COMMUNITY VOICES

An HIV Gender Assessment in Pakistan

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Acronyms

AEM	Asian Epidemic Model
CBO	Community-based organisation
EID	Early Infant Diagnosis
FGD	Focus group discussion
GBV	Gender-based violence
GF	Global Fund
HIVST	HIV self-testing
HTS	HIV testing services
IDI	In-depth interview
IPV	Intimate partner violence
KI	Key informant
KP	Key population
LHW	Lady Health Worker
LSP	Living support package
LTFU	Loss to follow up
MIS	Medical information system
MLHIV	Men living with HIV
MSM	Men who have sex with men
MWID	Men who inject drugs
NPR	National Program Review
PEP	Post-exposure Prophylaxis
PLHIV	People living with HIV
PR	Principle Recipient
PrEP	Pre-exposure prophylaxis
PSE	Population size estimate
PWID	People who inject drugs
RDS	Respondent-driven sampling
SOP	Standard operating procedures
SR	Sub-recipient
VL	Viral load
WLHIV	Women living with HIV

Executive Summary

This gender assessment identifies gender-specific vulnerabilities, needs and barriers to services, and assesses program effectiveness at addressing gender issues in Pakistan's response to HIV. It is based on a review of key documents, such as the national and provincial AIDS Strategies, relevant published articles and grey literature, and reports to the Global Fund from the country's Primary Recipients; in-depth interviews with 20 key informants; and 17 focus group discussions with people living with HIV and key populations, encompassing a total of 113 participants.

The gender assessment identified critical gender gaps in data, policies, programmatic reach, programmatic integration of gender-specific considerations, and across every level of the treatment cascade.

In the area of data, the gender assessment encountered numerous gaps: insufficient data to determine the gender breakdown for HIV incidence; absence of age-disaggregated HIV data for key populations; lack of gender-disaggregated data for HIV testing rates; and absence of gender-disaggregated data for viral load suppression. Sex disaggregated data for treatment was available, and showed that access to treatment is low for both women and men, but men's access is worse than women's: Just 11% of the total estimated number of men living with HIV were on treatment in 2022, compared with 17% of the total estimated number of women living with HIV. Sex-disaggregated data for death rates among PLHIV in Pakistan was available for this gender-assessment and shows that men living with HIV are more likely to die of AIDS than their female counterparts: a 3.5% death rate among women (1,700 deaths), against a 4.5% death rate among men (9,500 deaths).

- The gender assessment recommends improving and updating data on gender and key populations, including by conducting IBBS and population size estimates for key populations, ensuring that gender and age-disaggregated and gender-specific data is collected.

A gender analysis of Provincial and National AIDS Strategies 2021 - 2025 found that all the AIDS strategies appropriately identify intimate partners of key populations as a vulnerable population. However, very little gender-disaggregated data is presented, no data-driven gender-responsive interventions are proposed, and no gender-differentiated, norms, barriers and inequalities are discussed. None of the AIDS Strategies recognise the critical issue of violence, including gender-based violence (GBV), no data on violence is presented, GBV prevention is not mentioned and linkage to care – including both medical and legal support – for GBV survivors is not included in any of the AIDS Strategies. While the challenges posed by stigma and discrimination, especially in healthcare settings, figure prominently in the AIDS Strategies, there is no recognition of gender-specific stigma and discrimination, nor are there any strategies to address it. Harmful laws and policies, including criminalisation, and the gender-differentiated impacts they have, are not discussed in any of the AIDS Strategies.

- The gender assessment recommends revising and updating the national and provincial AIDS strategies to take gender issues into account across all aspects of the AIDS Strategies, including budgeting.

The gender assessment found that, while spouses of key populations constitute

approximately half of all PLHIV in Pakistan, and, according to the Pakistan AIDS Strategy, the vast majority of these spouses are cisgender women who are married to men who have sex with men, the gender-specific barriers to reaching female spouses have not been explored and there are no operational programs effectively reaching the wives of MSM, transgender women, migrant male workers, or any other key population, with the notable exception of people who inject drugs (PWID). In the case of PWID, the program successfully reaches the spouses of men who inject drugs (MWID) with home-based assisted partner notification, home-based testing, ongoing social support, prevention information and condoms, and on-going adherence support for HIV-positive MWID and their families. The program reports that 80% of the HIV-positive MWID whose spouses have been accessed with services, are successfully linked to treatment; and ART adherence between 2012 and 2018 among this cohort was 96%

- The gender assessment recommends utilising the successful program for reaching spouses of MWID in Pakistan, to build spousal outreach programs for other key populations and integrating spousal outreach into the existing interventions for key populations.

A number of missing key populations were identified in the course of the gender assessment – populations for whom no tailored programming is available: women who inject drugs, female prisoners, young male sex workers, and young transgender women.

- The gender assessment recommends developing services for vulnerable gender-delineated sub-populations – women who inject drugs, female prisoners, young male sex workers, and young transgender women, who have inadequate or no access to services at this time.

This assessment found that gender-specific vulnerabilities are largely unrecognised and unaddressed in HIV programming. For example, in some areas, especially tribal and rural areas, women may be unable to leave the house without the permission of a male family member, or may be required to have a male companion escort, in order to leave the house or attend health services. This makes it difficult or impossible for women to access any HIV services. Restrictions on widows' movement also constitutes a barrier to accessing services. A woman whose husband has died is expected to observe *Iddat*, or the requirement that she spend 4 months and 10 days in seclusion.

- The gender assessment recommends reaching women in their homes by training the Lady Health Workers (LHW) who already access women, to conduct HIV testing and addressing gender-specific vulnerabilities that impact women observing *Iddat*, by including information on how to access HIV services during *Iddat* in programming for spouses of people living with HIV, by sensitizing families of MLHIV about the importance of facilitating access to HIV testing and ART for women during *Iddat*, and by providing multi-month dispensing to cover the entire *Iddat* period i.e. around 5 months to ensure the full *Iddat* period is covered.

The gender assessment found that gender-specific stigma, discrimination and violence in families and society disproportionately impacts cisgender women, men who have sex with men, and transgender women, many of whom report instances of being evicted from the family home once their HIV status is discovered. Transgender women additionally reported that stigma, discrimination and hatred towards their community has increased since the passage of the passage of the Transgender Persons (Protection of Rights) Act in 2018,

- The gender assessment recommends working with community, media, parliamentarians and religious leaders to design practical approaches to reduce gender-based stigma and discrimination in family settings and in society; continuing work that UNAIDS has begun on stigma reduction, utilising the relevant tools developed by UNAIDS for that purpose; and implementing HIVST, especially for transgender populations.

Violence plays an outsized role in the lives of key populations and women in Pakistan, and severely impacts their ability to access, attend and adhere to the HIV-related services they need. High levels of domestic and intimate partner violence against women have been well documented in Pakistan, and the trend appears to be worsening. For example, the Punjab Gender Parity Report 2021 reports that: "A Survey conducted by the National Institute of Population Studies between 2017 and 2018 in which more than 4,000 Pakistani women participated, found that between the ages of 15 and 49, 28% faced physical violence and 6% faced sexual violence. Data from domestic violence helplines in Pakistan suggests that domestic violence increased significantly during Covid, with an increase of 200% between January and March 2020, and worsening during the lockdowns after March 2020." Barriers to accessing post-rape medical care or seeking justice are largely prohibitive: Rape survivors are required to file a report at specific "notified" public hospitals, making it difficult or impossible for women living in remote areas to file a report. Efforts have been made to introduce the use of rape kits for medical care of rape survivors and to collect the evidence needed for a legal case, but these efforts have been hampered by gaps in the availability of equipment needed to use the rape kits, and insufficient capacity among medical providers. Legislative protections for women and girls, and for key populations, remain weak in Pakistan.

The experience of police violence was widespread among key populations, especially in the PWID and transgender communities, and there is little legal recourse. Same-sex relations, sex work and drug use are criminalised in Pakistan. Male sex workers who participated in focus group discussions for this gender assessment reported that the most common form of police violence against their community is forcing them to provide sexual services without payment. Similarly, a 2016 study by the Aurat Foundation, found that physical torture, sexual abuse and harassment was endemic against the transgender community across Pakistan. Safe havens or shelters for people who are experiencing violence are poor quality or non-existent. The gender assessment also found that police violence impacts NGO outreach workers, and thus the quality of services they can provide.

The gender assessment did identify a number of good programming practices to address violence, including hiring transgender police officers, and the ground-breaking initiative by the Gender Interactive Alliance (GIA) to engage the services of a transgender legal specialist and utilise the power of community-friendly virtual communications to ensure real-time access to the legal specialist and prompt and effective resolution of disputes. The assessment also noted the excellent and much-needed work supported by UNFPA to educate women on their rights in cases of domestic violence, including working to capacitate midwives, Lady Health Workers, and medical doctors, in clinical management of rape survivors and provision of psycho-social support; as well as the critical work UNDP has started with the Aurat Foundation, putting together a group of lawyers who will take on transgender cases.

- The gender assessment recommends developing and scaling up interventions that address violence against women and key populations, including supporting

safe spaces for GBV survivors; conducting a targeted study on GBV in key populations and using that data to design GBV prevention interventions for key populations, referral systems to the medical and legal interventions that GBV survivors need, and/or in-house GBV expertise and capacity at public and non-governmental services; establishing a tracking system for CBOs to document incidents of police violence and harassment of outreach workers and conducting training and sensitization programming for police on non-violent interaction with key populations; and continuing the critical programming on women's legal rights and clinical management of rape survivors under UNFPA, the work of the legal specialist with GIA, and the legal services supported by UNDP.

The gender assessment explored barriers across the treatment cascade and found that they disproportionately impact cisgender women, transgender women, and key populations, especially cisgender male, cisgender female, and transgender sex workers, women who use and inject drugs, and men who have sex with men.

Stigma and discrimination in healthcare settings are recognised barriers to accessing HIV services in Pakistan, and addressing these barriers figures prominently in the national response. The gender assessment draws attention to the additional gender-specific aspects of stigma, discrimination and abuse that are prevalent in healthcare settings in Pakistan. This includes singling out of transgender women for elevated levels of harassment. Transgender women reported that medical professions asked them: "Do you do oral sex?" and informed them that "HIV is the consequence of your dirty activities." Members of the transgender community reported that they are frequently turned away from ART centers at public hospitals, and transgender women, in particular, that they were refused entry to health services for women and/or forced to attend men's services. Cisgender women living with HIV who are pregnant were especially targeted by healthcare providers. Healthcare providers at specialised PPTCT centers told these women: "Why do you want to increase HIV in this world? Your baby will also be HIV positive, you stupid people."

The gender assessment also identified good practice examples, such as the ART Centre in PIMS, where transgender women reported that: "The lady doctor there treats us with extra care and softness… She is not afraid to touch us. She listens attentively."

- To reduce gender-based stigma and discrimination in healthcare settings, the gender assessment recommends designing and delivering training and sensitization for healthcare providers on non-discriminatory delivery of health services, including medical professionals working at ART centers, and actively engage PLHIV and key populations in designing and delivering the trainings; engaging PLHIV and key populations in service delivery; and establishing a functional, discrete, confidential mechanism to lodge complaints about stigma and discrimination in healthcare settings and a mechanism to ensure prompt, effective, and independent follow-up on complaints.

The gender assessment found significant gender-specific knowledge gaps in communities, and among governmental and non-governmental service providers. Knowledge about HIV appeared to be particularly low in the transgender community, with common misperceptions such as beliefs that NGOs in Pakistan are purposely infecting people with HIV, and that HIV tests are "lying."

At ART Centers, the gender assessment identified gaps in professional expertise such

as a lack of female counsellors, and insufficient skills in areas that cisgender and transgender women especially need, such as mental health services.

- The gender assessment recommends reinforcing knowledge about HIV in communities, by using the communication tools with which community members are most familiar and feel most comfortable, especial virtual technologies and apps such as TikTok, WhatsApp, Tinder, Grinder, and Blued. At ART Centers, the gender assessment recommends provide training on pre-and post-test counselling, integrating community and peer counsellors into ART Center staff rosters, and establishing effective referral networks to include mental health services.

In the area of primary prevention, the gender assessment found that condom use was sporadic in a number of key population communities. Female sex workers, in particular, reported that condom use with clients was low because clients pay more for unprotected sex. Among male sex workers, the gender assessment found a widespread belief that getting themselves and their clients tested for HIV every 3 months, meant that they did not need to use a condom.

For most community members who contributed to the focus group discussions that inform this gender assessment, PrEP was is accessible. Female and transgender sex workers, or particular, reported that because PrEP services are located inside ART Centers in public hospitals, accessing PrEp would potentially associate them with HIV and feed the perception that they were HIV-positive, and this would have a detrimental effect on their work – making them lose clients or reducing the amount they could charge for their services. Discriminatory comments by the medical staff providing PrEP also discouraged potential clients from accessing this service.

- The gender assessment recommends reinforcing primary prevention messaging especially for sex workers and their clients, dispelling misperceptions that a negative HIV test means condom use is not necessary, and making PrEP available in community settings.

The gender assessment found that the requirement to attend facility-based ART centers in public hospitals in order to access confirmatory HIV testing, was onerous, and for some, prohibitive. Further, community members shared multiple instances in which ART Center staff failed to follow up with people who did manage to access a confirmatory test. In one case, doctors at the ART center did not follow up with a man who was diagnosed with HIV, did not inform him about treatment options, did not counsel him to bring his wife for testing, or inform him about the need to practice safe sex with his wife. As a result, his wife was infected.

- The gender assessment recommends providing confirmatory HIV testing in community settings on the same day as the two initial rapid tests, through approaches such as mobile vans or assigning a doctor to CBOs that conduct rapid tests for key populations. Other recommended approaches include offering home-based HIV-testing, including blood collection for confirmatory tests, through CBO workers and/or LHWs.

The gender assessment identified numerous gender-specific barriers to accessing and adhering HIV treatment: The physical design of ART Centers in public hospitals makes it difficult or impossible to maintain confidentiality, and women in particular, reported a lack of visual and auditory privacy in centers. In one reported

instance, for example, male and female doctors sit together in the ART Centre, and women clients felt extremely uncomfortable having a man *de facto* listening in to their consultation with the female doctor. Transgender women reported that the very public layout of waiting rooms exposes them to harassment, including being propositioned for sex while waiting to see the doctor. Common practices in public hospital departments other than the ART Center, such as prominently displaying a large sign on the hospital bed indicating the person's HIV-positive status – were also reported to put PLHIV at risk, and pregnant cisgender women living with HIV suffered from this in particular, when they attempted to access ANC services. Transgender women reported that they have difficulty even registering for services at public hospitals because hospitals provide just two lines to wait: One for cisgender men and one for cisgender women. Transgender women frequently report that they are pushed out of both lines.

- The gender assessment recommends conducting a rapid assessment of ART Centers to identify issues related to the physical layout that can compromise confidentiality, and on the basis of findings, supporting ART centers to improve discretion for people who need their services. Public health facilities can also better support transgender women to access the services they need by offering a dedicated waiting queue for transgender women.

Restricted opening hours at ART Centers are a well-documented barrier to service access in Pakistan, and the findings of this gender assessment corroborate that finding and build on it. The standard 2PM closing time at ART Centers poses an insurmountable barrier for key populations who work at night – such as male, transgender and female sex workers. Many members of the transgender community are employed as dancers for weddings and other late-night events, and are not able to attend health services that are only open during the day and close at 2PM – precisely the time when they need to sleep. For cisgender men who work outside the home, it is difficult or impossible to attend ART services, because the opening hours fall squarely during their regular working hours. Even for those with more flexible work hours, attending ART Centers causes them to lose income. In Punjab, the ART Center has imposed additional restrictions on people who inject drugs, accepting registration for PWID only one day a week – Thursdays between 8AM and 2PM, and allowing PWID to refill their ART prescriptions on Saturdays only. These restrictions are reported to significantly contribute to treatment loss to follow up among PWID who are living with HIV.

- The gender assessment recommends adjusting the hours of existing ART centers to meet the needs of the populations who need these services by extending hours and making ART available in the evenings.

The gender assessment found that the prohibitively long time lag between testing and treatment initiation is driving loss to follow up at this critical juncture. Same-day ART initiation is generally not available in Pakistan. Community members who contributed to this gender assessment, reported that they were compelled to make as many as five separate trips to ART Centers and other health facilities in order to complete the stringent requirements and numerous tests required prior to ART initiation, and some were forced to wait up to a week between confirmatory testing and initiating ART. Many simply gave up. In some cases, high fees levied for the tests required to initiate ART further raised the barrier for vulnerable PLHIV to start treatment. One community member, for example, reported that: "I did not have that

much money, so I carried on with my life, and a few years later, I tested again to give blood to my wife, who was going through childbirth, and HIV was detected again. Unfortunately, by that time, my wife also had been infected."

- The gender assessment recommends simplifying and expediting pre-ART testing requirements, and reducing or eliminating fees, in order to guarantee same-day treatment initiation following a confirmatory test.

The gender assessment found that a lack of doctors at ART Centers discourages PLHIV from attending. Issues reported include no doctors whatsoever at many ART Centers; the doctor is available only one day per week; even if the ART Center has a doctor, oftentimes ART is dispensed by a clinical psychologist – who is not qualified to address all patient questions.

- The gender assessment recommends ensuring that ART staff are appropriately staffed with doctors.

Community-based ART is increasingly available globally, and in South Asia, but in Pakistan, access to ART free of charge, is restricted to ART Centers in public facilities, and is not available in community settings. Ready access to ART in community settings is especially effective at overcoming the gender-specific barriers faced by key populations such as transgender women, cisgender women and sex workers. Some promising good practice examples were also identified, such as a mobile ART unit in Sindh and agreements in Sindh that allow NGO workers to pick up ART for stable patients and bring ART directly to patients. Sindh key informants also reported that they are planning to pilot evening HIV testing and ART delivery services in Karachi via community-based organisations.

- The gender assessment recommends providing community-based ART services by bringing qualified doctors into the CBOs and NGOs where vulnerable transgender women, cisgender men, cisgender women, and all key populations feel the most comfortable; empowering outreach workers to pick up ART refills and transfer them to stable patients; and providing mobile ART at times and locations that are most convenient for key populations.

Restrictions on multimonth dispensing and on referrals among ART Centers exacerbate gender-related barriers and contribute to loss to follow up among the most vulnerable and most affected people. Multi-month dispensing for at least two months is routinely provided to stable patients in Pakistan, but the combined requirements that the patient present in person (except for the excellent example of Sindh) and the restriction that people can only access a refill when they are down to two days of pills (again, with the exceptional performance in Sindh which allows people to access refills when they have 10 days of pills left) – makes adherence difficult. Treatment interruption and loss to follow up are also a facet of the archaic paper-based reference system among AIDS Centers, which requires PLHIV to obtain a paper reference letter from the ART Centre where they registered, in order to pick up their medication at a different location.

- The gender assessment recommends making the refill process user-friendly, by allowing PLHIV to pick up refills 10 days before they run out of pills. Relaxing the requirement for a paper-based referral letter from an ART Center, and implementing an electronic registration system to allow PLHIV to easily access ART wherever they are without the need for a reference letter.

There is no nation-wide system to track loss to follow up, and help patients who have dropped out return to treatment, and this gap especially impacts cisgender women, transgender women, cisgender men, and key populations. The gender assessment team heard frequent accounts from PLHIV of dropping out at various points along the cascade, with little or no follow-up from the public health system. Some NGOs that work with specific key populations – particularly those working with PWID, MSM and transgender women, have established their own systems to track their beneficiaries.

- The gender assessment recommends developing and implementing a peer-based system to track loss to follow up cases and support treatment adherence.

