Pakistan Global AIDS Response Progress Report (GARPR) 2015

COUNTRY PROGRESS REPORT PAKISTAN

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By

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CONTENTS

ACRONYMS

ACP	AIDS Control Programmes
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
APLHIV	Association of People Living with HIV
ART	Antiretroviral Therapy
ARV	Antiretroviral
CBO	Community Based Organisation
CHBC	Community and Home Based Care
CoPC	Continuum of Prevention and Care
CSO	Civil Society Organisation
DHS	Demographic Health Survey
FATA	Federally Administered Tribal Areas
FSW	Female Sex Worker
GARP	Global AIDS Response Progress
GF	Global Fund
GFATM	Global Fund to Fight AIDS TB and Malaria
GoP	Government of Pakistan
HASP	HIV AIDS Surveillance Project
HIV	Human Immunodeficiency Virus
HSW	Hijra Sex Worker
HTC	HIV Testing and Counselling
IBBS	Integrated Biological and Behavioural Surveillance
IDU	Injecting Drug User
KP	Key Population
KPK	Khyber Pakhtunkhwa
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MIS	Management Information System

MoH	Ministry of Health
MSM	Men who have Sex with Men
MSW	Male Sex Worker
MTR	Mid Term Report
NACP	National AIDS Control Programme
NEP	Needle Exchange Program
NGO	Non-Governmental Organisation
NMHA	Naz Male Health Alliance
NSEP	Needle Syringe Exchange Program
NSF	National Strategic Framework
NTP	National TB Program
NZ	Nai Zindgai
OST	Oral Substitution Therapy
PACP	Provincial AIDS Control Program
PAS	Pakistan AIDS Strategy
PC-1	Planning Commission Proforma-One
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PPTCT	Prevention of Parent to Child Transmission
PR	Principal Recipient
	People Who Inject Drugs
SDP	Service Delivery Project
SGS	Second Generation Surveillance
SOP	Standard Operating Procedure
SR	Sub Recipient
SRA	Situation Response Analysis
STI	Sexually Transmitted Infections
TG	Transgender
ToR	Terms of Reference

TWG	Technical Working Group
UN	United Nations
UNAIDS	United Nations Joint Program on AIDS
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UNODC	United Nations Office for Drugs and Crime
USAID	United States Agency for International Development
VCCT	Voluntary Confidential Counselling and Testing
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organisation

STATUS AT A GLANCE

Inclusiveness of stakeholders in the development of the GARP report

The process of GARP report writing was guided by the Technical Working Group (TWG) on HIV and AIDS formed by the National AIDS Control Programme (NACP). The group comprised of all key partners in HIV response in the country namely NACP, the provincial AIDS Control programs from the provinces of Khyber Pakhtunkhwa (KPK), Punjab, Sindh and Balochistan, UN agencies consisting of UNAIDS WHO, UNICEF, UNODC, UNFPA, Civil society represented by the Association People Living with HIV (APLHIV), Nai Zindagi (an NGO working with PWID and PR-1 in GF Round 9 grant, Naz Male Health Alliance another NGO working with providing services to MSM.

The Technical Working Group met in late February to decide on the process of development of GARP report, the availability of data in the country, selection of a consultant, and appointment of focal persons in NACP and UNAIDS to work with the consultant. It was realised that in the absence of new surveillance rounds in the country, the data of the last round of IBBS surveillance (IBBS 2011) would be reported in this year's report. The Global AIDS Progress Report (GARPR) 2015 guidelines only required submission of the core indicators and the narrative country progress report, while the National Commitments and Policy Instrument (NCPI) was not required.[1]

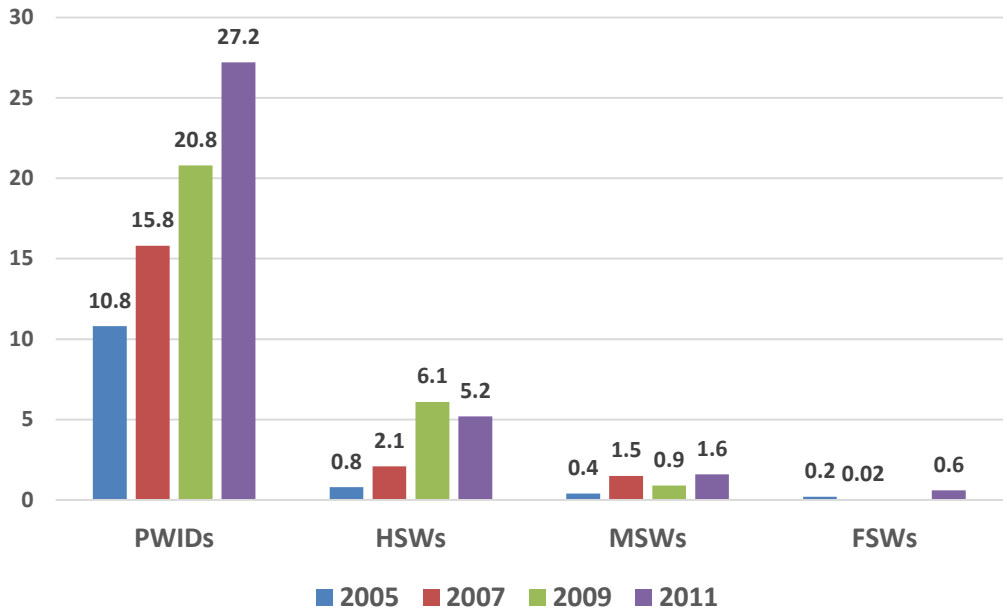
The first draft of the report was shared with members of the TWG. Discussions were held on key indicators to be reported in the report.

The status of 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. Pakistan's epidemic is primarily concentrated among two of the key population groups driving the epidemic in the country.[2] These are People Who Inject Drugs (PWID) with a national prevalence of 27.2% (weighted prevalence of 37.8%); followed by Hira (Transgender) Sex Worker (HSW) standing at 5.2% and then 1.6% among Male Sex Worker (MSW). Fortunately the prevalence in Female Sex Workers still remains low at 0.6%.[3]

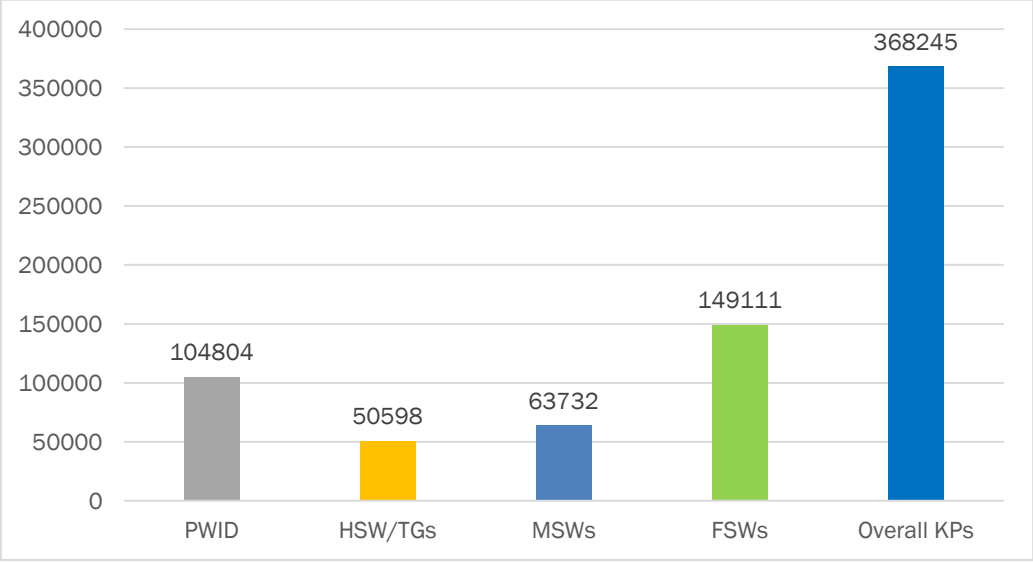
Overall the geographic trend of key populations is from major urban cities and provincial capitals, expanding over time to smaller cities and peripheries.

[1] http://www.unaids.org/sites/default/files/media_asset/JC2702_GARPR2015guidelines_en. pdf
[2] www.nacp.gov.pk;
[3] National Integrated Biological and Behavioural Surveillance (IBBS) was conducted in 2005 (Round I), 2006-7 (Round II), 2008 (Round III) and the last one in 2011 (Round IV). Round V is planned for 2015. The Punjab conducted IBBS in 10 cities in 2014 but results are not yet disseminated.



Graph 1: Epidermiological Trends among Key Population in Pakistan – 2005 to 2011[i]

Key Population estimations were revised during the 2014 Spectrum exercise in collaboration with UNAIDS Asia Pacific Regional Support Team.[4]



Graph 2. Esimated Number of Key Populations – Data Extrpapolated from Mapping 2011.[5]

These prevalence figures are from the last round of Mapping and IBBS carried out in Pakistan. Since then no new surveillance rounds have been conducted in the country. Looking at the trends from the previous rounds the epidemic is fairly concentrated in big towns and cities but

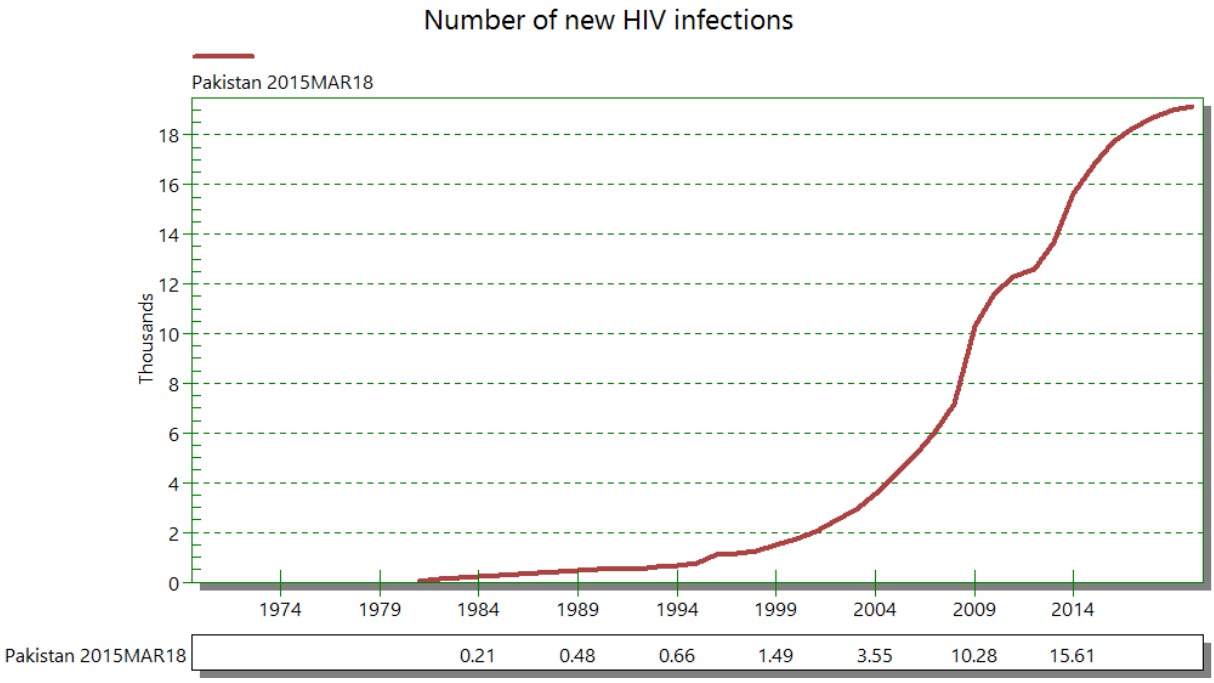
[4] Populations Estimation exercise: Pakistan National AIDS Programme and UNAIDS Asia Pacific Regional Support Team, February 2015, Bangkok, Thailand.
[5] Populations Estimation exercise: Pakistan National AIDS Programme and UNAIDS Asia Pacific Regional Support Team, February, 2015, Bangkok, Thailand.

this trend is now changing and even smaller towns showing increasing prevalence in key populations.

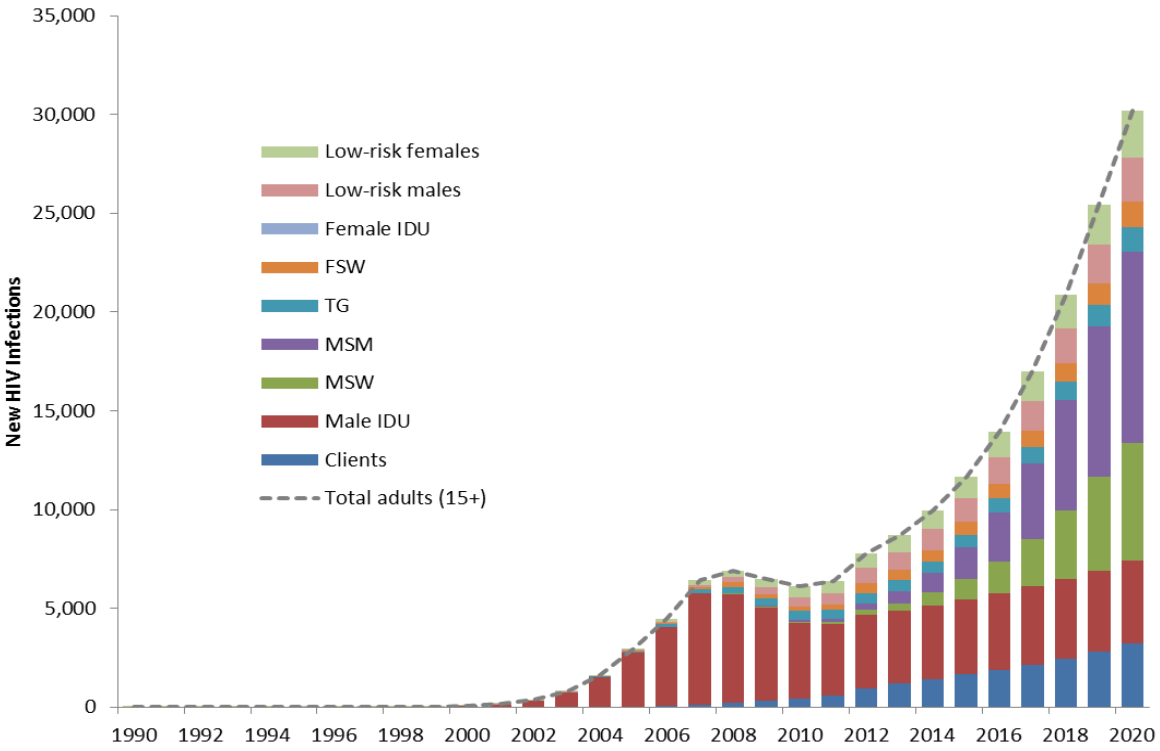
Pakistan epidemic is mainly driven by PWID. The country sits on one of the world's busiest drug trafficking corridors, largely due to the cultivation of opium in neighbouring Afghanistan. This leads to the local use of drugs and most of drug users including PWID reside on this trade. This route passes through main cities and commercial centres in the country. The UNODC study of drug use 2013 is showing substantial rise of drug use in the country with PWID doubling between 2000 and 2012[ii].[6] Many of them are married and transmitting the infection to their spouses while others are buying/offering sex from FSWs[7].

The other important Key Population with high prevalence of HIV is Hijra (Transgender) Sex Worker. This is an ancient community in Indian subcontinent classified as third sex. Traditionally a respectable community recognised by Muslim rulers was incarcerated during British rule and was left with no option but to sell sex for money. The prevalence of HIV is rising fast in this population and their overlap with PWID and other KP could lead to spread of this disease.[iii] The national prevalence stand at 0.08% and estimated number of HIV positives in the country at 91,340 with a breakup of 63,872 males and 27,468 females (Spectrum modelling 2014).[8] Incidence is not directly measured in Pakistan, only estimated through Spectrum and AEM modelling. Very few NGOs are able to calculate incidence from their regularly tested clients. Spectrum data at the end of 2013 showed an increase of new HIV cases of 16 per cent on average from 2005 through the end of 2014 *(Figure 4)*.[9] AEM Modelling took place at the end of 2013 for Punjab and Sindh. Currently PWID produce the bulk of new infections, and will continue to produce the same absolute number of new infections although the relative proportion of HIV among PWID becomes smaller. The largest contributions of new infections over time are by MSM and TG. Projections in the Model predict increasing prevalence of HIV in all population groups, rapidly rising among MSM and transgender persons, although PWID plateau in Punjab at 35 per cent and in Sindh at 30 per cent.

[6] http://www.unodc.org/documents/pakistan/Survey_Report_Final_2013.pdf
[7] WWW.nacp.gov.pk; HASP IBBS Report, 2011
[8] Populations Estimation exercise: Pakistan National AIDS Programme and UNAIDS Asia Pacific Regional Support Team, February 2015, Bangkok, Thailand.
[9] Spectrum file Pakistan 2015MAR18.



