolve its overall HIV response strategy to prioritize high-impact programming with key populations, social and programme enablers remain critical for ensuring the success of an effective HIV response. A number of factors are hindering an enabled environment for Pakistan's response. Chief among these is the shift from a human rights based response approach to a clinical response approach. This shift in strategic direction may be a result of prioritizing limited funds, but in a socially conservative culture with an epidemic concentrated among marginalized and criminalised populations, a rights based approach is critical so that those who need are even able to access services (*for more details see Target 8: Eliminating stigma and discrimination in section 3 National response*).

In concentrated epidemics where risk behaviours are often criminalised, a responsive and non-punitive legal environment becomes essential. While Pakistan has made some strides including not restricting travel, not putting PWID into compulsory detention centres (except prison as injection drug use is illegal), and thus far not criminalizing the transmission of HIV, there remain challenges in the mitigation of punitive laws regarding same-sex sexual relations, sex work, and death penalty for drug offences.

Figure 17. Punitive laws hindering the response in Asia and the Pacific: Pakistan

⁶⁷ Final draft: Determinants to Improve Antiretroviral (ARTs) Access, Initiation and Adherence among People Living with HIV/AIDS in Pakistan, Asia Pacific Network of People Living with HIV/AIDS (APN+), 2013. Available through the Pakistan Association of People Living with HIV.

Punitive laws hindering the HIV response in Asia and the Pacific



The legislative environment remains mostly unsupportive of the needs of those vulnerable and at risk and those already living with HIV. An HIV Policy and an HIV Act were developed in 2007 but have not yet been approved by Parliament. Of those reported in the Stigma Index as having their rights abused (replied yes or were not sure - 183/883), 23% tried for legal redress and of those only 22.7% replied that that the matter was resolved; 25.8% attempted to solicit action by a government employee with only 9.5% reporting the matter had been resolved⁶⁸; and of those approaching a local or national politician to take action against an abuse of rights as PLHIV (n=61), only 16% reported the matter as resolved.⁶⁹

While global commitments have been endorsed by Pakistan, resources allocated are not enough meet these targets set and the PLHIV community is by-in-large shut out from national level monitoring and reporting. The 2009 PLHIV Stigma Index reported 99.3% (n=883) of PLHIV surveyed had never heard of the DoC.⁷⁰

Finally, but not exhaustively, gender plays an important role in enabling Pakistan's environment to respond to its epidemic. Culture plays a strong role in determining women's and transgendered persons' decision making process including negotiating their own risk and vulnerability to HIV, early marriage, in access to services, and in allowing (mandated) rights to be fulfilled. Although Pakistan is a signatory to CEDAW, perhaps the most protective international instrument for women's rights, implementation has proved difficult, and it fails to protect transgendered persons. The Committee on the Elimination of Discrimination against Women reported in its concluding observations on the fourth periodic report of Pakistan, adopted by the Committee at its fifty fourth session (11 February - 1 March 2013), iterated the

⁶⁸ The PLHIV Stigma Index, Pakistan 2009-10, Pg. 33-34.

⁶⁹ The PLHIV Stigma Index, Pakistan 2009-10, Pg. 34.

⁷⁰ The PLHIV Stigma Index, Pakistan 2009-10, Pg. 31.

concerns they have with Pakistan's implementation of the convention, many around its implementation in the new context of devolution. One of their overarching principle areas of concern was "the persistence of patriarchal attitudes and deep- rooted stereotypes concerning women's roles and responsibilities that discriminate against them and perpetuate their subordination within the family and society" (21).⁷¹

