PAKISTAN

AIDS Strategy III

2015 - 2020

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Pakistan AIDS Strategy III Outline

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANF	Anti-Narcotics Force
APLHIV	Association of People Living with HIV
ART	Antiretroviral Therapy
ARV/s	Antiretroviral/s (medication)
BISP	Benazir Income Support Program
CBO	Community-Based Organization
CCM	Country Coordination Mechanism
CD4	Cluster of Differentiation 4
CHBC	Community and Home-Based Care
CoC	Continuum of Care
CoPC	Continuum of Prevention and Care
DHS	Demographic Health Survey
DOTS	Directly Observed Treatment Short-Course
EHACP	Enhanced HIV/AIDS Control Programme
EID	Early Infant Diagnosis
FATA	Federally Administered Tribal Areas
FIA	Federal Investigation Agency
FSW	Female Sex Worker
GARPR	Global AIDS Response Progress Report
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	Gesellschaft für Internationale Zusammenarbeit
GoP	Government of Pakistan
HASP	HIV/AIDS Surveillance Project
HIV	Human Immunodeficiency Virus
HSW	Hijra Sex Worker
HTC	HIV Testing and Counselling
IBBS	Integrated Biological and Behavioral Surveillance
ICT	Islamabad Capital Territory
KP	Key Population
KPK	Khyber Pakhtunkhwa
LMIS	Logistic Management Information System
M&E	Monitoring and Evaluation
MIS	Management Information System
MSM	Men who have Sex with Men
MSW	Male Sex Worker
MTCT	Mother to Child Transmission
MTR	Mid-Term Review
NACP	National AIDS Control Program
NGO	Non-Governmental Organization
NMHA	Naz Male Health Alliance
NPM	National Program Manager
NSEP	Needle Syringe Exchange Program
NSF	National Strategic Framework
ORW	Outreach Worker
OST	Opiate Substitution Therapy
PACP/s	Provincial AIDS Control Programme/s
PC-1	Planning Commission Proforma – One (Project Document)

PLHIV	People living with HIV
PMRC	Pakistan Medical Research Council
PMTCT	Prevention of Mother-to-Child Transmission
PPM	Provincial Program Manager
PPTCT	Prevention of Parent-to-Child Transmission
PR	Principal Recipient/s – GFATM
PSM	Procurement and Supply Management
PWID	People who Inject Drugs
QA	Quality Assurance
SARA	Service Availability and Readiness Assessment
SDP	Service Delivery Package
SIUT	Sindh Institute of Urology and Transplantation
SOP	Standard Operating Procedure
SR	Sub-Recipients - GFATM
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
TACA	Technical Advisory Committee for AIDS
TB	Tuberculosis
TG	Transgender person
TWG	Technical Working Group
UN	United Nations
UNAIDS	United Nations Joint Program on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

Part I: Summary

I.1. About the Pakistan AIDS Strategy III

The Pakistan AIDS Strategy III 2015 – 2020 was developed by a team of consultants under the technical guidance and supervision of the National AIDS Control Programme, UNAIDS Pakistan and an expanded HIV Technical Working Group of the Country Coordination Mechanism. Prior to the development of the PAS III, a mid-term review of the four Provincial AIDS Strategies 2012 – 2016 was undertaken and recommendations for strengthening made. The PAS III is a consolidation of the four Provincial Strategies,and recommendations made by key stakeholders during the MTR process and country dialogues for the PAS IIIdevelopment (*see III.2. Development of the PAS III*).Provincial Secretaries of Health and Planning, or their representatives, endorsed MTR recommendations in the presence of the State Minister of Health, January 15th, 2015.

The purpose of the PAS III is to guide Pakistan's overall national response for HIV and AIDS through 2020, through focused interventions with set targets, costs, roles and responsibilities. The successful implementation of PAS III involves multiple stakeholders to achieve priority Outcomes outlined in the Strategy. The Strategy focuses on allocating limited resources to scale up high-impact, high-value interventions such as HTC and treatment to reduce AIDS-related deaths and new HIV infections.[1]Priorities in the PAS III have been identified to ensure maximum impact in reducing new infections, especially among key populations, improving treatment uptake and retention, and improving the quality of life of people living with HIV and AIDS in the context of limited financial and human resources.

The PAS III and the accompanying Operational Plan will serve as key tools for coordination and oversight of Pakistan's HIV response. The Operational Plan indicates resource needs for key strategic interventions to achieve Strategic Outputs and can be used as a reference for resource mobilisation. Roles and responsibilities for the PAS III are shared between the National and Provincial AIDS Control Programmes (inclusive of the Khyber Pakhtunkhwa Directorate of Public Health's HIV Unit), public and private sectors, and with the technical support of the United Nations. The PAS III is aligned with the Government of Pakistan's Vision 2020[2], which stresses achieving HIV incidence and mortality reductions is contingent upon innovative models of public-private partnership service delivery.