Graph 3. HIV New Infection – Spectrum / EPP 2014[10]



Graph 4. AIDS Epidemic Modelling, Pakistan[11]

[10] Spectrum file Pakistan 2015MAR18.
[11] AEM Modelling Exercise, 2013

Among the vulnerable populations, migrant worker form the majority where most of HIV positives in the early days were diagnosed and being treated in the existing treatment centres.[12] Pakistan is characterised by 400,000 migrants formally leaving Pakistan each year for overseas employment mainly to Gulf (IOM 2012)[iv] while another 3.5-4.0 million go abroad to undocumented channels (UNDP 2010).[v] These migrants are mostly unskilled male workers majority of who work in construction companies. These young men represent a vulnerable population and bridging population due to higher rates of unprotected sex with sex workers or casual partners. Although migration policy of Pakistan states that all migrants before leaving should receive knowledge that include infectious diseases including HIV but this practise is not followed in at least 83% of cases (UNDP 2008). All registered workers undergo mandatory testing, from defined medical centres, without consent, confidentiality and pre and post-test counselling. A survey carried among migrants showed that majority of them perceived not be at risk of HIV, STIs, Hepatitis or TB.[13]

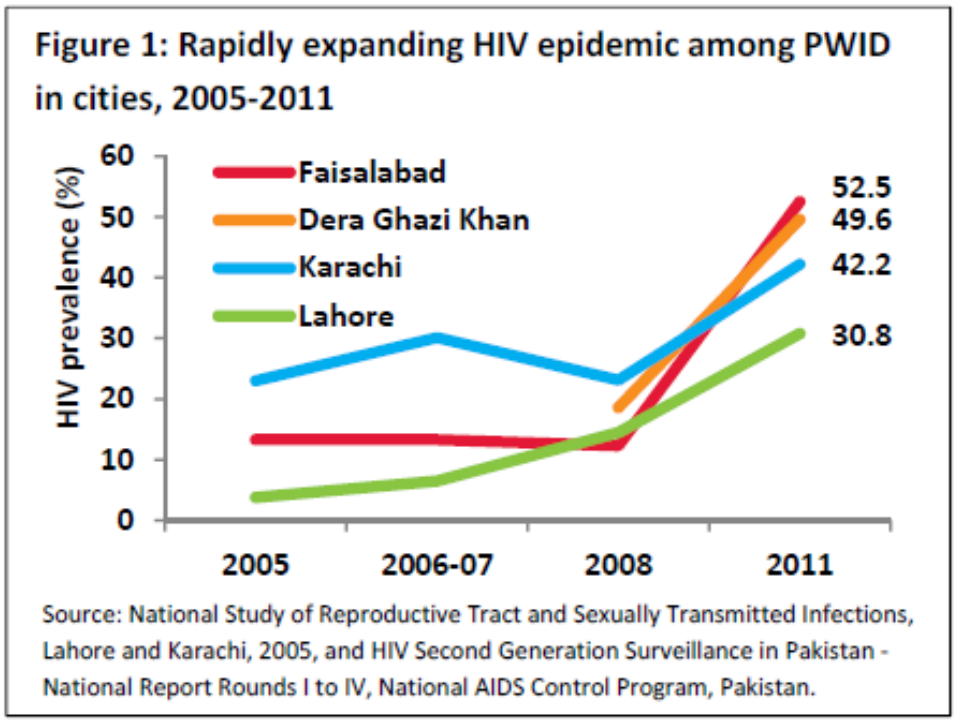
With around 180 million people[14], Pakistan is the sixth most populous country in the world.[15] Despite of facing host of domestic social, economic and political issues the country is a key actor, politically and economically in south Asian region. The country is ranked 146 out of 186 countries by the 2013 United Nations Development Index (UNDP 2013 Human Development Report: The Rise of South: Human Progress in a Diverse World). Levels are low with an overall literacy rate of 58% only 46% of women in the country are literate. The mean duration of schooling in a formal education setting is 4.9 years.[16]

The country consisted 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). 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.[17] 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.[18]

Pakistan's HIV epidemic started in 1980s when cases surfaced mostly in migrant workers working abroad. This stage of low prevalence continued for next two decades when suddenly surveillance studies in Karachi exposed an expanding epidemic in Injecting Drug Users in Karachi

12 www.nacp.gov.pk
13 Baseline Assessment of health vulnerabilities of departing and returnee migrants by IOM.
14 Ministry of Finance, Government of Pakistan 2012 Economic Survey of Pakistan
15 http://www.indexmundi.com/pakistan/demographics_profile.html
16 Pakistan Bureau of statistics, Government of Pakistan. 2012
17 www.nacp.gov.pk; HASP IBBS 2011
18 www.nacp.gov.pk; GARPR 2014

(26%) and Larkana (9.7%). These revelations were alarming for the health authorities in the country who then conducted four HIV and AIDS surveillance rounds for next ten years that exposed a well-entrenched concentrated epidemic in people who inject drugs (PWID) in whom the national prevalence has now reached to 27.2% in the last round of IBBS surveillance in 2011.



Graph 5. Rapid Expanding Epidemic among in Pakistan[19]

People Who Inject Drugs

Estimated to be 104 804[20], HIV prevalence amongst PWID (defined as a person who has injected drugs regularly for non-therapeutic purposes in the last six months[21]) has steadily increased from 10.8 per cent in 2005 to 37.8 per cent (weighted; 95% CI: 37.3%, 38.3%) in 2011.[22] Large concentrations of PWID are found in cities such as Karachi, Faisalabad and Lahore, the largest metropolitan areas. Based on the 2011 data, PWID are overwhelmingly male (98.4%)[23] with an average age between 25-40 years old. The high HIV prevalence among PWID is consistent with their frequent and risky injection practices: 71.5 per cent report 2-3 injections per day; another

[19] www.nacp.gov.p; HASP IBBS 2005 – 2011
[20] Populations Estimation exercise: Pakistan National AIDS Programme and UNAIDS Asia Pacific Regional Support Team, February 2015, Bangkok, Thailand.
[21] Integrated Behavioural and Biological Surveillance Round IV, 2011.
[22] Un-weighted prevalence of females who inject drugs in IBBS R IV was 17.9% (IBBS, R IV, 2011).
[23] Although there are few women who inject drugs, many may also be part of a wider sexual network, hence more at risk and a bridging population. Besides, dependence on their partners for drug use, fear of violence or actual violence restricts their ability to insist on clean needles, negotiate, condom usage, and access harm reduction and HIV-related services [UNDP, WAP+, APN+ and Unzip the Lips, (2013). *Discussion paper: Linkages between violence against women and HIV in Asia and the Pacific*. Bangkok.]

21 per cent report more than 3 injections a day; and only 39 per cent report always using a new syringe.

On the other hand UNODC drug survey report 2012 report drug users population of 430,000[24]. Of these 78% are injecting heroin while the rest tranquillizers and prescription medicines. According to this report the injecting population has doubled from year 2000 to 2012. The survey further observes that among 73% report sharing of syringes. While the average number of injection per day is 3 it is believed that average user uses just about one syringe per day rather that one syringe per injecting episode. Syringes are cleaned in 35% of cases with boiling water which is not safe to remove viruses. Injections in groups are a norm while large majority use the services of professional injectors or street doctors which lead to sharing of injecting equipment.

This high prevalence among this population is consistent with their high risky injection behaviour: 71.5% reporting 2-3 injections per day and only 38.6% report always using a new syringe for each act of injection. Sexual interaction between PWID and other key populations varied by city but overall 4.8% had sex with Male of Hijra sex workers and 9.4% with FSWs in the past 06 months while condom use was low (16.3%). On the other hand 33.8% of PWID were currently married. A new trend seen in PWID in last surveillance round is the significant increase in the use of professional injectors or street doctors by PWID for getting injections.[25]

A study by APLHIV on drug users in Pakistan, indicated structural and systemic barriers such as the stigma of being identified by others as a drug user or fear of police harassment prevent people from initial access or continued use of services. The findings suggested that taking steps for overcoming barriers, including establishing systems for their identification and handling by the service providers may assist in improved outcomes in relation to HIV prevention and treatment of IDUs and their partners.[26]

Male Sex Workers

The estimated population size is 63 732[27], the majority found in larger cities, the average age less than less than 30 years and the HIV prevalence 3.1 per cent (weighted; 95% CI: 2.8%, 3.4%), rising from 0.9 per cent in 2008. Bisexual behaviour was reported by approximately 39.5 per cent. Consistent condom use was very low at 13 per cent with paying partners, and even lower with non-paying partners at almost 11 per cent. 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. In 2011 42.1 per cent of MSW were 13-19

[24] Drug use in Pakistan 2013 by UNODC
[25] www.nacp.gov.p; HASP IBBS 2005 – 2011
[26] National Study on Access of Drug Users to Treatment and Fundamental Human Rights, Dr. Safdar Kamal Pasha, for APLHIV; 2013
[27] Populations Estimation exercise: Pakistan National AIDS Programme and UNAIDS Asia Pacific Regional Support Team, February 2015, Bangkok, Thailand.

years and 36.1 per cent were 20-24 years. *Of all MSW mapped in the country in 2011 78.2 per cent were under 24 years of age*. Overall, only 1.7 per cent of MSW reported having injected drugs in the previous six months, but 52.5 per cent reported using alcohol or drugs while having sex during the same time period.[28]

Hijra Sex Workers

Currently there are no official baseline estimations on transgender persons. At the end of 2014 Spectrum estimated 50,598 transgender persons, however, the only information available was the inputs of 2011 estimates of HSW. In Rounds I – IV of the IBBS, *hijra* (traditionally eunuchs, now a sub-cultural denotation) who sell sex are defined as transgender/transvestites. The continuum of sexuality, however, is more fluid than the definition can capture and from Round V IBBS, transgender will be considered a separate population with hijra self-identifying as either transgender or MSM. The UNAIDS Gap Report 2014 states "estimates from different countries indicate that the transgender population could be between 0.1% and 1.1% of reproductive age adults."[29] Based on only the current estimate of males between the ages of 15 and 49 in Pakistan, and a conservative proportion of 0.3 of the male population (as in the AEM MSM modelling), the transgender population could be as high as almost 150,000.[30] Transgender persons are considered at high risk for HIV in Pakistan given their female gender based identity and socially constructed deferent role in society (including anal receptive sexual role), making condom negotiation more difficult.[31]

Female Sex Workers

The estimated population of FSW is 149 111[32], the majority located in large cities, with an HIV prevalence of 0.6 per cent (weighted; 95% CI: 0.4%, 0.9%) in 2011, rising from 0.2 per cent in 2007. Their average age in 2011 was 26.9 years. For 43.1 per cent their mode of selling sex through a brothel, *kotikhana*[33] or home-based mostly operating through a *madam*, while 22.3 per cent were street-based and 24.7 per cent 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 per cent reported that they always used a condom with their client in the last month (vaginal sex), and 20.6 per cent reported consistent condom use with non-paying partners. Brothel-based FSW

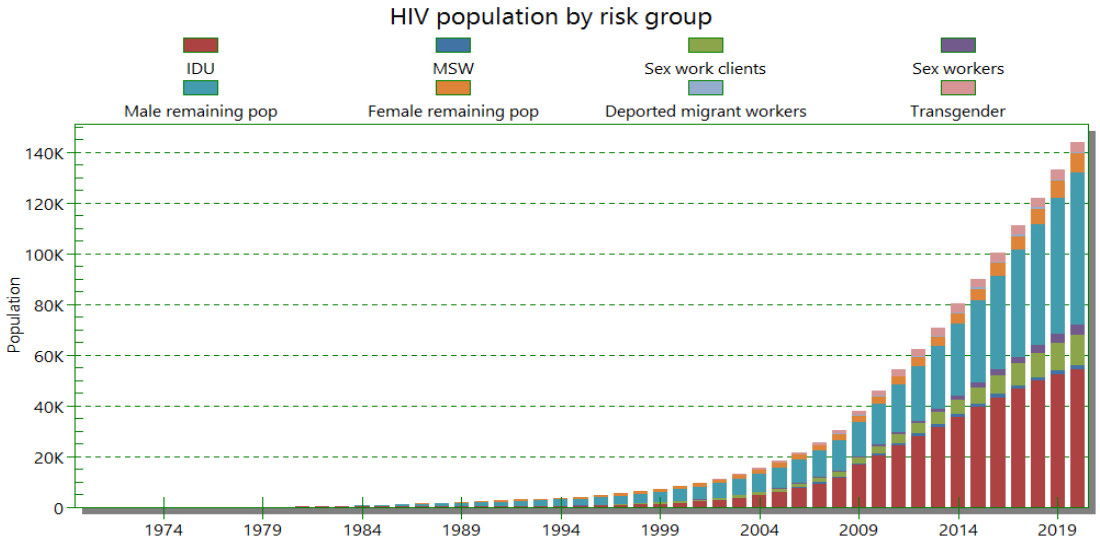
[28] NACP, Canada-Pakistan HIV/AIDS Surveillance Project, 2007.
[29] The Gap Report, UNAIDS, 2014.
[30] This percentage is calculated on an estimated 49 269 000 adult males aged 15-49 years in 2015. Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, *World Population Prospects: The 2012 Revision*, http://esa.un.org/unpd/wpp/index.htm
[31] GARPR 2014 cited from Collumbien M, Qureshi AA, Mayhew SH, et al. Understanding the context of male and transgender sex work using peer ethnography. Sex transm infect. 2009. April 85 suppl 2:ii 3-7.
[32] Ibid.
[33] Refers to a rented house in a residential neighborhood proving sex work services. Reference: Mapping Networks of Female Sex Workers in KothiKanas and Private Homes, NACP, Canada-Pakistan HIV/AIDS Surveillance Project, 2007.

reported substantially more condom use than the other types of sex workers. The longer number of years in school had a positive association with condom use. Both injecting drugs and having sex with a PWID were highest amongst brothel-based FSW at 7.2 per cent and 15.8 per cent, respectively.

The disease has not yet spread to the general population. A 2001 [34]study in antenatal clinics showed no HIV and rare STIs in this study population. Subsequently two other studies in men from general population showed similar results.

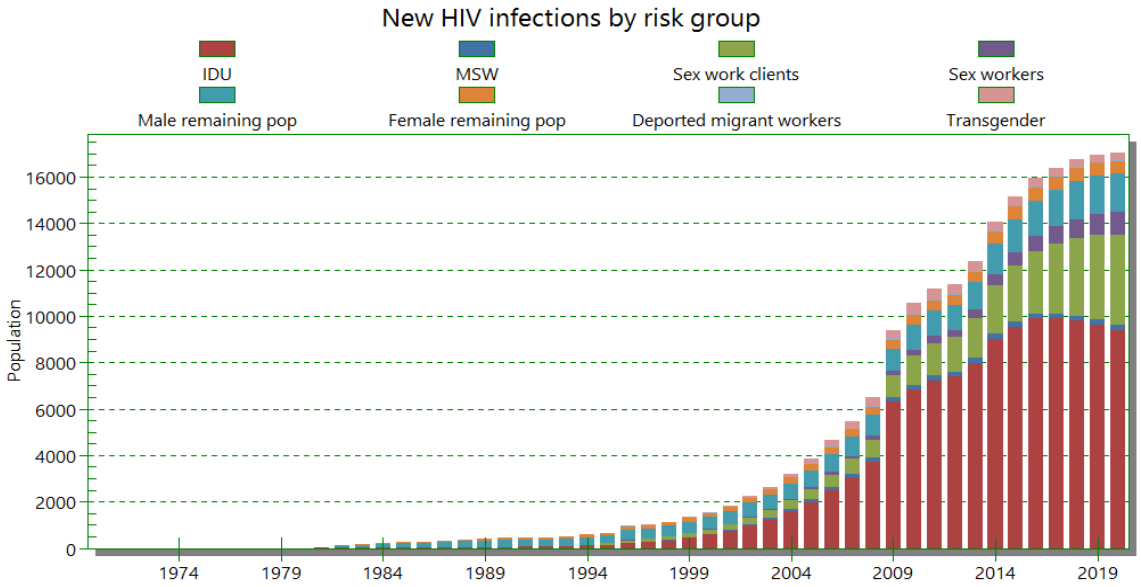
Males who have sex with male (MSM).

There is no baseline information on behaviour, knowledge, or HIV prevalence of MSM, or consensus on population estimates (MSM will be included in the 2015 IBBS). UNDP and APCOM estimate the number of MSM in Pakistan to be 2285500.[35] The technical working group established for the AIDS Epidemic Modelling process determined MSM to be 0.3 per cent of the male adult population[36], or approximately 150000 adult males[37], lower than the estimated lifetime prevalence of 6-12 per cent male to male sex for Southeast and South Asia.[38]



Graph 5. HIV Population by Risk Group[39]

[34] National AIDS Control Programme. The STI Prevalence study of Pakistan 2001
[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.
[36] AIDS Epidemic Modelling in Pakistan: Country Case Study Report for UNAIDS. 2014.
[37] As with transgender persons, this percentage is calculated on an estimated 49 269 000 adult males aged 15-49 years in 2015. Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat,
World Population Prospects: The 2012 Revision, http://esa.un.org/unpd/wpp/index.htm
[38] Cáceres C, Konda K, Pecheny M, et al. Estimating the number of men who have sex with men in low and middle income countries. *Sex Transm Infect* 2006;**82**:iii3-iii9.
[39] Spectrum file Pakistan 2015MAR18.



Graph 6. HIV Population by Risk Group[40]

Overlapping Risk.

Linkages with sex workers exist with around 14 per cent and 7.1 per cent reporting paying for sex with FSW and M/HSW respectively in the past six months, but only around 16 per cent used a condom in their last sexual act. Figure 6 below shows the interactions between different key populations as reported in Round IV.

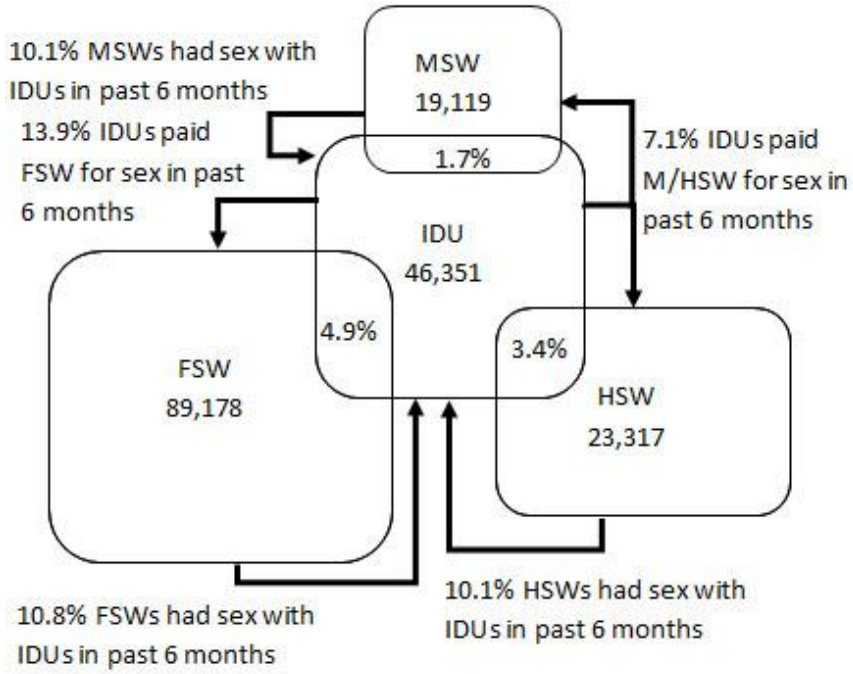


Figure 1:

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

[40] Spectrum file Pakistan 2015MAR18.