Transgender women, cisgender women, cisgender men and key populations face severe challenges accessing viral load testing in some locations. For example, in Sindh, PLHIV must travel to the laboratory, take the viral load test, obtain their results, and take a paper copy of their results to the ART clinic in person. In Punjab, conversely, at all three ART centers, the procedure is convenient: ART centers take the blood samples and send them to the laboratory, which sends the results directly to the ART doctor. The gender assessment also identified a good practice in providing NGO-led mobile viral load testing to PWID.

- The gender assessment recommends improving access to viral load testing by collecting blood samples at the sites where PLHIV are already comfortably accessing services; transporting the samples from point of collection directly to laboratories; expanding access to mobile viral load testing for all key and vulnerable populations; and establishing a system of electronic data-sharing between laboratories that conduct viral load testing and the locations or facilities where PLHIV attend HIV services.

The gender assessment found that PPTCT services are difficult to access and PPTCT coverage in Pakistan is at crisis levels. According to UNAIDS, in 2022, only 347 pregnant women living with HIV received ART for PPTCT, constituting just 12.4% coverage. The gender assessment documented a number of barriers to PPTCT: PPTCT Centers in Pakistan do not dispense ART. This means that pregnant women living with HIV cannot obtain ART at the PPTCT sites, but must instead go to an ART site. PPTCT centers are not always co-located with ART centers. Further, while ART Centers are charged with dispensing ART for PPTCT, key informants reported that only some ART centers, not all, will provide ART for PPTCT. Absence of post-test counselling at ART Centers, including a failure to discuss pregnancy and PPTCT with women of reproductive age, means that most women living with HIV become pregnant without the benefit of appropriate ANC and PPTCT.

Additionally, pregnant women face stigma and discrimination from gynaecologists, including from gynaecologists working in the PPTCT centers designated for women living with HIV. In FGDs conducted for this gender assessment, WLHIV reported multiple instances of severe stigma and discrimination during pregnancy, from healthcare providers. For example, a community member reported that: "A big signboard was placed near my bedside, 'HIV Patient'. Doctors did not touch me. They would talk to me from a two feet distance; they kept the curtains around me closed all the time as if not to pollute the air in the general ward." Even at specialised PPTCT services, women reported harassment from medical staff. At one PPTCT center, the doctor told a WLHIV: "You are HIV-positive. Your husband is HIV-positive. Why are you bringing more HIV into this world?" Focus group discussion participants reported that

some pregnant women living with HIV had been denied access to ANC services due to their HIV status – physically denied entrance to the ANC ward. As a result, some women living with HIV have been obliged to go to the hospital to give birth, request a C-section, and not reveal their HIV status.

Uneven access to Early Infant Diagnosis and paediatric care and poor coordination between PPTCT and ART services were widely reported. Key informants reported that EID is not provided at PPTCT sites, but is provided at ART Centers only.

A number of provinces reported that they have taken proactive measures to address stigma and discrimination in PPTCT services. Khyber Pakhtunkhwa AIDS Control Program has run a training on PPTCT specifically for those gynaecologists who refused to work with women living with HIV. The Punjab Provincial AIDS Control Program has run trainings with gynaecologists to encourage testing for HIV in the first trimester, and also trainings at PPTCT centers on safe delivery and on early infant diagnosis and paediatric treatment. Sindh reported that they are utilising female "mobilizers" and conducting outreach to men, in order to increase knowledge and generate support for women to attend ANC services, including PPTCT. Key informants in Sindh also reported that efforts are also being made to make all ART centers also PPTCT centers, by training ART doctors in PPTCT. In rural and tribal areas, such as those in Balochistan and Khyber Pakhtunkhwa, key informants recommended that LHW and community mid-wives (based in clinics) be engaged in HIV testing for pregnant women and facilitating access to PPTCT.

- The gender assessment recommends fully integrating PPTCT into regular ANC services, and discontinuing the practice of segregating services for pregnant women living with HIV in separate clinics or wards. In rural and tribal areas, the gender assessment recommends providing HIV testing for pregnant women via mobile units or via LHWs; and the gender assessment recommends providing access to self-testing kits for all pregnant women. The gender assessment recommends deploying female "mobilizers" and conducting outreach to men, in order to increase knowledge and generate support for women to attend ANC services, including PPTCT their first trimester; and offering HIV testing as part of routine antenatal care at a pregnant woman's first visit. The gender assessment also recommends building the capacity of ART doctors to provide EID and paediatric care in PPTCT units, and to convey accurate information about PPTCT including about breastfeeding (to combat misperceptions and misinformation).

Key informants interviewed for this gender assessment noted a lack of female role models and leadership in the national response. This gender assessment team's experience aligns with this observation: The team that conducted Pakistan's National Programme Review (NPR) in 2023 was composed of nine men and had no gender expert; findings from this gender assessment were not integrated into any national policy processes, including the NPR and the Global Fund Funding Requests.

- The gender assessment recommends fostering female leadership in Pakistan's response to HIV, including by increasing WLHIV's representation in leadership and decision-making forums, providing leadership capacity-building opportunities for WLHIV, and instituting a mentoring program through community organisations and networks such as the Positive Female Network (POFEN).

Introduction

The HIV epidemic in Pakistan displays clear gender dimensions: Men are markedly more impacted than women. Of the estimated 260,000 adults (aged 15 and older) living with HIV in 2022, 81% (210,000) are men and 19% (49,000) are women.[1] The majority of men living with HIV belong to a key population. According to AEM 2022 estimates, 48.5% (126,119) of the PLHIV in Pakistan belong to a key population.[2] Of those, 112,590 are male, 6,504 are female, and 7,027 are transgender women.[3] This means that 54% of men living with HIV come from key population communities, while just 13% of women living with HIV are members of a key population, and 3.3% of the estimated "male population" is transgender women. (UNAIDS data is sex-disaggregated male/female only, therefore it was not possible to distinguish transgender women in the gender breakdown of data). Pakistan's four Provincial AIDS Strategies and the National AIDS Strategy 2021 – 2025 all focus on key populations and their intimate partners, and utilise Spectrum modelling data to show that key populations and their intimate partners account for virtually all people living with HIV (PLHIV) in the country. Punjab AIDS Strategy data, for example, shows that 48% of the 89,025 adult PLHIV (15-49 years) in the province belong to a key population, and 52% are intimate partners of key populations.

Key Population size estimates and HIV prevalence 2023

KP	2023		Gender assumption	Number of PLHIV	Male and female KP
	KP PSE	Prevalence			
MSM	856,466	6.8%	male	58,240	M: 112,590
MSW	75,240[a]	21.8%	male	16,402	
PWID[b]	112,437	37.5%	90% male	M:37,948	
			10% female [c]	F:4,216[d]	F: 6,504
FSW	190,629	1.2%	female	2,288	
TG/SW	61,623	11.4%	Transgender women	7,025	TG: 7,025

Sources: KP PSE and prevalence from HIV estimates AEM 2022 cited in Pakistan Global Fund Funding Request Window 1 2023. Number of PLHIV and male/female breakdown calculations are based on that data
[a]ssumes that MSW PSE is distinct from MSM PSE
[b]there is no data for TG PWID, so this group is not distinguished in this analysis

1 https://www.unaids.org/en/regionscountries/countries/pakistan. As much as possible, data in this gender assessment has been taken from official website, such as that of UNAIDS and also Pakistan's Funding Request to the Global Fund. The HIV data was found to be highly variable, with widely different figures sited on the UNAIDS website, in the National Program Review Report, in various cited publications, and in Pakistan's Funding Request to the Global Fund.

2 In the Global Fund Funding Request (Window 1), the data presented in the KP PSE and prevalence table for KP-PLHIV is 141,648 (54.5% of the total estimates number of PLHIV), however, this is not aligned with the calculations for PLHIV for each KP, presented in the same table in the Funding Request. The total number of KP-PLHIV presented in this gender assessment is calculated on the basis of the individual KP data provided in the Window 1 Funding Request.

3 This gender assessment uses the term "transgender women" throughout. This community variously refers to itself as Hijra, Khawaja Sira, and Murat. The gender assessment team selected the term "transgender women" to clarify that this is a community of people who were assigned male gender at birth, but identify as female gender. The gender assessment team recognises that many in this community identify as "third gender," but decided to maintain the term "transgender women" to sustain clarity in the English rendition of the community's identity. This gender assessment did not identify or interview anyone who was assigned female gender at birth, but identifies as male gender.

[c]data on the percentage of PWID who are women is not available; the analysis here has assumed that 10% of PWID are women.
[d] Assumes that HIV infection rates for women who inject drugs (WWID) are the same as for men who inject drugs (MWID). Global data shows that infection rates are significantly higher among WWID than among MWID, however, since gender-disaggregated PSE and prevalence data for PWID in Pakistan is not available, the assumption has been made that prevalence is the same. For this reason, the total number of PWID-PLHIV is likely underestimated in this table.

Women in Pakistan experience multiple serious gender-related vulnerabilities and barriers: Pakistan ranks 145 out of 146 countries on the Global Gender Gap Index,[4] 108 out of 113 on the Women's Economic Opportunity Index, and 100 out of 100 on the Female Opportunity Index.[5] Pakistan's 2023 window 1 Funding Request notes that "violence against women, girls and transgender women, including rape, murder, acid attacks, domestic violence, and forced marriage, are endemic in Pakistan." The Funding Request also reports that child marriage remains an issue in Pakistan, with an estimated 18% of girls married before the age of 18 years, including 4% before their the age of 15.[6]

Approach

Purpose

The purpose of this gender assessment is to identify gender-specific vulnerabilities, needs and barriers to services, and assess program effectiveness at addressing gender, including the use of existing resources. The gender assessment aims to generate practical and feasible recommendations designed to foster real-world solutions to address those gender barriers and to strengthen the national HIV response in Pakistan.

Methodology

This gender assessment is based on a document review, in-depth interviews (IDIs) with key informants, and focus group discussions (FGDs) with members of key populations.

Documents for review were provided by the two Primary Recipients (PR). Documents were also provided over the course of interviews with key informants. The consultants also collected relevant documents themselves. A list of documents consulted can be found in Annex 1.

The methodology for the gender assessment, including all tools, was laid out in an Inception Report, which was submitted to UNDP, and subsequently revised on the basis of comments received, finalised, and approved by UNDP. The tools developed guided the key informant interviews and the FGDs with key populations. One interview guide was developed for the key informant interviews, and can be found in Annex 2. Nine tools were developed for the FGDs, tailored to specific key populations. The FGD guides were developed in English and the national consultant translated the guides into the local language. The list of tailored guides is provided below, and the nine FGD guides can be found in Annex 3.

4 World Economic Forum, Global Gender Gap Report: Insight report July 2022, World Economic Forum: Switzerland p. 374.

5 Data reported in the National Gender Policy Framework, Ministry of Planning, Development and Special Initiatives, Government of Pakistan. March 2022. p. 10.

6 Human Rights Watch. Human Rights Watch: Pakistan Events of 2021.2023; Available from https://www.hrw.org/world-report/2022/country-chapters/pakistan

Tailored FGD Tools	
1	Women Living with HIV
2	Men Living with HIV
3	Women who use drugs
4	Men who use drugs
5	Men who have sex with men
6	Female and transgender sex workers
7	Male and transgender sex workers
8	Transgender and gender non-conforming people
9	Spouses and female sexual partners of men living with HIV, of men who use drugs and/or of men who have sex with men

The list of key informants to be interviewed was provided by UNDP, and the list of key informants who were interviewed can be found in Annex 4. UNDP provided email introductions to key informants, and interviews were conducted virtually. A total of 20 key informants participated in interviews.

A team of two consultants – one international and one national – conducted this gender assessment. The international consultant worked remotely. She conducted the desk review, developed the tools, wrote the inception report, organised and conducted the key informant interviews, supervised the national consultant, and wrote the gender assessment report. The national consultant reviewed and provided inputs on the tools, arranged the focus group discussions, conducted the focus group discussions and also two in-person key informant interviews, wrote reports on all FGDs and the two in-depth interviews (IDIs) she conducted, and revised those reports based on feedback and discussion with the international consultant.

The FGDs carried out by the national consultant took place in Islamabad, Rawalpindi, Lahore and Karachi. PR UNDP and its SRs, and PR Nai Zindagi supported the national consultant to organise the FGDs. The national consultant compiled the findings from each FGD in a template designed for that purpose, and shared the completed template with the international consultant for review and discussion. The FGD reporting template can be found in Annex 5. To respect confidentiality for FGD participants, the FGD reports were shared only between the national and international consultant. In this gender assessment report, names and any information that could be used to identify the FGD participant, including the geographic location of individual FGDs and the names of the hospitals they discussed, have been anonymised. The gender assessment team believes these steps are critical to honour the anonymity promised to FGD participants.

A total of 17 FGDs took place and a total of 113 members of key population communities participated.

Focus Group Discussions			
#	**Population**	**Location**	**Number of participants**
1	Men who use drugs	Rawalpindi	6
2	Women living with HIV	Islamabad	4
3	Transgender women	Islamabad	8
4	Transgender women	Lahore	8
5	Female sex workers	Lahore	6
6	Men who have sex with me	Lahore	8
7	Male and transgender sex workers	Islamabad	7
8	Men who have sex with men / male sex workers	Islamabad	9
9	Female sex workers	Karachi	9
10	Women living with HIV	Karachi	5
11	Men living with HIV	Karachi	7
12	Women living with HIV	Lahore	5
13	Men living with HIV	Lahore	6
14	Men who use drugs	Karachi	5
15	Men who use drugs plus one woman who uses drugs – separate interview	Lahore	5
16	Transgender women	Karachi	9
17	Men living with HIV	Islamabad	6
TOTAL			113

Although no FGD was held for the spouses of key populations or men living with HIV, the FDGs did include spouses of key populations, as shown in the table below.

Key Population	Total # of FGD participants	# of FGD participants reporting they are or were married[a]	Spouses
FSW	15	12	12 female KP reporting they have a male spouse
MLHIV	19	17	17 MLHIV reporting they have a female spouse, one reported he got infected from his wife, others were KP or migrant workers
MSM / MSW	24	5	13 male KP reporting they have a female spouse
MWID	16	8	
WLHIV	14	12	12 non-KP WLHIV[b] reporting they are/were married and 11 of those reported that they got infected from their husband
TG	25	0	none

[a]Includes participants who are widowed or divorced. (All widowed and divorced participants were cisgender women).
[b]Of the WLHIV, two reported that they are married to a MLHIV, but they themselves are HIV-negative.

A total of twelve cisgender women who are or were married to a man from a key population or a man living with HIV, participated in the FGDs. Additionally, 17 of the MLHIV FGD participants reported that they are married, as did 5 of the MSM/MSW FGD participants and 8 of the MWID participants. None of the transgender FGD participants reported being married.

The methodology for this gender assessment puts women and men living with HIV, and key populations, front and center. The approach adopted here aims to elevate the voices of those most affected by the epidemic, in other words, to make them heard. For this reason, direct quotes from the men, women and transgender women who participated in the focus group discussions feature prominently across the findings. The gender assessment team's opinion, key and vulnerable populations are best equipped to speak for themselves.

Limitations

From the outset, the primary goal of this gender assessment was to support and strengthen the response to HIV in Pakistan. In particular, the gender assessment aimed to address the multiple and stubbornly persistent gender issues that have plagued the response to HIV in Pakistan for decades. To that end, the gender assessment team was tasked with working in close partnership with a team of consultants who were undertaking a National HIV Programme Review (NPR) from December 2022 through March 2023. The NPR was designed to serve as the foundation of Pakistan's response to HIV and to inform Pakistan's 2023 funding request to the Global Fund. Despite consistent efforts by the Gender Assessment team, there was no coordination with the NPR team. As a result, the data and approaches utilised by the two teams, could not be aligned.

Findings

Finding 1: Gendered gaps in the HIV data

With the exception of sex workers, gender-disaggregated data for key populations was generally not available. However, 2021 from a needs assessment of women who inject drugs in Pakistan, with a sample size of 55, found a 36% prevalence rate in this population.[7]

Critical gender disaggregated data, including across the treatment cascade was not available for this gender assessment: Based on the data available for this gender assessment, **it was not possible to determine the gender breakdown for HIV incidence.** Pakistan's Funding Request to the Global Fund (window 1) states that, according to UNAIDS estimates, there were 31,000 new HIV infections in Pakistan in 2022; although the window 1 Funding Request does not provide gender-disaggregated data on new infections, it does state that: "There is also an increasing number of women being infected…." This statement appears to suggest that the number of new HIV infections may be increasing faster among women than among men, however, as no data or source was provided, it was not possible to determine whether this statement is data-driven, or anecdotal.

Age disaggregated HIV data for key populations was also not available for this gender assessment. Disaggregated data by gender and sex is especially useful for key populations, and UNAIDS has noted that in all settings, young women within key populations are at particularly high risk.[8] Age disaggregated HIV incidence data for female sex workers in Pakistan would be especially interesting and important, as UNAIDS reports that in many settings, HIV incidence rates are highest among young women selling sex.[9]

Across the treatment cascade, the gender-disaggregated data available for this gender assessment was spotty. With the data available, **it was not possible to determine gender differences is HIV testing rates.** Citing an HIV Epidemiological Review 2023 – which was not available for review for this gender assessment – the TRP review form for 2023 Pakistan's UNAIDS testing data is available for some key populations, and shows 48% testing coverage among FSW, 53% among MSM and 39% among PWID,[10] (gender-disaggregated data for PWID was not available for this gender review).

Sex-disaggregated data is available for treatment, showing that access to treatment is low for both women and men living with HIV in Pakistan, but men's access is worse than women's: Just 11%

7 Nai Zindagi Trust, Needs Assessment Study with Female Injecting Drug Users. September 2021.

8 UNAIDS, Decision-making aide for investments into HIV prevention programmes among adolescent girls and young women Version for use in 2023 planning processes. April 2023. Available at https://hivpreventioncoalition.unaids.org/wp-content/uploads/2020/06/Decision-making-aide-AGYW-investment-Version-March-2020-Final.pdf

9 UNAIDS, Decision-making aide for investments into HIV prevention programmes among adolescent girls and young women Version for use in 2023 planning processes. April 2023. Available at https://hivpreventioncoalition.unaids.org/wp-content/uploads/2020/06/Decision-making-aide-AGYW-investment-Version-March-2020-Final.pdf

10 https://www.unaids.org/en/regionscountries/countries/pakistan. Data on HIV testing coverage varies widely across sources. For example, Pakistan's Funding Request to the Global Fund (2023 window 1) states that "the overall, number of KP tested is low with an estimated coverage of 12- 14% per year of PWID, MSW and TG, and between 1 and 3% for MSM and FSW."

of the total estimated number of men living with HIV were on treatment in 2022, compared with 17% of the total estimated number of women living with HIV.[11]

Accurate data on viral load suppression is difficult to come by, with various sources reporting widely different levels and **gender-disaggregated data for viral load suppression was not available for this gender assessment.** Citing the above-mentioned HIV Epidemiological Review 2023, the TRP review form for 2023 Pakistan's Window 1 submission states that only 6% of people on ART in Pakistan are virally suppressed; Pakistan's National Program Review 2023 provides the same figure; however, in Annexes, the NPR shows that in 2022 there were 34,386 PLHIV on treatment, of whom 11,796 (34.3%) were virally supressed. The UNAIDS website shows that in 2022, there were 4,119 virally suppressed PLHIV in Pakistan, out of a total 5,981 PLHIV who received a viral load test; in other words, this data shows that 69% of those PLHIV who took a VL test in 2022 were virally suppressed. [UNAIDS data shows 34,386 PLHIV on treatment in 2022. Even if all those PLHIV who did not access VL testing were not virally suppressed (a highly unlikely scenario), VL suppression would still stand at 12% (4,119 / 34,386); thus, it is difficult to understand the data for the third 95, i.e. 6%, presented in the TRP form].