c. Proposed remedial strategies

1. **Funding:** Funding remains a critical concern as resources and commitment to the HIV response by major donors diminishes globally, and in Pakistan with a concentrated epidemic and many competing development priorities. Since 2005 through the new PSPs, Pakistan has continually sharpened its investment approach, focusing its resources on high-impact interventions for the populations with the highest risk of acquiring and transmitting HIV. With devolution provinces have been able to access greater budgetary allocations for HIV, as reflected by the PC-1s beginning next fiscal periods from July 2013 and from July 2014. In addition, guaranteed funding from the GF is being awarded to Pakistan through its new funding model. An envelope of a fixed amount is expected to be decided 1st quarter 2014 for HIV, TB and malaria. The CCM will decide the proportionate allocations between these three diseases. Lastly, mainstreaming the HIV response through other sectors is a globally promoted strategy in the landscape of dwindling resources, however, mainstreaming services for marginalized and criminalized populations is extremely challenging. While the new PSPs call for mainstreaming only through the health and social sectors, advocacy is on-going with law enforcement, narcotics control and others to include programming elements, primarily advocacy and sensitization.
2. **Plugging the test and treat cascade:** Provincial AIDS Strategies prioritize a Continuum of Care approach from the provision of testing through ART to all those determined to be at risk and in need in the country. Provincial PC-1s have also earmarked substantial financial resources for all steps in the test and treat cascade through public sector funds. In addition, provincial strategies focus on reducing the barriers to testing and ART access for PWID, transgender people and other key populations with improved referral linkages within the continuum of treatment and care, including for TB diagnosis and treatment. Mechanisms to strengthen the current ART M&E and ART related procurement and supply chain management systems have also been planned to ensure the quality and timely provision of ART in line with the best practices in the field to achieve national and HLM targets. National level guidance on promoting PITC/VCCT among specific populations including key populations, endorsed by

⁷¹ Convention on the Elimination of All Forms of Discrimination against Women, Committee on the Elimination of Discrimination against Women, Concluding observations on the fourth periodic report of Pakistan adopted by the Committee at its fifty fourth session (11 February – 1 March 2013), CEDAW/C/PAK/CO/4, 1st March 2013, pg. 8. Accessed at: <http://www2.ohchr.org/english/bodies/cedaw/cedaws54.htm>.

provinces, will be released in 1st quarter 2014. This will support the first step in the cascade, increasing uptake of PITC/VCCT by key populations and those highly vulnerable to HIV.

The APLHIV study on determinants to improve ART access, initiation and adherence recommended initiation of ART treatment literacy programmes, including on OIs, especially for those suffering from co-infections (HCV, TB etc.); addressing the issue of stigma and discrimination including non-discriminatory policies at healthcare settings; developing continuum of care through linking CHBC and CoPCs etc.; decentralization of ART management to primary health care levels; promoting access to free and affordable diagnostic care services; supporting community organization through PLHIV's empowerment and involvement; promoting PLHIV network and community working with KAPs to enhance registration; mainstreaming gender in terms of access to HIV care, treatment and support; introducing social and safety nets to reduce financial burdens on PLHIV; addressing barriers to ART initiation; reducing lost to follow-up of PLHIV to ART treatment; ensuring community participation in monitoring and evaluation; developing PLHIV adherence interventions; mobilizing resources education programmes for PLHIV, prompting internet usage and use of cell phones for ART follow-ups. It also recommends that improving adherence requires collaborating with the patient in an effort to understand and ameliorate individual impediments to adherence, generally by establishing dedicated time with every patient to educate, plan for adherence, and maintain support and collaboration throughout the course of treatment.

3. OST: There is an urgent need to introduce and scale-up the provision of OST, inclusive of residential drug treatment, accompanied with either importation or local manufacture of sub-lingual Buprenorphine tablets in 2mg, 4 mg and 8mg dosages. Advocacy for resource mobilization and sensitizing of policy makers and law enforcement agencies is necessary to ensure an enabling policy environment where the provision of quality HIV harm reduction services, including OST, for PWID can be delivered effectively. Initial results from the pilot project at the Institute of Psychiatry supported by UNODC and WHO will be released in 2014 and will provide a perspective on the way forward for OST in Pakistan. Under the GF R9, protocols for sub-lingual buprenorphine OST have been drafted and finalized after feedback from a national level designated OST committee including WHO, UNODC, UNAIDS, UNICEF, National AIDS Control Programme, Ministry of Narcotics, Anti-Narcotic Force, Institute of Psychiatry, Benazir Shaheed Hospital, and Nai Zindagi, PR R9 for PWID. They will be disseminated in 2014. This committee explored the feasibility of locally producing 2, 4 and 8 mg sub-lingual buprenorphine. A report is expected in the first half of 2014, including supply chain management recommendations.

