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COUNTRY SNAPSHOTS:

PAKISTAN

BACKGROUND

Pakistan is world's 6th most populated country with a population of 207 million people of which 51% are men and 49% are women with an average life expectancy of 66 years. As per the census of 2017, this population is growing at the rate of 2.4% and the median age of Pakistan's population is 22 years. Overall 64% population lives in the rural area. Pakistan borders India on the eastern side and Afghanistan, Iran and China on the western and northern side respectively. Pakistan has also endorsed the Declaration of Commitment (DoC) of the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS of 2001. In June 2011 at the 65th Session Pakistan endorsed the UN GA Resolution "Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS" thereby paving the way for continued commitment to respond to HIV/AIDS despite change in the political leader ship in last few years.

Like its neighbors, Pakistan is also experiencing concentrated epidemic. Groups like the PWID, MSM, TG and FSWs as also vulnerable populations with their partners, remain focus of the HIV prevention and treatment. Pakistan has also endorsed the Declaration of Commitment (DoC) of the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS of 2001. In June 2011 at the 65th Session Pakistan endorsed the UN GA Resolution "Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS" thereby paving the way for continued commitment to respond to HIV/AIDS despite change in the political leader ship in last few years.

Like its South Asian counterparts, there is a stigma associated with the HIV and it is coupled with the stigma associated with the same sex behaviour for which there are severe punitive legal measures as well as religious diktat. Therefore at the country level there is recognition of MSM as a group however, services are rendered under `Male Health' by several NGOs. NGOs/ CSO deliver prevention and testing services for the community members also serve as a link to the health care system. Within MSM and TG populations, Pakistan has done further segmentation of this group as transgender sex workers (TGSW), non-sex worker transgender (NSWTG), male sex workers (MSW) and non-sex worker MSM (NSWMSM. Transgender people are popularly known as `Khwaja Sira' term parallel to `Hijra'.

COUNTRY PRIORITIES

Pakistan AIDS Strategy[1] III identifies three Strategic Outcomes which are to mitigate the trend in the epidemic, halt new infections and ensure those needing treatment receive it. Following objectives have been set towards that direction.

1. Targeting epidemic among People who Inject Drugs; followed by key populations where HIV prevalence or risk of transmission is highest;
2. Providing high impact services in cities and peripheries having sizable presence of Key Populations and **focusing on HTC uptake for all key populations and treatment for all needing it;**
3. Strengthening capacities and coordination of, and referral between, Government, civil society, communities and people living with HIV for a more effective and sustained response; and
4. Increasing cost-effectiveness of programmes through innovation, systems strengthening and mainstreaming HIV in health and other sectoral work-plans and budgets where relevant and possible.

DATA SUMMARY

Epidemiology	Estimate	Year
MSM		
Estimated No. of MSM[2]	46,264	2017
As per AIDS epidemic modeling[1]	1,50,000	2015-20
As per UNDP & APCOM[3]	22 85500	2010
HIV Prevalence[2]	5.4%	2016-17
Estimated no. of MSW[4]	63,732	2015
TG/Hijra		
Estimated no.[1]	50,598	2014
Community estimates from Khyber Pakhtoonwala, Sindh and Punjab	90,000	2016
Census [6]	10,418	2017
TGSW		
HIV Prevalence[2]	7.1%	2016-17
Non SWTG		
HIV Prevalence[2]	3%	2016-17
MSM (Non Sex Work MSM)		
Average number of partners[2]	4.8	2016-17
Condom use during last encounter[2] (anal sex)	13.2%	2016-17
HIV test in last 12 months[2]	12.6%	2016-17
Prevention knowledge[2] (Condom as method of Prevention)	31.1%	2016-17
Alcohol/IDUse[2]	38.1	2016-17
IDUse[2]	2.8	2016-17
Male Sex Workers		
Average number of partners[2]	24	2016-17
Condom use during last encounter[2] (anal sex)	26.4%	2016-17
HIV test in last 12 months[2]	29.3%	2016-17
Prevention knowledge[2] (Condom as method of Prevention)	48.4%	2016-17
Alcohol/IDUse[2]	24%	2016-17
IDUse[2]	47.7%	2016-17

DATA SUMMARY

Epidemiology	Estimate	Year
TG/Hijra		
TGSW		
Average number of partners[2]	31	2016-17
Condom use during last encounter[2] (anal sex)	27.7%	2016-17
HIV test in last 12 months[2]	37.3%	2016-17
Prevention knowledge[2] (Condom as method of Prevention)	49.6%	2016-17
Alcohol/IDUse[2]	44.2%	2016-17
IDUse[2]	2.6%	2016-17
NTGSW		
Average number of partners[2]	3.7	2016-17
Condom use during last encounter[2] (anal sex)	12.1%	2016-17
HIV test in last 12 months[2]	9.3%	2016-17
Prevention knowledge[2] (Condom as method of Prevention)	30.5%	2016-17
Alcohol/IDUse[2]	31%	2016-17
IDUse[2]	0.3%	2016-17