Sex-disaggregated data for death rates among PLHIV in Pakistan was available for this gender-assessment. That data shows that men living with HIV are more likely to die of AIDS than their female counterparts: UNAIDS 2022 data show a 3.5% death rate among women (1,700 deaths), against a 4.5 % death rate among men (9,500 deaths).[12] This suggests that women may be achieving VL suppression at higher rates than men.

This data is somewhat surprising, given that the available data on HIV knowledge shows that in Pakistan, women's knowledge of HIV is significantly weaker than men's: Only 32% of women compared with 67% of men have heard of HIV/AIDS; and the quality HIV knowledge among women is weaker than among men: Just 4% of women have comprehensive knowledge, compared to 10% of men.[13]

Recommendation 1: Improve and update data on gender and key populations

Conduct IBBS and PSE for key populations, ensuring the gender-disaggregated and gender-specific data is collected. In cases where collection of gender-disaggregated data within key populations may be methodological challenging – such as when using RDS in key populations, utilise program data, survey data, MIS, or qualitative studies to identify gender-differentiated experiences in HIV.

11 https://www.unaids.org/en/regionscountries/countries/pakistan

12 https://www.unaids.org/en/regionscountries/countries/pakistan

13 Pakistan Demographic & Heath Survey (PDHS) 2017-18

Finding 2: Gender Gaps in the National Response: an analysis of Provincial and National AIDS Strategies 2021 - 2025

Findings

A gender analysis of Provincial and National AIDS Strategies was undertaken. The key gender variables considered in the analysis were drawn from the Global Fund's Technical Brief on Gender Equality Allocation Period 2023 – 2025 (especially pp. 10-12),[14] the TRP Observations Report for 2020-2022,[15] the TRP Lessons Learned Report for 2020-2022[16], and Technical Review Panel's observations and recommendations on Window 1 funding applications: Part I.[17]

Some of the critical gender issues that were raised across these resources include:

- the availability and use of disaggregated data, especially by population (key and vulnerable), by sex, by gender, and by age. (TRP observations report for 2020-2022 pg. 4, and the Technical Review Panel's observations and recommendations on Window 1 funding applications: Part I);
- the importance of including gender-sensitive programming for women who use drugs, men who sell sex, female prisoners, feminine/masculine-presenting men who have sex with men, transgender, non-binary and gender non-conforming people, and others, as relevant to the country context. (TRP lessons learned report for 2020-2022 pg. 15)
- prioritizing funding for interventions to address gender-based violence against women, trans and queer people, or other forms of violence. (TRP lessons learned report for 2020-2022 pg. 33).

The table below summarises the results of the gender analysis of the Provincial and National AIDS Strategies 2021 – 2025. Rows highlighted in green indicate gender issues that are well-addressed in the AIDS Strategies. Rows highlighted in yellow correspond to gender issues that are somewhat addressed in the AIDS Strategies. Rows that are not highlighted are gender issues that are not addressed in the AIDS Strategies.

In terms of approach to gender, the analysis found no significant differences among the four provincial AIDS strategies. The structure, analysis and strategic approaches in the provincial AIDS strategies were all very similar, and each provincial strategy referred to, and drew heavily on, the National AIDS Strategy.

14 https://www.theglobalfund.org/media/5728/core_gender_infonote_en.pdf

15 https://www.theglobalfund.org/media/12137/trp_2020-2022observations_report_en.pdf

16 https://www.theglobalfund.org/media/10771/trp_2020-lessonslearned_report_en.pdf

17 https://aidspan.org/?action=catelog_singlepost&id=26641

Gender Analysis of Provincial and National AIDS Strategies 2021 - 2025					
Gender Issue Areas	**Punjab**	**Sindh**	**Balochistan**	**KP**	**National**
Gender and Data					
Gender-disaggregated HIV data is presented and used to develop targeted interventions	no	no	no	no	no
The partners of KP are identified as a vulnerable population	yes	yes	yes	yes	yes
Gender-Specific Vulnerabilities and Barriers					
The Strategy discusses gender-related differences, norms, barriers and inequalities and proposes interventions to address harmful gender norms and support social norm change, such as interventions to increase women's and girls' empowerment and agency, and increase equality within relationships.	no	no	no	no	no
Recognises the age-specific vulnerability of young sex workers	yes	yes	yes	yes	yes
Recognises the existence of gender-specific stigma and discrimination in HIV and proposes ways to address gender discrimination	no	no	no	no	no
Recognises the impact of GBV on the vulnerability of women and girls and gender-diverse communities and proposes interventions to address this, such as GBV prevention activities and access to legal services and health services for survivors of gender-based violence including the provision of Post-exposure Prophylaxis (PEP)	no	no	no	no	no
Recognises harmful laws and policies, including criminalisation and proposes interventions to address them, such as actions to change discriminatory and punitive laws on same-sex activity, sex work, drug use, HIV transmission, abortion and create enabling legal and policy frameworks; and Legal literacy and "know your rights" programs that increase understanding of gender equality and the rights of women, girls, trans and gender-diverse communities	no	no	no	no	no
Identifies gender-specific barriers to accessing health services	no	no	no	no	no

Gender Analysis of Provincial and National AIDS Strategies 2021 - 2025					
Gender Issue Areas	**Punjab**	**Sindh**	**Balochistan**	**KP**	**National**
Gender and Service Provision					
Envisions gender-aware / sensitive SOPs	no	no	no	no	no
Capacity building to strengthen understanding of gender-specific vulnerabilities and needs among service providers, for gender-responsive service provision	no	no	no	no	no
Plans for gender-sensitive service provision	no	no	no	no	no
Includes gender-sensitive programming for women who use drugs, men who sell sex, female prisoners, feminine/masculine-presenting men who have sex with men, transgender, non-binary and gender non-conforming people	no	no	no	no	no
Increase linkages to sexual and reproductive health services	PPTCT, STI	PPTCT, STI	PPTCT, STI	PPTCT, STI	PPTCT, STI
Plans for gender-sensitive outreach	no	no	no	no	no
Prioritizes interventions to address gender-based violence against women, trans and queer people, or other forms of violence	no	no	no	no	no
PrEP	yes	yes	yes	yes	yes
Community-based or home-based HTS services	yes	yes	yes	yes	yes
Includes HIVST	Yes for MSM	Yes for MSM	Yes for MSM	Yes for MSM	Yes for MSM
Includes community-based ART treatment (to reach women, girls, transgender women, and key and vulnerable populations)	no	no	no	no	no

Discussion

All the AIDS Strategies draw attention to a number of important gender-specific vulnerabilities, and also lay out approaches to the HIV response that can address some of those vulnerabilities:

First, and most notably, all the AIDS strategies present data showing that intimate partners of key populations account for close to half of all PLHIV, identify intimate partners of key populations as a vulnerable population, make a strong case that reaching intimate partners with HIV services is critical to the fight against HIV in Pakistan. Reaching intimate partners (majority female) of HIV-positive key populations (majority male) has gender implications, and requires a gender-informed approach in order to be successful.

Second, in line with global findings and UNAIDS' analysis, Pakistan's AIDS strategies recognise the age-specific vulnerability of young sex workers, and the need for age-specific approaches to reaching this population.

Third, the AIDS strategies set forth several approaches that can, or have the potential to, address gender-specific vulnerabilities. These approaches include community-based or home-based HTS services – both of which are excellent evidence-based approaches to overcoming stigma and discrimination barriers, including those that are gender-specific. Home-based HIV testing is particularly effective at reaching women in rural areas who may face gender-defined barriers to leaving the house to access services. PrEP is also integral to the AIDS Strategies, including for sero-discordent couples – in particular, for the spouses of KP-PLHIV, although the strategies acknowledge that this intervention has yet to be implemented. The AIDS strategies also emphasize the importance of STI screening and treatment, and referral to PPTCT services as needed; access to family planning – a critical component of reproductive health – is mentioned, although the AIDS Strategies lack a discussion of referral mechanisms in this instance. Finally, AIDS Strategies introduce HIVST – an approach that can effectively address gendered barriers to service access – however, this service is envisioned only for men who have sex with men.

A number of notable gender gaps present themselves in the tabular analysis above: Very little gender-disaggregated data is presented, and no data-driven gender-responsive interventions are proposed. No gender-differentiated, norms, barriers and inequalities are discussed. None of the AIDS Strategies recognises the issue of violence, including gender-based violence, no data on violence is presented, GBV prevention is not mentioned and linkage to care – including both medical and legal support – for GBV survivors is not included in any of the AIDS Strategies. While the challenges posed by stigma and discrimination, especially in healthcare settings, figure prominently in the AIDS Strategies, there is no recognition of gender-specific stigma and discrimination, nor are there any strategies to address it. Capacity building of service providers is an important component of all the AIDS Strategies, but gender awareness and capacity are not part of envisioned capacity building work. Harmful laws and policies, including criminalisation, and the gender-differentiated impacts they have, are not discussed in any of the AIDS Strategies – except to note that prisons are a good entry point to reach key populations because people from these communities are often incarcerated.

Recommendation 2: Strengthen country ownership of gender-responsive and gender-transformative responses to HIV

Engage needed technical support, and/or national resources such as provincial government Women Development Departments, to update the national and provincial AIDS strategies, and ensure that they identify and address gender-specific vulnerabilities, needs and barriers utilizing evidence-based approaches.

Finding 3: Critical gender gaps in programmatic reach undermine the response to HIV in Pakistan

Finding 3.1: In many cases, the spouses of key populations are not reached

The spouses of key populations constitute approximately half of all PLHIV in Pakistan, and, according to the Pakistan AIDS Strategy,[18] the vast majority of these spouses are cisgender women who are married to men who have sex with men. The national and provincial AIDS strategies all cite findings based on the Asian Epidemic Model (AEM) that "programmes for KPs should expand efforts and research to prevent transmission to the intimate partners of current and former KP members, including clients."[19] The need to reach spouses is strongly emphasized throughout the national and provincial AIDS Strategies for 2021 - 2025, but the gender-specific barriers to reaching female spouses are not acknowledged, explored, theorised or enumerated, the mechanisms to reach spouses are not clearly laid out, and there are no operational programs effectively reaching the wives of MSM, transgender women, migrant male workers, or any other key populations, with the notable exception of people who use or inject drugs. The Pakistan AIDS Strategy 2021- 2025 specifically draws attention to this gap, stating that the "intimate partners, spouses and family members of key populations are not being reached by the programme and linked to testing and treatment services."[20]

Policymakers and most service providers interviewed for this gender assessment reported that it is difficult or outright "impossible" to reach the female spouses of key populations and MLHIV, especially the female spouses of MSM and female-identifying transgender populations. In interviews with key informants who work with these communities, service providers reported that, in their expert opinions, approximately 30% of the transgender women with whom they work are married to a cisgender woman, and over half of MSM are married to a cisgender woman. The gender assessment team heard reports that in the MSM and transgender communities, marriages to cisgender women are hidden, discussion of marriage between a MSM or a transgender women and a cisgender woman is considered taboo, and service provider access to female spouses is virtually non-existent. Even asking the question can reportedly result in MSM or transgender women opting out of services altogether. Key informants reported that the married transgender women with whom they work

18 The Pakistan AIDS Strategy IV 2021 – 2025, states: "For other key populations, especially MSM, where the bulk of key population female spouses are to be found, the viability of different methods of partner notification in the Pakistan context is not yet known." (p. 28) The statement is reproduced in each of the Provincial AIDS Strategies.

19 Evolving HIV epidemics: the urgent need to refocus on populations with risk by Tim Brown and Wiwat Peerapatanapokin – Current Opinion on HIV and AIDS, 2019

20 Pakistan AIDS Strategy IV 2021 – 2025, p. 16.

do not use condoms in their marriages. For this gender assessment, just 20% of the MSM/MSW who participated in FGDs reported being married, and not one of the 25 transgender women reported ever being married.

In the case of PWID/PWUD, however, Nai Zindagi's program successfully reaches the spouses of men who inject drugs (MWID) with home-based assisted partner notification, home-based testing, ongoing social support, prevention information and condoms, and on-going adherence support for HIV-positive MWID and their families. Nai Zindagi data shows 8.5% HIV prevalence among the spouses of HIV-positive MWID.[21] To access spouses, Nai Zindagi sensitizes and works with the mothers of MWID who live in multi-generational homes, and supports the spouses of MWID to attend HIV services by providing transportation to and from services by vehicle, connecting spouses with a female outreach worker who accompanies them to ART Centers and any other related services they may need, including to PPTCT Centers for HIV-positive spouses who are or who become pregnant, and sending text message reminders to support them to attend appointments.

Nai Zindagi reports that the most critical element of their support, and the primary reason their support for spouses and MWID has been so successful, is the living support package (LSP)[22] that Nai Zindagi provides directly to the spouses of HIV-positive MWID. Reports from FGDs with MWID conducted for this gender assessment corroborate this finding. The LSP approach has been especially successful at linking HIV-positive MWID and their spouses to HIV care and treatment and supporting adherence to treatment. Indeed, Naizindagi reports that HIV-positive MWID whose spouses have receive the LSP, are more likely to access and adhere to treatment than HIV-positive MWID whose spouses have not been accessed with this service. According to Naizindagi, 80% of the HIV-positive MWID whose spouses have also been accessed with services, are successfully linked to treatment; and ART adherence between 2012 and 2018 among this cohort was 96%[23].

The benefits to women of home-based healthcare outreach are well-known and were also noted in Pakistan's 2023 NSP (March draft version), which noted in its desk review section that: "Outcomes for women were found to be better when community peers are used to deliver door-to-door and group-based approaches at PHC level and the integration of financial vouchers for poorer population groups, according to Rizvi Jafree, et al."[24]

Key informants from the international, governmental, and non-governmental organisations that were interviewed for this gender assessment, recommended building on the successful example provided by Nai Zindagi's program, to integrate spousal outreach programs into current interventions with key populations.

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21 Jenny Iversen et.al., HIV incidence and associated risk factors, Harm Reduction Journal *(2021) 18:51* https://doi.org/10.1186/s12954-021-00497-1

22 LSP is provided quarterly, and consists of: 3 KG Dal Mung-Lentil; 3 KG Dal Masur- Lentil; 3 KG Dal chana- Lentil; 2 KG White Sugar; 3 KG Basmati Rice; 5 KG cooking oil; 20 KG Fine Flour; 1 KG Washing Soap (4*4); 6 packs of Bath Soap (1*6).

23 Malik M, Jamil MS, Johnson CC, et al. Integrating assisted partner notification within HIV prevention service package for people who inject drugs in Pakistan. J Int AIDS Soc. 2019 Jul;22 Suppl 3(Suppl Suppl 3):e25317. https://doi.org/10.1002/jia2.25317, as cited in the Pakistan National Program Review Draft Report March 2023.

24 Rizvi Jafree S, Mahmood QK, Mujahid S, et al. Narrative synthesis systematic review of Pakistani women's health outcomes from primary care interventions. BMJ Open. 2022 Aug 1;12(8):e061644. doi: 10.1136/bmjopen-2022-061644

Reaching the female spouses of men who inject drugs

X got married to a drug user. It was an arranged marriage. She met her husband after the wedding. She noticed that from day one, her husband was taking a pill regularly. She was so scared of him that she did not dare to ask him about the medicine he took. In YEAR X, her husband was tested by Nai Zindagi outreach workers, and their female worker came home to test the patient's wife. X then realized that her husband was taking ARV. She and her husband were registered with the ART Center. Her husband passed away. X was very hurt that before and after marriage, her husband and his family hid his HIV status from her. Not only that, her husband did not use a condom, even though he knew about this precaution, and as a result, she became HIV infected.

WLHIV, FGD

Family Counselling Alleviates Stigma

X's husband used to be a drug user, but now he stopped using drugs after spending two months in Nai Zindagi's Rehabilitation Centre in City X. He was diagnosed by Nai Zindagi outreach workers, and his wife was then tested by a female outreach worker. X was living with an extended family of her in-laws. When the family found out they had HIV, she and her husband were put into confinement in one room of the home. Their children were forbidden to come to that room, and their utensils were separated. This situation continued for three months. Finally, X discussed the problem with the Nai Zindagi outreach worker. The outreach worker counselled the family, which improved the living situation for X and her husband.

WLHIV, FGD

Recommendation 3.1: Develop and implement programs that reach the spouses of MLHIV and key populations

Utilise the successful spousal outreach program for PWID in Pakistan, to build spousal outreach programs for other key populations and integrate spousal outreach into the existing interventions for key populations. Include the key elements of the successful PWID spousal outreach program: counselling family members especially mothers-in-law, providing a Living Support Package to spouses, home-based assisted partner notification, home-based testing and counselling, ongoing psycho-social support, prevention information and condoms, connecting HIV-positive spouses with female outreach workers who accompany them to AIDS Centers, PPTCT and any other related services, and on-going treatment adherence support.

Finding 3.2: Programmatic gender gaps: Missing key populations

3.2.1 Women who use and inject drugs

Globally, women who inject drugs have gender-specific vulnerabilities and tend to have significantly higher HIV infection rates than their male counterparts, as well as significantly higher rates of mother-to-child transmission of HIV, compared to HIV-positive women who do not use drugs. Over the past decade, there have been repeated efforts on the part of Nai Zindagi and of UNODC to establish gender-responsive HIV prevention programming in order to better reach women who use and inject drugs. To date, however, that programming remains severely under-developed.

Data on women who use and inject drugs in Pakistan is limited. According to 2018 data cited in a recent study of women who inject drugs in Pakistan, 22% of people who use drugs in Pakistan are women, amounting to a total of 1,672,000 women who use drugs in Pakistan.[25] In 2021, Nai Zindagi conducted a study on women who inject drugs, in which 54 women drug users were interviewed.[26] That study found that 36% of the women who knew their status were HIV-positive, and that 32% of the women drug users who were HIV-positive, had accessed ART; 93% of the women were interested in attending drug treatment services, but only 7% accessed detoxification services from government or other private hospitals; 94% of respondents reported that they do not use a condom despite the fact that 43% of respondents reported that they were receiving NGO-based condom services; 100% of respondents reported that there is no safe space for women to rest. The study reported that majority of drug services available in Pakistan are focused on the needs of male drug users and do not adequately address the physical and mental health needs, as well as family issues, of female clients.

Indeed, women who use and inject drugs in Pakistan have few options for accessing services, and therefore remain hidden. The drug treatment centers run by Nai Zindagi are for men only, and Nai Zindagi reports that it lacks funding to establish a drug treatment center for women.

Although the number of women who inject drugs in Pakistan are not known, interviewed key informants who work with sex workers, reported that in the last two to three years, there has been a noticeable increase in the numbers of street-based sex workers, as well as an increase in drug use, including injecting drug use, in this population.

3.2.2 Female prisoners

Over the past decade, UNODC has run a number of trainings, and developed a number of capacity building resources, designed to introduce HIV services for women in closed settings. Information collected for this gender assessment indicated that, while there are a number of female prisons in Pakistan, very few of them provide any HIV services. For example, key informants from Punjab reported that there are a total of 43 prisons in the province, of which 5 are for women – but none of those prisons provide HIV services. Nai Zindagi reports that they are providing services in one female

25 Data attributed to a United Nations study, cited in Sana Asghar, "Drug abuse in Pakistan reaches alarming level," The Nation, February 10th 2018, available at https://www.nation.com.pk/10-Feb-2018/drug-abuse-in-pakistan-reaches-alarming-level, cited in Nai Zindagi Trust, Needs Assessment Report with Female Injecting Drug Users September 2021

26 Nai Zindagi Trust, Needs Assessment Study with Female Injecting Drug Users. September 2021.

prison in Karachi. Those services include counselling and testing, access to a female psychologist, and for those women prisoners who are living with HIV, facilitating transfer to AIDS Centers to access ART upon release. According to key informants, the female prison in Karachi has a capacity of 200 prisoners, but is running at double capacity, with most prisoners being women and children refugees from Afghanistan.