4. **Enabling the environment:** Enabling an enhanced policy environment for an efficient public health HIV response is one of the key outputs of the new provincial strategies. When provincial AIDS strategies are brought under one overall national strategy in 2014, anti-stigma strategies should be incorporated as integral components and through the strategies determinants of vulnerability addressed and gender responsive plans made with indicators and gender responsive budgeting.

PLHIV empowerment is a key factor in an enabled environment. Development partners advocating GIPA principles should financially support implementation of recommendations made around stigma and discrimination from the ART adherence study. The national level helpline and provincial chapters are potentially important mechanisms for addressing and redressing rights violations for PLHIV and their families.

Devolution is an opportunity to address rights based issues, particularly gender and vulnerability, in a concentrated way at provincial and district levels, however the mechanism for provinces to implement global commitments such as CEDAW is yet unclear (HIV is easier as PACPs already existed at the time of devolution). As part of implementation, an effective coordination mechanism at national and provincial levels where NACP/PACPs and Ministry of Human Rights, Law and Justice and Women Development Departments can interact to enhance coordination and cohesiveness towards programming, and fulfill obligations related to health equity. Lastly, laws that offer protection against HIV related discrimination and equal enjoyment of human rights and that are stuck in legislative limbo should be pushed for immediate enactment.

VI. SUPPORT FROM COUNTRY'S DEVELOPMENT PARTNERS

Development partners align their efforts with the Government's national response to achieve success in responding to the HIV epidemic. Roles for development partners defined in the under construction PAS-III will continue to be the same as outlined in the previous NSF-II. They are to:

1. Provide strategic technical guidance and financial assistance that facilitates the government in attaining the national goals and MDG targets related to the epidemic.
2. Seek out and make available innovations that assist in implementation of the national HIV response.
3. Forge partnerships to address emerging and unattended priorities as well as ensure

adaptability, within the context of their existing mandates, to respond effectively.

4. Support modalities of the national response viewed as core challenges but that “fall off the radar” of the program.
5. Provide assistance through standardized, regulated channels to avoid duplication and ensure sustainability of services.

In Pakistan, bilateral and multilateral donors and other development partners have been key collaborators in mounting a national response to HIV. In the past, the major partners - listed in no specific order - included the One UN Joint Programme Component on HIV/AIDS (implemented through the Joint UN Team on AIDS), GIZ, USAID, World Bank, GFATM, DFID, CIDA and others. In 2012-2013, GFATM, One UN, the World Bank, USAID and to a lesser extent the Dutch and Norwegian Governments were the main donors for Pakistan’s HIV response.

In 2012-2013, the Joint UN Team on AIDS supported funding and implementation gaps in specific areas of HIV prevention, treatment and care in the context of drug use, sex work, antiretroviral therapy (ART), continuum of care, prevention of mother- to-child transmission, humanitarian responses, strengthening the Association of PLHIV and supporting the development of key strategic documents including provincial AIDS strategies, and a national communication strategy and a national VCCT strategy. have been being supported by the Joint UN Programme on AIDS in 2012-2013. The Joint UN Team on AIDS is also essential in creating an enabling environment for taking up initiatives with parliamentarians, media and religious leaders and women groups.

Continued support is however needed from the various development partners both on financial and technical fronts as Pakistan’s national programs transition continue to devolve over the coming years and as global strategy for HIV shifts to a more integrated one. Support in building the capacity of provincial counterparts will be a key cornerstone in ensuring the continuation of HIV prevention services and surveillance at these levels. Commitment from donors is also needed for ensuring the provision of ARV medicine for an increasing number of HIV patients who are on ART.

VII. MONITORING AND EVALUATION ENVIRONMENT

Overview of the Current M&E system

The principal role of both the NACP and Provincial M&E Units is to coordinate surveillance and M&E activities all over the country and between Provinces. They are responsible for M&E of the interventions that are implemented and to collate and assimilate all epidemiological and program information available within provinces (PACPs) and overall in the country (NACP) in order to analyse the current stage and future epidemic directions and to inform about the effectiveness of the

response. Monitoring & Evaluation for HIV and AIDS in Pakistan is guided by four principles:

1. A multi-sectoral approach
2. Developed based on national priorities
3. Built on existing systems and practices
4. Government-owned and led

The goal of this system is to ensure effective use of available data for evidence-based decision-making in policy and program development, advocacy, and resource mobilization and allocation. A set of core national indicators has been outlined in the National M&E Plan of Pakistan for this purpose. The M&E Plan was developed in consultation with all relevant stakeholders, has an inbuilt system for achieving and maintaining quality standards for program areas, forms the basis for measuring performance, analysing variances, identifying bottlenecks and serves as an early warning mechanism for facilitating corrective actions.