[1]Merely reallocating existing resources toward core interventions and away from less strategic non-core approaches would increase the impact of efforts by 20%. Hallett T (2013). Historic Gains in the Fight Against HIV Are Within Reach and Within Budget. *GlobalFund blog*, May 27. Available: www.theglobalfund.org/en/blog/32206/.

[2] Pakistan in the 21st Century: Vision 2020. Planning Commission Government of Pakistan Islamabad, August 2007.

The PAS III is geographically all encompassing, covering four main Provinces: Punjab, Sindh, Baluchistan, and Khyber Pakhtunkhwa (KPK); two autonomous states: Azad Jammu Kashmir (AJK), Gilgit-Baltistan, the Federally Administered Tribal Areas (FATA) and the Islamabad Capital Territory (ICT). Each province or region features its ownsocio-demographic characteristics. While the PAS III is geographically all encompassing, priorities vary slightly across provinces and regions.

Figure 1: Map of Pakistan (source: AEM modelling)

PAS III is a living document, whose intervention priorities, strategies to reach those priorities, and targets will be updated as new strategic information becomes available, including Integrated Biological and Behavioural Surveillance and impact evaluations.

I.2. Summary of PAS III: the Strategic Outcomes, Outputs and Cross-Cutting Interventions

The PAS III identifies three Strategic Outcomes to mitigate the trend in the epidemic, halting new infections and ensuring those needing treatment receive it. There is some overlap between Outputs under the Outcomes given the fact that many of the SDPs providing prevention services (Outcome I) are also providing either services or referrals along the entire Continuum of Care. And while the primary focus under Outcome II is increasing uptake to ensure those who need treatment receive it, there is an obvious correlative effect of increased prevention of transmission when HIV positive persons have suppressed viral loads.[3]

- Strategic Outcome I: HIV Prevention is increased and sustained among key populations: People who Inject Drugs (PWID), Males Who Have Sex With Males (MSM), Transgender Persons (TG), Female Sex Workers (FSW); and vulnerable populations with their sexual partners.

[3]Research findings demonstrate that ART is highly effective in reducing the risk of HIV transmission by 96%. *(N Eng J Med. 2011; 365: 493-505).*

The populations to be targeted under this outcome are based on prevalence levels and those determined to be at higher risk. They include PWID, TG (including *hijra* sex workers), MSM (including male sex workers), FSW, prisoners, returned migrant workers, and intimate partners of HIV positive males (mostly within the key populations). Prevention targets will be achieved through provision of relevant service packages for identified key and vulnerable populations including prevention interventions and referrals into treatment and care where indicated.

- Strategic Outcome II: HIV related mortality and morbidity among children, adolescents and adults is reduced through available and equitable access to quality continuum of care services

Strategic Outcome II focuses on increasing HTC uptake and getting those who need it into treatment, care and support services. At the end of 2014, the gap between persons eligible for treatment and those who are receiving treatment was 90.8% for adults and 94.2 per cent for children.[4]

- Strategic Outcome III: Environment for Effective AIDS Response is Enabled

Strategic Outcome 3 supports both Strategic Outcomes I and II through use of strategic information to monitor HIV response coverage, quality and impact; increased multi-sectoral coordination at Federal and Provincial Levels; and increased sustainability of the response through advocacy, multi-sectoral coordination and promotion of rights. Figure 2 below outlines Strategic Outcomes and Outputs.

Figure 2. Strategic Outcomes and Outputs

[4] Spectrum file Pakistan 2015MAR18.

In Part IV of the PAS III, strategic outcomes, outputs, implementation strategies,keypartners and linkages within the Strategy are fully articulated. Strategic actions have been translated into activities in the Operational Plan (*see Annex IIICosted Operational Plan*).

Crosscutting Interventions

There are several cross-cutting interventions throughout the PAS III reflected across Outcomes and Outputs, including developing service standards, implementing guidelines, and capacity building of service providers. Crosscutting interventions that are not connected to a specific programmatic intervention are included under Outcome 3, i.e. advocacy and use of strategic information, including programme data through a strengthened MIS, as well as efforts towards developing Provincial HIV legislation. In PAS III gender-responsive and human-rights based approaches are integrated into activities that support its goals, objectives and strategies to mitigate vulnerability and risk.

Part II: Situational Analysis

II.1. Context

The population of Pakistan is estimated at approximately 188 million in 2015[5] making it the sixth most populous nation in the world with an average annual growth rate of 2 per cent[6] and over 96 per cent of its population Muslim.[7] Conservative religious values and cultural normative systems have contributed to keeping the epidemic from becoming generalized, remaining concentrated in Key Populations (PWID, MSM, TG, and FSW).