3.2.3 Young male sex workers

The gender assessment identified a need for expanded services for men who sell sex, particularly those who are under the age of 18. For example, key informants reported that boys and young men work as sex workers in remote mining areas, such as those in Balochistan. Most of these MSW are under the age of 18 and come from areas that are geographically distant from mining communities, including other provinces such as Sindh and Punjab. These young boys are reportedly brought to the mining areas by their family members, to work as sex workers. There are no HIV services in the mining communities.

3.2.4 Young female sex workers

The gender assessment identified heightened vulnerability among young female sex workers under the age of 18, associated with a growing demand among clients for young girls. "Aunties" who run brothels or otherwise manage FSWs, reported that clients told them: " give us a girl younger girl and we will make you happy with extra payment."

3.2.5 Young transgender women

The gender assessment identified an elevated need for outreach and services for young transgender women. In FGDs, transgender participants repeatedly reported that they had been forced to leave their homes when they were between the ages of 12 and 17, and that it was precisely during those young years, that they engaged in unsafe sexual practices, lacked information on HIV, and were most likely to be engaged in inter-generational relationships in which they could not exercise decision-making power. According to FGD participants, current HIV programming for the transgender community does not reach this age group.

Recommendation 3.2: Develop services for the vulnerable gender-delineated sub-populations who have inadequate or no access to services at this time.

- For women who use and inject drugs: Initiate a small-scale community / NGO-based drug treatment option for women who use drugs, including gender-appropriate support to access and adhere to ART and attendant services, reproductive health services, and PPTCT for those who are pregnant. Develop and deploy a strategy to reach the growing numbers of street-based sex workers who inject drugs.
- For female prisoners: Conduct a review of HIV-related needs in female prisons in Pakistan and develop and implement evidence-based programming including HIV prevention, violence prevention, HIV testing, treatment, and PPTCT.
- For young male sex workers: Conduct a review of HIV-related needs among young male sex workers (under the age of 18), and develop interventions to meet their needs.
- For young transgender women: Conduct a review of HIV-related needs among young transgender women (under the age of 18), and develop interventions to meet their needs.

Finding 4: Gender-specific vulnerabilities are largely unrecognised and unaddressed in HIV programming

Finding 4.1 Gender-specific norms, roles and expectations impact cisgender women's vulnerability to HIV

The gender assessment found little or no documentation of the ways in which gender norms, roles and expectations impact HIV vulnerability and access to services for cisgender women in Pakistan. In other countries, a range of gender issues are known to impact women's ability to access services including family care responsibilities, lack of decision-making power, de-prioritisation of female family members health, and restricted mobility, among others.

For this gender assessment, interviews with key informants and FGD participants pointed out that in some areas, especially tribal and rural areas, women may be unable to leave the house without the permission of a male family member, or may be required to have a male companion escort her, in order to leave the house or attend health services. This can make it difficult or impossible for women to access any HIV services, from prevention to testing, treatment, and viral load testing. Key informants from Khyber Pakhtunkhwa Province, for example, reported restrictions on women's movement outside the home, and a need for women to obtain permission from male family members to leave the house.

Another area that arose during FGDs was the restriction put on widows' movement. A woman whose husband has died is expected to observe *Iddat*, or the requirement that she stay confined to her house for 4 months and 10 days. For the widows of MLHIV who have died, the Iddat practice can hamper or preclude access to HIV testing during that time, and constitutes a significant barrier

for widows living with HIV to access ART. As a result, widows who have not been on ART for long enough to access multi-month dispensing, may be unable to travel to the ART center to obtain medication during Iddat, and even widows who are stable patients may not be able to access the full 4 months and 10 days' supply that they need. In FGDs, widows living with HIV reported that they could not access ART and therefore their treatment was interrupted, because they were observing *Iddat* in a geographic location other than that of the ART center where they were registered. These women either did not know how to access ART at the most proximate ART center – a letter from the center where the woman is registered is required, or else were unable to obtain such a letter.

Recommendation 4.1: Addressing gender-specific norms, roles and expectations

- To reach women who are unable to leave the home or face challenges to obtain male permission to leave the home (especially in rural areas), train the Lady Health Workers who already access women in their homes, to conduct HIV testing; equip Lady Health Workers with knowledge about HIV, ART and PPTCT.
- Develop approaches to addressing gender-specific vulnerabilities that impact especially vulnerable populations, such as women observing Iddat, by, for example (1) including information on how to access HIV services during I*ddat* in programming for spouses of PLHIV; (2) sensitizing families of MLHIV about the importance of facilitating access to HIV testing and ART for women during Iddat; and (3) training Lady Health Workers to administer HIV testing for women in the home and during Iddat; (4) establishing procedures for mobile home delivery of ART for women during Iddat and extending multi-month dispensing for WLHIV to cover the full Iddat period.
- Simplify the procedures for PLHIV to obtain treatment at ART Centers other the one where they are registered, by establishing an electric tracking system and relaxing the requirement for a referral letter.

Finding 4.2: Gender-Specific Stigma, discrimination and violence in families and society impacts women, men who have sex with men, and transgender women

Stigma about HIV within families especially impacts women, MSM and transgender populations, who frequently report instances of being evicted from the family home once their HIV status is discovered.

A woman living with HIV is evicted from her home

X's husband was a drug user, and his family wanted to send him to a Rehabilitation Centre. It was the requirement of the Rehabilitation Centre that the patient should be tested for HIV, Hepatitis, and TB before admission. This is how his family found out about his status. But they did not tell his wife for over a year. The family was afraid that the wife would leave him if told about his status.

One day by chance, X overheard that her husband had HIV, but she was too scared to ask her husband and his family about it. She told her mother, and her mother asked her landlord's wife. The landlord's wife got so upset that she told X's mother to immediately send her away and never allow her in the house, or their rental lease would be cancelled. X's husband passed away, and her husband's family took the children away from her because she was HIV positive, and threw her out. X's family also disowned her, and she had no place to go.

"I used to go to my mother's home and sit outside. My mother would bring food outside for me, and my siblings living with my mother were annoyed even with this level of interaction. I got very sick and remained admitted to X Hospital for four months.

An NGO focused on HIV prevention gave me a job and residence in a Rehabilitation Centre. Now I am working with an HIV organisation and I have a home. My children have returned to me, and my relationships with my in-laws and my family are good.

WLHIV, FGD

Transgender woman is forced out of her family

When my family realized that I had transgender tendencies and I was spending time in transgenders' company, they used to abuse me, beat me to leave this path and go straight. When I continued, they put me in chains and in one room within our home. Then my brothers planned to kill me, but my mother heard them and told them she would take them to court if they tried. Then they prepared a legal document stating that I give up rights to my family property. I signed those papers, and they let me go.

Transgender FGD participant

Men who have sex with men experience violence from family members

Five out of 7 participants reported violence from their families, so finally, they had to leave their families and live elsewhere. The reason for the violence was their inclination towards activities and games considered for girls only (e.g., playing with dolls, cooking, wearing makeup) and/or due to their suspicious relationships with boys/men. The forms of violence included physical beating and emotional/psychological torture (sarcastic remarks, exclusion) "Our family members killed us with their taunting comments."

MSM, FGD

The gender assessment team also heard multiple instances of societal discrimination, especially that impacting the transgender community. Transgender key informants report that stigma, discrimination and hatred towards their community has increased since the passage of the passage of the Transgender Persons (Protection of Rights) Act in 2018, and that seven petitions have been filed against that law, culminating in the 2023 Federal Shariat Court of Islamabad ruling.

Societal discrimination against MSW

When we go out in a van to the hubs of MSWs, to provide them with home-based HIV testing services, other people in the communities are offended. They comment that people who do the dirty acts picked up this disease and let them die.

MSM, FGD

In the transgender community, some people have also been targeted by conspiracy theorists, who equate support for LBGT rights with foreign infiltration of the country. Another barrier that NGO HIV testing providers service face are common misperceptions and fears permeating the transgender community, such as a belief that the NGO outreach workers who provide testing services are financially compensated on the basis of the number of HIV-positive people they identify and that therefore, NGO staff use contaminated equipment and purposely infect people with HIV; or the (less common) belief that identifying more PLHIV equates to more foreign aid for the government of Pakistan, and that this also provides an incentive to purposely infect people with HIV.

In terms of programming to address gender-specific family and societal stigma and discrimination, the gender assessment team was not able discern whether any trainings in these areas have had an impact; however, UNAIDS did report several promising activities that it has completed, including developing a training guide for religious leaders, and conducting trainings on stigma and discrimination reduction with parliamentarians and the media.

In addition, the 2023 National Program Review (NPR) (March 2023 draft version) reports that a review of HIV self-testing (HIVST) among transgender women in Larkana, found that more than 90% stated

that HIVST was easy to perform independently and 95% would recommend it to their peers.[27] The draft NPR recommended developing and disseminating national guidelines and protocols for HIVST and partner notification, including for end users.

Recommendations 4.2: Stigma and discrimination

- Work with community, media, parliamentarians, and religious leaders to design practical approaches to reduce gender-based stigma and discrimination in family settings and in society.
- Continue the work that UNAIDS has done on stigma reduction, utilising the relevant tools developed by UNAIDS for that purpose.
- Implement HIVST, especially for transgender populations, as recommended in the draft NPR.

Finding 4.3: Violence impacts cisgender women and key populations access to HIV services

4.3.1 Violence against women

Studies in Pakistan have found high levels of domestic and intimate partner violence (IPV) against women. According to the Punjab Gender Parity Report 2021:[28] "A Survey conducted by the National Institute of Population Studies between 2017 and 2018 in which more than 4,000 Pakistani women participated, found that between the ages of 15 and 49, 28% faced physical violence and 6% faced sexual violence. Seven percent of women who had been pregnant disclosed that they had faced violence during pregnancy. In 2019, lifetime physical and/or intimate partner violence was at 24.5% in Pakistan."[29] Data from domestic violence helplines in Pakistan suggests that domestic violence increased significantly during Covid, with an increase of 200% between January and March 2020, and worsening during the lockdowns after March 2020.[30] Despite this data, during FGDs conducted for the gender assessment, women and men – including from key populations and PLHIV – did not report any instances of IPV in their families. From a statistical standpoint, this appears statistically improbable.

Barriers to accessing post-rape medical care or seeking justice are largely prohibitive. The system requires rape survivors to file a report at specific "notified" public hospitals, making it difficult or impossible for women living in remote areas to file a report. Further, in key informant interviews conducted for this gender assessment, UNFPA reported that, while efforts have been made

27 Altaf A, Pasha MSK, Majeed A, et al. Acceptability and feasibility of HIV self-testing among transgender people in Larkana, Pakistan: Results from a pilot project. PLoS One. 2022 Jul 8;17(7):e0270857. https://doi.org/10.1371/journal.pone.0270857

28 Punjab Commission on the Status of Women, Punjab Gender Parity Report 2021, p. 211.

29 Court Companion On Gender-Based Violence Cases, 2021 cited in Punjab Commission on the Status of Women – Women Development Department, Punjab Gender Parity Report 2021, p. 211.

30 World Report 2021: Rights Trends In Pakistan, cited in Punjab Commission on the Status of Women – Women Development Department, Punjab Gender Parity Report 2021, p. 211.

to introduce the use of rape kits for medical care of rape survivors and to collect the evidence needed for a legal case, these efforts have been hampered by gaps in the availability of equipment needed to use the rape kits, and insufficient capacity among medical providers. Further, there is no specialised cadre of medico-legal officers at health facilities, and as a result, the requisite evidence is not consistently collected, and post-exposure prophylaxis (PEP) for rape survivors is not consistently provided. UNFPA is advocating for a special cadre of trained medico-legal officers.

Legislative protections for women and girls, and for key populations, remain weak in Pakistan. The Domestic Violence Prevention and Protection Bill of 2020 has not passed,[31] the Window 1 Funding Request reports that crimes against women and girls are not adequately investigated, and that when convicted, perpetrators of violence against women tend to receive short sentences. Women are often victims of revenge violence in the form of rape and murder, when the perpetrators are released after a short sentence, and as a result, in order to protect themselves, most women either do not file a case, or else withdrawn from the case /compromise with perpetrators during the court process. In 2021, the Supreme Court of India ruled that the "two-finger" or "virginity test," administered on rape survivors to determine their sexual past, is unconstitutional.[32] Later that same year, anti-rape legislation passed in Pakistan, requiring the government to establish special courts to try rape cases in secrecy and decide them "expeditiously, preferably within four months."[33] However, implementation remains weak with a conviction rate for sexual crimes at a low 3.6%.[34]

4.3.2 Violence against men who have sex with men, transgender women, people who inject drugs, and sex workers

FGDs conducted for this gender assessment found that the experience of violence – in particular police violence, was widespread among key populations, especially in the PWID and transgender communities. Violence by police increases vulnerability and poses a barrier to accessing services for key populations and PLHIV.

31 Human Rights Commission of Pakistan, State of Human Rights in 2021: Pakistan 2021, Human Rights Commission of Pakistan Islamabad p. 254.

32 Mohd Ayan Sadik, Supreme Court of Pakistan declares "two-finger test" unconstitutional May 18, 2021. Available at https://ohrh.law.ox.ac.uk/supreme-court-of-pakistan-declares-two-finger-test-unconstitutional/

33 Ayaz Gul, Pakistan Drops 'Un-Islamic' Chemical Castration as Penalty for Rapists, November 19, 2021. Available at https://www.voanews.com/a/pakistan-drops-un-islamic-chemical-castration-as-penalty-for-rapists-/6320005.html

34 Xari Jalil, Anti-Rape Act 2021: the road to implementation. April 8, 2023. Available at https://voicepk.net/2023/04/anti-rape-act-the-road-to-implementation/

Police demand free sexual services from male sex workers

The most common form of police violence is forcing us to provide sexual services without payment. The policemen blackmail us, as most of our families are not aware of our activities, and policemen threaten us with calling our families to the police station and telling them about our MSW activities. "Police men often ask for my phone number. I give them a phone number which I have kept only for such dogs, and when they call I never pick up the phone, because I know they will ask for free sex.

MSW, FGD

Police sexually assault transgender woman

Many transgender women have suffered violence from police. Policemen ask for money or sexual services or both. And if a transgender refuses, policemen threaten to take them to jail on the false accusation of possession of drugs. One transgender woman said she was in X City and two policemen blackmailed and threatened her and would take her every week to an empty house and have sex with her.

Transgender FGD

Police gang rape female sex workers

Almost all FSW had experienced violence from the police. The primary form of violence they face is police extort sexual services without payment. Once they pick a FSW, then many policemen would have sex with her in the few hours of captivity – in the police station or in a house/flat/office.

FSW FGD

Police blackmail male sex workers

One day I was returning with a client on a motorcycle after having sex, and the police caught us. They found condoms in our pockets and threatened to take us to the police station and call our family. Finally, they agreed to let us go and took all our money and our phones. When we requested, they gave us 1000 rupees for petrol.

MSW, FGD

Similarly, a 2016 study by the Aurat Foundation, found that physical torture, sexual abuse and harassment was endemic against the transgender community across Pakistan. The report found that transgender women faced physical abuse from their family members, clients, male sexual partners, and the general public; and sexual abuse from clients who solicit transgender women for sex, including inviting their friends for gang-raping them. The study found that police often refused to respond to or acknowledge complaints from transgender women, that the police mock the complainants, harass transgender women at their birthday and dance events, and often make sexual advances.[35] The draft National Program Review (draft version March 2023) also reported widespread violence against transgender women, especially in the context of sex work, but also at dance functions, and reported cases of murders of transgender women in rural areas.

Key informant interviews and FGD participants in this gender assessment reported that police violence also impacts outreach workers, and thus the quality of services they can provide.

Police harass outreach workers in MSM Communities

Policemen often interfere when we go out in the communities for testing, which is a huge barrier in our work. Even when the extension workers show the policemen government and organization documentation, they continue to harass the workers on one pretext or another. This interrupts the testing process and undermines their authenticity and trust with the beneficiaries.

MSM, FGD

35 Aurat Foundataion, Silent No More: Transgender Community in Pakistan, A Research Study. 2016. Available https://af.org.pk/gep/images/GEP%20Gender%20Studies/Transgender%20Community%20in%20Pakistan.pdf

Police disrupt HIV testing and outreach to MSM

A significant problem is the police's interference with the NGO's work at various gathering places of MSM/MSWs. Sometimes policemen interfere and ask us to come to the police station and interrogate us about our testing and awareness activities; sometimes, police stop us right in the middle of our testing session or condom distribution. We show the policemen the authority letter from NACP and our NGO Identity Card. Still, they often make nasty comments such as "Why are you saving these bastards who are indulging in such shameful acts" "You are promoting homosexuality and vulgarity."

MSM Outreach worker, FGD

There is little legal recourse for key populations who are subjected to police abuse and violence. Same-sex relations, sex work and drug use are criminalised in Pakistan.[36] Under Section 377 (Unnatural Offences) of the Pakistan Penal Code of 1860, "Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal shall be punished with imprisonment for life, or with imprisonment of either description which shall not be less than two years nor more than ten years, and shall also be liable to fine." The provision was amended in 1980 to raise the minimum punishment to ten years and a fine.

The Transgender Persons (Protection of Rights) Act was passed by Parliament in 2018 to secure the fundamental rights of transgender Pakistanis. It ensures their access to legal gender recognition, among other rights. But in May 2023, The Federal Shariat Court of Islamabad ruled that the sections 2(f), 3 and 7 of the Transgender Act 2018, which relate to gender identity, the right to self-perceived gender identity and the right of inheritance for transgender women, do not conform with their interpretation of Islamic principles.[37] Islamic law prohibits transgender women from marrying.

Safe havens or shelters for people who are experiencing violence are poor quality or non-existent. Key informants from Nai Zindagi reported that they are aware of high levels of gender-based violence experienced by women who use drugs and female sex workers who use drugs, but that there are no services to which survivors can be referred. For this reason, data on GBV is not being recorded. For these women, accessing legal services only aggravates their situation as attempts to access legal recourse result in immediate expulsion from their family home, and they have no alternative living situations.

36 Human Rights Watch. Human Rights Watch: Pakistan Events of 2021. 2023. Available from: https://www.hrw.org/world-report/2022/country-chapters/pakistan

37 Amnesty International. Pakistan: Revocation of rights of transgender and gender-diverse people must be stopped, May 19, 2023 https://www.amnesty.org/en/latest/news/2023/05/pakistan-revocation-of-rights-of-transgender-and-gender-diverse-people-must-be-stopped/

No safe haven for women experiencing violence

A few years ago I went to Darulaman [women's shelter] to escape my drug addict husband, who used to bring customers for me and would take the money from them against the sexual services provided. In Darulaman, the manager was worse than my husband. She used to force me to provide sexual services to many men, often up to 7 men per day, and I would get only a fraction of the amount she was charging them. This Darulaman is right next to a police station and ironically most of the girls in Darulaman provide sexual services to the policemen from these police stations.

FSW, FGD

4.3.3 Existing programming to address violence

The gender assessment identified a number of good programming practices to address violence, including hiring transgender police officers, and engaging the services of a transgender legal specialist.