Routine program data gathering is done by provincial level units and analysed to generate quarterly provincial level reports. Subsequently, the data is forwarded to the federal unit that manages the central national HIV and AIDS database/repository established in the NACP. Due to the devolution of Health Ministry in June 2011, the PACPs are now directly managing some M&E functions that were previously managed at a national level such as surveillance and monitoring of the HIV treatment centres. However, as the NACP is the PR for GF R9 objective 2, treatment and care interventions implemented through their sub-recipients under this objective are directly monitored by the PR unit at national level. To facilitate coherence between the NACP and the PACPs in monitoring treatment and care, it is expected that in 2014 PACPs will become SRs under the objective 2 PR. The PR for Objective 1, PWID, Nai Zindagi, also is responsible for implementation of GF R9 through their sub-recipients. Programme outputs and outcomes tracked through their MIS system are shared with both PACPs and NACP, as well as directly with GF.

All international reporting (e.g. MDGs or the Global AIDS Response Progress Report) is still managed by the NACP. Data for all national core indicators, including for this report, is obtained from the following channels:

53

- Integrated Biological and Behavioral Surveys (IBBS)
- M&E of programs and projects
- Special studies and research
- Financial monitoring of national response
- Others: AIDS Case reporting System, DHS, MICS, HMIS, Statistical Bureau

AIDS Epidemic Modeling (AEM)

AEM was conducted in 2013 as part of a multi-country initiative of UNAIDS, the Global Fund and the East-West Center at University of Hawaii. The goals were to 1) inform national strategic planning; 2) inform sub-national action plans; contribute to better resource mobilisation. A technical working group was set up in December 2012 (same as EPP/Spectrum TWG: UNAIDS, NACP, PACPs, University of Manitoba/IBBS, WHO, UNICEF, UNODC, Nai Zindagi and Save the Children) after an initial workshop in Bangkok on data inputs and collection (Punjab and Sindh only). Three months of data collection and review by the TWG was followed by a modelling exercise at the East-West Centre in Honolulu, Hawaii. The TWG met again in August 2013, after which intervention scenarios were presented in Geneva to UNAIDS and the GF Pakistan team. The TWG met again in November and presented in a country consultation workshop in December 2013. The final report was completed early 2014.

Challenges faced in implementation of M&E system

The key challenge being faced in the implementation of an M&E system is that after devolution the federal level roles and responsibilities regarding M&E are not very clear. In addition is the limited capacity at the implementation level for data collection and its usage, lack of standardized tools for data collection, compilation and non-use of electronic forms of data collections and reporting. Lastly, M&E activities are budgeted at only 2-5% of the total HIV programme (e.g. the GF recommends 5-10% be budgeted The Global Fund recommends that five to ten percent of the national program budget be used for M&E activities, including efforts to strengthen M&E systems).

Remedial Actions

The NACP and PACPs, in collaboration with UNAIDS, CIDA, and other partners have conducted several trainings for the implementing partners at provincial level. As part of the review of the M&E plan 2012, a comprehensive action plan has been developed to address the capacity, data collection tools and database gaps that exist at various levels.

Under the Global Fund R9, the M&E system is being strengthened through several measures. The NACP PR2 unit has developed standardized data collections tools for HIV treatment centres and CHBC sites, and an online version of the MIS currently being developed by the NACP will allow fast and accurate collection of data and reporting. Specialized M&E staff has been hired at both national and provincial levels. Similarly Nai Zindagi PR1 is already implementing a comprehensive MIS system to track their clients and upload client information on a daily basis for more accurate, targeted programming. Both these measures are expected to facilitate strategic planning, monitoring, evaluation, surveillance and research. However, as CoPC+ sites are providing CD4 diagnostics and ART referral to HIV treatment centres, there is an urgent need to harmonize these systems, at least information collection tools and reporting.