Adolescent and Young Key Populations.

Between 2008 and 2014, estimated new HIV infections among 15-24 year olds have more than doubled in Pakistan to 12 per cent of the overall PLHIV population.[41] In 2011 IBBS R IV, prevalence among adolescent key populations has been estimated as follows: PWID: 1 per cent of PWID were 18-20 years were HIV positive; and 0.3 per cent of HSW, 0.1 per cent of FSW were 15-19 years old and HIV positive, and 0.7 per cent of MSW were 13-19 years old and HIV positive, one third of all MSW HIV infections in 2011. Safe injection practices among adolescent PWID in 2011 was low with only 1.9 per cent of people who inject drugs who reported using sterile injecting equipment the last time they injected.[42] Condom use at last sex act with regular partner amongst adolescent PWID was 22.6 per cent in IBBS R IV.[43] Among adolescent *hijra* who engaged in selling sex 18 per cent reported consistent condom use with clients.[44] Of adolescent males who sell sex, only 9.5 per cent in 2011 reported consistent condom use with clients.[45] Testing remains a challenge and rates among adolescent key populations are particularly low. In 2011 the percentage of PWID <20 years of age who received an HIV test in the past 12 months and know their results was 12.4 per cent; among adolescent *hijra* who sell sex it was 13.9 per cent; 2.7 per cent among males 13-19 years who sell sex, and 5.7 per cent among females who sell sex.[46]

Returned Migrant Workers.

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.[47] Significant numbers of HIV cases reported to the health care services, especially in Khyber Pakhtunkhwa, have been and continue to be among returning migrants deported from the Gulf States when found to be HIV positive.[48] Spectrum estimated over 51000 deported migrants at the end of 2014.[49] The risks of onward HIV transmission to spouses and to children have been documented upon the return of migrant workers from abroad. In KP for example, at the end of 2013, among the 1257 PLHIV ever-registered (includes dead and missing) 41.8 per cent (526) were migrants. Among the 819 on ART at the end of 2013, 28.9 per cent were migrants (237). In the last

[41] Spectrum file Pakistan 2015MAR18.
[42] IBBS variable: The last time you injected did you inject with a used syringe/needle? (Optional answers: yes, no, don't know, no response)
[43] Registration Analysis (Client) 18-20 years, Nai Zindagi. 104/635 respondents 1st Jan 2011 through 16th Oct 2014.
[44] HIV second generation surveillance in Pakistan: National Report Round IV. 2011.
[45] Ibid.
[46] GARPR Pakistan 2014.
[47] Source: Mapping of HIV Risk and Vulnerabilities of Temporary Contractual Workers from Pakistan to GCC Countries 2011, Government of Pakistan, IOM and UNAIDS.
[48] At the end of 2013, 0f the 526 migrants registered at Hayatabad Medical Complex in Peshawar, 60% were from UAE and 23% from Saudi Arabia.
[49] Spectrum file Pakistan 2015MAR18.

quarter of 2014 a total of 27 returned migrant men were registered at the HIV Clinic in KP. All were married and of 27 spouses 6 were found to be HIV positive and none of the children.

Prisoners

Prisoners, including female[50] and juvenile, are considered a key vulnerable population in Pakistan given the prevalence found in sample cohorts to date. At the end of 2013 there were over 77500 prisoners in Pakistan either under trial or already convicted.[51] There has been limited HIV testing in prisons, however sporadic testing has taken place. In 2009 almost 5000 jail inmates were voluntarily tested across nine jails in Sindh, with an overall HIV prevalence of 1 per cent;[52] in 2009 Camp Jail in Lahore over 1000 inmates were tested with a prevalence of 2.4 per cent;[53] and in District and Central Jails of Lahore almost 5000 prisoners were tested with an overall HIV prevalence of 2.0 per cent and 77.8 per cent of them had co-infections. HIV/HCV co-infection was detected in 73.7 per cent of HIV positive inmates.[54] Even earlier studies showed a similar prevalence. In Camp Jail in Lahore from January to June 2008, 261 inmates were tested for HIV and 6 (2.3%) were found to be HIV positive.[55]

Clients of Sex Workers

Clients of sex workers are considered a vulnerable population in Pakistan. Considering the prevalence rates among sex workers alone, male clients of both MSW and HSW may be considered most at risk among clients, however they overlap with the MSM population and may be addressed through MSM programming. Clients of female sex workers are also considered a vulnerable population, given the low overall prevalence rate of FSW, their risk may not be as high. While there has been no formal studies on, nor services provided to clients of sex workers, a 2008 Population Council STI study in six major urban cities across Pakistan showed that 5.8 per cent (141/2400 men surveyed, median age 23 years) had visited a female sex worker during the

[50] Of the more 4000 female prisoners reported in a study, 373 were injection drug users and 1512 were using drugs in nine prisons and female barracks in Pakistan [GARP 2014]. Female prisoners who are also injecting drugs tend to be vulnerable to sexual HIV transmission through unprotected sex with male guards, sex work, sex for favours (such as drugs), and rape (UNODC Pakistan: Case management for female prisoners in preparation for release: suggestions for the South Asia context).

[51] Government of Pakistan, Ministry of the Interior, National Academy of Prisons Administration, Province-Wise Statement of Prisons / Prisoners, Position as on 31-12-2013.

[52] Safdar S, Mehmood A, Abbas SQ. Prevalence of HIV/AIDS among jail inmates in Sindh. J Pak Med Assoc. 2009 Feb;59(2):111-2.

[53] Shah SA, Ali M, Ahmad M, *et al.* Screening of Jail inmates for HIV and Tuberculosis. http://pjmhsonline.com/JanMar2013/screening_of_jail_inmates_for_hiv.htm

[54] HIV Infection, HIV/HCV and *Nafees M, Qasim A, Jafferi G, et al.* HIV/HBV co-infections among Jail Inmates of Lahore. Pakistan Journal of Medical Sciences, Vol 27, No 4 (2011). http://pjms.com.pk/index.php/pjms/article/view/1649.

[55] Manzoor S, Tahir Z, Anjum A. Prevalence of HIV and Tuberculosis among Jail Inmates in Lahore Pakistan. Biomedica Vol.25, Jan. – Jun. 2009/Bio-7.Doc.

last 12 months.[56] Spectrum HIV population modelled figures (2014) estimates over 3430 infections among an estimated population of 6048254 clients of sex workers (clients of which group of SW not indicated, however, all male).[57]

Studies have also been carried out in bridging population, estimated to be 5 million, in Pakistan.[vi] The first such study was conducted in May-June 2007 by Balochistan AIDS Control Program[58] in mine workers and deep sea fisherman that showed high risk behaviours among the former group who visited sex workers (5%) and had sex with colleagues (42%) while 16% reported STI symptoms within past 3 months. Another study in migrant men was carried out in Lahore [59]showed considerable high risk behaviours in this population. Over half (55%) of single men were sexually experienced. But the prevalence of STIs infection among them was low (3.2%). The other crucial groups among the bridging populations are the spouses of PWID and clients and spouses of sex workers and migrant workers. A study in wives of PWID by Nai Zindagi have found HIV prevalence of 15% but no follow up studies have been carried out this important group. Similarly no surveillance has been conducted in the clients and spouses of sex workers although HIV prevalence in MSWs has shown a rising trend in the four IBBS surveys.

Transmission of HIV from blood and blood products is another major source of infection in Pakistan that is overlooked in many instances. Pakistan is one of the highest prevalence countries in the World for Hepatitis C and B. The national prevalence survey carried out in 2008 by Pakistan Medical Research Council [60]showed a national prevalence of Hepatitis C at 4.9% (95% CI: 4.7-5.1) and Hepatitis B at 2.4% (95% CI: 2.3,2.6). Provincial breakup showed highest prevalence of Hepatitis C in Punjab at 6.7%. The most common reason for this spread was very high number of injections for common ailments (30% of the population getting 5-10 injection every year), reuse of syringes and improper sterilization of medical instruments and devises. The study clearly linked higher number of injections and reuse of syringes with increasing incidence of hepatitis C in the study population. It is thus perceived that since the virus in non-existent in the general population therefore the spread through this route is insignificant in the country but once introduced a rapid spread through this route is inevitable. Example of such a spread was witnessed in an outbreak of HIV in Gujrat in 2008 where investigations revealed 53 HIV positives in a small town Jalalpur Jattan who were not part of KPs. The reason for this spread was cited to be unsafe injection practices, unsafe invasive medical equipment.[vii]

[56] Study of Sexually Transmitted Infections among Urban Men in Pakistan: Identifying the Bridging Population. Population Council, 2008.
[57] Spectrum file Pakistan 2015MAR18.
[58] Bio Behavioural survey among Mine workers in Balochistan, Pakistan January 2012
[59] Study of Sexually Transmitted Infections among urban men in Pakistan. Identifying the bridging population 2008
[60] Pakistan Hepatitis B and C Prevalence survey 2007-2008

The Blood Transfusion system in Pakistan is weak, fragmented and mostly unregulated. With an estimated number of 1830 blood banks the major source of blood is family replacement donation (National Blood Transfusion Programme 2014).[61] With an estimated 2.8 million bags transfused in the country every year (Nuzhat Salamat Hematology updates 2009)[62] with uncontrolled and unregulated screening for Transfusion Transmitted Infections the chances of spread of blood borne infections are very high. In December 2014 press reports suggest spread of HIV in Thalassemia children in Lahore. In depth investigations by the Punjab AIDS Control Program (PACP), along with NACP, revealed insufficient evidence in support of the reported epidemic. However, PACP, with support of the donors, undertook an extensive screening of Thalassemia children in the province.

On the other hand widespread injection use and weak infection control in health care setting could lead to widespread outbreaks of blood borne infections in the community. This is evident from the recent study by Association of People Living with HIV and AIDS conducted in PWID to find prevalence of Hepatitis C in this group. More than 93% of PWID tested were found positive.[63] This explains the fact that once the virus is introduced in a population injection use could fuel the widespread outbreak which would be the case if the virus is introduced in the general population where therapeutic injection use and reuse of infected syringes and equipment is very high.

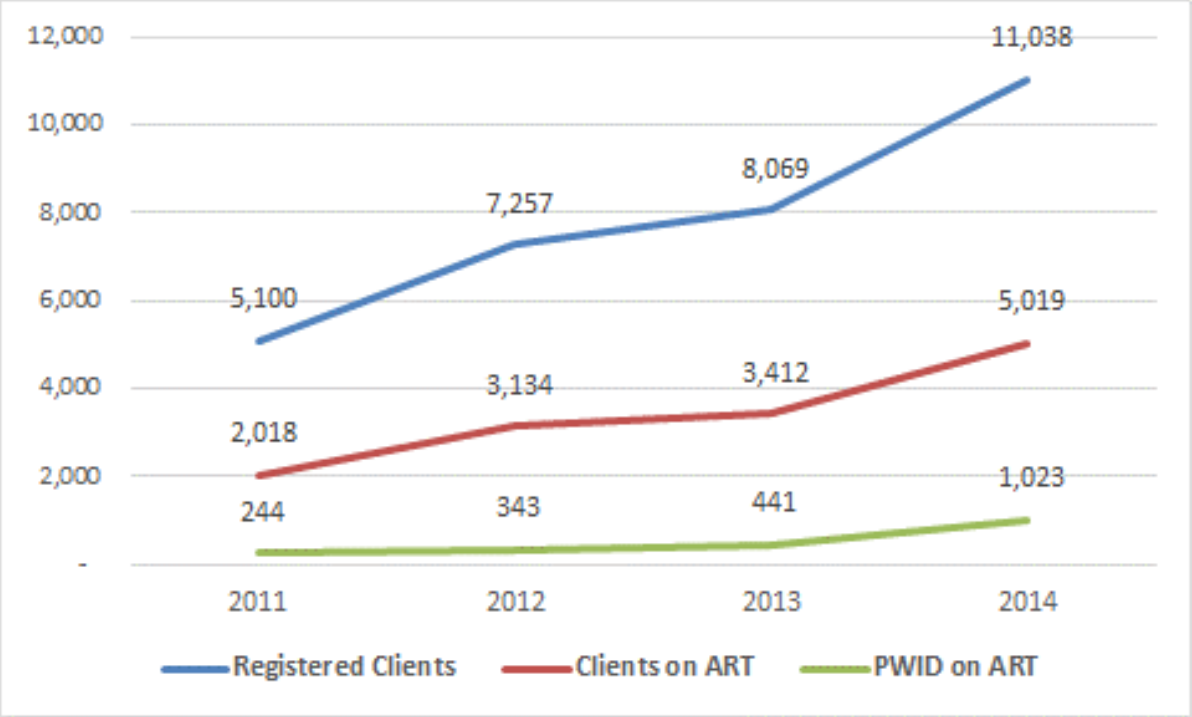
There are approximately 85,000 people incarcerated in Pakistan in 97 prisons (UNODC study). According to 2012 prison statistics approximately 11,137 prisoners have been convicted for drug related offenses. Of these 3630 were drug users and 7507 were drug traffickers. It is suspected that the number of drug users in prisons is significantly higher than these official statistics. Drug use in prisons is reportedly widespread because of the availability of drugs in the prisons. Correctional settings including prisons remain high risk environment for the transmission of HIV and other blood borne infections. Drug users admit using drugs and having un-protected sex in the same settings.[64]

People Living with HIV & AIDS.

At the end of 2014 there were 5019 PLHIV on ART, out of whom 102 were children. Relative to the estimated number of PLHIV in the country, the number of registered PLHIV within the health care system remains low and ART coverage for those eligible remains low at 9.08 per cent[65] end 2014 for both adults and children.[66] At the end of 2014 HIV treatment and care facilities were

[61] National Blood Transfusion Programme 2014
[62] Nuzhat Salamat Hematology updates 2009
[63] http://www.theaplhiv.org.pk/
[64] UNODC study Drug Use in Pakistan 2013.
[65] Populations Estimation exercise: Pakistan National AIDS Programme and UNAIDS Asia Pacific Regional Support Team, February 2015, Bangkok, Thailand.
[66] Ibid.

available through 18 HIV treatment centres, most with 5 paediatric HIV management capacity and some with PPTCT/PMTCT[67] services. The majority of the treatment, care and support facilities are confined to key cities[68].



Graph 7. ART registration, ART coverage and PWID[69].

The policy and programmatic response

Response in Pakistan

Realizing the rapid spread of HIV among KPs and spreading concentrated epidemic in the country Pakistan and following the 'Declaration of Commitment (DoC) in the 2001 UNGASS' session; the GoP approved the 'Enhanced HIV/AIDS Control Project' (EHACP) for 2003-8[viii] funded by the World Bank (soft loan and grant), DFID and Government. The strategy of EHACP partially decentralized the program to five provincial (PACP) programmes[70] and followed a more strategic investment approach for the concentrated epidemic.[71] The 2nd National Strategic Framework completed its five-year timeframe in December 2011.[72] It had four Strategic

[67] Although both terms – PMTCT and PPTCT - are globally acceptable, Pakistan primarily uses PPTCT.
[68] http://www.nacp.gov.pk/programme_components/hiv_prevention/hiv_care/
[69] www.nacp.gov.pk; ART MIS Data
[70] Including at that time the Azad Jammu Kashmir (AJK) Provincial AIDS Control Programme.
[71] EHACP addressed five 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.
[72] See http://www.nacp.gov.pk/introduction/NSF-NACP.pdf.

Objectives including: A) Scale Up Programme Delivery; B) Create and Enabling Environment; C) Build the Right Capacity; and D) Strengthen Institutional Framework. The breadth of priority areas remained coherent with available funding at the time.[73]

The present response is mainly guided by Provincial AIDS Strategies feeding into Pakistan AIDS Strategy (PAS) for control of HIV and AIDS (NSP) for 2015 to 2020. The plan emphasizes targeted and evidence based and high impact interventions in KPs where the disease is spreading. It also puts high emphasis on provision of quality HIV treatment and care services to be provided to those in need by reaching out them. Pakistan is committed to the United Nations General Assembly Political Declaration on HIV and AIDS and commitments and targets for 2015.

After the devolution in 2011, the Provincial AIDS Control Programmes in the four provinces of Pakistan are taking charge of HIV control in their respective provinces. Except Khyber Pakhtunkhwa Province all provinces have their own provincial program with their budgets. But except Punjab other two provinces are still struggling to get their budget approved by the Government. This significantly hampers implementation of Provincial AIDS Strategies.

Out-sourcing health services to private sector organizations is a common delivery mechanism in Pakistan.[74] Private sector organizations, both for-profit or not for-profit, are critical partners in the roll-out of the HIV response in Pakistan. Since the implementation of EHACP, the NACP and PACPs have engaged in public-private partnership (PPP) arrangements with NGOs and CBOs through their PC-1s (see III.7 Implementation arrangements).

Main source of continued funding is coming through Global Fund Round 9 grant and Pakistan is under preparation of a concept note to get additional GF grant under new funding model starting from the year 2016. Which is 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 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*).