Good Practice: Tahafuz Centre

These protection centers are a new initiative – a couple of years old. The government has introduced Tahafuz Centres to protect transgender women. Tahafuz Centres have been established in the existing women's police stations in many districts in Punjab and in Rawalpindi. Transgender police officers head these centers and are provided with police officers, a police car and office space within the women's police station. Transgender women can take their cases of harassment to Tahafuz Centres, and they get a prompt and fair response to their complaints. The FGD participants expressed great satisfaction and joy about this arrangement: "I used to feel scared whenever I had to walk by a police station or would see a police man approach me. Now I am not frightened. I know I have a place where I will be heard."

Transgender FGD

Good Practice: Effectively Addressing Violence in Karachi

The Gender Interactive Alliance has developed effective mechanisms to deal with the violence and harassment from police. A transgender legal activist works with GIA and she has taken many cases of violence against transgender women to court and won some. She has connections within the police and District Management Systems. She is also representing the transgender community on the police-citizen joint action committee. There is a WhatsApp group for all the transgender women associated with GIA, as well as mid-level police officers from Karachi and some other districts. If a transgender woman is in trouble with the police, all they have to do is post a message on this group, and the transgender legal activist calls up the relevant persons or goes to the police station herself, and the issue is resolved. FGD participants explained that: "When a transgender woman is harassed/bothered by the police, and the message is posted, within an hour, the relevant police officer will call and provide a report of the status of the case. And when the complaint is addressed, it is immediately posted on the WhatsApp group."

A Transgender woman activist from Karachi, FGD

The gender assessment found that a number of strong, evidence-based interventions have been planned or are already being implemented, to address the issues of violence against women and key populations: UNFPA is working to educate women on their rights in cases of domestic violence, including working to capacitate midwives, Lady Health Workers (LHWs), and medical doctors, in clinical management of rape survivors and provision of psycho-social support; UNDP has started a new initiative with the Aurat Foundation, putting together a group of lawyers who will take on transgender cases, while UNDP pays the fees for the lawyers; UNDP has held trainings with police officers on stigma and discrimination facing key populations and is also working with the police to develop long term strategies to facilitate police support for key population communities to better access health services; and Pakistan's Window 1 Funding Request includes interventions to train law enforcement officers, including prison officers, on "key population and PLHIV friendly policing practices" as well as activities in which the APLHIV will design a capacity building initiative for outreach workers to provide immediate support to GBV survivors, build referral mechanisms and link survivors to the services they need.

Recommendation 4.3: Develop and scale up interventions that address violence against women and key populations

- Support safe spaces for GBV survivors either by providing capacity building for existing shelters to ensure they meet minimum standards of safety, or supporting the design and building of shelters.
- Address the data gap in domestic and intimate-partner violence experienced by PLHIV and key populations by conducting a targeted study on GBV in these populations. Utilise the data generated to design programming to fit the need, such as GBV prevention interventions for key populations, referral systems to the medical and legal interventions that GBV survivors need, and/or in-house GBV expertise and capacity at public and non-governmental services.
- Establish a system for NGOs and CBOs to report and track incidents of police violence and harassment against NGO/CBO workers, and conduct training and sensitization programming for police on non-violent interaction with key populations, and SOPs to guide police in these interactions; ensure strong cooperative linkages with leadership in the Ministry of Internal Affairs to ensure that SOPs and trainings are co-developed together with police leadership, are smoothly integrated into police trainings, and are sustainably enforceable and enforced.
- Continue the critical programming on women's legal rights and clinical management of rape survivors under UNFPA and expand the legal services supported by UNDP.

Finding 5: Gender barriers across the treatment cascade disproportionately impact cisgender women, and key populations, especially transgender women, male, female, and transgender sex workers, women who use and inject drugs, and men who have sex with men

Finding 5.1 Gender-specific stigma, discrimination and abuse in healthcare settings

Stigma and discrimination in healthcare settings are a recognised barrier to accessing HIV services globally, and the same is true in Pakistan. Pakistan's national and provincial AIDS Strategies all appropriately draw attention to the deleterious effect of stigma and discrimination on people living with, and at elevated risk of HIV, and their families.

This gender assessment is aligned with the national discourse on stigma and discrimination in healthcare settings. It builds on, and adds to, that national discussion, by highlighting the ways in which stigma and discrimination in healthcare additionally impact specific segments of the population, based on their gender identity and sexual orientation. It highlights the gender-specific ways in which stigma and discrimination in healthcare impact transgender women, cisgender women, female sex workers, and men who have sex with me. The voices of those people, and their experiences, are shared here.

Harassment of transgender women in healthcare settings

The attitude of the paramedic staff on duty at this Centre is very derogatory. He asks irrelevant and derogatory questions. "Do you do oral sex? How many clients did you have last night? I replied I only dance in the functions. The paramedic said: "Lier! Then, how did you get this dirty disease, haha." "When you do such bad/dirty activities, then you have to face the consequence. HIV is consequence of your dirty activities."

-Transgender woman, FGD

Harassment of cisgender woman during her pregnancy

When I was pregnant and having ARV, doctors at X PPTCT Center were very angry with me for getting pregnant. Many doctors said, why do you want to increase HIV in this world? Your baby will also be HIV positive, you stupid people. Literally, they made me shed tears of blood.

WLHIV, FGD

The gender assessment also found that some healthcare facilities were reported to be providing exemplary care, free of gender-based stigma and discrimination, and indeed of stigma and discrimination in general. Such was the case of the PIMS ART Center in Islamabad.

Good Practice: PIMS ART in Islamabad

The ARV Centre in PIMS is much better. The lady doctor there treats us with extra care and softness. She addresses us as 'Beta' [my son in Urdu /Punjabi.] She is not afraid to touch us. She listens attentively. The ART Centre is well located and has good space. The counsellor there, Ms. X is excellent and never makes a bad remark. Always helpful and respectful.

Transgender woman, FGD

I did not have any issue in getting the treatment for last 10 years. The lady doctor explained about the medicine and how to protect others and also about children. Now there is a counsellor who gives medicine, and I can ask her any questions. If I have any medical issues I talk to the doctor when I go for the refills.

WLHIV, FGD

Men who have sex with men and transgender women, and the community service providers who support them, reported that due to stigma and discrimination, members of their communities are frequently turned away from public hospitals. Transgender women, in particular, have been turned away from health services for women and/or forced to attend men's services. Key informants from Sindh, for example, reported that stigma and discrimination on the part of medical professionals against transgender women, accounts for especially poor access to healthcare in the transgender community. CBOs working with transgender women in Sindh similarly reported that the reason for overall low ART coverage in the transgender community was gender-based stigma and discrimination in ART Centers.

Transphobic stigma in healthcare

The behaviour of the ART staff members was terrible. They commented that God had created you a man, but you have become this, and this disease results from your defiance and evil activities. Then they send me to many different departments in the hospital to get tested and for X-rays. Everywhere I had to face degrading attitudes and nasty remarks.

-Transgender woman, FGD

Harassment of men who have sex with men in healthcare settings

I took a MSW patient to the ART Center. The doctor asked why you do this work? Why do not you marry and leave this dirty work? When the patient told the doctor he was married, the doctor said: Why don't you give your wife her right (to have sex with you)? Why are you giving your wife's rights to other men?

Outreach worker MSM, FGD

Men who have sex with men are afraid to ask for the critical healthcare they need

We are afraid to go to health services. Instead of getting services, when we go to the hospitals we get a lecture on Islamic teachings. We cannot ask for treatment for anal STIs.

MSM, FGD

The community voices raised here echo the findings of Pakistan's National HIV Programme Review (draft report March 2023),[38] in which the authors share the following quote from a female sex worker: "They [doctors] are also creating awkward situation for us, if I am telling a doctor that I am a sex worker, then he should not ask irrelevant question, like they used to ask, what you do, how you, why you doing all this. It should not be the business of them... I have my friends and they are not taking medications because of these [sic] kind of questions and demands from the facility. We don't want to disclose our work to our families."

FGD and IDI respondents to this gender assessment also frequently reported that medical practitioners did not respond to questions that key and vulnerable populations asked about their own health. The scope of this gender assessment did not allow the team to determine if medical practitioners' reticence to share pertinent health-related information was based on gender considerations in particular, or was universal across the healthcare system. The struggles of PLHIV and key populations to obtain information about their own health are related here.

Short and Curt

Medical practitioners at ART Centers do not share relevant health information with patients. Doctors' and paramedical staffs' attitudes are not good, doctors do not pay proper attention, do not explain things, and give short and curt answers if a patient asks a question. It is as if they do not want the patients to ask questions.

MLHIV, FGD

I never dared ask this question again

"I asked a doctor about the scores of my CD4, he said why do you need to know? I have told you already your tests are ok. I never dared to ask this question again."

Young MLHIV FGD

38 Pakistan's National HIV Programme Review (draft report March 2023) p. 53

No explanation

It took 15 days to get the results of all the tests (tests required prior to initiating ART), and in the meantime the doctor asked me to continue having disprin, panadol, and an anti-biotic every day. They did not give me any explanation for these medicines. I was not given any counselling before and after the HIV test.

Transgender woman, FGD

Recommendation 5.1: Reduce gender-based stigma and discrimination in healthcare

- Design and deliver training and sensitization for healthcare providers on non-discriminatory delivery of health services, including medical professionals working at ART centers. Actively engage PLHIV and key populations in designing and delivering the trainings.
- Improve the friendliness of clinical HIV services by engaging PLHIV and key populations in service delivery, by, for example, hiring PLHIV / key population counsellors, to work in clinical settings, providing support to clients and assisting with follow-up to improve adherence to treatment.
- Establish a functional, discrete, confidential mechanism to lodge complaints about stigma and discrimination in healthcare settings, a clear protocol for addressing complaints in a fair, dispassionate and timely manner, provide clear information to community members about the existence of the complaint mechanism and how to use it, and establish and train a committee – which includes community and medical stakeholders – to oversee complaints.

Finding 5.2: Knowledge and capacity gaps in key populations and at both government and NGO services

The gender assessment found significant gender-specific knowledge gaps in communities, and among governmental and non-governmental service providers.

Correct information and understanding about HIV transmission and the benefits of accessing services such as HIV testing and treatment, is critical to an effective response. The gender assessment found that ciswomen, transwomen, and female sex workers are at a particular disadvantage in terms of access to reliable information:

As noted above in the discussion of data gaps, in Pakistan, women's knowledge of HIV is significantly weaker than men's: Only 32% of women compared with 67% of men have heard of HIV/AIDS; and

the quality HIV knowledge among women is weaker than among men: Just 4% of women have comprehensive knowledge, compared to 10% of men.[39]

FGDs conducted with transgender women in the course of this gender assessment identified numerous and widespread misperceptions about HIV and the response to HIV in Pakistan. Community key informants reported that knowledge about HIV and the extent of misperceptions about HIV are especially high among transgender women; the gender assessment team was not able to identify comparative data on knowledge and misperceptions across key populations in Pakistan, and therefore relied on the expert opinions of CBOs that work closely with the transgender population.

Poor knowledge and a preponderance of misperceptions about HIV in transgender communities

Common misperceptions reported in FGDs with transgender women were the belief that NGOs in Pakistan are purposely infecting people with HIV, that HIV tests are "lying," and that any medical injection will transmit HIV.

- It is a disease which can be cured. It is not a lifetime condition
- HIV is not transmitted through sex
- There is no real danger from HIV.
- The extension workers are testing them because they get paid for the tests

Transgender women, FGD

Lack of access to accurate information about HIV has real-world impacts for mothers

I have not been hugging and kissing my children, not eating with them from the same plate, or letting them sleep next to me for fear of contaminating them with HIV.

FSW living with HIV, FGD

The gender assessment did not include a medical evaluation of capacities in government hospitals, but rather focused on the experience of patients as they interacted with those facilities. Therefore, a determination of professional capacity gaps in medical doctors working at hospitals and ART Centers falls beyond the scope of this gender assessment. However, based on reports from men, women and key populations who attended ART Center services, the gender assessment identified several professional expertise gaps at ART centers, with gender-specific repercussions. Chief among

39 Pakistan Demographic & Heath Survey (PDHS) 2017-18

these were (1) insufficient numbers or availability of dedicated counsellors at ART, especially a lack of female counsellors, and insufficient skills set and training among existing counsellors; (2) absence of pre- and post-test counselling – many community members reported that they received no such counselling when they went for confirmatory testing at ART Centers; (3) absence of a system to follow up with patients on ART in order to support adherence and reduce loss to follow up (LTFU); (4) a gap in provision of mental health services and/or capacity to identify mental health needs and refer to appropriate services. Mental health is a service that is particularly requested by cisgender and transgender women living with HIV.

In the wider hospital – beyond the ART Center, key informants and FGD participants identified significant gaps in knowledge, especially about HIV transmission routes, leading to widespread fear among medical professionals of becoming HIV infected themselves. As discussed below in the section on PPTCT, these knowledge gaps and misperceptions, coupled with gender-specific stigma about HIV and pregnancy, especially impacted ciswomen living with HIV and accounts in part for the poor coverage of PPTCT in Pakistan.

Among NGO services providers as well, the gender assessment identified knowledge gaps: Counsellors and other providers at some NGOs lacked correct knowledge about HIV transmission modes; U=U messaging was a specific gap noted among some NGO providers; and some CBOs lack capacity – either due to knowledge gaps, lack of staff or lack of funds – to support community members to adhere to treatment and to follow up in cases of LTFU.

Recommendations 5.2: Address knowledge and capacity gaps in communities and among governmental and non-governmental service providers

Bolster and reinforce knowledge about HIV among community members by using the communication tools with which they are most familiar and feel most comfortable.

- For example, virtual technologies, may be most appropriate for reaching transgender communities. Transgender women reported that they use Facebook, Instagram, and Ticktock social media forums, posting their pictures and videos regularly. They have WhatsApp groups with more than 250 members. Some of the names of these WhatsApp groups are *Piyar Diya Divyan, Islamabad Diyan Rania, and Lahore Diyan Rania.* (Divas of Love, Queens of Islamabad, Queens of Lahore). These groups and Facebook pages can convey brief "cheeky," and funny messages on the prevention and treatment of HIV. Another forum for communication with the transgender community is Murat TV (Murat is a name that transgender women call themselves).
- MSWs use various Apps, such as Tinder, Grinder, and Blued, to find clients. They recommended using these same Apps to inform MSWs about prevention and access to HIV services. MSWs are active on social media forums such as TikTok, Facebook, and Instagram.

For medical professionals at ART Centers: Provide training on counselling, including pre- and post-test; establish SOPs on counselling and mechanisms to monitor and support adherence to SOPs; assess counselling gaps and address them by, for example, integrating community and peer counsellors into ART Center staff; establish effective referral networks.

For medical professional outside ART Centers: Design and deliver capacity building trainings for providers in the health services most needed by PLHIV (men and women) and key populations, including ANC, TB, public drug treatment (for PWUD), and mental health services. Include knowledge of PEP.

For NGO service providers: Develop a standard training package for all NGO service providers working with PLHIV and key populations, to bolster knowledge of HIV transmission, ART, adherence, and gender-specific needs. The training course could be self-directed and on-line, and include a series of tests to demonstrate understanding and competency in critical areas. Require providers to successfully complete the training course, and include a requirement for refresher training at set intervals.

Finding 5.3 Gender-specific barriers to HIV prevention including PrEP

Finding 5.3.1 Primary Prevention

The gender assessment found that condom use was sporadic in a number of key population communities. In FGDs, most sex workers, for example, reported that condom use with clients was low because clients pay more for unprotected sex. This finding appears surprising, given that the data show a comparatively low 1.2% HIV infection rate in the female sex worker community.[40]

40 AEM 2022 data, cited in Pakistan Global Fund Funding Request Window 1 2023

Foregoing a condom when the client pays more

We are doing this work out of necessity (Majburi) so we do what client asks us to do, whatever disease is written in destiny we will suffer from it no matter what we do.

FSW, FGD

Steady clients always demand not to use condoms. For my wealthy clients who give me expensive gifts and extra money, happy by not using condoms.

MSW, FGD

Many of the transgender women FGD participants reported that they do not use condoms with their steady partners, and sometimes forego a condom with clients who are ready to pay more for sexual services without condoms.

Among male sex workers, FDGs found a widespread belief that getting themselves and their clients tested every 3 months, meant that they did not need to use a condom.

Regular HIV testing means we do not need to use a condom

We do HIV tests after every three months. We bring our clients and steady partners as well for HIV testing. When our clients test for HIV, we feel very comfortable having sex with them without a condom.

MSW, FGD

Finding 5.3.2 PrEP

Key informants, female and transgender sex workers, and men who have sex with men reported a number of barriers to accessing PrEP, some of which were prohibitive.

Female and transgender sex workers reported that locating PrEP services inside ART Centers in public hospitals discouraged them from accessing PrEP. Lack of anonymity and concerns that potentially being associated with HIV or the perception that they were HIV-positive, would have a detrimental effect on their work – making them lose clients or reducing the amount they could charge for their services.

Discriminatory comments by the medical staff providing PrEP also discouraged potential clients from accessing this service.

Doctors harass and insult PrEP recipients

Doctors ask embarrassing questions before prescribing PrEP, such as when did you do it, how did you do it, and how many clients in the last week you did it.

Doctors say: "You could have chosen to do a job, but you chose this work."

FSW, FGD

Community members all reported that they would prefer to receive PrEP in community settings.

PrEP in community settings for community members

We would use PrEP when it is available at X NGO. We do not want to go to ART centres to get it because of the behaviour of the ART staff members.

MSM, FGD

Provide all the ART services at the CBO office. The CBO can hire a couple of doctors to take our blood for tests in the office and send it to a laboratory for tests and, based on the results, provide treatment. In such a setup, a large number of FSWs will take PrEP regularly, and also HIV positives will take their medicine regularly.

FSW, FGD

Recommendation 5.3: Address common misperceptions about HIV prevention, and make PrEP services low threshold and community-based

Reinforce primary prevention messaging especially for sex workers and their clients, dispel misperceptions that a negative HIV test means condom use is not necessary, and make PrEP available in community settings.

Finding 5.4: Gender and access to confirmatory HIV testing

Confirmatory HIV testing – following two positive rapid tests that can be accessed in community settings – is only available free-of-charge at ART Centers in public hospitals. In FGDs and key informant interviews, community members expressed discomfort with attending services at ART Centers, and a preference for community-based HIV testing. Further, as noted above, the absence of pre and post-testing counselling for confirmatory testing, lack of follow up following receipt of

test results, means that community members tend to drop out along the treatment cascade, many before even initiating treatment. In one case, doctors at the ART center did not follow up with a man who was diagnosed with HIV, did not inform him about treatment options, counsel him to bring his wife for testing, or inform him about the need to practice safe sex with his wife.

Good Practice – home-based HIV testing for women

UNAIDS reports that they have conducted training for lady health workers (LHWs) on HIV-testing. This is an excellent approach to accessing women, especially those in remote rural areas and those whose movement outside the home may require male permission and accompaniment, or who may be subjected to other gender-specific restrictions.

Key informant interviews and focus group discussions conducted over the course of this gender assessment, were unfortunately unable to detect any evidence that the LHW HIV-testing program has been implemented, and several key informants reported that LHW are overburdened with their current responsibilities and are therefore not able to take on additional tasks, such as those related to HIV.

The gender assessment team was unable to identify any women who had accessed HIV testing via LHW or who had heard of this service, or any other key informant who was aware of the HIV-testing training for LHWs. However, the Lady Health Workers Strategic Plan 2022 – 2028,[41] does list the following among LHWs' responsibilities: "Disseminating health education messages on individual and community hygiene and sanitation, as well as information regarding preventive measure against spread of sexually transmitted infections including HIV & AIDS." It also lists the following responsibilities of CBO workers: "Community based HIV testing, counselling and referral (In high-risk groups by CBO worker)" and "Provision of condoms and disposable syringes (In high-risk groups by CBO worker)"

Recommendation 5.4: Offer confirmatory HIV testing in community settings

- Provide confirmatory HIV testing in community settings on the same day as the two rapid tests, through approaches such as mobile vans or assigning a doctor to CBOs that conduct rapid tests for key populations.
- Offer home-based HIV-testing, including blood collection for confirmatory tests, through CBO workers and/or LHWs.