ANNEX I: CONSULTATION PROCESS

The NACP in collaboration with UNAIDS initiated the process of developing the GARP report 2014 by creating a Technical Working Group (TWG) composed of representatives from the Provincial Programmes (Punjab), WHO, UNODC, UNICEF, and 4 CSO, one a PR for Pakistan GF R9, and 2 SRs on regional grants, one R9 for MSM under UNDP and one R10 for PLHIV under APN+. Given the short time-frame, consultants for the report (1 for narrative, 1 for NCPI) were agreed upon by the NACP and UNAIDS and were brought into the TWG.

The first meeting of the TWG took place in February 2012 to outline the way forward and process methodology for the development of the NCPI indicator of GARP Report 2014. Due to a security incident in the district courts in Islamabad, several participants were on lock-down, delayed, or could not make it to the NACP. Absent members were brought in virtually after the meeting.

Meeting of Working Group on Global AIDS Progress Reporting

Venue: National AIDS Control Programme

Date: 18th February 2014

Participants:

	Name	Organization
1	Dr Safdar Kamal Pasha	NACP, GF PR
2	Dr Quaid Saeed	WHO
3	Mr. Masood Fareed	UNAIDS
4	Dr. Anne Bergenstrom	UNODC
5	Mr Salman Qureshi	Nai Zindagi, GF PR
6	Mr. Asghar	APLHIV, SR
7	Ms. Bushra Rani	Naz Male Health Alliance, GF SR
	<i>Absent, brought in virtually</i>	
8	Dr. Abdool Gafoor	NACP, GF PR
8	Dr. Salman Shahid	Punjab ACP
9	Dr. Marc Saba	UNAIDS
10	Dr Nasir Sarfraz	UNICEF

Proceedings:

The meeting began with an introduction of participants, then moved directly into a review of the agenda followed by a review of the narrative report, Consensus was sought on indicators to submit, whether or not we should report beyond the previous disaggregation of <25, 25+ for key population

indicators given we had the data and there had been no new round of surveillance since the last reporting - we could add a new dimension of analysis. Changes in format from the last GARPR 2012 were reviewed including additional indicators and inclusion of results from the mid-term review of the Declaration of Commitment targets all countries completed in 2013. Consensus was reached on which indicators to report on and which additional evidence should be articulated in the narrative section. The group proposed and agreed upon examples for both the Best Practice and Challenges and Remedial Action sections.

Decisions reached:

1. Respondents for Part A and B were identified and the most efficient means to reach them given the security in the country and subsequent travel restrictions.
2. The working group will support the consultant in data collection and drafting of the report.
3. Relevant indicators for reporting were identified. The decision to disaggregate by additional age cohorts <24 for key populations indicators was agreed upon and the NACP took responsibility.
4. Additional data, including programme and modeled, identified and agreed to be included in narrative.
5. Draft report to be prepared by 19th March and shared with all stakeholders in a consultative meeting to be held 21st March 2013.
6. Agreed on text boxes: OST, APLHIV Helpline; female PWID/prisoners programme; reaching spouses with PITC/VCCT
7. Agreed on Best Practices: I) Comprehensive programming for PWID and their families; II) Community based monitoring and oversight support; III) Community based services for MSM and transgendered persons; IV) Optimizing Diagnostics through mobile CD4 and enhancement of general viral load services for HIV.
8. Agreed on Major Challenges and Remedial Actions. Challenges include: 1) Funding; 2) A leaky test and treat cascade; 3) Opioid Substitution Therapy

Follow up Actions

1. Provincial AIDS Strategies to be shared by NACP.
2. One UN documents to be shared by UNAIDS.
3. NACP to disaggregate data <24 years.
4. NACP to share AEM and Spectrum data with the consultant for indicators and inclusion in narrative
5. PACP and SACP to provide programme data on PWID clients reached and syringes distributed
6. Relevant TWG members to provide information for text boxes, best practices and major challenges as well as specific studies including ART adherence by APLHIV.

7. TWG members to provide what information they have on current development partners outside the UN.

A National Consultation was held 21st March for validation of indicators and consensus on both indicators and the narrative content e.g. best practices and main challenges.