[73] 1) Expanded Response; 2) High-risk, Vulnerable & Bridge groups; 3) Women, Children, and Youth; 4) Surveillance and Research; 5) Transmitted Infections; 6) General Awareness; 7) Blood and Blood Products Safety; 8) Infection Control; 9) Treatment, Care, and Support; 10) Institutional Arrangements; 11) Commodities and Procurement; and 12) Management Information.

[74] Ahmed F, Nisar N. Public–private partnership scenario in the health care system of Pakistan. Eastern Mediterranean Health Journal La Revue de Santé de la Méditerranée orientale (EMHJ). Vol. 16, No. 8, 2010. http://applications.emro.who.int/emhj/V16/08/16_8_2010_0910_0912.pdf

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.

Target 1: Reduce sexual transmission of HIV by 50 percent by 2015.

Is this a priority target for the country?	Yes
Does the National Strategic Plan address this target	Yes
Is the country on track to reach the target and commitment	No

General Population

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 transmission[75]

This indicator is relevant, but data in Pakistan is only partially available, limited to ever-married women and men interviewed through the Demographic Health Survey.[76] The percentage of ever-married men women age 15-49 who said in the 2012-13 PDHS 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 Islamabad Capital Territory.

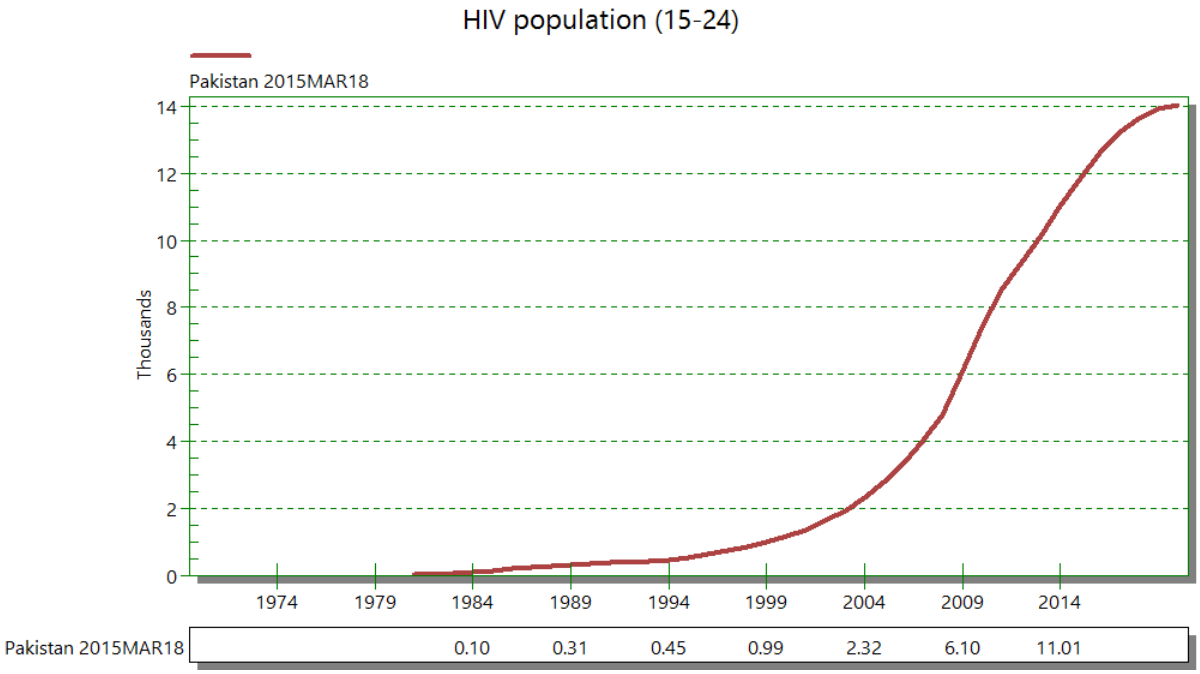
Indicators 1.2 to 1.5

Though the indicators are relevant, yet the data is not available.

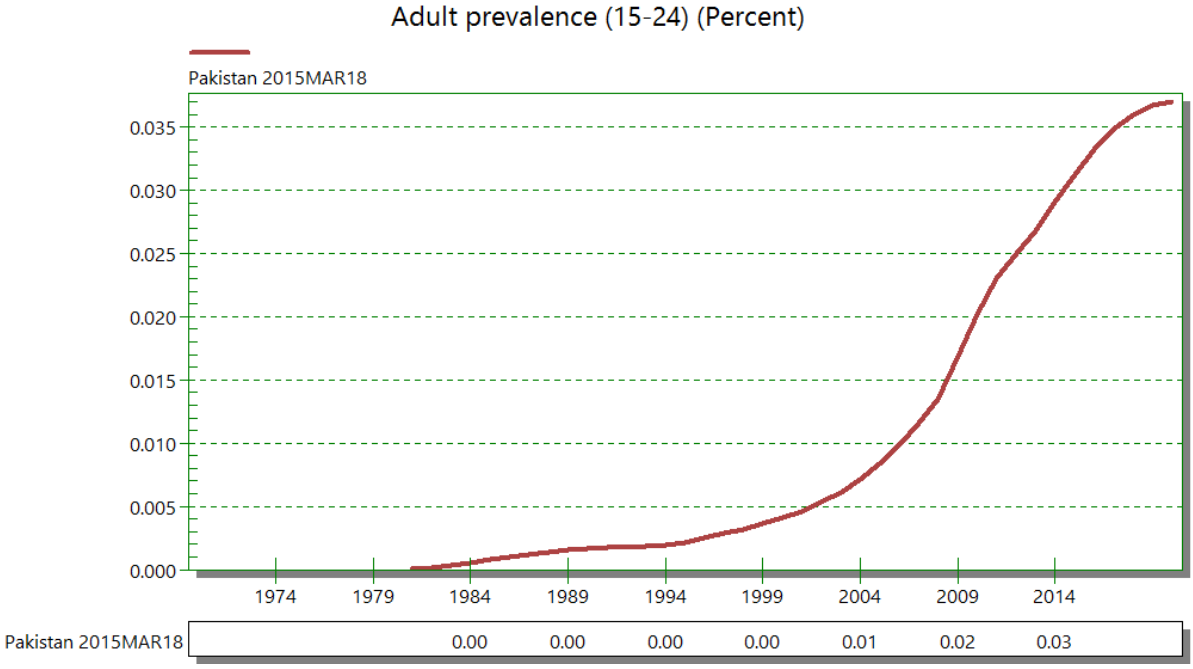
Indicator 1.6: Percentage of young people aged 15-24 who are living with HIV

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 2014 (incidence 0.01% 2014).[77] The prevalence burden for this cohort was estimated at 12.04% of the total estimated PLHIV population in 2014 (n=11,005/91,340).

[75] The language "AIDS virus" used here under indicator 1.1 is the language used in the DHS 2012-13.
[76] http://www.nips.org.pk/abstract_files/Priliminary%20Report%20Final.pdf
[77] Spectrum file Pakistan 2015MAR18.



Graph 8. HIV Young population – 15 to 24[78]



Graph 9. HIV Prevalence amomg Young population – 15 to 24[79]

During IBBS Round IV,[80] 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.

[78] Spectrum file Pakistan 2015MAR18.
[79] Spectrum file Pakistan 2015MAR18.
[80] http://www.nacp.gov.pk/library/reports/Surveillance%20&%20Research/HIV-AIDS%20Surveillance%20Project-HASP/Antenatal%20Sero-Surveillance%20for%20HIV%20in%20Pakistan%202011.pdf

Sex Workers

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

Data was captured from 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. 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.[81]

Indicator 1.8: Percentage of sex workers reporting the use of a condom with their most recent client

The IBBS 2011 indicated 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%).[82]

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 HTC 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*.[ix]

[81] National Integrated Biological and Behavioural Surveillance (IBBS) was conducted in 2011 (Round IV)
[82] National Integrated Biological and Behavioural Surveillance (IBBS) was conducted in 2011 (Round IV)

Men who have Sex with Men (MSM).

Indicators 1.11 – 1.14

With no baseline information on behaviour, knowledge, or HIV prevalence of MSM, or consensus on population estimates (MSM will be included in the 2015 IBBS). UNDP and APCOM estimate the number of MSM in Pakistan to be 2285500.[83] The technical working group established for the AIDS Epidemic Modelling process determined MSM to be 0.3 per cent of the male adult population[84], or approximately 150000 adult males[85], lower than the estimated lifetime prevalence of 6-12 per cent male to male sex for Southeast and South Asia.[86]

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 VCCT services for MSM and transgendered persons. Through 2014 a total of 25765 MSM and 5140 transgendered persons were registered in 6 service centres in 5 cities of Punjab and Sindh (4 locations for MSM and 2 for hijra). Approximately 8620 MSM availed VCCT services and 464 including 326 MSM, and 138 TGs were screened positive.

Target 1: Core indicators; Summary

Indicator 1.1	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Indicator is relevant but data is partially available through Demographic Health Survey. Reported in GARPR 2014. 5.2 % for men, 4.2% for women	PDHS 2012 – 13
Indicator 1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse	Indicator relevant, but data is not available	NA

[83] 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.
[84] AIDS Epidemic Modeling in Pakistan: Country Case Study Report for UNAIDS. 2014.
[85] As with transgender persons, this percentage is calculated on an estimated 49 269 000 adult males aged 15-49 years in 2015. Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat,
World Population Prospects: The 2012 Revision, http://esa.un.org/unpd/wpp/index.htm
[86] Cáceres C, Konda K, Pecheny M, et al. Estimating the number of men who have sex with men in low and middle income countries. *Sex Transm Infect* 2006;**82**:iii3-iii9.

	before the age of 15		
Indicator 1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	Indicator relevant, but data is not available	NA
Indicator 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 relevant, but data is not available	NA
Indicator 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 relevant, but data is not available	NA
Indicator 1.6	Percentage of young people aged 15-24 who are living with HIV	0.08%. Spectrum modelling 2014	Spectrum 2014
Indicator 1.7	Percentage of sex workers reached with HIV prevention programmes	5.2% for FSW 9.7% MSW 19.8% HSW	HASP IBBS 2011
Indicator 1.8	Percentage of sex workers reporting the use of a condom with their most recent client	41.5% FSW 27.4% MSW 36.6% HSW	HASP IBBS 2011
Indicator 1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	5.7%: All FSW	HASP IBBS 2011
Indicator 1.10	Percentage of sex workers who are living with HIV	0.8% FSW 3.1% MSW 5.2% HSW	HASP IBBS 2011
Indicator 1.11	Percentage of men who have sex with men reached with HIV prevention programs	Indicator is relevant, but data is not available	NA
Indicator	Percentage of men reporting the use of a condom the last	Indicator is relevant, but	NA

1.12	time they had anal sex with a male partner	data is not available	
Indicator 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	NA
Indicator 1.14	Percentage of men who have sex with men who are living with HIV	Indicator is relevant, but data is not available	NA

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

Is this a priority target for the country?	Yes
Does the National Strategic Plan address this target	Yes
Is the country on track to reach the target and commitment	Yes

With an estimated population of 104,804[87] PWID are driving the HIV epidemic in Pakistan. The, country being the next door neighbour of the largest producer of heroin in the world is faced with increasing problem of drug use. With other social problems associated with drug use those are injecting the drug pose another challenge of transmitting blood borne infections. HIV is one of those infections that is rapidly spreading in this population and it seems that the country is leading the path of other nations where this infection spilled over to general population as suggested by Asian Epidemic model.

Since drugs for OST have not been initiated in the country therefore all s have to undergo detox before being eligible for HIV treatment if they are HIV positive. This is posing a challenge since relapse rates are very high in this population leading to loss to follow up in quite a number of them who are put on ART.

Midterm review showed gaps in service provision in Khyber Pakhtunkhwa Province. Since the Provincial AIDS Control Program is non-functional in the province and there are no SDPs, while only 01 NGOs (DOST welfare foundation is providing services to PWID. Detox facilities are available in 12 tertiary care hospitals but services are not being optimally utilized.

Sind province is supporting preventive services to PWID, through their own resources and through the support from GF and UNODC. There are 07 NGOs providing services to them that are covering a target of 25% of the total estimated population in the province. They are also providing services to spouses of the PWID. There are no linkages with detoxification and rehabilitation for PWID between public and private sectors.

In province of Balochistan PWID preventive services, are supported through GF grant, UNHCR and ANF funding. 03 NGOs are working in Quetta and Turbat. Detoxification services are provided by Anti-Narcotics Fore funds but quality of these services need improvement to meet international standards. There are weak referrals from hard reduction services to other essential services.

[87] Populations Estimation exercise: Pakistan National AIDS Programme and UNAIDS Asia Pacific Regional Support Team, February 2015, Bangkok, Thailand.

In Punjab province PWID projects are supported through Government own funds supplemented by funding from World Bank, GF, UNODC and US embassy funding. Through UNODC funding limited assistance is being provided to Female s in prison settings. Overall 05 NGOs are providing preventive services to PWID among then 03 NGOs have been given funding from the Punjab Government to cover 27.5% of all PWID with preventive package of services, throughout the province.

Opioid substitution treatment (OST)

Uptake of and adherence to HIV treatment among people living with HIV in Pakistan is among lowest in Asia, with some 5,019 people of the estimated 91,340 people (5.6%) living with HIV currently on treatment.[88] While the proportion of PWID of all PLHIV on HIV treatment is unknown it is expected that PWID account for a significant proportion of all PLHIV in need of HIV treatment in view of the large population of PWID (n= 104,804)[89] and high prevalence of HIV among PWID in Pakistan.

Once on anti-retroviral treatment (ART), adherence to HIV medicines among PWID remains a challenge and is increasingly raising concerns about possible resistance to ARVs, including second line ARVs. For example, a prospective study of 162 HIV positive male patients, including 81 men who injected drugs and 81 non drug users, in an ART centre in a major public hospital in Islamabad found that 41 (50.6%) per cent of the PWID were lost to follow-up compared with only two (2.5%) of the non-injection drug users who were lost to follow-up at the end of the five year study. Furthermore, adherence to ART ranged from 46.9% among non-injection drug users to 19.8% among injection drug users.[90]

Introduction of pharmacologically assisted treatment of opioid dependence in Pakistan, as envisaged in the Pakistan AIDS Strategy III, will require availability of Buprenorphine in the required dose of 2mg, 4mg, 8mg and 10mg sub-lingual tablets. The National AIDS Control Programme, motivated a licensed pharmaceutical manufacturer (M/S Wilshire Pharmaceuticals) to initiate a formal process with Drug Regulatory Authority of Pakistan, aimed at registration of Buprenorphine in the required dose on 6 August 2014 as per Drug Registration Rules 1976.

In addition to the processes adopted for availability of Buprenorphine in the required doses, a range of other initiatives are under way by concerned stakeholders to create a conducive environment. These include, among other, organization of a Dialogue on Pharmacologically

[88] Spectrum, March 2015. Note: while PWID population size estimate is being used for national strategic planning purposes, including development of the HIV Concept Note, a national drug use survey estimated that 430,000 (range: 190,000 to 657,000), or 0.4 % (range 0.3% to 0.5%), people aged 15-64 inject drugs in the country. UNODC and Ministry of Interior and Narcotics Control, Narcotics Control Division, Government of Pakistan Drug Use in Pakistan 2013.UNODC, 2013.
[89] Spectrum, March 2015.
[90] Daud MY, Qazi RA, Bashir N. Anti-retroviral drugs compliance in intravenous and non-intravenous drug abusers. Journal of Ayub Medical College Abbottabad. 2014;26(4):437-40.

Assisted Treatment of Opioid Dependence and Prevention of Blood-borne viruses by UNODC, in close cooperation with the Narcotics Control Division and the National AIDS Control Programme in the second quarter of 2015. The objective of the Dialogue is to provide a platform for senior policy makers and experts in the field, including HIV physicians and psychiatrists, to discuss the role of OST in treatment of opioid dependence and prevention of HIV and hepatitis C.

People Who Inject Drugs – Preventive Programs

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 2014; 7714524 syringes were distributed among 43300 PWID[91] (178 syringes pp/yr).

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.[92]

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.

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[91] 2012: GFATM Objective 1 MIS: 2014: 4557274 syringes distributed/26000 registered clients (175 pp/yr/project); Punjab ACP report: 15786250 syringes distributed, among 17300 PWID reached during 2014 (912.5 pp/yr/project).