II.1.a. International Commitments

Pakistan endorsed the Declaration of Commitment (DoC) of the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS of 2001. In June 2011 at the 65th Session Pakistan endorsed the UN GA Resolution "Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS." Following a 2013 Mid-Term Review, Pakistan was found not to be on target for over 50 per cent of their targets (6 out of 10). Progress on Millennium Development Goal 6 is also at 50 per cent; Pakistan is on track to meet the indicator *HIV prevalence among 15-49 year old Pregnant Women is halved by 2015 from baseline*, but not on track to meet the indicator "*HIV prevalence among vulnerable groups (IDU/PWID, FSW, MSW and HSW) is halved from baseline to 2015*".[8]

Figure 3. 2013 Mid-term review of the Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS

[5] United Nations, Department of Economics and Social Affairs: Population Division, Population Estimates and Projections Section. http://esa.un.org/unpd/wpp/unpp/p2k0data.asp.

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

[7] The Future of the Global Muslim Population. Pew Research Center. 2010.

[8] There is little baseline data available on the first indicator, except an ANC study conducted during IBBS R IV with the support of UNICEF. Out of 26,510 antenatal clinic attendees from 41 antenatal clinics in four provinces, 34.3% (9,095) women were in the age bracket of 15-24 years and had an HIV prevalence of 0.04% (4/9095 confirmed sero-positive). It is assumed that this target will be met by the end of 2015. Progress on the second indicator is not being made. HIV prevalence among all key populations has gone up since baseline (2005). Final progress will be reported after Round V of the IBBS is conducted in 2015. Pakistan is also a signatory to several international conventions such as the Convention on the Elimination of All Forms of Discrimination against Women (ratified in 1996)[8]; and the Convention on the Rights of the Child (ratified 12th December 1990); however these Conventions have only guided limited aspects of the HIV response, particularly in advocacy.

2013 MTR of the Political Declaration on HIV & AIDS: Intensifying Our Efforts to Eliminate HIV & AIDS

Not on Track : Target 1: Reduce sexual transmission of HIV by 50% by 2015

On Track : Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015

Not on Track : Target 3: Eliminate mother-to-child transmission of HIV by 2015 & substantially reduce AIDS related maternal death

Not on Track : Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2011

On Track : Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015

Not on Track : Target 6: Reach a significant level of annual global expenditure (US $22-24 billion) in low & middle-income countries

Not on Track : Target 7: Eliminate Gender Inequalities

Not on Track : Target 8: Eliminate stigma and discrimination

On Track : Target 9: Eliminate travel restrictions - *No Restrictions*

On Track : Target 10: Strengthening HIV integration

II.1.b. Structural Impediments

Targets set for the PAS III cannot be achieved without addressing structural impediments that continue to impact the ability to reach populations and provide services.

- **Poverty:** Poverty drives vulnerability into risk, fuelling sex work and unsafe injections. Just over 21 per cent of Pakistani's live below the global Purchasing Power Parity rate of USD 1.25 per day and the employment rate to the population in Pakistan is only 56.3 per cent.[9]Multi-dimensional poverty is high (Pakistan ranks 146/187 countries) indicating deprivations across health, education and living standards.[10]Only 29 per cent of married women age 15-49 are employed, compared to 98 per cent of married men age 15-49 and only half of women earning cash could make independent decisions on spending their earnings. Seven in ten women reported earning less than their husband.[11] Among women living with HIV, 44.9 per cent of women living with HIV are unemployed as compared 32 per cent male.[12]
- **Low level of education:** Education levels are strongly correlated with the uptake of safer behaviours including condom use. Education levels are very low despite attempts to legislate mandatory primary education. The mean years of schooling remain only 4.7

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[9] UNDP Human Development Reports (http://hdr.undp.org/en/countries/profiles/PAK)
[10] Ibid.
[11] Pakistan Demographic Health Survey 2012-13.
[12]Country Report On National Research Study On HIV Community Access To Treatment, Care And Support Services In Pakistan. Safdar Kamal Pasha. 2013.

years for adults with 57 per cent of women and 29 per cent of adult men having no education.[13]Only 9 per cent of women and 16 per cent of men have completed more than secondary level of education. The quality of education however is poor, indicated by literacy rates: 32.2 per cent of men and over 50 per cent of women completing 9th class could not read.[14] More than half of the total female living with HIV (56.3%) had no formal education as compared to only 27.5 per cent of the total HIV.[15]