Programmatic	Estimate	Year
HIV Testing Coverage[7]	22%	2017
National level strategy for MSM/TG[8]	Yes	2014
Country Status	**Status**	**Year**
Male to male sex [9]	Illegal	2017
Sex work in private [10]	Illegal	2017
Soliciting for sex [10]	Illegal	2017
Sections criminalising same sex activities [9]	377, Hudood	2017
Third gender recognised [6]	Under way	2017
TG/H Policy or bill [33]	Underway	2017
HIV Policy [32]	Yes	2006-17

FAST TRACK RESPONSE

HIV TESTING STATUS

As per PAS III HTC focus will be mainly on increasing uptake among key populations and specific vulnerable populations. Innovative testing strategies with standardised SOPs will be developed with key partners for HIV testing uptake including PoC rapid HIV testing using 3-rapid test algorithm. This will be done through home/community-based testing including through task-shifting finger-prick testing to trained, non-medical staff. Public and/or private HTC sites are proposed to be available across every Division in Pakistan by 2020. These HTC site/facility cum one stop shop will be established, free of cost. The capacities will be built of relevant departments, in the same facilities, on potential HIV case referrals for HTC from Dermatology, Urology, Paediatrics and Gynaecology.

HIV TREATMENT DELIVERY

There are 25 HIV treatment centres spread all over Pakistan. As of October, 2017 there were 21575 PLHIVs were registered and 11541 on ART. These center provide Pre ART services, ART services, Diagnostic services, HIV confirmation, Baseline investigations, CD4 testing, Viral Load testing, Hospital admission, 24/7 Emergency services and Post-exposure prophylaxis after a potential exposure to HIV[13].

CHBC Model[14,15]

Pakistan is implementing a Community and home-based care (CHBC) for HIV infected and affected people. This care is provided to the terminally or chronically ill people living with HIV (infected) in the comfort of their homes or their familiar communities. Under this Palliative care is provided under the care of loved ones in the comfort of home. Currently 20 centers are providing CHBC, which have reached out to 6,204 PLHIVs for comprehensive care. Following services are provided under CHBC model:

Services:

- School Support Package
- School Tuition Fees
- Nutrition Services/Food support package
- Medical Referral Support
- Emergency Medical Support
- Travel for ART Registration
- Counseling Services at CHBC
- Counseling Services through Household Visits
- Support to PLHIV or their Family Members who are already skilled

FAST TRACK RESPONSE

INTENSIFIED COMBINATION PREVENTION

A majority of key population lives in urban areas and the condom usage is known to be low[16]. Male sex workers and TG sex workers particularly require knowledge and condoms for HIV prevention. Social marketing of condom brands such as `Sathi'[17], `Josh'[18] is being done in Pakistan as family planning product as well as a product that prevents STIs. As per the NSP III, both MSM and TG are being offered a similar comprehensive package of services including targeted IEC, condom programming including lubricants, and HTC. The NGOs/CBOs that work for Male Health are delivering these services. Treatment as prevention among migrant workers and their spouses is also offered. Provisions are made for migrant workforce as well[1]. Services such as HIV related knowledge and testing to departing and treatment services to returned HIV positive migrant workers will be provided in close collaboration between NGOs (SDPs), the HIV sector, and Government sectors serving migrant workers.

Significant communication initiatives to intensify prevention approach

- Pakistan has a detailed communication strategy[19] that gives strategic directions for communication as well as audience segmentation, communication matrix, monitoring and evaluation as well as role of media. This document serves as a guideline.
- World Health Day[20] is observed in Pakistan in a major way by the national programme and its partners UN, WHO, UNAIDS, UNFPA, UNICEF, APLHIV and by NGOs and CBOs working for MSM and TG organisations.
- There are comprehensible IEC materials available in Urdu language.
- The National AIDS Control Programme also has social media presence.
- Key national newspapers like The Dawn, Tribune Pakistan Today cover news pertaining to HIV/AIDS on as per the relevance.