[92] National Integrated Biological and Behavioural Surveillance (IBBS) was conducted in 2011 (Round IV)

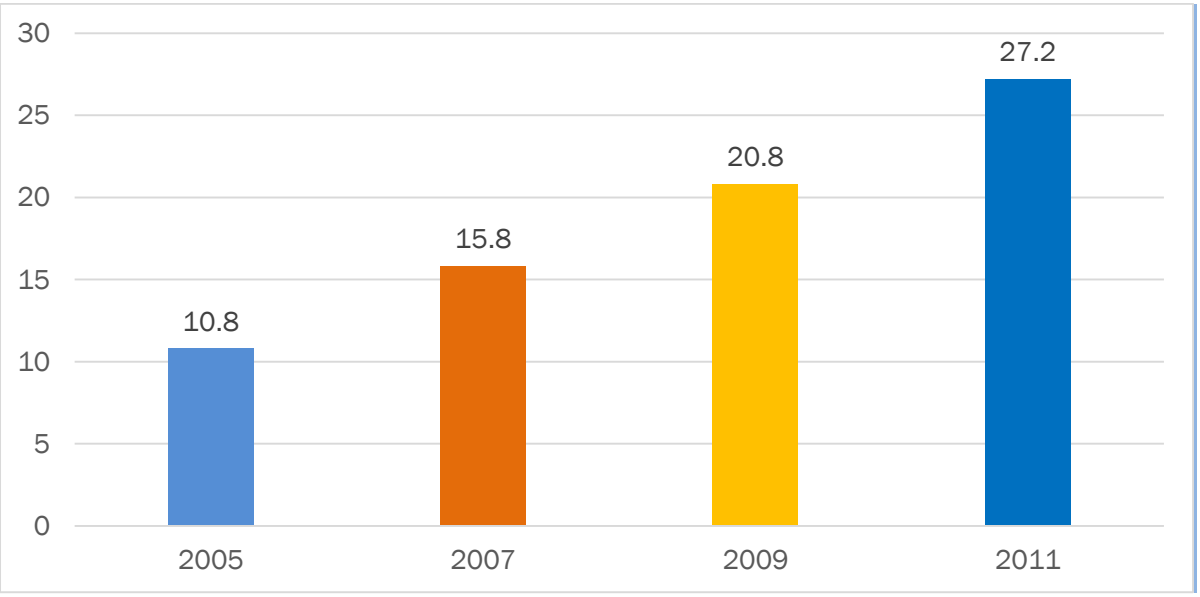
Overall, 38.6% of PWID reported that they always used a new syringe in past month with substantial variation across cities. Despite harm reduction services being implemented at a lower scale across the country in 2011, 66% PWID reported using sterile injecting equipment the last time they injected.[93]

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.[94]

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

Pakistan is one of three expanding epidemics in the Asia Pacific region along with Indonesia and the Philippines.[95] 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%).[x]



Graph 10. HIV Prevalence among PWID, in Pakistan[96]

[93] National Integrated Biological and Behavioural Surveillance (IBBS) was conducted in 2011 (Round IV)
[94] National Integrated Biological and Behavioural Surveillance (IBBS) was conducted in 2011 (Round IV)
[95] HIV in Asia and the Pacific, UNAIDS
[96] National Integrated Biological and Behavioural Surveillance (IBBS) was conducted in 2005 (Round I), 2006-7 (Round II), 2008 (Round III) and the last one in 2011 (Round IV). Round V is planned for 2015. The Punjab conducted IBBS in 10 cities in 2014 but results are not yet disseminated.

Indicator 2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programs	470 syringes per PWID per year	Program Data
Indicator 2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	22.6%	HASP IBBS 2011
Indicator 2.3	Percentage of people who inject drugs who reported using injecting equipment the last time they injected	66%	HASP IBBS 2011
Indicator 2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	6.7%	HASP IBBS 2011
Indicator 2.5	Percentage of people who inject drugs who are living with HIV	27.2%	HASP IBBS 2011

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

Is this a priority target for the country?	**Yes**
Does the National Strategic Plan address this target	Yes
Is the country on track to reach the target and commitment	No

Pakistan is committed to achieving the goal of eliminating mother to child transmission of HIV by 2015 as well as substantially reducing AIDS related maternal deaths in the country. Since the inception of Prevention of Parent to Child Transmission (PPTCT) in the country efforts have been put in all partners and key stakeholders to eliminate vertical transmission of HIV by keeping up with new and better initiatives learning from past experiences. Following initiatives were put in the area:

Treatment as Prevention (TasP): UNICEF supported the initiation of a pilot on TasP in Khyber Pakhtunkhwa province, where HIV positive spouses in sero-discordant couple were counselled and encouraged to initiate ART even if their CD4 count was above 500 cells/mm^3. Till December 2014, 40 such partners were receiving ART as TasP and their spouses were HIV negative.

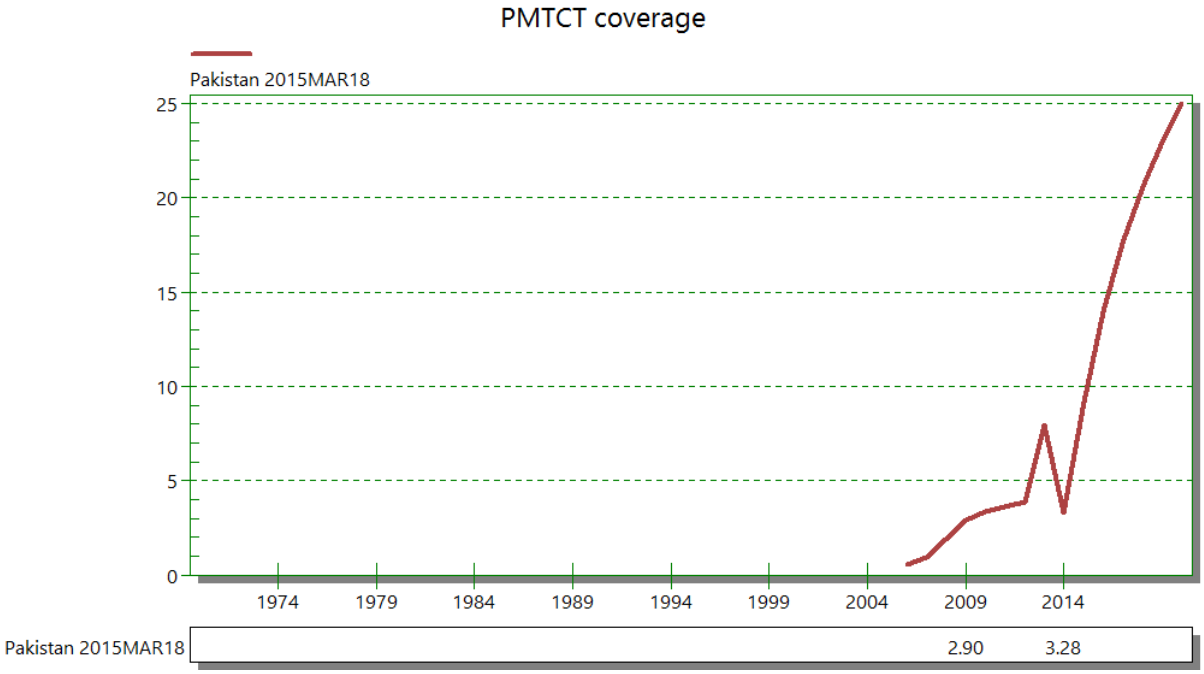
Community Home Based HIV Testing & Counselling (HTC): Punjab AIDS Control Programme, through UNICEF support initiated home based HTC for spouses of HIV positive. The pilot was successful in providing HTC to 1,563 to wives of HIV positive clients and in identifying 85 HIV positive spouses and linking them to treatment, in the province.

District Model Approach to Prevention of Parent to Child Transmission (PPTCT) of HIV: Through UNICEF's support to the district model approach and support to the PPTCT centres across the country, 4,967 women of reproductive age were screened for HIV, 28 were found positive and linked to prevention and treatment services, 144 Healthcare professional were trained on identifying and referring HIV positive cases, 771 Lady Health Workers were trained on HIV and applying risk criteria to identify women at risk for HIV. Through these efforts 59 HIV positive pregnant women in 2014 received ARVs for prevention of mother to child transmission, all infants born were HIV negative.

At the end of 2013 WHO published updated guidelines on the diagnosis of HIV care of PLHIV and the use of antiretroviral drugs for treating and preventing new HIV infections. The guidelines recommended that all pregnant and breastfeeding women and children younger than five year's old living with HIV should initiate ART as lifelong treatment irrespective of CD4 count or clinical stage.

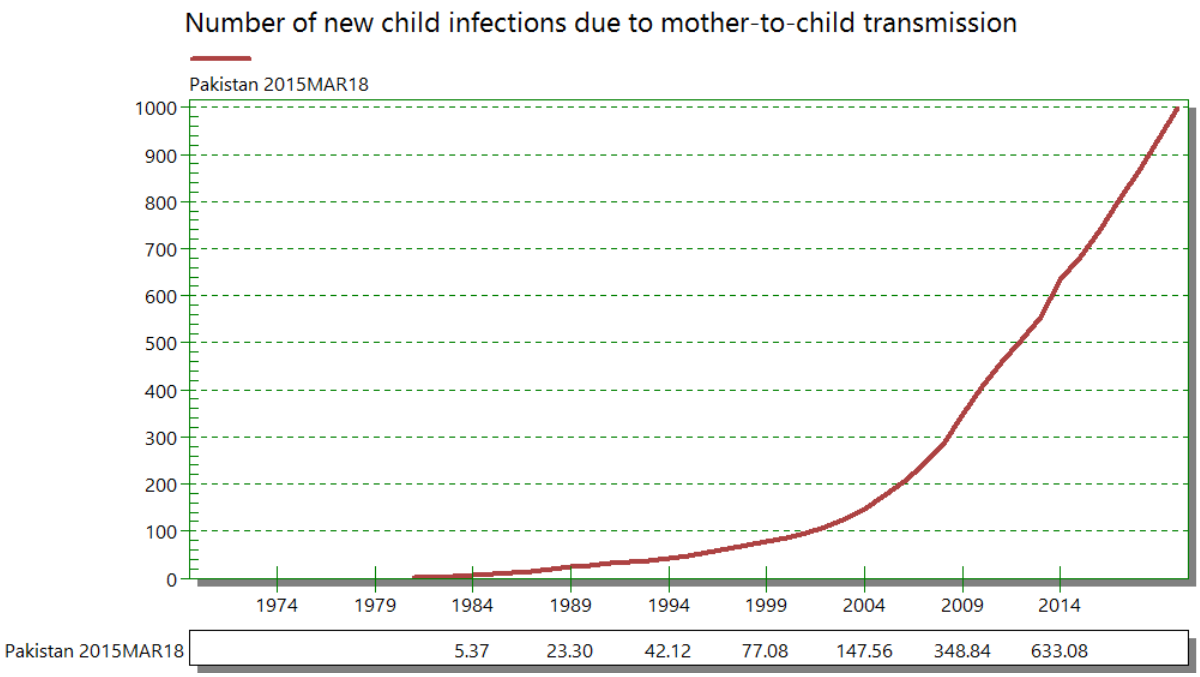
Pakistan adapted the new WHO recommendation by revising its 2010 ART guidelines including the PMTCT recommendations. The guidelines were revised with wide consultation with all HIV treating physicians in the country. The programme then conducted 04 training workshops for doctors and other health care providers in all the four provinces of the country. In all 128 physicians from the country were trained on the new ART guidelines.

The updated 2013 country guidelines recommend a standardized triple drug regimen including a fixed dose combination (FDC) to treat pregnant women living with HIV regardless for CD4 count or clinical stage during pregnancy and breastfeeding with continuation of ART after breastfeeding for women with CD4 counts less than 500.



Graph 11. PMTCT Coverage 2014[97]

[97] Spectrum file Pakistan 2015MAR18.



Graph 12 New Infections due to PMTCT 2014[98]

Indicator 3.1	Percentage of HIV positive pregnant women who receive antiretroviral medicine to reduce the risk of mother to child transmission	4% = (59/1500)x 100	Program Data
Indicator 3.1a	Percentage of women living with HIV receiving who are provided with antiretroviral medicines for themselves or their infants during the breastfeeding period	2.2% = (33/1500) x 100	Program Data
Indicator 3.2	Percentage of infants born to HIV positive women receiving a virological test for HIV within 2 months of birth	86% = (33/38) x 100	Program Data
Indicator 3.3	Estimated percentage of child HIV infections from HIV positive women delivering in the past 12 months	42.2% = (633/1500) x 100	Program Data & Spectrum

[98] Spectrum file Pakistan 2015MAR18.

Target 4: Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

Is this a priority target for the country?	**Yes**
Does the National Strategic Plan address this target	Yes
Is the country on track to reach the target and commitment	No

In the province of Khyber Pakhtunkhwa there are 02 ART sites Peshawar and Kohat providing ART services to 1429 patients.[99] CD4 facility is available in Peshawar but viral load facility is not available and patients have to travel to Islamabad for the service. Global fund is supporting CHBC (Community and Home Based Care) sites that are linked with ART services and regularly refer patients to ART sites. NACP (PR2) has established 19 CHBC sites, in the four provinces. During 2014, CHBC sites provided services to approximately 2400 PLHIV and 5744 family members of PLHIV. VCCT services was provided to 12340 clients, while 1596 were screened HIV positive (12.9%).[100]

There are 02 ART sites in Balochistan, Quetta and Turbat, providing ART services to 212 patients.[101] CD4 facility is available but for viral load patients have to travel to Karachi. Staff working in HIV treatment centres are experienced and trained. CHBC sites are linked with treatment centres and client referrals are currently happening regularly.

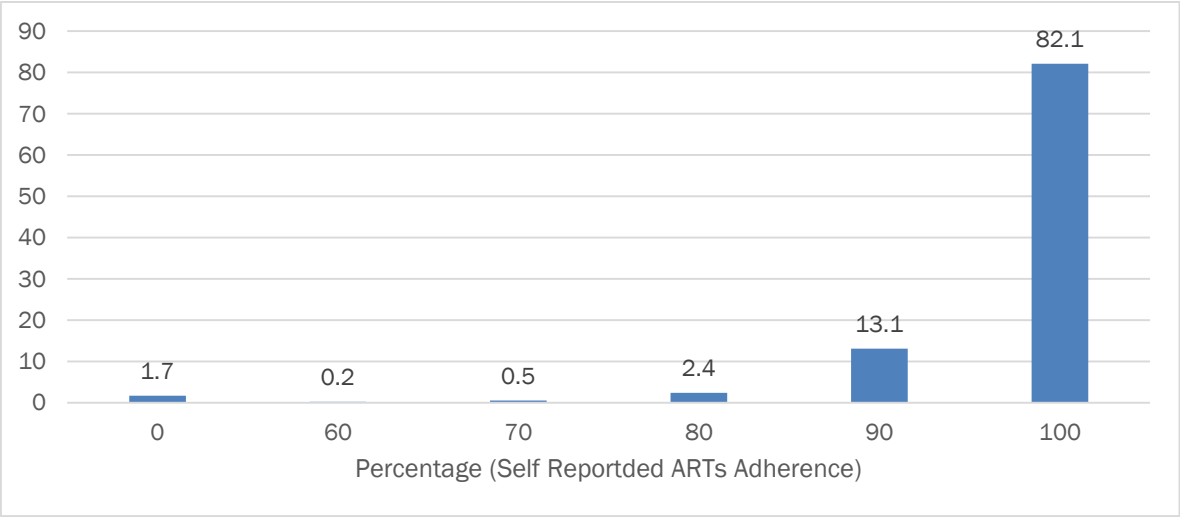
In Punjab province there are 09 ART sites providing treatment to 4263 patients.[102] Punjab started through WHO support got 2 mobile point of care CD4 machines (PIMA) that is being successfully used by rotating the machine to far flung HIV treatment centres that are providing treatment. This effort has saved lot of human and financial cost and has provided the crucial facility at the door step of the patients.

In Sindh province there are 04 treatment centres in Karachi and one in Larkana treating a total of 2777 patients in the province.[103] The province has the facilities of CD4 including PoC PIMA machine given by WHO with viral load testing being done in Karachi.

Current ART MIS for Treatment Centre, don't capture data on 'ART clients known to be on treatment 12 months after initiation' however a study by APLHIV in Pakistan, recorded Self-Reported / Self-recalled Adherence among 525 PLHIV, in Pakistan.[104] Almost 17.9 percent self-

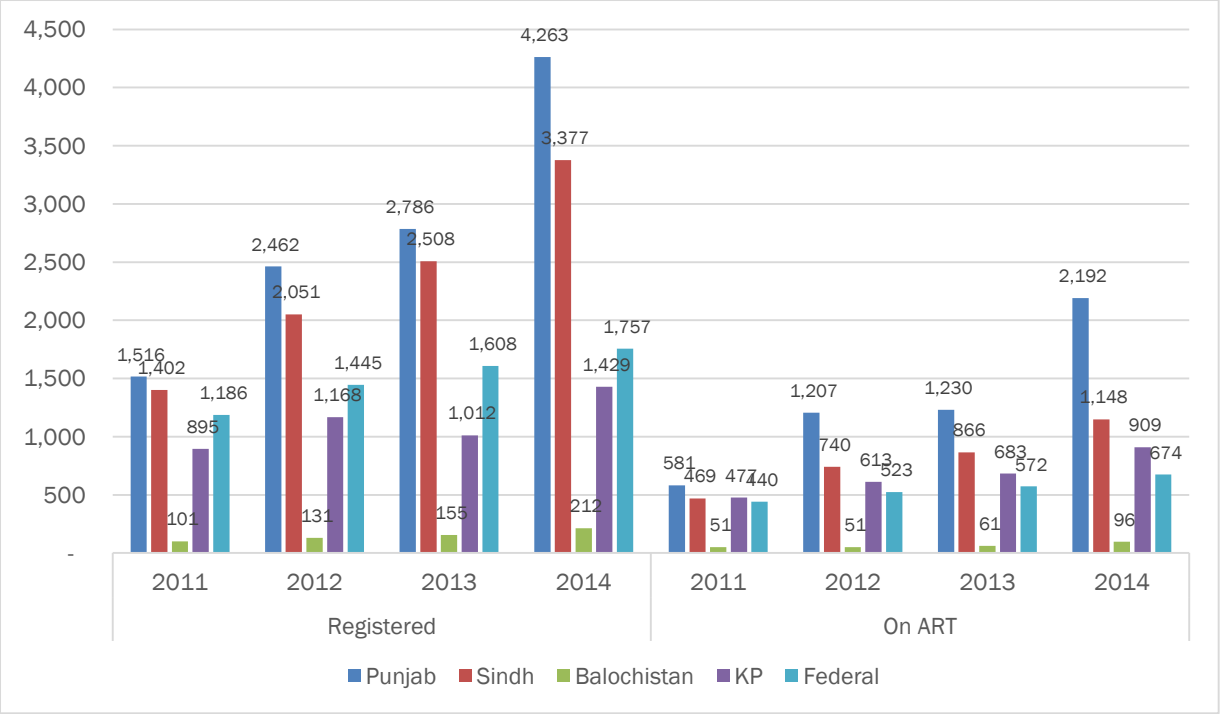
[99] NACP ART MIS Q4 2014
[100] NACP GF PUDR P6
[101] NACP ART MIS Q4 2014
[102] NACP ART MIS Q4 2014
[103] NACP ART MIS Q4 2014
[104] APLHIV. Regional Study on Community Access to Treatment 2013; Dr. Safdar Kamal Pasha

reported poor ART adherence in past month, based on their self-recall, 82.1 percent self-reported 100 percent adherence during last months.