41 Ministry of National Health Services, Regulations and Coordination, Government of Pakistan. Lady Health Workers' Strategic Plan (2022 – 2028): Primary Health Care for Universal Health Coverage and Resilient Health System, November 2022

Finding 5.5: Gender barriers to accessing HIV treatment

Finding 5.5.1 Design barriers

Community FGD participants in this gender assessment reported that the physical design of ART Centers in public hospitals makes it difficult or impossible to maintain confidentiality and that this constitutes a very significant barriers to accessing HIV services. According to these community reports, HIV services in public hospitals are separated from the other hospital services and are clearly marked with signs. This means that anyone in the hospital can readily observe who goes in and out of the ART Center, and indeed, community members expressed fears of being seen by others who could then identify them as a person living with HIV. This set-up is of specific concern to female sex workers and transgender women, because even a suspicion about their HIV status could result in losing their livelihood.

Need for discrete services

Transgender women cannot afford to be seen in an ART Centre. This will ruin their profession as well as their social life. So a transgender woman would prefer to continue her treatment in a district far away from where she lives: "I know a transgender woman who lives in Gujranwala, but she travels to Islamabad for her treatment. It is an 8-hour travel round trip, because she does not want anyone in Gujranwala to find out about her disease."

Transgender FGD

Lack of privacy during consultations at ART Centers, due to the physical arrangement of the space, was a concern frequently voiced by cisgender women who participated in FGDs for this gender assessment.

No auditory or visual privacy at ART Centers

At the hospital, male and female doctors sit together in the ART Centre. We have to answer the questions the lady doctor asks in the presence of that male doctor, and otherwise also, paramedics and other people come and go as they please during the conversation.

WLHIV, FGD

Finally, community members from all key populations as well and ciswomen and men living with HIV expressed their concern with the physical set up of ART Center waiting rooms – which do not offer privacy and also expose people to harassment.

Harassed by people who are on their way to the mosque

The location of the waiting room is such that it is near the mosque, and many people go to the mosque through this area and sneer at transgender persons on their way to the mosque.

MLHIV, FGD

Transgender women are propositioned in ART Center waiting rooms

In the waiting area at the ART Center, people make passes at us or give dirty looks, or say something or the other when they see us. They make dirty remarks like, how was last night? how much you charge? Go to hell, you are the scum of this society

TG, FGD

Common practices in hospital departments other than the ART Center were also reported to put PLHIV at risk. For example, hospital systems publicly indicate – with a sign on the bed showing the person's HIV-positive status – when PLHIV are referred from the ART Center to other hospital departments for treatment of opportunistic infections.

Recommendation 5.5.1: Improve the physical layout of ART Centers to support confidentiality and safe access for all

Conduct a rapid assessment or review of ART Centers to identify issues related to the physical layout that can compromise confidentiality, such as signage, location, entry and exit points, and internal layout for visual and auditory privacy. On the basis of findings, support ART centers to improve discrete access to their services, by developing standards and guidelines and assisting ART centers to make the adjustments needed to meet the new standards. The guidelines should specify an adequate size for waiting rooms, and a separate counselling and examination room that provides auditory and visual privacy.

Finding 5.5.2 No place for transgender women

Transgender women reported significant challenges waiting in line at ART Centers to register and access services, because hospitals provide just two lines to wait: One for cismen and one for ciswomen. Transgender women frequently report that they are pushed out of both lines and for this reason are not able to register with health services.

Recommendation 5.5.2: Provide a space for transgender women

Public health facilities that house ART Centers can better support transgender women to access the services they need by offering a dedicated waiting queue for transgender women.

Finding 5.5.3: Restricted opening hours at ART Centers pose gender-specific challenges to access treatment

The negative impact of constricted opening hours at ART Centers has long been noted in Pakistan's approach to the epidemic, and the findings of this gender assessment align with this. The gender assessment documented the various gender-specific ways in which ART Centers short opening hours – generally between 8AM and 2PM – differentially impact men, women and key populations. Indeed, the early closing time of 2PM poses an insurmountable barrier for key populations who work at night – such as male, transgender and CIS female sex workers. Many members of the transgender community are employed as dancers for weddings and other late-night events, and are not able to attend health services that are only open during the day and close at 2PM – precisely the time that they need to sleep.

For cismen who work outside the home, it is difficult or impossible to attend ART services, because the opening hours fall squarely during their regular working hours. Even for those with more flexible work hours, attending ART Centers causes them to lose income.

Too much time at the ART Center

The timing of the ART centers is an issue because doctors often come late or they take long breaks – one to three hours. I work as Bykia driver (a motorcycle delivery service). Spending so much time at the ART Center means I cannot earn enough to put the food on the table.

MLHIV, FGD

Some ART Centers have placed further time restrictions on access. For example, PWID FGD participants reported that in Punjab, the ART Centers accept registration for PWID only one day a week – Thursdays between 8AM and 2PM, and allow PWID to refill their ART prescriptions on Saturdays only. These restrictions are reported to significantly contribute to LTFU among PWID who are living with HIV. These findings are aligned with those reported in the NPR draft report of March 2023 (p. 51), which found that " some ART Centres limit enrolment of PWID to 5 people on just one day each week, thereby limiting the immediate initiation onto treatment for most PWID and an ever-increasing backlog of PWID waiting to access ART."

Recommendation 5.5.3: Introduce longer and more flexible hours at ART Centers

Adjust the hours of existing ART centers to meet the needs of the populations who need these services. This means extending hours past 2PM, through the afternoon and as much as possible, into the evening.

Finding 5.5.4 The lengthy lag-time to complete the tests required to initiate ART contributes to LTFU

Same-day ART initiation is generally not available in Pakistan. Key informants and FGD participants reported that an array of tests are required following the final confirmatory test, and prior to initiating ART. In that complex bureaucratic process, many are lost. In Punjab, key informants reported that it takes 24-48 hours to complete the required tests. Khyber Pakhtunkhwa reported longer. In some instances, community members reported that they were compelled to make five separate trips to ART Centers in order to complete the stringent requirements for ART initiation, and some were forced to wait up to a week between confirmatory testing and initiating ART. Many simply gave up.

Prohibitively long wait times and onerous requirements to access treatment

It can be up to a week to complete the tests that are required prior to initiating ART. Sometimes the doctor is not there or lab results are late, so from 3 to 5 days, it varies within and across ART Centers. In the same ART Center sometimes all tests can be done within 2 to 3 days, sometimes it may take a week.

FGD

Good Practice

When a person is identified as positive, Darecha extension workers take them to PIMS or Rawalpindi ART center for registration. Darecha workers accompany the HIV-positive person through the registration process and baseline tests.

MSM, FGD

GIA outreach workers are on duty at some ART Centers, and they guide and help transgender women who come for testing and treatment.

Transgender women FGD

Recommendation 5.5.4: Ensure same-day treatment initiation following a positive confirmatory test

Bring pre-treatment testing requirements in line with WHO guidelines, and consistently provide same-day ART initiation for all.

Finding 5.5.5 Prohibitive costs are levied for the tests required to initiate ART

The gender assessment team heard multiple reports of prohibitive costs making it difficult or impossible for PLHIV to access ART.

I do not have that kind of money

I had my blood test at X Hospital. The doctor on duty told me that they suspected HIV, but to correctly identify this disease, I should go to X Hospital in another city, and it will cost 35 to 50 K. I did not have that much money, so I carried on with my life, and a few years later, I tested again to give blood to my wife, who was going through childbirth, and HIV was detected again. Unfortunately, by that time, my wife also had been infected.

Man living with HIV, FGD

FGD participants reported that while there are mechanisms to reduce these costs, they are difficult to access.

Barriers to reducing fees

To decrease the amount, the patient has to go to MS (the most senior officer in the hospital), and he will reduce by 60%. Meeting him takes a lot of effort and waiting. This process is painful and time-consuming for the patient.

MLHIV, FGD

Recommendation 5.5.5: Reduce or eliminate costs associated with pre-treatment testing

Lower the threshold for accessing treatment by simplifying pre-treatment testing requirements, lowering fees, simplifying access to reduced fees, or eliminating fees altogether.

Finding 5.5.6: Doctors are unavailable or not on staff at ART Centers

The gender assessment heard from both key informant interviews and FGDs, that many ART Centers have no doctors; that even if the ART Center has a doctor, oftentimes ART is dispensed by a clinical psychologist; and in one case, that the doctor at the local ART Center is available only one day per week. Community members also reported that doctors rarely or never see ART patients who come for refills, and that refill services are provided by junior paramedic staff.

Recommendation 5.5.6: Ensure that ART staff are appropriately staffed with doctors.

Finding 5.5.7: There is no community-based ART

Community ART is increasingly available in South Asia, but in Pakistan, access to ART free of charge, is restricted to ART Centers in public facilities, and is not available in community settings.

In most key informant interviews, government officials expressed reluctance to loosen the restrictions that confine ART in public facilities, and distrust of community organisations' ability to provide ART.

In some instances, attempts to bring ART closer to communities have been rolled back. In Punjab, for example, community outreach workers were, until recently, permitted to pick up ART at AIDS Centers, however, that practice has been rescinded and PLHIV must present themselves in person at AIDS Centers to obtain refills. This change was reported to be in conjunction with requirements for biometric identification. AIDS Center requirements that PLHIV present a National Identification Card in order to register for biometric identification, is also a barrier for key populations, as many do not have this card. (Obtaining the card requires having a birth certificate, which many do not have). Efforts have been made to arrange for AIDS Center doctors to provide ART in community settings – either at NGO drop-in centers or else working with outreach teams, however, so far this system has not been put into practice.

Sindh is a bright spot, with multiple good practices being introduced.

Good practices in HIV treatment in Sindh

Key informants from Sindh reported that mobile ART services are provided using a van. Further, social mobilizers who work with key populations can pick up ART refills at ART centers and transfer the medication to their clients. Finally, Sindh key informants report that they are planning to pilot evening HIV testing and ART delivery services in Karachi via community-based organisations.

Recommendation 5.5.7: Introduce community-based ART nationwide

Build on the innovations already underway in Sindh to bring treatment closer to communities by:

1) bringing qualified doctors into NGO / CBOs to prescribe ART; [This recommendation is aligned with the proposed activities in Pakistan's 2023 Global Fund Funding Request (Window 1), namely: "decentralizing treatment services for KPs to CBOs by involving private GPs and use of telemedicine platforms for patients living in far off places."]
2) empowering outreach workers to pick up ART refills and transfer them to stable patients;
3) expanding ART provision via mobile units in vans at times and locations that are most convenient for key populations.

Finding 5.5.8: Restrictions on multimonth dispensing and referrals among ART Centers

While multi-month dispensing for at least two months is routinely provided to stable patients in Pakistan, in most cases (with the exceptions noted above in Sindh), PLHIV are required to present in person at ART Centers to get their medication. This is a real barrier for people living in remote rural areas and for many key populations, and an insurmountable barrier for women in remote tribal areas. Further, the short lead-time allowed for obtaining refills in some settings has contributed to treatment interruption and loss to follow up.

Short lead-time for refills in some settings undermines treatment adherence, but Sindh leads the way with good practices

The patient can go for a refill only when two days of the medicine is left, and this is a problem, because if one must go out of town, one cannot take the medication in advance. When the patients go for refills even three days before their pills finish, ART staff say they should come only two days before their pills finish.

Man living with HIV, Punjab FGD

We can get medication for up to three months and can go for refills when 10 days of pills are left.

Man living with HIV, Sindh FGD

Treatment interruption and loss to follow up are also a facet of the archaic paper-based reference system among AIDS Centers. When PLHIV travel to another city, they must obtain a paper reference letter from the ART Centre where they registered. They must show that reference letter to the

staff of the ART Centre in the city to which the person is traveling. Obtaining that reference letter requires an additional trip to the ART Center – costing the person time and money.

Further, while referrals among AIDS centers are possible utilising this cumbersome system, the 113 FGD participants who contributed to this gender assessment, were unaware of the system. People who had travelled to a district other than the one in which they were registered, were unable to access ART at AIDS Centers in their travel destination. Men who travel for work, and women whose mobility may be limited by gender norms and expectations – especially widows – reported experiencing treatment interruption because they were denied access to ART at AIDS Centers other than the one where they registered.

The barriers to obtaining ART from AIDS Centers outside the one where a patient is registered, can be prohibitive

Currently, if a patient is registered at X Hospital and they want to continue the treatment at Y Hospital, it is not possible, and a letter from the AIDS Control Programme would be required stating the reasons for this change of ART Centre. Such letters are hard to obtain.

FGD

Recommendation 5.5.8: Simply the refill process, decentralise ART provision down to the local level and institute an electronic registration system to replace paper-based referral

- Simplify the refill process nationally and make it user-friendly, by allowing PLHIV to pick up refills 10 days before they run out of pills.
- Decentralise ART provision down to the local health clinic level to allow people access treatment refills in the manner that is most convenient for them, and to assist people in remote rural areas to easily access treatment.
- Discontinue the paper-based reference letter system and implement an electronic registration system to allow PLHIV to easily access ART wherever they are.

Finding 5.5.9: No nationwide system to track loss to follow up, and help patients who have dropped out, return to treatment

The capacity of the healthcare system to systematically track people across the treatment cascade is spotty. The gender assessment team heard frequent accounts from PLHIV of dropping out at various points along the cascade, with little or no follow-up from the public health system.

No Follow-up

Patients do not receive a call if they do not come for their regular ARV refill. One patient stopped taking medicine for many months, but there was no follow-up on the ART Centre's end. Finally, the patient started using ARV again when, after months of trial, alternative treatments failed.

MLHIV, FGD Report

Some NGOs that work with specific key populations – particularly those working with PWID, MSM and transgender women, have established their own systems to track their beneficiaries, and in one province, key informants reported that a program that supports community outreach workers to link LTFU cases with AIDS Centers is in operation, but remains at small scale – just 250 people tracked per quarter.

Good practice in treatment access and support: Gender Interactive Alliance

Two of the eight extension workers are permanently deployed at the ART Centers. They have links and connections and know their way around these ART centers. When an HIV positive transgender woman is identified, an extension worker takes this person to an ART Center relatively close to the person's residence. From there, the extension worker supports them to register at the ART Center and facilitates the whole process. Regarding the issues that other people reported, such as doctors' attitudes and lack of guidance, the transgender women registered through GIA avoid those. The HIV-positive transgender women in the group vouched that they do not face any problems in getting their treatment at ART Centres.

FGD with transgender women

Engaging community outreach workers to support treatment adherence and track LTFU cases is a well-documented good practice that is especially efficient at strengthening adherence among key populations. In FGD discussions, participants suggested hiring PLHIV to work in ART centers, to provide peer counselling, support adherence, track people who are LTFU and assist them to return to treatment.

Employ PLHIV as peer counsellors in ART Centers

We are in a position to guide new patients because we have learned so much from our experience with this disease. And the patient will trust us and are likely to share their deepest concerns and fears with us because we are one of them.

MLHIV, FGD

Indeed, Pakistan's Funding Request to the Global Fund (Window 1 2023) proposes: "To reduce treatment attrition, we will implement innovative interventions including case managers, counsellors and APLHIV to closely follow patients for appointments, adherence counselling and follow-up calls."

Recommendation 5.5.9: Develop and implement a system to track LTFU cases and engage peers to support treatment adherence

Develop and deploy a data tracking system in the public healthcare system to reliably identify LTFU cases across the treatment cascade, and work closely with NGOs and CBOs to engage with / employ peer counsellors who can support people to access and remain in treatment, and assist those who are LTD+FU to return to treatment.

Finding 5.5.10 Uneven access to viral load testing

The gender assessment found that the ease with which PLHIV can access viral load testing varies significantly. In some geographic locations, viral load testing is available at specific laboratory locations that are separate from the hospital in which the ART center is located. In order to get a viral load test, PLHIV must travel to the laboratory, take the test, obtain their results, and take a paper copy of their results to the ART clinic themselves. This is difficult for many people to do, and contributes to low coverage of viral load testing and suboptimal reporting of viral load results. Additionally, some PLHIV who participated in FGDs for this gender assessment, reported that ART Center medical practitioners do not inform patients about the need for viral load testing or else do not instruction PLHIV to get a viral load test, thereby restricting access even in locations where laboratories are conducting the test on a regular basis.

Challenges to accessing viral load testing in Sindh

At all three ART Centres, viral load tests are done regularly. However, the procedure is cumbersome for the patients. Patients are given a reference slip during a regular visit for ARV refills. They take that slip to Agha Khan lab, have their test done, and physically bring the results back to their respective ART Centres; however, the results are discussed on the next visit.

FGD participant from Sindh

Good practices for viral load testing in Punjab

At all three ART centers, viral load tests are done regularly. The procedure is convenient. ART Centre takes the blood samples and send them to the laboratory. The results report is directly sent to the ART doctor.

FGF participant from Punjab

Mobile viral load testing using Cepheid GenExpert

Nai Zindagi procured four portable machines along with viral load testing cartridges. A team of qualified staff went through standardization training on development of a work plan, execution of sampling and viral load testing procedures and reporting mechanisms. In 2022, 4,638 PWID obtained viral load tests using this mobile service; 66% were virally suppressed. In that same year, 498 spouses of MWID accessed mobile viral load testing services; 71% were virally suppressed.

Nai Zindagi program data

Recommendation 5.5.10: Build on the good practices in Punjab to facilitate access to viral load testing

Improve access to viral load testing by taking steps such as (1) collecting blood samples for VL testing at the sites where PLHIV are already comfortably accessing services; (2) transporting the samples from point of collection directly to laboratories for VL testing; and (3) establishing a system of electronic data-sharing between laboratories that conduct VL testing and the locations or facilities where PLHIV attend HIV services; (4) expanding access to mobile viral load testing.

Finding 5.5.11 Gendered preferences for accessing HIV services in the private sector

Some FGD participants reported accessing HIV testing at private hospitals and laboratories. The gender assessment team was not able to determine gendered preferences for accessing services in private facilities. Data from some countries shows that women who have the means to pay tend to prefer private practitioners for the additional confidentiality they provide; sex workers in particular, have showed a marked preference for private practitioners in many countries. In other settings, more men than women access private HIV services because men have better access to the financial resources needed to pay.

It was not clear to the gender assessment team how this dynamic operates in Pakistan, exactly which HIV services are available in the private sector, who is accessing them, and whether or not data from private sector services feed into national data systems. However, some MLHIV who participated in FGDs did report that they accessed HIV testing, including confirmatory testing, at private facilities, but were not systematically referred to ART center for treatment.

Recommendation 5.5.11: Establish or strengthen existing systems to track people who access HIV services in the private sector, and conduct analysis of that data to determine any gendered preferences for private sector services.

Finding 5.6: PPTCT services are difficult to access

PPTCT coverage in Pakistan is at crisis levels. In 2022, only 347 pregnant women living with HIV received ART for PPTCT, constituting just 12.4% coverage.[42]

Further, available data shows that women's knowledge about preventing parent to child transmission appears to be lower than men's, and is falling: According to the 2017 PDHS, men are more aware than women that HIV can be transmitted during pregnancy (39% versus 21%), during delivery (32% versus 20%), and through breastfeeding (37% versus 19%) and that the risk of transmission can be reduced by the mother taking special drugs (23% versus 9%).