OWNERSHIP

The HIV/AIDS programmes are completely implemented by the government however NGOs play an important role as implementing partners. The Association of People Living with HIV/AIDS (APLHIV) and the NACP has entered into a public-private partnership via a Global Fund grant. Under this partnership APLHIV will provide community-based monitoring of services, which is expected to enable NACP to achieve further improvements in service delivery to strengthen the HIV response[21]. The other partners are private sector organisations like the Employer's Federation of Pakista[22], which have committed to ILOs' key principles on HIV/AIDS and Shell[23] Company that has HIV/AIDS work place policy. These commitments provide necessary social support to a PLHIV.

FAST TRACK RESPONSE

BEST PRACTICE

Three best practices are identified in Pakistan[24]:

1. Expansion of CD4 and Viral load facilities in Punjab: To overcome the problem of patient load and long wait, the Punjab AIDS Control Programme developed a plan with WHO Pakistan of introducing Point of Care CD4 machine in the province that would travel from center to center on specific dates to conduct all tests in that city. With two machines donated by WHO the programme now has a laboratory based CD4 machine in Lahore and two Point of Care machines moving around the centers. This made services accessible to people thus saving their time and expense on transportation.
2. Similarly there was just one viral load machine in Lahore where all patients had to come at least twice in a year for testing. WHO Pakistan after conducting a pilot in NACP reference laboratory Islamabad introduced optimisation of already available PCR machines in Lahore. These machines were made available to nearly all HIV treatment centers in the country thus equipping centers for patient load.
3. In 2014, the APLHIV, a community network NGO engaged in independent monitoring of equity principles to ensure that humane, dignified and non-discriminatory services. This yielded good results as the community felt empowered and also shared their feedback at the policy and decision-making levels. As this was a participatory process, it was recorded as a best practice.

ZERO DISCRIMINATION

As per the IBBS[2] TG (52%) and MSM (15.9%) reported being discriminated as also denied health care (TG 16.6) and (MSM 3.7). Pakistan has affirmed its commitment to 90-90-90 principle and

As per the national HIV and AIDS Policy 2007, “People with HIV and AIDS and people thought to be at risk of HIV infection will enjoy the same rights that are afforded to all citizens of Pakistan. They will be treated with dignity and respect when they seek health and welfare services and this will encourage them to maintain contact with these services”. Another provincial act The Sindh HIV and AIDS Control Treatment and Protection Bill, 2013[25] also provides for protection of rights of PLHIV.

MONITORING AND EVALUATION

As per the PAS III, M&E system needs to be strengthened. For that the national electronic MIS will collate data from service delivery points e.g., HIV clinics, ART satellite, HTC, PPTCT, and Paediatric AIDS sites, as well as SDP service sites for key and vulnerable populations, e.g. prisons), based on standardised MIS data collection and reporting tools. This will inform planners to get strategic information at a regular frequency, which could be then used to improvise interventions.

PROGRAMMATIC ALLOCATIONS

Since year 2007, Pakistan is receiving Global Fund grant[26] and has maintained B1 grade (score 7). An analysis of 2007-2013 data[27] reveals that Pakistan received 60% funding for its HIV programme from international donors, mainly multilateral agencies, remaining was domestic spending. Pakistan's domestic funding to HIV programmes has consistently reduced. Further analysis reveals that a sizeable portion was set aside for prevention followed by the care and support.

TREATMENT CASCADE

Treatment cascade is a major area of challenge for Pakistan as out of estimated 130,000 people only 7% are on ART of which only 4% have suppressed viral loads[28]. According to a study[29] a PLHIV typically experiences challenges that either prevents or delays taking treatment, thereby affecting treatment cascade.

These challenges are as follows:

- PLHIV referred by a health worker for HIV testing due to suspected HIV-related symptoms were more likely to link to HIV care on time.
- Participants diagnosed with HIV at government hospitals or public voluntary counselling and testing centres were more likely to present late for HIV care than those diagnosed at a private hospital. People with low socioeconomic status usually seek health service from the public sector because it costs significantly less than a private hospital. They are also less likely to seek health services and to present late for care because they cannot pay.
- PLHIV living in rural/small town were more likely to present late for HIV care than their urban counterparts.
- PLHIV having fear of confidentiality breach by health workers in relation to their HIV-related medical records were less likely to make timely appointments for HIV care.
- PLHIV with no formal education were more likely to seek HIV testing and care. Factors like trust and dependence on health workers may influence the association we observe between literacy level and acceptability of HIV testing. PLHIV with good HIV treatment literacy were more likely to initiate HIV care than those with poor literacy. Knowledge of ART and what taking it would mean may encourage PLHIV to retain HIV care despite presenting late for it initially.
- PLHIV having co-infection with TB was more likely to initiate ART.
- PLHIV having satisfaction with the information provided by their health worker was more likely to adhere to ART.