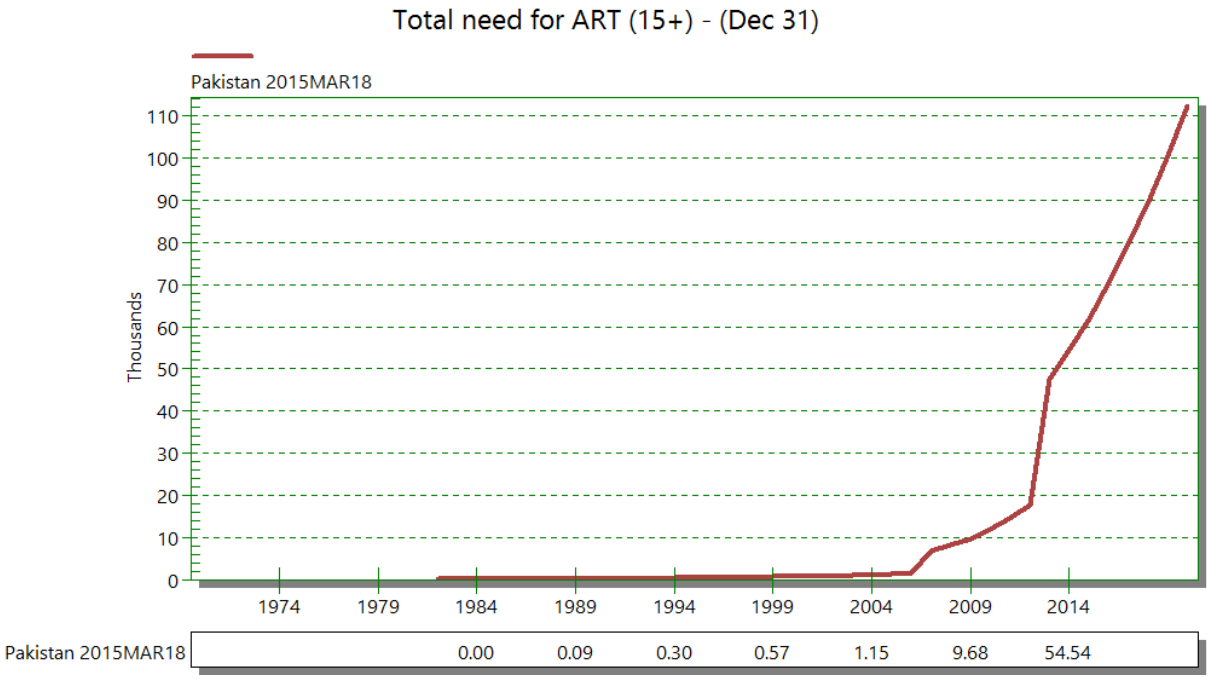
Graph 13. Self-Reported Adherence among 525 surveyed PLHIV in Pakistan.

With new WHO international guidelines for ART being revised in 2013 Pakistan also revised its ART 2010 guidelines by incorporating all new WHO recommendations in its new guidelines. The treatment guidelines were updated, including the introduction of Fixed Dose Combination ARVs and revising the first and second line regimens.

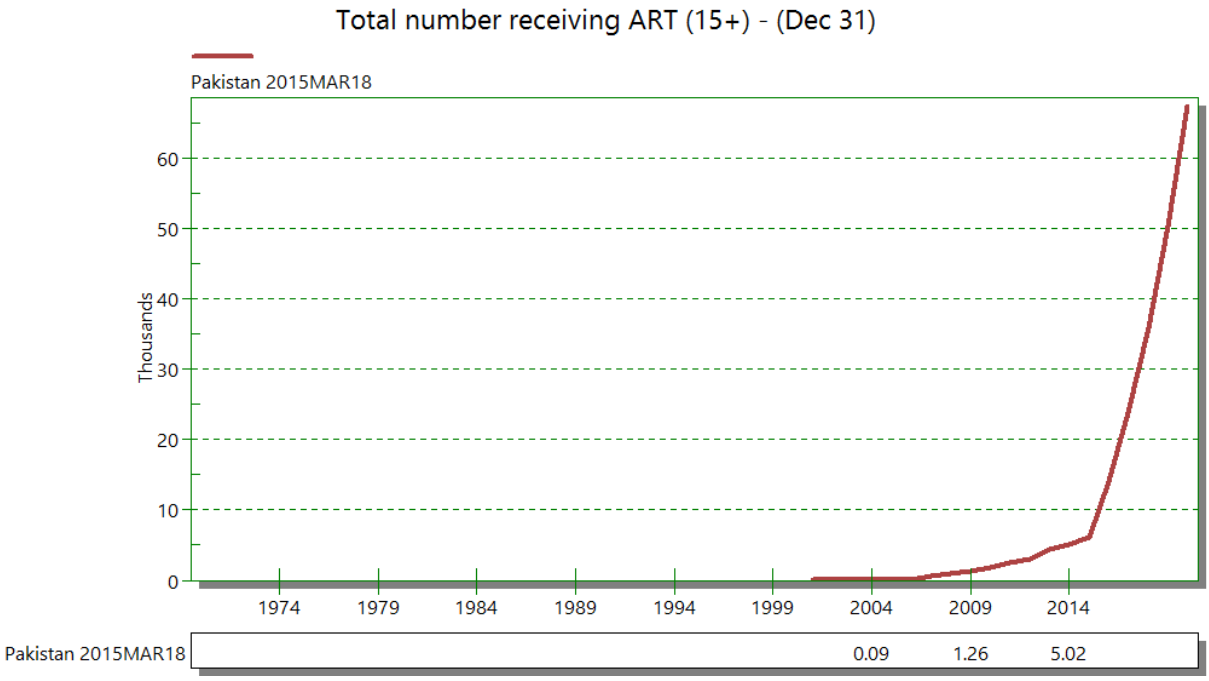


Graph 14. Province wise Number of PLHIV on ART 2011 – 2014.[105]

[105] NACP ART MIS

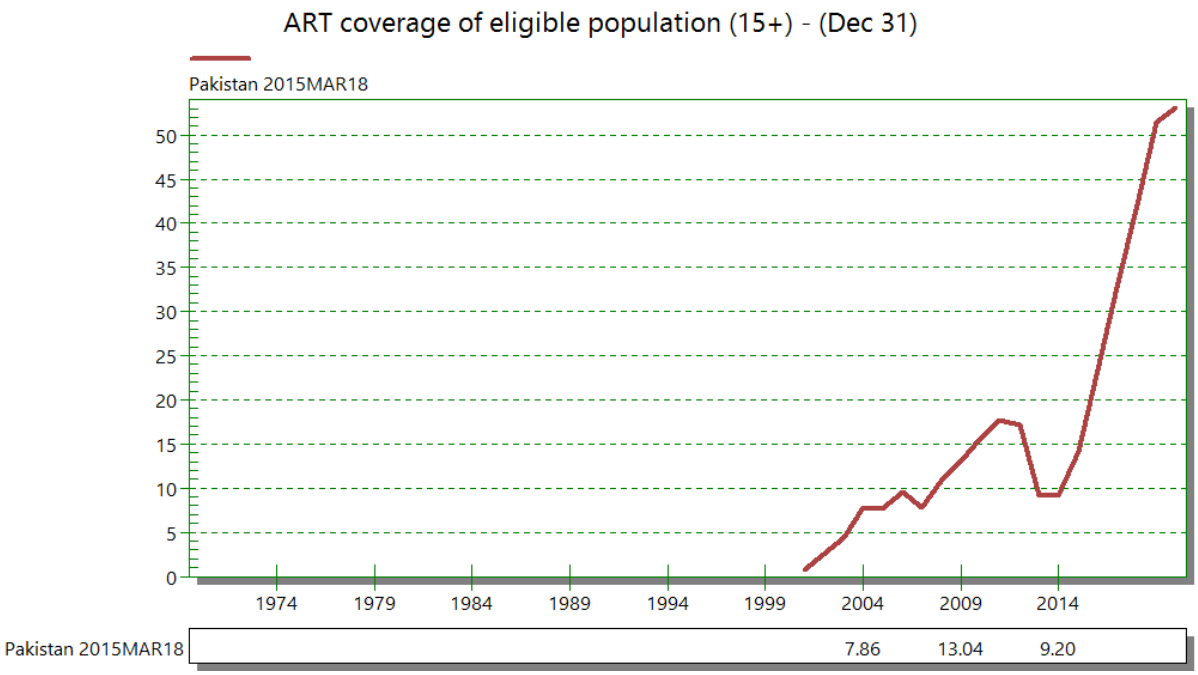


Graph 15. Total in need of ART (15+ Population)[106]

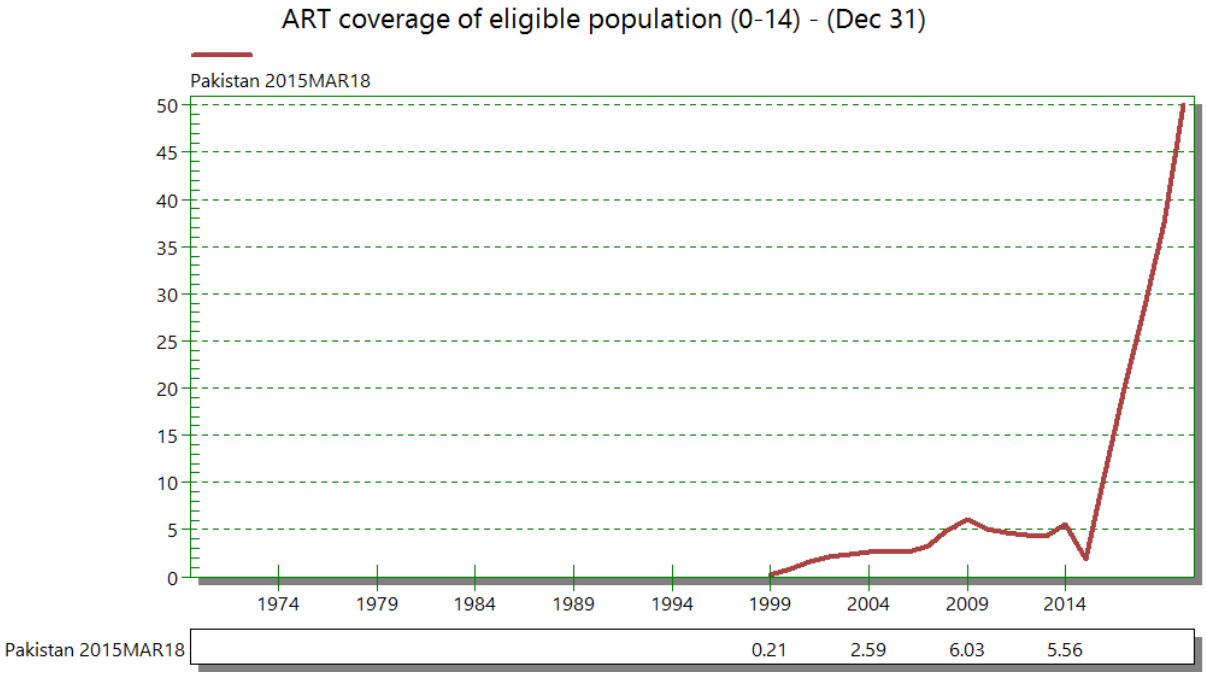


Graph 16. Total receiving ART (15+ Population)[107]

[106] Spectrum file Pakistan 2015MAR18.
[107] Spectrum file Pakistan 2015MAR18.



Graph 17. ART Coverage of Eligible Population (15+ Population)[108]



Graph 18. ART Coverage of Eligible Population (0 – 14 Population)[109]

[108] Spectrum file Pakistan 2015MAR18.
[109] Spectrum file Pakistan 2015MAR18.

Target 4 – Summary of Indicators

Indicator 4.1	Percentage of adults and children currently receiving antiretroviral therapy	5019/91340 5.5%	Program Data
Indicator 4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation	Indicator is valid but data is not available	

Target 5: Reduce Tuberculosis deaths in people living with HIV by 50% by 2015

Is this a priority target for the country?	**Yes**
Does the National Strategic Plan address this target	Yes
Is the country on track to reach the target and commitment	No

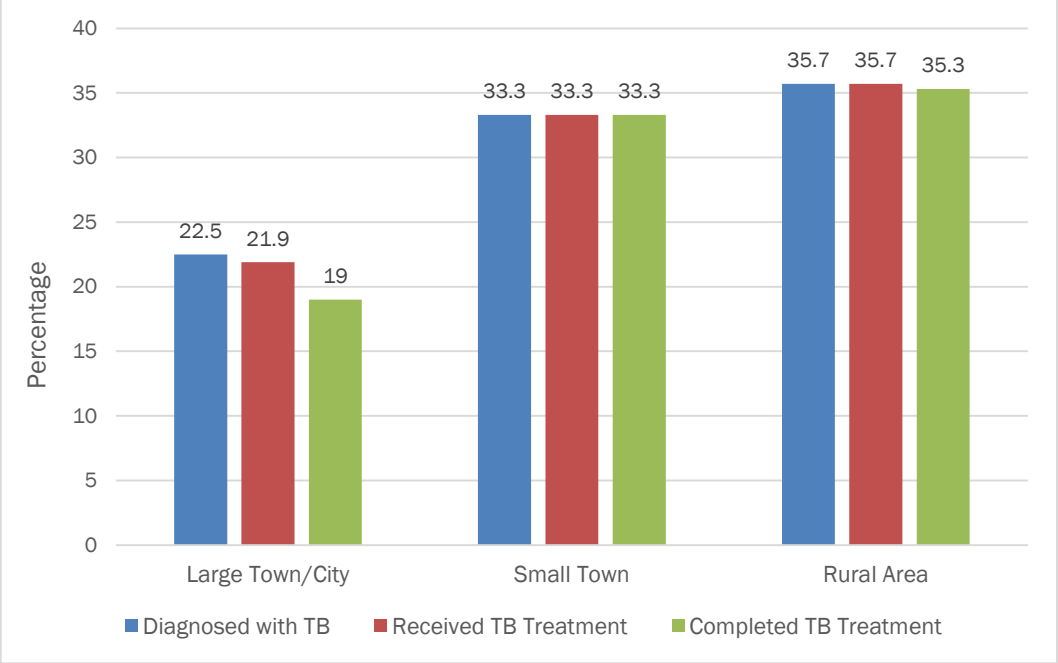
Pakistan is the 5th highest burden countries globally in terms of TB burden. Guidance is provided by National and Provincial TB control programs in the country that have a robust TB control program that also includes drug resistance monitoring and treatment. Guidelines for the management of DR-TB and HIV-TB co-infection are in place and trainings of treating physicians have been conducted.

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.

Meanwhile, National TB Control Program (NTP) has submitted a concept note to Global Fund in 2014, which also a component on HIV/TB Co-infection, through which the GF-supported HIV/TB collaborative activities will be intensified. Screening of TB patient for HIV will be increased from 3% to 10% and screening PLHIV for TB will be increased up to 90% by establishing linkages and improving access to HIV screening and TB diagnosis for people living in cities with known concentrated epidemics.

The APLHIV ART study in 2013 (Community Access to Treatment)[110] reported on PLHIV receiving TB treatment. Rates of receiving and completing treatment were similar (>50%). No major difference was observed by living area and diagnosis / completion of tuberculosis treatment among study participants infected with tuberculosis. Almost all tuberculosis infected study participants completed the tuberculosis treatment, except for minor difference in large town / cities.

[110] APLHIV. Regional Study on Community Access to Treatment 2013; Dr. Safdar Kamal Pasha



Graph 18. Prevalence of TB-HIV co-infection and its treatment among surveyed PLHIV by living area, in Pakistan.

Target 5. Summary of Indicator

Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Indicator is relevant, but data is not available	NA

Target: 6 Close the Global AIDS resource gap by 2015 and reach annual global investment of US$22-24 billion in low and middle income countries

Is this a priority target for the country?	Yes
Does the National Strategic Plan address this target	Yes
Is the country on track to reach the target and commitment	No

Using parallel financing arrangements, in partnership with the private sector, the United Nations and other donors have supported the HIV response since its inception.[111] The funding landscape has changed over the last several years, from primarily World Bank soft loan and grant funding, to increased domestic allocations through PC-1s and strengthened GF support. In 2013 GF (including regional grants) accounted for over 50 per cent of the total HIV response[112], Provincial Government 37 per cent, the UN 7 per cent[113], other external donors 3 per cent and National Government 3 per cent. From 2011 through 2013, expenditures by the National Government decreased given Devolution, while expenditures by Provincial governments and Global Fund increased, primarily due to the World Bank loan contribution to the Punjab Government for Health Systems Strengthening, which includes HIV.