- **Gender inequalities:** Gender inequalities exacerbate other individual and structural vulnerabilities for HIV. Pakistan is a male dominated culture where women and girls have lower socio economic status (Gender Development Index (GDI) = 146 among 187 countries).[16] Although there has been some improvement in the status of women over the last few years, significant gaps remain particularly in education and health that may increase their vulnerability to HIV. Women's use of services and ability to adopt healthy sexual and reproductive behaviour are limited due to social restrictions and decision-making power in the household; e.g. almost two-thirds of women reported having at least one problem accessing health care for themselves,[17]yet only 52 per cent are most likely to have the final or joint say on decisions regarding their own health care.[18]The epidemic in Pakistan is driven in part, and will continue to be, norms around acceptable and unacceptable knowledge / behaviour such as women's awareness about condoms and negotiating condom use with spouses/intimate partners[19], or the cultural barriers to discussing SRH with adolescent girls and boys. In Pakistan gender is not limited to only women but includes feminised males and *hijra* whose vulnerability is driven by underlying gender inequality and social marginalization. For these populations, stigmatization (including the condoning of violence) occurs in large part because society perceives their behaviour as violating the accepted norms of what women or men should do. Stigmatization in turn, makes the task of reaching key populations HIV prevention, care and treatment services difficult. The lack of research on the specific nexus between gender based violence (GBV) and HIV is limiting the formulation of a strategy to address this issue (*see Output 3.1. Enhanced use of strategic information to monitor HIV response coverage, quality and impact*).
- **Punitive Laws:** Pakistan has punitive laws against behaviours that are not viewed as acceptable by the wider society, making key populations hard to identify, monitor and reach with HIV prevention programmes. The Penal Code, Section 377, criminalizes male-to-male sex as "carnal intercourse against the order of nature" with the punishment of

[13] Ever married, 15-49 years. PDHS 2012-13.
[14] Pakistan Demographic Health Survey 2012-13.
[15]Country Report On National Research Study On HIV Community Access To Treatment, Care And Support Services In Pakistan. Safdar Kamal Pasha. 2013.
[16] http://hdr.undp.org/en/content/table-5-gender-related-development-index-gdi.
[17] For example, more than half of women were concerned about going alone; four in ten women were concerned about management of transportation; and more than one-third of women were concerned about distance to the health facility. Pakistan Demographic Health Survey 2012-13.
[18] PDHS 2012-13.
[19] Condoms are primarily accessed from the private sector and by men, indicating men's discretion and power in exercising condom for prevention purposes. PDHS 2012-2013.

imprisonment with the possibility of fines.[20] Sharia law also carries heavy penalties for homosexuality – of imprisonment for 2-10 years or for life, or of 100 lashes or stoning to death (depending on whether the person is married or not).[21] Sex work is also illegal and Section 9 of the Control of Narcotics Substances Act (CSNA), 1997 allow for the death penalty for drug offences depending on the quantity of the narcotic drug, psychotropic substance or controlled substance.[22]Progress in responding to the prevention, treatment and care needs of criminalised populations depends on mitigating punitive actions through engaging in public health and rights-based discourses with legislators and law enforcement agencies *(see Strategic Output 3.2Increased multi-sectoral coordination at Federal and Provincial Levels).*

- **Stigma and Discrimination:** Stigma and discrimination in the general population against PLHIV is measured through the DHS. The 2012-13 DHS reported that overall, 17 per cent of women and 15 per cent of men expressed accepting attitudes of PLHIV.[23]The Stigma Index assessment was carried out September 2009 – July 2010 by the APLHIV, in which 833 PLHIV were interviewed by 33 peer data collectors. A major challenge faced by most PLHIV was poverty and lack of employment opportunities due to discrimination against their HIV status.[24] In 2013 The APN+ regional study undertaken by the APLHIV looking at ART access, initiation and adherence, found that 49.2 per cent of the total respondents (n=525) reported being denied medical services due to their HIV status; another 40 per cent experienced some type of housing instability (forced to change place of residence or been unable to rent accommodation because of HIV status) and 25 per cent reported that their children were prevented, dismissed, or suspended from attending school in last 12 months.[25]Though the HIV response in Pakistan advocates against stigma and discrimination of PLHIV at multiple levels, there is no formal redress or legal services available to PLHIV. Although there are no HIV specific laws, Pakistan's constitution articulates equality and non-discrimination as fundamental rights. Articles 3 and 25 obligate the State to eliminate all kinds of exploitation, and to guarantee that all citizens of the country shall be equal before law and shall be entitled to equal protection of law.
- **Low knowledge of HIV in the general population**: While more than four in 10 ever-married women (42%) and seven in 10 ever-married men (69%) in Pakistan have heard about AIDS, only one in five ever-married women (20%) and two in five ever-married men (40%) says that consistent use of condoms is a means of preventing the transmission of

[20] Pakistan Country review-2011: Prepared by www.aidsdatahub.org based on HIV/AIDS Surveillance Project, IBBS round I, II, III and special round for FSW, NACP, MOH, Pakistan, 2005 – 2009.
[21] Ibid.
[22] Ibid.
[23]Among both women and men, accepting attitudes toward those living with HIV or AIDS increase with increasing education and wealth. Except for women in Balochistan and men in Balochistan and Sindh, accepting attitudes toward people with HIV and AIDS are more or less similar in all regions. PDHS 2012-13.
[24] The People Living with HIV Stigma Index: An Index to measure the Stigma and Discrimination experienced by People Living with HIV in Pakistan, 2009-10.
[25] Final draft: Determinants to Improve Antiretroviral (ARTs) Access, Initiation and Adherence among People Living with HIV/AIDS in Pakistan, Asia Pacific Network of People Living with HIV/AIDS (APN+), 2013. Available through the Pakistan Association of People Living with HIV.