42 https://www.unaids.org/en/regionscountries/countries/pakistan

Finding 5.6.1 PPTCT Centers are inconveniently located and do not dispense ART

PPTCT Centers in Pakistan do not dispense ART. This means that pregnant women living with HIV cannot obtain ART at the PPTCT sites, but must instead go to an ART site. PPTCT centers are not always co-located with ART centers. Pregnant women living with HIV find it difficult or impossible to travel to PPTCT centers that are located at some distance from the ART center at which they access treatment. Further, while ART Centers are charged with dispensing ART for PPTCT, key informants reported that only some ART centers, not all, will provide ART for PPTCT.

> My wife, who is HIV positive, was in the hospital for delivery and operation; her ARV medicine had finished, so I went to the ART where she was registered and asked them to give her medicine to me, but I was told that she should come herself for biometrics.
>
> Man living with HIV, FGD

Finding 5.6.2 Pregnant women who do not know their HIV status when they become pregnant, tend to be diagnosed late in their pregnancies, too late to access the full benefit PPTCT throughout their pregnancy

According to the 2023 National Program Review (March draft) (p. 41-42) screening of pregnant women during ANC is mandatory from a policy perspective in Sindh, Khyber Pakhtunkhwa and Punjab.

In practice, HIV testing is not systematically provided in routine ANC screening at public hospitals. As a result, pregnant women living with HIV who are not already aware of their status at the time they become pregnant, are often missed. In general, women in Pakistan tend to attend ANC services later in their pregnancy. In FGDs conducted for this gender assessment, women who learned of their positive HIV status during their pregnancy, reported that they were tested late in their pregnancy, when they experienced some unexplained illness. All FGD participants who learned of their status during pregnancy, received their diagnosis when they were already in their third trimester.

Tested for HIV in her third trimester

X was diagnosed during routine tests during the 7th month of pregnancy. X's husband knew about his status. He neither informed his wife nor did he use condoms after marriage. When she told him that during routine pregnancy tests, she had been diagnosed as positive and the doctor suggested that her husband should be tested as well, he said, "There is no such thing, doctor is making a fool out of you. I will not get myself tested." After much pressure from his and her family, he got the test done from a private lab, hid the report, and told her he was ok. She found the report after a few days, and he was HIV positive. X begged her husband to go for treatment, but he refused, and she took a divorce and started living with her mother. Her sister-in-law, who lived in the same house, moved out because she did not want to live with an HIV-positive person.

WLHIV, FGD

Diagnosed at eight months of pregnancy

X's husband's HIV was identified, and her test was done at X Hospital when she was 8 months pregnant. After baseline tests, she was immediately put on ARV. Her daughter was tested after birth, and she was negative. There was no counselling involved at any stage.

WLHIV, FGD

Finding 5.6.3 In some cases, pregnant women who know their HIV status is positive, do not receive ARV for PPTCT

Absence of post-test counselling at ART Centers, including a failure to discuss pregnancy and PPTCT with women of reproductive age, means that women living with HIV become pregnant without the benefit of appropriate ANC and PPTCT.

Absence of counselling about pregnancy and PPTCT at the ART Center

X got it from her husband. Two months after their marriage, her husband found out when his blood was tested because he wanted to donate blood. He immediately called his wife who was in another city at that time, and told her about his HIV status. She went to X Hospital in that city and her HIV status was positive. The ART Centre in X Hospital did not counsel her before or after the test or follow-up with her for HIV treatment. She returned home to her husband. Her husband was on treatment at the ART Center, but the medical practitioners at the ART Center did not inquire about his wife's HIV status, did not suggest that he bring his wife for testing or treatment, did instruct him about safe sexual practices, and did not provide information about pregnancy, mother-to-child-transmission and PPTCT. Two years after her diagnosis, she got pregnant. She registered at the hospital for delivery. She tested again in the 6th month of her pregnancy, when her husband informed the hospital about his HIV status. After more than 2.5 years from her original diagnosis, she was put on ARV.

WLHIV, FGD

In some cases, WLHIV reported that they did receive the proper counselling and support for PPTCT from the ART Center where they were registered.

Good Practice: ART Center provides counselling and support for PPTCT

X's husband was HIV positive when they met they fell in love. She knew about his status from day one. They practiced safe sex for five years. Then after consultation with doctors from the ART Centre, they conceived and have two HIV-free daughters. Her daughters were not given EID, nor was she ever given ARV during pregnancy. Her daughters were tested a month after birth, and both were negative. Her husband never faced any issues at ART Centres because he was working with a CBO focused on HIV, so he knew the system very well and could navigate his way easily.

WLHIV, FGD

Finding 5.6.4 Pregnant women face stigma and discrimination from gynaecologists, including from gynaecologists working in the PPTCT centers designated for women living with HIV.

In FGDs conducted for this gender assessment, WLHIV reported multiple instances of severe stigma and discrimination during pregnancy, from healthcare providers.

Stigma and discrimination against pregnant women living with HIV

The junior doctor refused to touch me for the fear of being infected by HIV.

She had a miscarriage and many doctors in the hospital refused to treat her and give her injections, before finally one doctor agreed. The trauma, pain and humiliation that she went through was immense and it was visible even after so many years when she talked about that incident.

When I delivered my two children in X Hospital, I was kept in the general ward and on my bed was written "This is an HIV patient" and the attitude of the other patients, their attendants, and medical staff was very hurtful. Many doctors and nurses would refuse to check me and to give me injections.

A big signboard was placed near my bedside, 'HIV Patient'. Doctors did not touch me. They would talk to me from a two feet distance; they kept the curtains around me closed all the time as if not to pollute the air in the general ward'

WLHIV FGDs

Even at specialised PPTCT services, women reported harassment from medical staff.

Stigma and discrimination in PPTCT services

You are HIV-positive. Your husband is HIV-positive. Why are you bringing more HIV into this world?

~Medical professional at a PPTCT, speaking to a pregnant woman living with HIV
Community member reporting in FGD

Focus group discussion participants reported that some pregnant women living with HIV had been denied access to ANC services due to their HIV status – physically denied entrance to the ANC ward.

Due to the challenges experienced by pregnant women who know their HIV-positive status, some women have been obliged to hide their HIV status in order to access the prenatal care they need. The gender assessment team heard of instances in which a women living with HIV went to the hospital to give birth, requesting a C-section, and not revealing their HIV status, for fear of being referred to a PPTCT center. Also, some women reported that they required permission from their husband to go to a PPTCT center, and this was not always possible to obtain – in which case they too attended ANC services without revealing their HIV status.

Accessing antenatal care by hiding their HIV status

The lady doctor who did my ultrasound told me to hold the ultrasound instrument in my own hand and slide it over my belly. That did not work. Then I was admitted and the hospital staff put a big sign next to my bed' HIV Patient' and it was a painful situation. So my friend took me to a private hospital and did not tell them about my HIV status. I had my delivery through operation, in peace without any shame.

WLHIV, FGD

Finding 5.6.5 Uneven access to Early Infant Diagnosis and paediatric care and poor coordination between PPTCT and ART services

Key informants reported that early infant diagnosis (EID) is not provided at PPTCT sites, but is provided at ART Centers only.

Inadequate EID and HIV paediatric care

Doctor gave me a bottle of liquid and told me to administer two drops once a day for forty days. He did not explain anything else, nor did he ask us to bring the baby back for a check-up. My daughter died on the 40th day. I do not know the cause of her death. My second child was born 6 months ago. He is HIV-negative. The doctors have me a syrup to give to my child for 40 days, and doctors told me not to breastfeed. They did not ask to bring my child back for follow-up.

WLIV, FGD

Good Practice: PIMS ART Center in Islamabad

I have three children, two born after the diagnosis. I had received PPTCT, children were given syrup for 45 days. I was informed about PPTCT at the PIMS where I go for my treatment. Both me and my husband are HIV positive but thank God none of my children have HIV. Dr. X at PIMs herself counselled me about the treatment before and after my pregnancies. I was counselled in detail by X at PIMS. When I told her about my desire to have more children she explained about the viral load and CD4. And then at the right time after these tests, I conceived.

WLHIV FGD

Finding 5.6.6 Provinces are working to improve access to PPTCT services

Key informants from Khyber Pakhtunkhwa reported that gynaecologists refuse to work with women living with HIV. The KP Provincial AIDS Control Program has attempted to address this issue with hospitals where gynaecologists had refused to provide services to HIV-positive women, and found that, while hospital management is ready to work on this issue, the gynaecologists have refused to reconsider their position. Khyber Pakhtunkhwa AIDS Control Program reported that it has run a training on PPTCT specifically for those gynaecologists who refused to work with women living with HIV; the program had a small budget and only covered a limited number of hospitals.

Some provinces, such as Punjab, reported that the Provincial AIDS Control Program has run trainings with gynaecologists to encourage testing for HIV in the first trimester, and also trainings at PPTCT centers on safe delivery and on early infant diagnosis and paediatric treatment.

Sindh reported that they are utilising female "mobilizers" and conducting outreach to men, in order to increase knowledge and generate support for women to attend ANC services, including PPTCT. Key informants in Sindh reported that efforts are also being made to make all ART centers also PPTCT centers, by training ART doctors in PPTCT.

In rural and tribal areas, such as those in Balochistan and Khyber Pakhtunkhwa, key informants recommended that LHW and community mid-wives (based in clinics) be engaged in HIV testing for pregnant women and facilitating access to PPTCT. The Balochistan key informant reported that there are 7,000 LHW working in the province and both provinces reported that the LHWs already cover 60% of households.

Recommendations 5.5: PPTCT

- Build on the good practices in Sindh to encourage pregnant women to attend ANC in their first trimester by deploying female "mobilizers" and conducting outreach to men, in order to increase knowledge and generate support for women to attend ANC services, including PPTCT.
- Offer HIV testing as part of routine antenatal care at a pregnant woman's first visit to ANC services. Develop SOPs to guide all ANC clinics in HIV testing, train gynaecologists in care for HIV-positive pregnant women, including addressing misperceptions and addressing stigma, ensure ready availability PEP at ANC clinics.
- Fully integrate PPTCT into regular ANC services, and discontinue the practice of segregating services for pregnant women living with HIV in separate clinics or wards.
- Provide HIV testing for pregnant women via mobile units or via LHWs in rural areas, with a particular focus on vulnerable women, and also provide access to self-testing kits for all pregnant women.
- Build the capacity of ART doctors to provide EID and paediatric care and convey accurate information of PPTCT including about breastfeeding.

Finding 6: Lack of female leadership and role models

Key informants interviewed for this gender assessment noted a lack of female role models and leadership in the national response. The gender assessment team's experience aligns with this observation: The team that conducted Pakistan's National Programme Review in 2023 was composed of nine men and had no gender expert. The NPR draft report from March 2023 notes that: "Little analysis is currently available on the important role of women in the HIV response as health care managers and workers, community-based outreach staff or as the social and economic managers within families as agents of change."

Recommendation 6: Foster female leadership

Increase WLHIV's representation in leadership and decision-making forums, provide leadership capacity building opportunities for WLHIV, and institute a mentoring program through community organisations and networks such as the Positive Female Network (POFEN). and youth-led organisations for girls, such as Girl Guides.

Conclusion

This report seeks to highlight the voices of ciswomen, men, and transgender women as they access the services they need and navigate the treatment cascade. It has drawn attention to critical gender gaps such as gaps in the data and in the policy response. It has highlighted programmatic gender gaps, such as outreach to female spouses and lack of programming for women who use drugs, female prisoners and young key populations especially transgender women; it has documented gender-specific vulnerabilities that remain unaddressed in the national response, such as gender-specific stigma and discrimination and gender-based violence; it has traced gender-specific barriers to access across the treatment cascade; and it has followed women's experiences accessing PPTCT during their pregnancies.

In presenting the findings from this gender assessment, it is our hope that these long-standing gender issues be addressed.

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Annex 1: Documents Consulted

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Annex 2: Key Informant Interview Guide

Tool for Key Informant Interviews

1. Please tell me about your work in the area of HIV. How long have you worked in HIV and what are your primary responsibilities?

2. Please tell me about any work your organisation has done on gender and HIV in Pakistan. For example, how has your organisation been working to support women, men, and gender non-conforming and transgender people to access HIV services?

3. In your view, do gender considerations impact access to HIV prevention services, especially for key populations? Can you provide some concrete examples of differences in the ways that men, women and gender non-conforming and transgender people access HIV prevention services?

4. In your opinion, in what ways do gender considerations impact access to HIV testing services, especially for key populations? Can you provide some concrete examples of differences in the ways that women, men and gender non-conforming and transgender people access HIV testing?

5. In your view, how do gender issues impact access to HIV treatment? How does accessing treatment differ for women, for men and for gender non-conforming and transgender people?

6. Have you noticed any differences in women's, men's, and gender non-conforming and transgender people's ability to adhere to HIV treatment? If so, what are those differences?

7. I would like to ask you about access to gender-specific services for people living with HIV, especially women and gender non-conforming and transgender people. For example, do people living with HIV have ready access to sexual and reproductive health services, including ART for PMTCT? to appropriate medical and legal services for gender-based violence?

8. I am interested in hearing about any work being done to access the female partners of men living with HIV. Are you aware of work being done in this area in Pakistan? If so, can you please describe it for me? What are its strong points? What could be done better?

9. I would like to ask for your suggestions about ways to improve the gender-responsiveness of Pakistan's national response to HIV. Thinking about the gender-specific vulnerabilities and barriers we have discussed today, in your view, what steps should be taken to address these barriers and improve access to HIV prevention, testing and treatment?

10. We have reached the end of our interview. Are there any further points you would like to raise?

Annex 3: Focus Group Discussion Guides

Tool 1

Women Living with HIV: Tool for Focus Group Discussion

Introduction: Hello, my name is _____. I am a consultant for UNDP. UNDP is conducting a gender assessment of the HIV program in Pakistan. The goal of the gender assessment is to better understand the ways that gender issues impact the HIV program and to find ways to further strengthen the HIV response in Pakistan by better addressing those gender issues. We are very interested to hear your opinions about this. We will not share individual opinions. I will be writing a report about this FGD, however, all information will be anonymous and I am not recording your names. Participation in this discussion is entirely voluntary. You are not obligated to speak, you do not have to answer the questions if you do not want to or do not feel comfortable, and you can leave the discussion at any time. However, I very much hope that you will all feel comfortable participating as your views are very important to the assessment and will be helpful for strengthening the HIV program in Pakistan. Do you have any questions for me? (Pause and address questions) Do I have your permission to start the discussion?

Discussion Questions:

1. Please tell me a little about yourself (age, gender identity, member of any key population community).
2. Have you ever received any HIV prevention services? If yes, which services did you receive? (condoms, PrEP, U=U messaging, STI testing and treatment, etc.) And where did you receive these services? (e.g. from an outreach worker, at a drop-in center, at a health clinic, etc.). Were the services helpful? (Did the service provider listen to you, did they understand you, did they treat you with respect, did they give you what you need. Were services available at a time that was convenient for you? Did you need to pay to receive services? Is there anything you wish they would have provided, but they did not?)
3. Please tell me about your experience getting a test for HIV. (Why did you decide to get an HIV test? How did you know where to get a test? Were you treated well by the service provider? Where did you get the test? Did you get pre and post-test counselling? Did you feel comfortable getting the testing services? How were you informed about the results of your test?)
    - 4a. Did you inform your husband / partner(s) about your HIV status? If not, why not? If yes, what was the reaction?
4. I am interested to hear about your experiences accessing HIV treatment. (Were you able to get HIV treatment? Was it easy to get? Were you able to continue taking it? Did you stop taking it at any point and if so, why? If it was difficult to get the treatment or else difficult to continue taking it, please tell me what the problems were).
5. Have you ever experienced violence? If so, did you consider reporting it? Do you know where you can report it? If you did report it, or considered reporting it, where did / would you report it? (NGO, police, lawyer, health clinic)? Were you able to get medical care? Legal support? If not, why not?
6. Have you ever been pregnant? Have you heard about ART for preventing parent to child transmission of HIV? Have you ever had access to PPTCT? Please tell me about your experience. (Where did you get it? How long did you take it? Did your child get any treatment?)
7. Please provide your suggestions: What should be done to improve HIV services?

Tool 2

Men Living with HIV: Tool for Focus Group Discussion

Introduction: Hello, my name is _____. I am a consultant for UNDP. UNDP is conducting a gender assessment of the HIV program in Pakistan. The goal of the gender assessment is to better understand the ways that gender issues impact the HIV program and to find ways to further strengthen the HIV response in Pakistan by better addressing those gender issues. We are very interested to hear your opinions about this. We will not share individual opinions. I will be writing a report about this FGD, however, all information will be anonymous and I am not recording your names. Participation in this discussion is entirely voluntary. You are not obligated to speak, you do not have to answer the questions if you do not want to or do not feel comfortable, and you can leave the discussion at any time. However, I very much hope that you will all feel comfortable participating as your views are very important to the assessment and will be helpful for strengthening the HIV program in Pakistan. Do you have any questions for me? (Pause and address questions) Do I have your permission to start the discussion?

Discussion Questions:

1. Please tell me a little about yourself (age, gender identity, member of any key population community).
2. Have you ever received any HIV prevention services? If yes, which services did you receive? (condoms, PrEP, U=U messaging, STI testing and treatment, etc.) And where did you receive these services? (e.g. from an outreach worker, at a drop-in center, at a health clinic, etc.). Were the services helpful? (Did the service provider listen to you, did they understand you, did they treat you with respect, did they give you what you need. Were services available at a time that was convenient for you? Did you need to pay to receive services? Is there anything you wish they would have provided, but they did not?)
3. Please tell me about your experience getting a test for HIV. (Why did you decide to get an HIV test? How did you know where to get a test? Were you treated well by the service provider? Where did you get the test? Did you get pre and post-test counselling? Did you feel comfortable getting the testing services? How were you informed about the results of your test?)
    - 3a. Did you inform your wife / partner(s) about your HIV status? If not, why not? If yes, what was the reaction?
4. I am interested to hear about your experiences accessing HIV treatment. (Were you able to get HIV treatment? Was it easy to get? Were you able to continue taking it? Did you stop taking it at any point and if so, why? If it was difficult to get the treatment or else difficult to continue taking it, please tell me what the problems were).
5. Have you ever experienced violence? If so, did you consider reporting it? Do you know where you can report it? If you did report it, or considered reporting it, where did / would you report it? (NGO, police, lawyer, health clinic)? Were you able to get medical care? Legal support? If not, why not?
6. Please provide your suggestions: What should be done to improve HIV services?

Tool 3

Women who use drugs: Tool for Focus Group Discussion

Introduction: Hello, my name is _____. I am a consultant for UNDP. UNDP is conducting a gender assessment of the HIV program in Pakistan. The goal of the gender assessment is to better understand the ways that gender issues impact the HIV program and to find ways to further strengthen the HIV response in Pakistan by better addressing those gender issues. We are very interested to hear your opinions about this. We will not share individual opinions. I will be writing a report about this FGD, however, all information will be anonymous and I am not recording your names. Participation in this discussion is entirely voluntary. You are not obligated to speak, you do not have to answer the questions if you do not want to or do not feel comfortable, and you can leave the discussion at any time. However, I very much hope that you will all feel comfortable participating as your views are very important to the assessment and will be helpful for strengthening the HIV program in Pakistan. Do you have any questions for me? (Pause and address questions) Do I have your permission to start the discussion?