Venue: NACP Conference Room

Date: 21st March 2012

List of Participants:

- Dr. Fazal-e-Mola, Provincial Programme Manager, Provincial AIDS Control Programme, KP
- Dr. Muhammad Ahmed Kazi, Provincial Programme Manager, Provincial AIDS Control Programme, Sindh
- Dr. Sofia, SPO, NACP
- Dr. Abdul Ghafoor, Senior Programme Coordinator, PR-Unit, NACP
- Dr. Safdar Kamal Pasha, M & E Specialist, PR-Unit, NACP
- Muhammad Arif Bashir, NACP
- Dr. Rajwal Khan, M & E Officer, KP
- Mr. Asghar Ilyas Satti, Representative, APLHIV
- Mr. Marc Saba, Country Coordinator, UNAIDS Pakistan & Afghanistan
- Fahmida Iqbal Khan, Country Community Mobilization and Networking Advisor, UNAIDS
- Dr. Tariq Zafar, Chief Executive Officer, Nai Zindagi
- Dr. Nasir Sarfraz, Specialist (HIV/AIDS), UNICEF, Islamabad
- Dr. Quaid Saeed, Programme Officer, HIV/AIDS, WHO, Islamabad
- Representative, UNDP, Islamabad
- Representative, UNFPA, Islamabad
- Representative, UN-Women, Islamabad
- Representative, UNESCO, Islamabad

Proceedings:

The meeting began with a recitation of the holy Quran followed by the welcoming of participants by Dr. Bashir, acting National Programme Manager. Following Dr. Basir, Dr. Marc Saba, Pakistan UCC, introduced the GARP reporting mechanism and then Dr. Safdar Kamal Pasha introduced the process of Pakistan submitting its 2014 GARPR. Following Dr. Pasha the 2 consultants presented for consensus, first Bettina T. Schunter on the indicators and narrative report and Dr. Nauman Safdar on the NCPI.

The participants agreed on the following issues:

Structural and semantic: Report format okay; use HIV treatment centres as opposed to ART centres etc.; use PWID as opposed to IDU; use PITC/VCCT to indicate both HTC promotion by service provider and uptake of services by people seeking them; use of modeling data in narrative report; use of programme data under targets/indicators in “national response”

Text boxes: Key Populations in Pakistan and their estimated populations (2009); Quick stats: Pakistan Demographic Estimates; Key pop Spectrum estimates: prevalence, incidence, deaths, ART coverage; MSW age concerns; Migration & HIV; Surveillance history; APLHIV helpline; Limitations of ANC study; PITC/VCCT for Spouses of PWID; Low cotrimoxazole coverage among children; and Prison interventions for female WID and prisoners.

Best Practices: 1) Comprehensive programming for PWID and their families: PoC HIV and CD4 diagnostics, services for spouses, District level AIDS Councils; 2) Community based monitoring and oversight support: APLHIV and provincial coordinators; 3) Community based services for MSM and transgendered persons: NMHA; 4) Optimizing Diagnostics through mobile CD4 and enhancement of general viral load services for HIV.

Major challenges and remedial action: 1) Funding gaps/Remedial action: PC-1s, new GF envelope (guaranteed funds), mainstreaming; 2) A leaky test and treat cascade (identification to registration, CD4, ART initiation, adherence, impact of new WHO consolidated guidelines)/Remedial action: National VCCT/PITC strategy, PC-1s, PoC CD4 being rolled out, capacity building on new guidelines (2014); 3) Opioid Substitution Therapy/Remedial action: Pilot project results, OST committee report exploring locally producing 2, 4 and 8 mg sub-lingual buprenorphine and supply chain management recommendations.

Two main follow up actions were identified and subsequently incorporated into the narrative:

1. Best Practices: WHO to send para including USAID support; ADD: PPTCT exponential increase from 2012 to 2013: 2 approaches: geographical prioritization and through key populations and their female intimate partners; ADD: Qualifying statement why these examples were chosen: innovative approaches with limited programmatic evidence.
2. Major challenges and remedial action: ADD: Enabling environment: include stigma, shift from HR perspective to clinical perspective; no legislation etc./Remedial action: APLHIV provincial chapters, Provincial AIDS strategies, gender, empowerment of PLHIV - look at both from

structural and HR/individual perspective