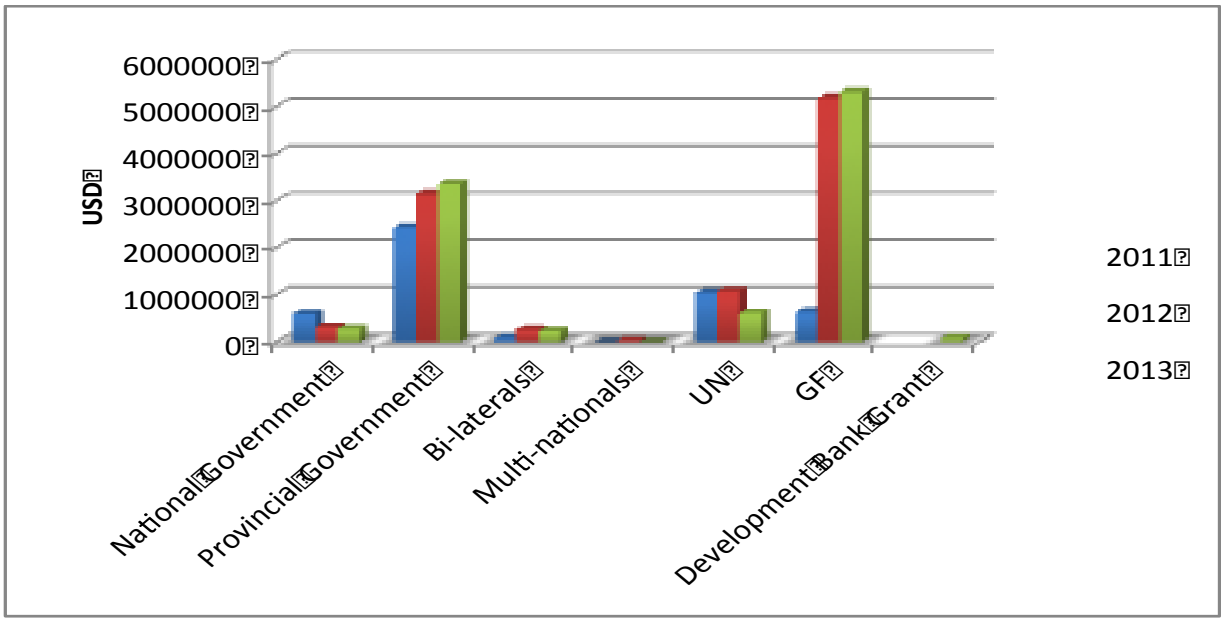


Figure 19: Financing sources of the HIV response in Pakistan for 2011-13 (Source: GARPR

[111] Key bilateral and multilateral donors to date include: The Global Fund to fight AIDS, Tuberculosis and Malaria; UN agencies (through the Joint Team on AIDS); World Bank (grant); CIDA, EU, DFID/UK Aid, USAID, GTZ/GIZ, Netherlands Ministry of Foreign Affairs, Norwegian Embassy.
[112] In 2000, the GFATM, with a commitment of USD 18.4 million till March 2013 to 2016.
[113] The UN Joint Team on AIDS had committed 1 396 169 USD for 2014-2017. Draft 'Delivering as One UN,' The Joint UN Programme of Support on AIDS 2014-2017. November 2014.

Looking at the eight areas of expenditure outlined by the Global AIDS Reporting system, expenditures in prevention have gone up over the past 3 years. Given the low ART coverage rates, expenditures need to be strengthened in care and treatment, dependent on PLHIV being identified for care (HTC), which comes under prevention and needs to continue to be strengthened. There is meagre expenditure on enabling the environment, key for a successful HIV response in a concentrated epidemic, or development synergies e.g. social protection and services.

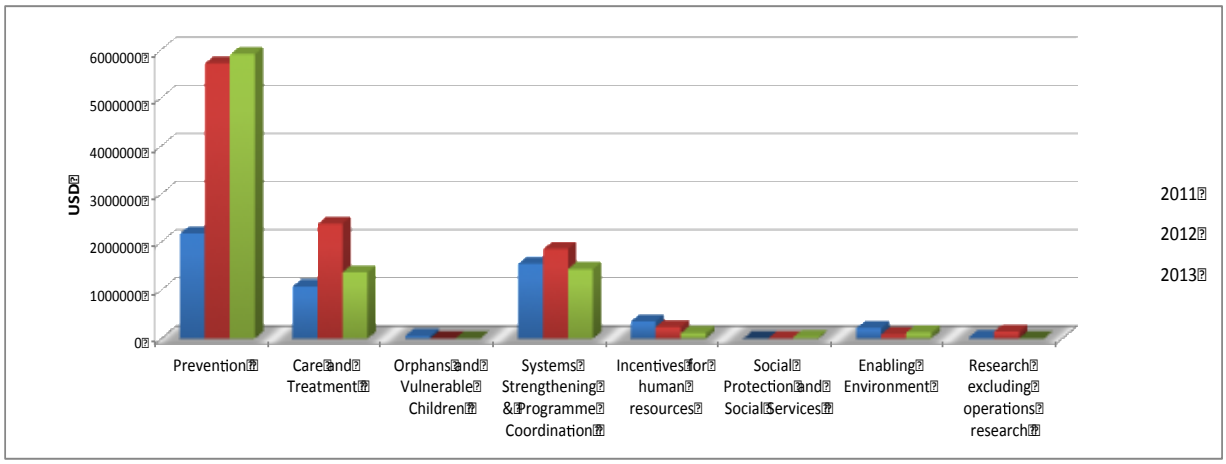


Figure 20: Eight areas of programme expenditure 2011 through 2013 (Source: GARPR 2014)

Expenditure within Prevention should be proportionate to the epidemic trend. Among key population expenditure, we see that while PWID and MSM expenditures have gone up, following the epidemic trend, expenditures for FSW and their clients have declined dramatically. Although the prevalence rate among FSW is still low, it has increased since 2005 and the number of sex workers in the country remains high and funding should remain at a level to mitigate any increase in incidence.

Target 6. Summary of Indicator

Domestic and international AIDS spending by categories and financing sources	Complete Matrix Submitted	Program Funding Data

Target 7: Eliminating gender inequalities

Is this a priority target for the country?	**Yes**
Does the National Strategic Plan address this target	Yes
Is the country on track to reach the target and commitment	No

Gender issues are key to provision of preventive and care services to Key Populations since HIV risks of MSM, HSW, and FSW, are driven by existence of extensive underlying gender inequalities and social marginalisation. For these population stigmatization occurs in large part because society perceives their behaviour as violation against the accepted norms of what women or a man should do. Stigmatization in turn makes the task of reaching key population with HIV prevention care and treatment services difficult.

The epidemic in Pakistan is driven in part, and will continue to be, norms around acceptable behaviour as well as common perceptions around unacceptable behaviour such as women's awareness about condoms and negotiating condom use with spouses/intimate partners, or the cultural barriers to the discussion of SRH for adolescent girls and boys. Punitive laws against behaviours that are not viewed as acceptable by the wider society, make key populations hard to identify, monitor and reach with HIV prevention programmes. The Penal Code, Section 377, criminalizes male-to-male sex as "carnal intercourse against the order of nature" with the punishment of imprisonment with the possibility of fines.114 Sharia law also carries heavy penalties for homosexuality – of imprisonment for 2-10 years or for life, or of 100 lashes or stoning to death (depending on whether the person is married or not).[115] Sex work is also illegal and Section 9 of the Control of Narcotics Substances Act (CSNA), 1997 allow for the death penalty for drug offences depending on the quantity of the narcotic drug, psychotropic substance or controlled substance.[116]

For key populations including, the risk of HIV is generated through sexual relationships that are influenced by underlying gender norms and other factors, such as economic vulnerability. If HIV risk is to be successfully reduced over the long term in Pakistan, programmes that serve key populations must also address the gender norms and inequalities that drive HIV risk. In addition to focusing on individual, peer-driven behaviour change models, interventions for key populations should be supplemented by a focus on partner transmission – especially intimate and commercial – to support an increase in uptake of services, reduced violence within relationships,

[114] Pakistan Country review-2011: Prepared by www.aidsdatahub.org based on HIV/AIDS Surveillance Project, IBBS round I, II, III and special round for FSW, NACP, MOH, Pakistan, 2005 – 2009.
[115] Ibid.
[116] Ibid.

better communication and joint responsibility for safe sex, contributing to an ultimate reduction in partner transmission.

Data from the HASP IBBS 2011, indicated that a significantly higher proportion of male than female IDUs (19.3 percent) reported being arrested in the past six months. Sexual violence was reported 2.1 percent of IDUs. Overall 10.1 percent of FSWs experienced arrest, during the past six months, while another 10.1 percent were subjected to physical/sexual violence, during the same period. 21 percent expressed no control over their money. Among MSWs approximately 11.5 percent were arrested, during the past six months, slightly higher (15.8 percent) experienced physical/sexual violence, while fewer (6.1 percent) reported shared their earning.[117]

In Pakistan AIDS Strategy 2015-2020; a gender-responsive M&E system will track gender-responsive activities, strategies and programmes to monitor funds allocation and to understand and analyse outcomes of these activities on uptake of services and HIV prevalence by age and gender. It will also aim to identify, integrate and track a standard set of indicators (such as violence, sexual behaviour, and use of family planning) to measure gender outcomes across districts over a period of time; should collect and use gender–disaggregated data at all levels. In the same strategy an operational research is planned to evaluate a nexus between HIV and gender based violence experienced by individuals (females, transgender persons and feminised males)[118] as well as institutionalised violence[119]to better understand violence as a risk factor for the transmission of HIV, and HIV as a risk factor for violence against women living with HIV, and how it can be translated into interventions.

NACP, is in process of submitting concept note for extension of global fund round 9 grant. Gender will be mainstreamed in Care, support and treatment strategies, to address gender inequalities.

Target 7 – Indicator Summary

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 spousal physical violence in past 12 months – DHS 2012-13: 24.6%

[117] National Integrated Biological and Behavioural Surveillance (IBBS) was conducted in 2011 (Round IV)
[118] According to the PDHS 2012-13, 1 in 5 women experienced physical violence in the past 12 months; one-third of ever-married women have ever experienced physical violence since age 15- most commonly by the current husband (79%); and overall 16% men (15-49 years), 9% urban and 20% rural men agree that a husband is justified in hitting or beating his wife if she refuses to have sex with him (2009-2013). In 2013, 18% of women in Pakistan experienced sexual violence by spouse or intimate partner, (2005-2013) (Prepared by www.aidsdatahub.org based on Demographic and Health Surveys).
[119] In Pakistan, 22% of women living with HIV who had a desire to have children reported being coerced to undergo sterilization, 2012-2013 (HIV and AIDS Data Hubs for Asia-Pacific Review in Slides.)

Target 8: Eliminating stigma and discrimination

Is this a priority target for the country?	**Yes**
Does the National Strategic Plan address this target	Yes
Is the country on track to reach the target and commitment	Yes

HIV infection is associated with stigma and discrimination as a product of lack of understanding of the illness, fear, prejudice and socially sensitive issues such as sexuality and gender identity. HIV related stigma and discrimination inhibit HIV prevention and mitigation.

Stigma and discrimination in the general population against PLHIV is measured through the DHS. The 2012-13 DHS reported that overall, 17 per cent of women and 15 per cent of men expressed accepting attitudes of PLHIV.[120] The Stigma Index assessment was carried out in September 2009 – July 2010 by the APLHIV, in which 833 PLHIV were interviewed by 33 peer data collectors. A major challenge faced by most PLHIV was poverty and lack of employment opportunities due to discrimination against their HIV status.[121] In 2013 The APN+ regional study undertaken by the APLHIV looking at ART access, initiation and adherence, found that 49.2 per cent of the total respondents (n=525) reported being denied medical services due to their HIV status; another 40 per cent experienced some type of housing instability (forced to change place of residence or been unable to rent accommodation because of HIV status) and 25 per cent reported that their children were prevented, dismissed, or suspended from attending school in last 12 months.[122] 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.

A study to find out HIV and AIDS issues in workplace was sponsored by UNAIDS and was carried in three cities of Pakistan (Islamabad, Lahore and Karachi). The findings of this study showed:

- No generic workplace policies or unified labour laws that exist in Pakistan making it difficult to approach and address all the labour force simultaneously. This state of affairs is partly due to

[120] 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. PDHS 2012-13.
[121] 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.
[122] 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 (Safdar Kamal Pasha). Available through the Pakistan Association of People Living with HIV.

the advent of 18th amendment and shift of roles from federal to provincial governments. The devolved labour departments have not developed their own labour policies.

- Workplace policies do not generally target population groups such as women workers, men workers, migrants and PLWHIV.
- Women have poor representation in labour offices and workers organizations
- HIV and workplace policies have not been raised as an issue by national organisations or international groups as part of policy and program discussions
- The HIV related social protection services are more focused on food nutrition and education without legal supporting measures
- PLWHIV are invisible in employment sector because of low prevalence of HIV in general population and majority of PLHIV do not work in formal job market and those working are reluctant to disclose their status due to fear of stigma and discrimination.
- PLWHIV face various job related issues such as employers reluctant to hire HIV positive worker.
- There is no workplace policy or programme that could help PLWHIV workers to improve their livelihood
- Although the national HIV and AIDS policy recognizes the importance of workplace the labour sector has not been effectively approached by the stakeholders in HIV response.

Target 8 – Summary of Indicator.

Discriminatory attitudes towards people living with HIV[123]	Overall : 52.7 Women: All: 53.8 Men: All: 51.6

[123] Pakistan reports on the indicator" "Would buy fresh vegetables from shopkeeper who has the AIDS virus?" from 2012-13 DHS but indicator has been calculated based on GARP indicator Answered "No" or "It depends" to question 1 "Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?"

Target 9: Eliminate travel restrictions

Is this a priority target for the country?	**No**
Does the National Strategic Plan address this target	No
Is the country on track to reach the target and commitment	Yes

There are no existing HIV related restrictions on entry stay and residence in the country. Pakistan is hosting a huge number of both internal and externally displaced populations including refugees. It is still hosting more than 1.5 million Afghan refugees in the country. However these populations who seek temporary and long term residence are provided free health care services without discrimination. Most of Afghan refugees seek their treatment in Pakistan and they get this treatment without any discrimination sometimes at the expense of local population. About 150 Afghans are getting their HIV treatment in HIV treatment centre in Hayatabad Medical Complex based in the city of Peshawar.

Other than refugees huge number of Pakistanis[124] (3.3 per 1000 inhabitants) (are working abroad mostly in Gulf countries as migrant workers. These migrant workers now form part of the vulnerable population in Pakistan AIDS Strategy 2015. Interventions would now be implemented to reduce the chances of HIV transmission among them.

Target 9 – Summary of Indicator

Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed	No travel restrictions.

[124] Mapping of HIV Risk and Vulnerabilities of Temporary Contractual Workers from Pakistan to GCC Countries 2011, Government of Pakistan, IOM and UNAIDS

Target 10: Strengthening HIV integration

Is this a priority target for the country?	**Yes**
Does the National Strategic Plan address this target	Yes
Is the country on track to reach the target and commitment	Yes

Pakistan AIDS Strategy 2015 strategic output 3.2 specifically focuses on strengthening multi-sectoral coordination at federal and provincial levels. It envisages to targeted and sustained advocacy actions for policy reform, HIV integration and addressing stigma and discrimination to enable high impact interventions and protection of rights. Advocacy and communication units should be established at federal and provincial levels to support advocacy, communications, including programme, as well as support resource mobilisation efforts.

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.

Target 10 – Summary of Indicator

Current school attendance among orphans and non-orphans aged 10–14[125]	Indicator is relevant, but data is not available.	NA
Proportion of the poorest households who received external economic support in the last 3 months	66.6% [126]	World Bank

[125] 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.

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

Best Practices

1. Expansion of CD4 and Viral load facilities in Punjab: Punjab is the biggest province of Pakistan harboring more than 60% of the population of the country. With highest HIV burden and long distances between cities all HIV positives had to travel from every nook and corner of the province to the capital city of Lahore to get CD4 and viral load testing which is crucial for HIV treatment monitoring. This had huge human and financial cost implications. There was just one CD4 machine available in Lahore when this was bought in 2005. To overcome this problem Punjab AIDS Control Program 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 program now has a laboratory based CD4 machine in Lahore and two Point of Care machines moving around the centers.

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 optimization of already available PCR machines in the country. Since these machines were already widely available in the country at various levels the HIV viral load testing facility was also made available to nearly all HIV treatment centers in the country.

3. The APLHIV is a Nationwide Network of People living with and affected by HIV and associated key population. The APLHIV was registered in 2008, with its Federal Secretariat located at Islamabad. It was established to address the rights and issues of marginalized people, to provide a quality life and to ensure dignity of the lives of people living with and affected by HIV. During 2014 APLHIV provide independent monitoring of equity principles to ensure that services are provided in a dignified manner, ensuring protection of rights of the clients and to ensure that interventions are provided in a non-discriminatory manner. The concept of community based monitoring proved to be a best practice as it is essentially helpful to identify the gaps in services being provided and to suggest remedial measures. This community based monitoring also gave a sense of empowerment to the community as their view points are being considered at policy and decision making levels. The community based monitoring is being provided through:

    a. The provincial Coordinators, who visit all the treatment centers and the CHBC sites in their respective provinces in every quarter (each site is visited every months).
    b. Assessment tools are used to perform the monitoring by the Provincial Coordinators.

c. Feedback from both the services providers and the clients is received which helps to identify the gaps and suggest measures to address these gaps.
d. In each province one FGD with clients is held in every quarter on various service delivery points on rotational bases.
e. Provincial Coordinators are also tasked to make contacts and establish links between the private sector and public sectors; visits of influential are also part of this aspect which is mainly conducted by the Federal Secretariat.
f. In addition the APLHIV is acting as a holding point for complaints, suggestions and feedbacks.
g. The APLHIV is also committed to provide leadership in engaging community participation at National level.

Basic information The APLHIV is also providing the services of Toll Free Helpline at National level. This is the only helpline at National level providing the services in Pakistan. Helpline is instrumental in provision of monitoring services across the country and round the clock. The helpline is responsible for provision of:

a. About HIV, HCV and HIV/HCV Co-Infection.
b. Telephonic Counseling
c. Referral Services
d. Receiving and processing of complaints, suggestions and feedback on the quality, quantity and equity of services being provided to the clients/community.