HIV. Having heard of AIDS was low among 20-24 year old women (37.4%), an age by which nearly half (49.1%) of young women are already married.[26]

- **Blood Screening**: Blood transfusions are common in Pakistan. In 2012 it was estimated that 40 per cent of the 1.5 million annual blood transfusions in Pakistan were not screened for HIV.[27]Thalassemia is a key concern as Pakistan has over 8 million carriers with a prevalence rate of 6 per cent in the Pakistani population. When 2 carriers of the gene marry, often relatives, their children are likely to be born with Thalassemia. In Pakistan almost half of all marriages (49%) are between first cousins.[28]There are currently more than 50 000 Thalassemia patients registered with associations and treatment centres all over the country receiving blood transfusions approximately every six weeks.[29]While relatives donate most needed blood for transfusion patients, 10 – 20 per cent of the blood supply is still donated by professional donors.[30]Anecdotal evidence suggests that professional donors have a significant population of drug users who also inject.

II.1.c. Devolution

The 18th constitutional amendment on Devolution was re-introduced in 2011 (the process began initially in 2001 but was halted) in part to address issues of Governance, transparency, accountability, and equity among provinces. On 30th June, 2011, as a result of the 18th constitutional amendment, the Ministry of Health was dissolved at the federal level even thoughthe Provincial governments had not developed plans on how to address the new health related environment under the Constitution. Although The NACP and Provincial AIDS programs were engaged in meaningful collaboration in a semi-devolved relationship since 2003, Devolution has resulted in further challenges to a cohesive overall HIV response.

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

The role of the NACP needs to be revisited. The NACP currently sits under the National Health Services Regulation and Coordination, established in 2013, however, in October 2011 the

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[26] Ever married. PDHS 2012-13.
[27] http://www.worldbank.org/en/news/feature/2012/07/10/hiv-aids-pakistan
[28] Pakistan Demographic Health Survey 2012-13.
[29]http://www.tfp.org.pk
[30] http://www.emro.who.int/pak/programmes/blood-safety.html

ToRs for the Federal HIV, as well as the Malaria and TB programmes were notified by the Ministry for Interprovincial Coordination: (1) To act as the Principal Recipients for all Global Fund-supported health initiatives; (2) To prepare proposals and liaise with international agencies for securing support of such partner agencies; and (3) To provide technical and material resources to the provinces for successful implementation of disease control strategies and disease surveillance.[31]In addition to the above charges, the PAS III recommends the NACP assume leadership in innovative programming, monitoring and impact evaluation including institutionalized capacity building/training; responsibility for all surveillance and collection of strategic information relevant to the overall epidemic; and maintaining a national MIS and database.

II.2. Epidemiology

Like other Asian countries, Pakistan is following a comparable HIV epidemic trend having moved from 'low prevalence, high risk' to 'concentrated' epidemic in the early to mid-2000s among key populations. The concentrated HIV epidemic trend amongst KP in Pakistan continues to be driven by PWID, followed by *hijra* sex workers (HSW), and male sex workers (MSW).[32]Female sex workers (FSW) exhibit the lowest HIV prevalence. The geographic trend of key populations is from major urban cities and provincial capitals, expanding over time to smaller cities and peripheries.

Key Population estimations were revised during the 2014 Spectrum exercise in collaboration with UNAIDS Asia Pacific Regional Support Team.[33]

- People who Inject Drugs (PWID): 104 804
- *Hijra*/transgendered Sex Workers (HSW): 50 598
- Male Sex Workers (MSW): 63 732
- Female Sex Workers (FSW): 149 111

Other than the key populations, including adolescent and young, evidence also suggests certain populations are at increased vulnerability and have started to become infectedsuch as migrant workers (mainly clients of sex workers), prisoners many of whom practice risk behaviours), intimate partners of HIV infected migrants and male key populations, clients of sex workers (male, *hijra* and female), and chronic transfusion patients. While evidence overwhelmingly calls for a focus on key populations, it is essential that prevention strategies and 'low-threshold' programs also be sustained for these larger segments of the population, to

[31] Government of Pakistan Inter Provincial Coordination, Notification No.F. 2(154)/2011-amn, Islamabad 14th October 2011.
[32] There are no population estimations for MSM but the AEM modelling done in 2013 suggests that .3% of the population (Sindh and Punjab) are MSM. In 2011 the number of males in Pakistan was estimated by the Pakistan Bureau of Statics to be 91.59 million (Pakistan Statistical Year Book 2011). In 2012 adolescents were around 22% of the population (United Nations Population Division). Excluding adolescent boys, a conservative estimate of MSM in Pakistan would be nearly 215,000.
[33] Populations Estimation exercise: Pakistan National AIDS Programme and UNAIDS Asia Pacific Regional Support Team, February, 2015, Bangkok, Thailand.