ADDITIONAL RESPONSE

UIC

National Identity Card (NIC) is issued to the citizens of Pakistan[30]. The unique 13-digit identification number is recognised all over the country. It is the first requirement of individuals as it is mandatory to obtain documents like license, NTN, bank account, passport, cellular connection etc. Every citizen of Pakistan, 18 years and above, is eligible for NIC. Currently it is not linked to seeking services for HIV treatment also there is no specific UIC for PLHIV. In year 2016, 4000 Hijras have been reported get their computerised NIC.

ADVOCACY

Pakistan has a well developed advocacy framework for MSM and TG[31] that focuses on issues of HIV, Human Rights, Sexual Orientation and Gender Identity related issues that need to be advocated on at the level of policy, implementation and cooperation and coordination between private and public partners. The national HIV/AIDS policy envisages multi sectoral cooperation to deal with the challenge. PAS III focuses on implementing targeted and sustained advocacy actions for policy reform, HIV integration and addressing stigma and discrimination to enable high impact interventions and protection of rights.

CAPACITY BUILDING

In both the HIV/AIDS policy and PAS III, the government has committed to strengthen the health systems to deliver the programme. In Pakistan, 6 CBOs working for the MSM and TG have been strengthened under the Global Fund's MSA grant[32] that systematically looked to build strengthening community systems to improve coordination with local governments and health care providers, deliver concentrated and quality capacity development support, and provide technical assistance to ensure high intervention impact and sustainability.

ADDITIONAL RESPONSE

NETWORKS

Both MSM and TG networks are present in Pakistan. Naz Male Health is one of the earliest MSM network in Pakistan[33].

TG N. TransAction Alliance[34], in Khyber Pakhtunkhwa and FATA, All Pakistan Transgender Election Network[35] which comprises TransAction Khyber Pakhtunkhwa, Sindh Transgender Welfare Network, Punjab Transgender Association, Balochistan Alliance for Transgender and Intersex Community, Blue Veins, PHRP, Hewad Peace Justice and Youth Organisation, Youth for Democracy and Development.

VIRTUAL NETWORK

As per IBBS 34.5% TGs and 38.6% MSM solicit sex partners through cell phones. This is yet an unexplored area for Internet outreach.

SOCIAL ENTITLEMENT SCHEMES

Social Schemes[36] are not particularly aimed at MSM/TG. These are social protection schemes like Benazir Income Support Programme, Sasti Roti (Punjab), Cash Grant, and Waseela-E-Rozgar, Waseela –e-haque, Waseela –e-Sehat for poor citizens of Pakistan. That range from cash transfers, food security to health insurance.

CHALLENGES

- HIV transmission and prevention related awareness in MSM and MSW people remains low.
- HIV testing and linking PLHIV to a care cascade is an area of challenge.
- Due to socio-cultural barriers and punitive laws, drawing men to talk about same sex behavior and anal sex is a challenge.
- There is an intersectionality of risk between MSM, TG, PWID and female partners.
- The barriers in the health care set up, stigma and discrimination faced by PLHIVs may impact treatment cascade.
- People have to travel long distances to utilise HIV related testing and treatment facilities. There is a need to expand the facilities.
- TGs face stigma, discrimination and violence therefore are vulnerable to HIV.

RECOMMENDA-TIONS

IBBS 2016-2017 has made following recommendations based on the evidence that has been gathered from across Pakistan:

- Key populations related services needed to be scaled up in the priority cities and towns where the populations have been identified.
- Reviewing programme design for the key populations and adding complementary behavioral, bio-medical and structural prevention strategies.
- Strengthening M&E and surveillance systems.

Additional Recommendations

- Plugging gaps in order to make HIV care continuum smooth for PLHIV.
- Capacities building of health care providers and workers to meet the challenge and provide stigma and discrimination free services.
- Large scale capacity strengthening and institutional arrangements will be required to fast track the response to HIV/AIDS.
- Involve MSM and TG organisation for advocacy and sensitisation with the health care providers.
- Rights based approach to be adopted for MSM and TG for effective HIV prevention.
- Integrating SRHR approach to reach out and intervene with the female partners of MSM.
- Exploring the possibility of HIV self test as well as PrEP.
- Incorporating consistent IEC and BCC for MSM and TG which can be conducted by using a community based, peer based and with the online community.
- Potential of NIC in linking with the health care services and social entitlement may be explored.
- Boost to rights based work that will benefit both MSM and TGs.

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We are united in advocating for issues around HIV and those that advance the rights, health and well being of people of diverse sexual orientation, gender identity, gender expression and sex characteristics.

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