Discussion Questions:

1. Please tell me a little about yourself (age, gender identity, number of years using drugs, types of drugs you use, method of using drugs – smoking, sniffing, injecting, other).
2. Have you ever received any HIV prevention services? Harm reduction services? If yes, which services did you receive? (needle and syringe program, wound management, pipe, other drug use paraphernalia, condoms, PrEP, U=U messaging, STI testing and treatment, etc.). And where did you receive these services? (e.g. from my husband / boyfriend, my dealer, an outreach worker, at a drop-in center for people who use drugs, at a drop-in center for sex workers, at a health clinic, etc.). Were the services helpful? (Did the service provider listen to you, did they understand you, did they treat you with respect, did they give you what you need. Were services available at a time that was convenient for you? Did you need to pay to receive services? Is there anything you wish they would have provided, but they did not?)
3. Have you had a test for HIV? If yes, please tell me about your experience getting a test for HIV. (Have you taken a test for HIV? How did you know where to get a test? Why did you decide to get an HIV test? Were you treated well by the service provider? Where did you get the test? Did you get pre and post-test counselling? Did you feel comfortable getting the testing services? How were you informed about the results of your test?)
    - 4a. This question only for people who disclose their HIV status as positive: Did you inform your husband / partner(s) about your HIV status? If not, why not? If yes, what was the reaction?
    - 4b. This question only for people who disclose their HIV status as positive: I am interested to hear about your experiences accessing HIV treatment. (Were you able to get HIV treatment? Was it easy to get? Were you able to continue taking it? Did you stop taking it at any point and if so, why? If it was difficult to get the treatment or else difficult to continue taking it, please tell me what the problems were).
4. Have you ever experienced violence? If so, did you consider reporting it? Do you know where you can report it? If you did report it, or considered reporting it, where did / would you report it? (NGO, police, lawyer, health clinic)? Were you able to get medical care? Legal support? If not, why not?
5. Have you ever been pregnant? Have you heard about ART for preventing parent to child transmission of HIV? Have you ever had access to PPTCT? Please tell me about your experience. (Where did you get it? How long did you take it? Did your child get any treatment?)
6. Please provide your suggestions: What should be done to improve HIV services?

Tool 4

Men who use drugs: Tool for Focus Group Discussion

Introduction: Hello, my name is _____. I am a consultant for UNDP. UNDP is conducting a gender assessment of the HIV program in Pakistan. The goal of the gender assessment is to better understand the ways that gender issues impact the HIV program and to find ways to further strengthen the HIV response in Pakistan by better addressing those gender issues. We are very interested to hear your opinions about this. We will not share individual opinions. I will be writing a report about this FGD, however, all information will be anonymous and I am not recording your names. Participation in this discussion is entirely voluntary. You are not obligated to speak, you do not have to answer the questions if you do not want to or do not feel comfortable, and you can leave the discussion at any time. However, I very much hope that you will all feel comfortable participating as your views are very important to the assessment and will be helpful for strengthening the HIV program in Pakistan. Do you have any questions for me? (Pause and address questions) Do I have your permission to start the discussion?

Discussion Questions:

1. Please tell me a little about yourself (age, gender identity, number of years using drugs, types of drugs you use, method of using drugs – smoking, sniffing, injecting, other).
2. Have you ever received any HIV prevention services? Harm reduction services? If yes, which services did you receive? (needle and syringe program, wound management, pipe, other drug use paraphernalia, condoms, PrEP, U=U messaging, STI testing and treatment, etc.). And where did you receive these services? (e.g. from my friend, my dealer, an outreach worker, at a drop-in center, at a health clinic, etc.). Were the services helpful? (Did the service provider listen to you, did they understand you, did they treat you with respect, did they give you what you need. Were services available at a time that was convenient for you? Did you need to pay to receive services? Is there anything you wish they would have provided but did not?)
3. Are you married?
    - 3a. For those who are married: Does your wife know that you use drugs? Does your wife also use drugs? If so, does your wife go to HIV and/or harm reduction services? And/or do you provide harm reduction equipment for your wife (needles and syringes, pipes, other paraphernalia)?
4. Have you had a test for HIV? If yes, please tell me about your experience getting a test for HIV. (Why did you decide to get an HIV test? How did you know where to get a test? Were you treated well by the service provider? Where did you get the test? Did you get pre and post-test counselling? Did you feel comfortable getting the testing services? How were you informed about the results of your test?)
    - 4a. This question only for people who disclose their HIV status as positive: Did you inform your wife / partner(s) about your HIV status? If not, why not?
    - 4b. This question only for people who disclose their HIV status as positive: I am interested to hear about your experiences accessing HIV treatment. (Were you able to get HIV treatment? Was it easy to get? Were you able to continue taking it? Did you stop taking it at any point and if so, why? If it was difficult to get the treatment or else difficult to continue taking it, please tell me what the problems were).
5. Have you ever experienced violence? If so, did you consider reporting it? Do you know where you can report it? If you did report it, or considered reporting it, where did / would you report it? (NGO, police, lawyer, health clinic)? Were you able to get medical care? Legal support? If not, why not?
6. Please provide your suggestions: What should be done to improve HIV services?

Tool 5

Men who have sex with men: Tool for Focus Group Discussion

Introduction: Hello, my name is _____. I am a consultant for UNDP. UNDP is conducting a gender assessment of the HIV program in Pakistan. The goal of the gender assessment is to better understand the ways that gender issues impact the HIV program and to find ways to further strengthen the HIV response in Pakistan by better addressing those gender issues. We are very interested to hear your opinions about this. We will not share individual opinions. I will be writing a report about this FGD, however, all information will be anonymous and I am not recording your names. Participation in this discussion is entirely voluntary. You are not obligated to speak, you do not have to answer the questions if you do not want to or do not feel comfortable, and you can leave the discussion at any time. However, I very much hope that you will all feel comfortable participating as your views are very important to the assessment and will be helpful for strengthening the HIV program in Pakistan. Do you have any questions for me? (Pause and address questions) Do I have your permission to start the discussion?

Discussion Questions:

1. Please tell me a little about yourself (age, gender identity, married (to a woman)).
2. Have you ever received any HIV prevention services? If yes, which services did you receive? (condoms, PrEP, U=U messaging, STI testing and treatment, etc.) And where did you receive these services? (e.g. from an outreach worker, at a drop-in center, at a health clinic, etc.). Were the services helpful? (Did the service provider listen to you, did they understand you, did they treat you with respect, did they give you what you need. Were services available at a time that was convenient for you? Did you need to pay to receive services? Is there anything you wish they would have provided, but they did not?)
    - 2a. This question only for people who said they are married to a woman and/or have female sexual partners: have you informed your wife / female sexual partner(s) that you have sex with men?
3. Have you had a test for HIV? Please tell me about your experience getting a test for HIV. (Why did you decide to get an HIV test? How did you know where to get a test? Were you treated well by the service provider? Where did you get the test? Did you get pre and post-test counselling? Did you feel comfortable getting the testing services? How were you informed about the results of your test?)
    - 3a. This question only for people who disclose their HIV status as positive: Did you inform your partner(s) about your HIV status? If not, why not? If yes, what was the reaction?
    - 3b. This question only for people who disclose their HIV status as positive and are married to a woman: Did you inform your wife / female partner(s) about your HIV status? If not, why not? If yes, what was the reaction?
    - 3c. This question only for people who disclose their HIV status as positive: I am interested to hear about your experiences accessing HIV treatment. (Were you able to get HIV treatment? Was it easy to get? Were you able to continue taking it? Did you stop taking it at any point and if so, why? If it was difficult to get the treatment or else difficult to continue taking it, please tell me what the problems were).
4. Have you ever experienced violence? If so, did you consider reporting it? Do you know where you can report it? If you did report it, or considered reporting it, where did / would you report it? (NGO, police, lawyer, health clinic)? Were you able to get medical care? Legal support? If not, why not?
5. Please provide your suggestions: What should be done to improve HIV services?

Tool 6

Female and transgender sex workers: Tool for Focus Group Discussion

Introduction: Hello, my name is _____. I am a consultant for UNDP. UNDP is conducting a gender assessment of the HIV program in Pakistan. The goal of the gender assessment is to better understand the ways that gender issues impact the HIV program and to find ways to further strengthen the HIV response in Pakistan by better addressing those gender issues. We are very interested to hear your opinions about this. We will not share individual opinions. I will be writing a report about this FGD, however, all information will be anonymous and I am not recording your names. Participation in this discussion is entirely voluntary. You are not obligated to speak, you do not have to answer the questions if you do not want to or do not feel comfortable, and you can leave the discussion at any time. However, I very much hope that you will all feel comfortable participating as your views are very important to the assessment and will be helpful for strengthening the HIV program in Pakistan. Do you have any questions for me? (Pause and address questions) Do I have your permission to start the discussion?

Discussion Questions:

1. Please tell me a little about yourself (age, gender identity, number of years selling sex, street-based / brothel-based / on-line).
2. Have you ever received any HIV prevention services? If yes, which services did you receive? (condoms, PrEP, U=U messaging, STI testing and treatment, harm reduction, etc.). And where did you receive these services? (e.g. from an outreach worker, at a drop-in center, at a health clinic, my husband / boyfriend, my dealer, etc.). Were the services helpful? (Did the service provider listen to you, did they understand you, did they treat you with respect, did they give you what you need. Were services available at a time that was convenient for you? Did you need to pay to receive services? Is there anything you wish they would have provided, but they did not?)
3. Have you had a test for HIV? If yes, please tell me about your experience getting a test for HIV. (Why did you decide to get an HIV test? How did you know where to get a test? Were you treated well by the service provider? Where did you get the test? Did you get pre and post-test counselling? Did you feel comfortable getting the testing services? How were you informed about the results of your test?)
    - 4a. This question only for people who disclose their HIV status as positive: Did you inform your clients / husband / partner(s) about your HIV status? If not, why not? If yes, what was the reaction?
    - 4b. This question only for people who disclose their HIV status as positive: I am interested to hear about your experiences accessing HIV treatment. (Were you able to get HIV treatment? Was it easy to get? Were you able to continue taking it? Did you stop taking it at any point and if so, why? If it was difficult to get the treatment or else difficult to continue taking it, please tell me what the problems were).
4. Have you ever experienced violence? If so, did you consider reporting it? Do you know where you can report it? If you did report it, or considered reporting it, where did / would you report it? (NGO, police, lawyer, health clinic)? Were you able to get medical care? Legal support? If not, why not?
5. Have you ever been pregnant? Have you heard about ART for preventing parent to child transmission of HIV? Have you ever had access to PPTCT? Please tell me about your experience. (Where did you get it? How long did you take it? Did your child get any treatment?)
6. Please provide your suggestions: What should be done to improve HIV services?

Tool 7

Male and transgender sex workers: Tool for Focus Group Discussion

Introduction: Hello, my name is _____. I am a consultant for UNDP. UNDP is conducting a gender assessment of the HIV program in Pakistan. The goal of the gender assessment is to better understand the ways that gender issues impact the HIV program and to find ways to further strengthen the HIV response in Pakistan by better addressing those gender issues. We are very interested to hear your opinions about this. We will not share individual opinions. I will be writing a report about this FGD, however, all information will be anonymous and I am not recording your names. Participation in this discussion is entirely voluntary. You are not obligated to speak, you do not have to answer the questions if you do not want to or do not feel comfortable, and you can leave the discussion at any time. However, I very much hope that you will all feel comfortable participating as your views are very important to the assessment and will be helpful for strengthening the HIV program in Pakistan. Do you have any questions for me? (Pause and address questions) Do I have your permission to start the discussion?

Discussion Questions:

1. Please tell me a little about yourself (age, gender identity, number of years selling sex, street-based / brothel-based / on-line).
2. Have you ever received any HIV prevention services? If yes, which services did you receive? (condoms, PrEP, U=U messaging, STI testing and treatment, harm reduction, etc.). And where did you receive these services? (e.g. an outreach worker, at a drop-in center, at a health clinic, from my sexual partner / spouse, my dealer, etc.). Were you able to access hormone therapy is you wanted it? Were the services helpful? (Did the service provider listen to you, did they understand you, did they treat you with respect, did they give you what you need. Were services available at a time that was convenient for you? Did you need to pay to receive services? Is there anything you wish they would have provided, but they did not?)
3. Have you had a test for HIV? If yes, please tell me about your experience getting a test for HIV. (Why did you decide to get an HIV test? How did you know where to get a test? Were you treated well by the service provider? Where did you get the test? Did you get pre and post-test counselling? Did you feel comfortable getting the testing services? How were you informed about the results of your test?)
    - 4a. This question only for people who disclose their HIV status as positive: Did you inform your clients / wife / partner(s) about your HIV status? If not, why not? If yes, what was the reaction?
    - 4b. This question only for people who disclose their HIV status as positive: I am interested to hear about your experiences accessing HIV treatment. (Were you able to get HIV treatment? Was it easy to get? Were you able to continue taking it? Did you stop taking it at any point and if so, why? If it was difficult to get the treatment or else difficult to continue taking it, please tell me what the problems were).
4. Have you ever experienced violence? If so, did you consider reporting it? Do you know where you can report it? If you did report it, or considered reporting it, where did / would you report it? (NGO, police, lawyer, health clinic)? Were you able to get medical care? Legal support? If not, why not?
5. Please provide your suggestions: What should be done to improve HIV services?

Tool 8

Transgender and gender non-confirming people: Tool for Focus Group Discussion

Introduction: Hello, my name is _____. I am a consultant for UNDP. UNDP is conducting a gender assessment of the HIV program in Pakistan. The goal of the gender assessment is to better understand the ways that gender issues impact the HIV program and to find ways to further strengthen the HIV response in Pakistan by better addressing those gender issues. We are very interested to hear your opinions about this. We will not share individual opinions. I will be writing a report about this FGD, however, all information will be anonymous and I am not recording your names. Participation in this discussion is entirely voluntary. You are not obligated to speak, you do not have to answer the questions if you do not want to or do not feel comfortable, and you can leave the discussion at any time. However, I very much hope that you will all feel comfortable participating as your views are very important to the assessment and will be helpful for strengthening the HIV program in Pakistan. Do you have any questions for me? (Pause and address questions) Do I have your permission to start the discussion?

Discussion Questions:

1. Please tell me a little about yourself (age, gender identity, married).
2. Have you ever received any HIV prevention services? If yes, which services did you receive? (condoms, PrEP, U=U messaging, STI testing and treatment, harm reduction, etc.) And where did you receive these services? (e.g. from an outreach worker, at a drop-in center, at a health clinic, etc.). Were the services helpful? (Did the service provider listen to you, did they understand you, did they treat you with respect, did they give you what you need. Were services available at a time that was convenient for you? Did you need to pay to receive services? Is there anything you wish they would have provided, but they did not?)
3. Have you had a test for HIV? If yes, please tell me about your experience getting a test for HIV. (Why did you decide to get an HIV test? How did you know where to get a test? Were you treated well by the service provider? Where did you get the test? Did you get pre and post-test counselling? Did you feel comfortable getting the testing services? How were you informed about the results of your test?)
    - 3a. This question only for people who disclose their HIV status as positive: Did you inform your partner(s) about your HIV status? If not, why not? If yes, what was the reaction?
    - 3b. This question only for people who disclose their HIV status as positive and are married: Did you inform your wife / husband / partner(s) about your HIV status? If not, why not? If yes, what was the reaction?
    - 3c. This question only for people who disclose their HIV status as positive: I am interested to hear about your experiences accessing HIV treatment. (Were you able to get HIV treatment? Was it easy to get? Were you able to continue taking it? Did you stop taking it at any point and if so, why? If it was difficult to get the treatment or else difficult to continue taking it, please tell me what the problems were).
4. Have you ever experienced violence? If so, did you consider reporting it? Do you know where you can report it? If you did report it, or considered reporting it, where did / would you report it? (NGO, police, lawyer, health clinic)? Were you able to get medical care? Legal support? If not, why not?
5. Please provide your suggestions: What should be done to improve HIV services?

Tool 9

Spouses and female sexual partners of men living with HIV, of men who use drugs and/or of men who have sex with men: Tool for Focus Group Discussion

Introduction: Hello, my name is _____. I am a consultant for UNDP. UNDP is conducting a gender assessment of the HIV program in Pakistan. The goal of the gender assessment is to better understand the ways that gender issues impact the HIV program and to find ways to further strengthen the HIV response in Pakistan by better addressing those gender issues. We are very interested to hear your opinions about this. We will not share individual opinions. I will be writing a report about this FGD, however, all information will be anonymous and I am not recording your names. Participation in this discussion is entirely voluntary. You are not obligated to speak, you do not have to answer the questions if you do not want to or do not feel comfortable, and you can leave the discussion at any time. However, I very much hope that you will all feel comfortable participating as your views are very important to the assessment and will be helpful for strengthening the HIV program in Pakistan. Do you have any questions for me? (Pause and address questions) Do I have your permission to start the discussion?

Discussion Questions:

1. Please tell me a little about yourself (age, number of years married, number and age of children, whether husband is a member of any key population community).
2. Have you ever received any HIV prevention services? If yes, which services did you receive? (condoms, PrEP, U=U messaging, STI testing and treatment, harm reduction, etc.) And where did you receive these services? (e.g. from my husband, an outreach worker, at a drop-in center, at a health clinic, etc.). Were the services helpful? (Did the service provider listen to you, did they understand you, did they treat you with respect, did they give you what you need. Were services available at a time that was convenient for you? Did you need to pay to receive services? Is there anything you wish they would have provided, but they did not?)
3. Have you ever had a test for HIV? Please tell me about your experience getting a test for HIV. (Why did you decide to get an HIV test? How did you know where to get a test? Were you treated well by the service provider? Where did you get the test? Did you get pre and post-test counselling? Did you feel comfortable getting the testing services? How were you informed about the results of your test?)
    - 4a. Did you inform your husband / partner(s) about your HIV status? If not, why not? If yes, what was the reaction?
4. I am interested to hear about your experiences accessing HIV treatment. (Were you able to get HIV treatment? Was it easy to get? Were you able to continue taking it? Did you stop taking it at any point and if so, why? If it was difficult to get the treatment or else difficult to continue taking it, please tell me what the problems were).
5. Have you ever experienced violence? If so, did you consider reporting it? Do you know where you can report it? If you did report it, or considered reporting it, where did / would you report it? (NGO, police, lawyer, health clinic)? Were you able to get medical care? Legal support? If not, why not?
6. Have you ever been pregnant? Have you heard about ART for preventing parent to child transmission of HIV? Have you ever had access to PPTCT? Please tell me about your experience. (Where did you get it? How long did you take it? Did your child get any treatment?)
7. Please provide your suggestions: What should be done to improve HIV services?

Annex 4: Key Informant List

Name	Position and Organisation	Contact
Dr. Saima Paracha	HIV Technical Advisor, NACP	saima_paracha@hotmail.com
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Fahmida Khan	Community Advisor, UNAIDS	khanf@unaids.org
Saliha Ramay	Programme Analyst GBV-UNFPA	ramay@unfpa.org
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Yasmine Akhtar	Director of Operations, Nai Zindagi	yasmeen@naizindagi.com
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Dr. Saima	CDC Sindh (AIDS Control Program)	saimashaikh666@gmail.com
Dr. Ghous	CDC Sindh (AIDS Control Program)	cdchivaids.sindh@gmail.com
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Zehrish Khanzadi	Manager Gender Interactive Alliance	zehrishkhangia@gmail.com
Syed Raza Tirmizi	Project Director, Dostana	syedraza.tir@gmail.com
Amar Ali	M&E Manager, Dostana	
Bushra Rani	Manager, Baham	bushrarani@gmail.com
Nayyab Ali	TG Activist	nayyab.ali@trconsultantspk.com

Annex 5: FGD Reporting Template

Date: **Location:** **Key Population:** **Number of FGD participants:** **Age and Gender of each participant:**
Comments on prevention:
Comments on testing:
Comments on treatment:
Comments on violence:
Comments on pregnancy / PPTCT:
FGD participant recommendations:
Comments and recommendations from the national consultant:


UN
DP