mitigate the epidemic becoming generalized. Other factors contribute to mitigation such as societal factors; and male circumcision may in part have also contributed to keeping lower HIV rates among non-injecting heterosexual males (e.g. clients of female sex workers);[1] however it is assumed to have no or little protective value for MSM.[34]

Trends in HIV Incidence and Prevalence[35]

Incidence is not directly measured in Pakistan, only estimated through Spectrum and AEM modelling. Very few NGOs are able to calculate incidence from their regularly tested clients. Spectrum data at the end of 2013 showed an increase of new HIV cases of 16 per centon average from 2005 through the end of 2014*(Figure 4).[36]*AEM Modelling took place at the end of 2013 for Punjab and Sindh. PWID currently produce the bulk of new infections, and will continue to produce the same absolute number of new infections although the relative proportion of HIV among PWID becomes smaller as prevalence among PWID plateaus in Punjab at 35 per cent and in Sindh at 30 per cent. The largest contributions of new infections over time are by MSM and TG. Projections in the Model predict increasing prevalence of HIV in all population groups, rapidly rising among MSM and transgender persons.

Figure 4. New HIV cases in Pakistan over Nine Years

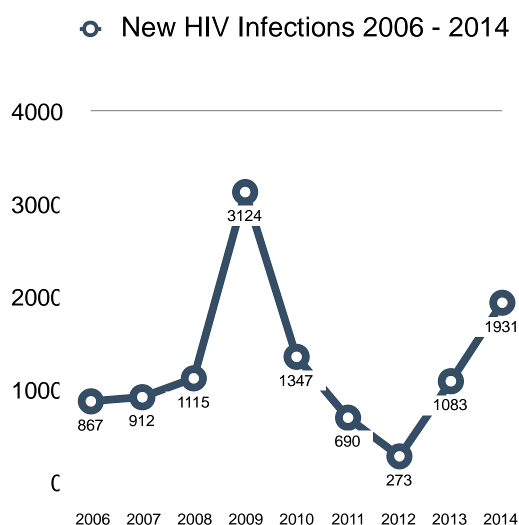


Figure 5. AEM Modelling in Punjab 2013

[34] Gust DA, Wiegand RE, Kretsinger K et al. Circumcision status and HIV infection among MSM: reanalysis of a Phase III HIV vaccine clinical trial. AIDS. 2010 May 15;24(8):1135-43.

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

[36]Spectrum Data Summary 2014 (final20Mar). The spike in new cases is unexplained although may be linked to the closure of KP programming by the World Bank in June 2009.

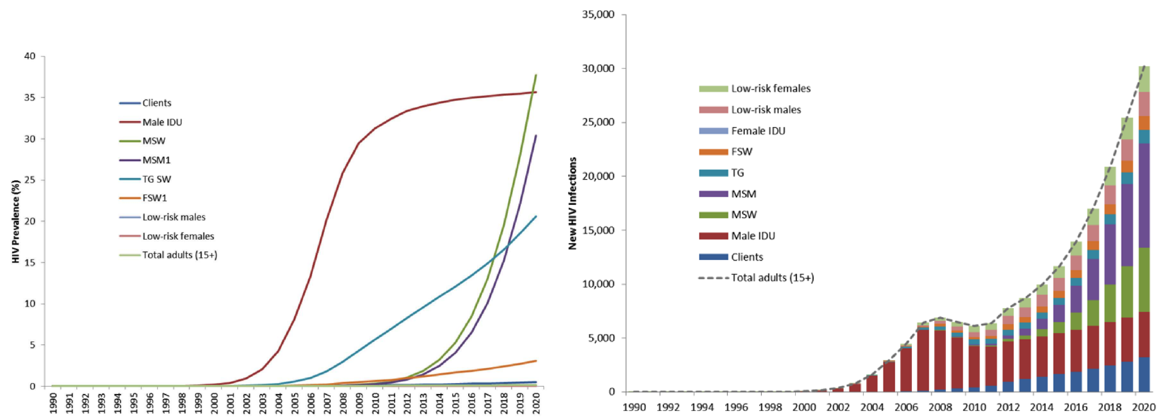
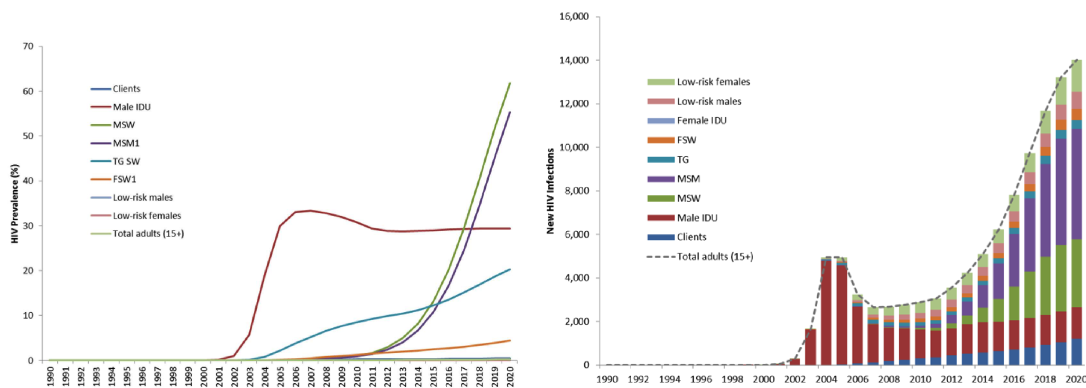