The helpline provided help in following areas in 2014w:

a. Total SMS sent for provision of information= 1063872
b. Total calls received from across the country=10123
c. Basic information provided= 8800
d. Counseling provided= 540
e. Referral services provided= 608
f. Complaints received= 175
g. Complaints processed=175
h. Appropriate action taken on complaints=175
i. Calls received from Punjab=3018

j. Calls received from Sindh =1995

k. Calls received from KP= 1650

l. Calls received from Balochistan=1576

m. Calls received from ICT, FATA, GB and AJK=800

n. Calls received from unknown locations= 1084

Other than above mentioned initiatives the APLHIV had helped the national and provincial AIDS Control Programme in following areas through monitoring and advised:-

a. Helped the program in reducing ARV stockouts in treatment centers. No stock out of ARVs has been reported last year.

b. Due to intensive follow up of complaints CD-4 machines donated by WHO were provided at Larkana, Quetta and Turbat

c. 3 PLHIVs were facilitated to be re-employed on their jobs.

d. A national level study was conducted on Access of community to treatment care and support and its report was shared in a national consultation workshop.

e. Conducted a national study to find HIV/HCV coinfection prevalence in HIV positives in the country. The results of this study would be shared in a national consultation workshop.

4. Under new WHO recommendation of Treatment as Prevention (TasP) new consolidated guidelines recommend use of ART to prevent transmission of HIV in sero discordant couples. In Pakistan most of those on HIV treatment are migrants working in Gulf countries who have returned with this infection. Largest number of this population is in Khyber Pakhtunkhwa province of Pakistan. HIV transmission was reported in quite a number of instances in the families from husband to their spouses. In order to test initiative of TasP in migrant workers where one partner was infected UNICEF started a pilot project. Till December 2014 40 such partners were receiving ART as TasP and their spouses were negative.

Major Challenges

1. **Poverty:** Poverty drives sex work and fuels unsafe injections. Just over 21 per cent of Pakistani's live below the global Purchasing Power Parity rate of USD 1.25 per day[127] and the employment rate to the population in Pakistan is only 56.3%. Multi-dimensional poverty is high (Pakistan ranks 146/187 countries) indicating deprivations across health, education and living standards. Only 29% of married women age 15-49 are employed, compared to 98% of married men age 15-49 and only half of women earning cash could make independent decisions on spending their earnings. Seven in ten women reported earning less than their husband.[128] Among women living with HIV, 44.9% of women living with HIV are unemployed as compared 32% male.[129]

2. **Low level of education**: Education levels are strongly correlated with the uptake of safer behaviours including condom use. Education levels are very low despite attempts to legislate mandatory primary education. The mean years of schooling remain only 4.7 years for adults with 57 per cent of women and 29 per cent of adult men have no education.[130] Only 9 per cent of women and 16 per cent of men have completed more than secondary level of education. The quality of education, however, is poor indicated by literacy rates: 32.2 per cent of men and over 50 per cent of women completing 9th class could not read.[131] More than half of the total female living with HIV (56.3%) had no formal education as compared to only 27.5 per cent of the total HIV.[132]

3. **Gender inequalities:** Gender inequalities exacerbate other individual and structural vulnerabilities for HIV. Pakistan is a male dominated culture where women and girls have lower socio economic status (Gender Development Index (GDI) = 146 among 187 countries).[133] Although there has been some improvement in the status of women over the last few years, significant gaps remain particularly in education and health that may increase their vulnerability to HIV. Women's use of services and ability to adopt healthy sexual and reproductive behaviour are limited due to social restrictions and decision-making power in the household. For example, almost two-thirds of women reported having at least one

[127] UNDP Human Development Reports (http://hdr.undp.org/en/countries/profiles/PAK)
[128] Pakistan Demographic Health Survey 2012-13.
[129] Country Report on National Research Study on HIV Community Access to Treatment, Care and Support Services in Pakistan. Safdar Kamal Pasha. 2013.
[130] Ever married, 15-49 years. PDHS 2012-13.
[131] Pakistan Demographic Health Survey 2012-13.
[132] Country Report on National Research Study on HIV Community Access to Treatment, Care and Support Services in Pakistan. Safdar Kamal Pasha. 2013.
[133] http://hdr.undp.org/en/content/table-5-gender-related-development-index-gdi.

problem accessing health care for themselves.[134] In addition, not all women have power to make their own decisions; only 52% are most likely to have the final or joint say on decisions regarding their own health care.[135] The epidemic in Pakistan is driven in part, and will continue to be, norms around acceptable behaviour as well as common perspectives around unacceptable behaviour such as women's awareness about condoms and negotiating condom use with spouses/intimate partners[136], or the cultural barriers to the discussion of SRH for adolescent girls and boys. In Pakistan gender is not limited to only women but includes feminised males and *hijra* whose vulnerability is driven by underlying gender inequality and social marginalization. For these populations, stigmatization (or the condoning violence) occurs in large part because society perceives their behaviour as violating the accepted norms of what women or a man should do. Stigmatization in turn, makes the task of reaching key populations HIV prevention, care and treatment services difficult. The lack of research on the specific nexus between gender based violence (GBV) and HIV is limiting the formulation of a strategy to address this issue.

4. **Devolution:** The 18th constitutional amendment on devolution was re-introduced in 2011 (the process began initially in 2001 but was halted) in part to address issues of Governance, transparency, accountability, and equity among provinces. On 30th June, 2011, as a result of the 18th constitutional amendment, the Ministry of Health was dissolved at the federal level even though the Provincial governments had not developed plans on how to address the new health related environment under the Constitution.

This led to abolishment of three disease control programs including HIV and AIDS, Malaria and TB. The Government in October 2011, re-established the three programs with following Terms of Reference (ToRs):

- To act as the Principal Recipients for all Global Fund-supported health initiatives;
- To prepare proposals and liaise with international agencies for securing support of such partner agencies; and
- To provide technical and material resources to the provinces for successful implementation of disease control strategies and disease surveillance.[137] The NACP currently sits under the National Health Services Regulation and Coordination, established in 2013.

[134] For example, more than half of women were concerned about going alone; four in ten women were concerned about management of transportation; and more than one-third of women were concerned about distance to the health facility. Pakistan Demographic Health Survey 2012-13.
[135] PDHS 2012-13.
[136] Condoms are primarily accessed from the private sector and by men, indicating men's discretion and power in exercising condom for prevention purposes. PDHS 2012-2013.
[137] Government of Pakistan Inter Provincial Coordination, Notification No.F. 2(154)/2011-amn, Islamabad 14th October 2011.

Health sector challenges under Devolution that particularly impact HIV include weak coordination authority at Federal level to streamline HIV interventions in the country; inadequate inter-provincial information sharing, collation, reporting and utilization mechanisms like evidence for planning and designing improvement in health services and inter-provincial harmonization. The provincial programme data aggregation is limited to only treatment, PPTCT and needle distribution (mostly for annual GARP reporting); In general, after devolution provinces have access to 40% more funds for health, but slow transfer of funds, poor resource tracking and lack of performance parameters due to absence of collated information (except in GF supported projects) have resulted in problems for vertical programmes including HIV.

5. **Non availability of OST** still remained an issue for s to be put on ART in 2014. Alternatively detox and rehabilitative adherence support was introduced by Nai Zindagi as an alternative to put them on ART.

6. **Funding Gap:** only the Punjab PC-1 was fully approved and funds released. In Sindh the PC-1 expired June 2014 and all service delivery packages stopped. Currently SACP has a one-year extension for operational costs. Their new PC-1 is under final approval. Balochistan has had no PC-1 since the strategy was developed. Their new PC-1 was approved recently in principle, but not signed. When PACP in Khyber Pakhtunkhwa was dissolved and integrated under the Public Health Directorate, their pending PC-1 was suspended. The unresolved status of the PC-1s has significantly hampered the implementation of the Provincial Strategies. Moreover KP is currently absorbing expense (through GF and Government funding) for FATA patients in it ART and CHBC centres.

Remedial Actions

Poverty: Safety nets should be provided to marginalised communities including those affected and infected with HIV. In this regard institutions such as Bait ul Maal, Benazir Bhutto income support projects (BISP) and health insurance schemes available in the country should be directed towards these marginalised populations.

- **Low level of education:** Special schools should be opened for marginalized communities. Similarly schooling grants should be provided to spouses and children of key populations and vulnerable population in order to increase their literacy rates.
- **Devolution:** The negative impacts of Devolution could be countered with increasing coordination at the federal level not only within the three disease areas but also with the provinces. Moreover an ambitious capacity building plan should be prepared and implemented so that the capacities of the provinces could be strengthened.
- **Non availability of OST:** The UN partners in collaboration with national and provincial AIDS Control programs have to speed up their efforts in getting OST approved in the country. This is a crucial step in putting on HIV treatment and breaking the cycle of transmission.

Support from the country's development partners

Pakistan receives external funding for HIV and AIDS services through bilateral and multilateral partners. There is considerable support coming from these partners that complement the efforts of the Government. While these external sources are of considerable importance still there is need for concerted efforts to ensure funding.

A. Prevention

In support of national efforts considerable support is coming from GFATM and UN partners in this area. For HTC UNICEF and WHO provided support for development of new HTC strategy for the country. Similarly WHO and UNICEF helped the Government to develop new HIV testing protocols based on rapid tests which is now under implementation in the country. Similarly through GFATM Round 9 the country is getting providing harm reduction services to all over Pakistan. UNODC is helping the country in getting OST drugs approved after successfully completing a one year pilot in Rawalpindi hospital on more than 100 s.

B. Treatment care and support

UN partners helped in revision of the national HIV treatment guidelines and introduction of FDC in the treatment program of the country. They also supported training of health care providers in the four provinces on the developed guidelines.

C. Programme Evaluation and strategic information

The development partners helped the national and provincial programmes in conducting program evaluations. Mid Term Review was carried out of the national program. This formed the basis of the provincial strategies and subsequently the national strategic framework III. WHO also helped the program to conduct epi-analysis of all surveillance information on HIV and AIDS, in Pakistan.

However support will still be needed by development partners in areas of prevention, treatment care and support and surveillance. IBBS surveillance rounds have not taken place after 2011. Except Punjab no new surveillance information is available in the country. This information is crucial for future planning and interventions. The partners should support the country in conducting IBBS surveillance rounds. The UN partners need to provide leadership in several program areas including developing effective partnerships and getting resources to bridge the funding gap.

The partners should continue supporting strengthening of technical capacity building of program management and civil societies. They have to support efforts in advocacy, community mobilization, policy and strategy development and delivery of comprehensive services. Lots of support is expected from them in areas of OST implementation, reducing stigma and discrimination, human rights violation in respect to Key populations.

Monitoring and evaluation environment.

Monitoring is one of the weakest areas throughout the provinces. Several key issues were identified in the Mid Term Review: 1) lack of coherence between monitoring of SDPs (Government and otherwise) and GF monitoring (same indicators not being reported on); 2) lack of coordination of strategic information at the provincial level (data aggregation, monitoring plans, research focus, piloting of innovative strategies etc. were not being collated and analysed on GF supported and Provincial ACPs supported SDPs, despite a specific GF supported Coordinator placed in Punjab and Sindh ACPs); 3) Lack of provincial aggregated data, based on SDP and GF services, to indicate the achievement against the indicators and targets set in the strategies. While it is unrealistic at this point to merge existing MIS's (GF and ACP supported) and /or expect all service providers to use the same, there is a need to create coherent data collection tools (same indicators), coherent means of analysis among the different MIS, and a coherent system of reporting data from service providers up through ACPs and the NACP for reporting on international commitments, and from District through Provincial through National for HIS indicators.

While the Monitoring Framework is similar for all provinces, many of the indicators rely on IBBS for their means of verification and are not collected at field level. Round V of the national IBBS is meant to get underway with Global Fund and UNAIDS support in 2015 and Punjab has reportedly completed their provincial IBBS.

Evaluation

While GF supported projects have conducted operational evaluations of their service provision models, no evaluation have been conducted by the programs for their past performance except Punjab AIDS Control Programme's Third Party Evaluation (End Project Evaluation) of the Enhanced HIV/AIDS Control Program Phase II (2009-13) conducted by Development Health Systems Evaluation in June 2013.

Study Limitations.

Last HIV surveillance round in Pakistan was conducted, in 2011. Last year, Punjab AIDS Control Program, carried out mapping and HIV surveillance in ten districts of Punjab, however the report of IBBS isn't yet officially launched.

Data on some of the surveillance related indicated, didn't changed during 2014 (as part of the current report) however in the narrative part, the existing information is augmented by any research study conducted, after 2011 IBBS round.

ANNEX. I:

CONSULTATION PROCESS

The NACP in collaboration with UNAIDS initiated the process of developing the GARP report 2015 by creating a Technical Working Group (TWG) composed of representatives from the Provincial Programmes (Punjab, Sindh, KPK and Balochistan), WHO, UNODC, UNICEF, and CSOs, 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+.

The first meeting of the TWG took place in February 2012 to outline the way forward and process methodology for the development of GARP Report 2015.

Meeting of Working Group on Global AIDS Progress Reporting

Venue: National AIDS Control Programme

Date: 18th February 2014

Participants:

Sr.	Name	Designation	Organization
1	Dr. Baseer Khan Achakzai	National Program Manager	NACP
2	Dr. Fareed Sumalani	PM Baluchistan	BACP
3	Dr. Aftab Ahmed	M&E Officer	SACP
4	Dr. Sajid Ahmed	CCM Coordinator	CCM Secretariat
5	Dr Tayyaba Rashid	Treatment Coordinator	PACP
6	Fehmida Iqbal	Advisor	UNAIDS
7	Dr Sofia Furqan	SPO	NACP
8	Dr. Atta Ullah	AD/PMU	KPK Dist.
9	Noman Manzoor	Project Advisor	NMHA
10	Qasim Iqbal	ED	NMHA
11	Dr. Aurangzeb	NPO-HIVAIDS	UNDP
12	Dr Amir Raza	Consultant	UNAIDS/NACP
13	Dr. Saima Paracha	PO	NACP
14	Dr. Malik safi	Program Director	NHS, R&C
15	Dr. M. Umair	Epidemiologist	NAP
16	Tariq Zafar	ED	Nai Zindgai
17	Salman Qureshi	PM	Nai Zindgai
18	Sadia Atta Mehmood	Program and Technical	UNFPA

		Advisor	
19	Asghar satti	NC	APLHIV
20	Dr. Rajwal Khan	Strategic Information Advisor	UNAIDS
21	Anne Bergenstrom	Regional Advisor	UNODC
22	Dr. Qutabuddin Kakar	NPO	WHO
23	Dr. Quaid Saeed	Consultant	UNAIDS
24	Dr. Safdar Kamal pasha	M&E Specialist / Country Focal Point for GRPR	NACP
25	Bettina T. Schunter	Consultant	NACP

Decisions reached:

1. Respondents for different parts of the report 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. Additional data, including programme and modeled, identified and agreed to be included in narrative.
4. Draft report to be prepared by 19th March and shared with all stakeholders in a consultative meeting to be held 21st March 2015.
5. Agreed on text boxes: OST, APLHIV Helpline; female PWID/prisoners programme; reaching spouses with PITC/VCCT
6. 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.

Follow up Actions

1. NACP to share Spectrum data with the consultant for indicators and inclusion in narrative
2. PACP and SACP to provide programme data on PWID clients reached and syringes distributed
3. Relevant TWG members to provide information for text boxes, best practices and major challenges as well as specific studies including ART adherence by APLHIV.
4. TWG members to provide what information they have on current development partners outside the UN.

ANNEX. II:

VALIDATION PROCESS

A National Consultation was held 25th. March for validation of indicators and consensus on both indicators and the narrative content e.g. best practices and main challenges.

Meeting of Working Group on Global AIDS Progress Reporting

Venue: National AIDS Control Programme

Date: 25th March, 2015

Participants.

Sr.	Name	Designation	Organization
1	Dr. Baseer Khan Achakzai	National Program Manager	NACP
2	Dr. Safdar Kamal pasha	M&E Specialist / Country Focal Point for GARPR	NACP
3	Dr. Fareed Sumalani	BACP	Health
4	Dr Tayyaba Rashid	Treatment Coordinator	PACP
5	Dr. Rajwal Khan	Strategic Information Advisor	UNAIDS
6	Qasim Iqbal	ED	NMHA
7	Dr. Aurangzeb	NPO-HIVAIDS	UNDP
8	Dr Amir Raza	Consultant	UNAIDS/NACP
9	Dr. Saima Paracha	PO	NACP
10	Dr Sofia Furqan	SPO	NACP
11	Dr. Atta Ullah	AD/PMUHIV	KPK Dist.
12	Asghar satti	NC	APLHIV
13	Noman Manzoor	Project Advisor	NMHA
14	Dr. M. Umair	Epidemiologist	NAP
15	Tariq Zafar	ED	Nai Zindgai
16	Salman Qureshi	PM	Nai Zindgai
17	Bettina T. Schunter	Consultant	NACP
19	Dr. Aurangzeb	NPO	UNDP
20	Anne Bergenstrom	Regional Advisor	UNODC
21	Dr. Qutabuddin Kakar	NPO	WHO
22	Dr. Quaid Saeed	Consultant	UNAIDS

Discussion.

Participants discussed about various aspects of the report. 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 modelling data in

narrative report; use of programme data under targets/indicators in “national response”. It was decided that consultant will share the final draft before the report uploading on the GARPR web portal.

References

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[v] http://www.pk.undp.org/content/pakistan/en/home/search.html?q=migration
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[viii] www.nacp.gov.pk; NSF I
[ix] http://www.nacp.gov.pk/library/reports/Surveillance%20&%20Research/HIV-AIDS%20Surveillance%20Project-HASP/HIV%20Second%20Generation%20Surveillance;
[x] National Integrated Biological and Behavioural Surveillance (IBBS) was conducted in 2005 (Round I), 2006-7 (Round II), 2008 (Round III) and the last one in 2011 (Round IV). Round V is planned for 2015. The Punjab conducted IBBS in 10 cities in 2014 but results are not yet disseminated.