Figure 6. AEM Modelling in Sindh 2013



Although AEM was only done for Punjab and Sindh, these two largest provinces have the bulk of both key populations and HIV cases.

II.3. Priority Population Groups

The following populations groups are considered at risk or vulnerability given their disproportionate risk compared to the general population in Pakistan. Information on population sizes, prevalence, and risk behaviours are found below.

People who inject drugs (PWID)[37]: Estimated to be 104 804[38], HIV prevalence amongst PWID (defined as a person who has injected drugs regularly for non-therapeutic purposes in the last six months[39]) has steadily increased from 10.8 per cent in 2005 to 37.8 per cent (weighted; 95%CI: 37.3%, 38.3%) in 2011.[40] Large concentrations of PWID are found in cities such as Karachi, Faisalabad and Lahore, the largest metropolitan areas. Based on the 2011 data,

[37] Information taken from Integrated Behavioural and Biological Surveillance Round IV, 2011.

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

[39] Integrated Behavioural and Biological Surveillance Round IV, 2011.

[40] Un-weighted prevalence of people who inject drugs in IBBS R IV was 27.2% (95% CI: 26.0%, 28.5%) (IBBS, R IV, 2011).

PWID are overwhelmingly male (98.4%)[41] with an average age between 25-40 years old. The high HIV prevalence among PWID is consistent with their frequent and risky injection practices: 71.5 per cent report 2-3 injections per day; another 21 per cent report more than 3 injections a day; and only 39 per cent report always using a new syringe.

Transgender persons: Currently there are no official baseline population estimations on transgender persons. At the end of 2014 Spectrum estimated66 161transgender persons, however, the only information available was the input of 2011 estimates of HSW. In Rounds I – IV of the IBBS, *hijra* (traditionally eunuchs, now a sub-cultural denotation) who sell sex are defined as transgender/transvestites. The continuum of sexuality, however, is more fluid than the definition can capture and from Round V IBBS, transgender will be considered a separate population with hijra self-identifying as either transgender or MSM. The UNAIDS Gap Report 2014 states "estimates from different countries indicate that the transgender population could be between 0.1% and 1.1% of reproductive age adults."[42] Based on only the current estimate of males between the ages of 15 and 49 in Pakistan, and a conservative proportion of 0.3 of the male population (as in the AEM MSM modelling), the transgender population could be as high as almost 150000.[43] Transgender persons are considered at high risk for HIV in Pakistan given their female gender based identity and socially constructed deferent role in society (including anal receptive sexual role), making condom negotiation more difficult.[44]

Hijra sex workers: HSW are estimated to be 50 598 HSW[45], primarily in the cities of Rawalpindi, Karachi, Quetta, and Peshawar, with an HIV prevalence rate of 7.2 per cent (weighted; 95% CI: 6.8%, 7.5%) in 2011, up from 6.1 per cent in 2008. The age of initiation is 16 years with 70 per cent living in *deras* (*hijra* communal residence), however only around 10 per cent depending on their gurus (head of the *deras*) for sexual partners.[46]Reported consistent use of condoms was low, with only 23 per cent of HSW reporting that they always used a condom with clients in the past month, and only around 18 per cent using condoms regularly

[41] Although there are few women who inject drugs, many may also be part of a wider sexual network, hence more at risk and a bridging population. Besides, dependence on their partners for drug use, fear of violence or actual violence restricts their ability to insist on clean needles, negotiate, condom usage, and access harm reduction and HIV-related services [UNDP, WAP+, APN+ and Unzip the Lips, (2013). *Discussion paper: Linkages between violence against women and HIV in Asia and the Pacific*. Bangkok.

[42] The Gap Report, UNAIDS, 2014.

[43] This percentage is calculated on an estimated 49 269 000 adult males aged 15-49 years in 2015. Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, *World Population Prospects: The 2012 Revision*, http://esa.un.org/unpd/wpp/index.htm

[44]GARPR 2014 cited from Collumbien M, Qureshi AA, Mayhew SH, et al. Understanding the context of male and transgender sex work using peer ethnography. Sex transm infect. 2009. April 85 suppl 2:ii 3-7.

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

[46] It has been noted in a study that as compared with FSW in Pakistan, HSW are more easily approached by their male clients owing to the popularity of social activities among males and greater tolerance towards extramarital sex with males than with females; therefore, HSWs are quite common in large cities (Siddiqui AuR, Qian H-Z, Altaf A, et al. Condom use during commercial sex among clients of Hijra sex workers in Karachi, Pakistan [cross-sectional study]. BMJ Open 2011;1:e000154. doi:10.1136/bmjopen-2011- 000154).

with non-paying partners.[47]More than half (55.1%) HSW reported using alcohol and/drugs during sexual intercourse in the past six months.

Males who have sex with males: There is no baseline information on behaviour, knowledge, or HIV prevalence of MSM, or consensus on population estimates (MSM will be included in the 2015 IBBS). UNDP and APCOM estimate the number of MSM in Pakistan to be 2285500.[48]The technical working group established for the AIDS Epidemic Modelling process determined MSM to be 0.3 per cent of the male adult population[49], or approximately 150 000 adult males[50], lower than the estimated lifetime prevalence of 6-12 per cent male to male sex for Southeast and South Asia.[51]

Male sex workers: The estimated population size is 63732[52], the majority found in larger cities, the average age less than less than 30 years and theHIV prevalence3.1 per cent (weighted; 95% CI: 2.8%, 3.4%), rising from 0.9 per cent in 2008. Bisexual behaviour was reported by approximately 39.5per cent. Consistent condom use was very low at 13 per cent with paying partners, and even lower with non-paying partners at almost 11 per cent. Consistent condom use during the past month varied significantly by age with younger less likely to use condoms when compared to older age groups, however, the vast majority of MSW are young. In 2011 42.1 per cent of MSW were 13-19 years and 36.1 per cent were 20-24 years. *Of all MSW mapped in the country in 2011 78.2 per cent were under 24 years of age*.Overall, only 1.7per cent of MSW reported having injected drugs in the previous six months, but 52.5per cent reported using alcohol or drugs while having sex during the same time period.

Females who sell sex: The estimated population of FSW is 149 111[53], the majority located in large cities, with an HIV prevalence of 0.6 per cent (weighted; 95%CI: 0.4%, 0.9%) in 2011, rising from 0.2 per cent in 2007. Their average age in 2011 was 26.9 years. For 43.1 per cent their mode of selling sex through a brothel, *kotikhana*[54]or home-based mostly operating through a *madam*, while 22.3 per cent were street-based and 24.7 per cent used cell phones for accessing clients.FSW reported an average of three clients a day. Condom use with clients was generally low as only 33.2 per cent reported that they always used a condom with their

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[47]For example 42.5% of HSW reported partners' objections as reason behind low condom use, thus indicating inequalities and power imbalances that limit healthy sexual choices and equitable relationship (GARPR 2014).

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

[49]AIDS Epidemic Modeling in Pakistan: Country Case Study Report for UNAIDS. 2014.

[50] As with transgender persons, this percentage is calculated on an estimated 49 269 000 adult males aged 15-49 years in 2015. Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, *World Population Prospects: The 2012 Revision*, http://esa.un.org/unpd/wpp/index.htm

[51]Cáceres C, Konda K, Pecheny M, et al. Estimating the number of men who have sex with men in low and middle income countries. *Sex Transm Infect* 2006;82:iii3-iii9.

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

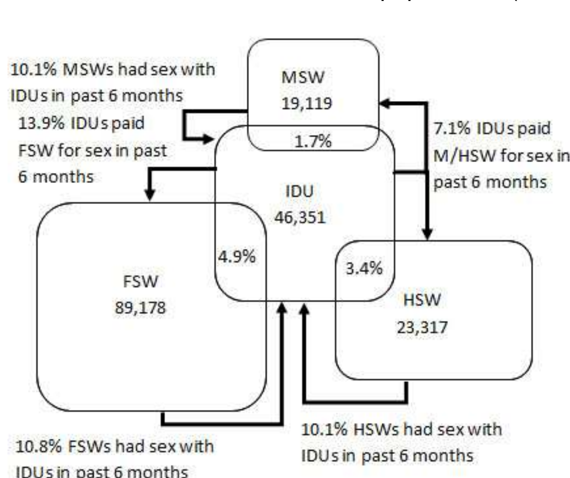
[53] Ibid.

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

client in the last month (vaginal sex), and 20.6per cent reported consistent condom use with non-paying partners. Brothel-based FSW reported substantially more condom use than the other types of sex workers. The longer number of years in school had a positive association with condom use. Both injecting drugs and having sex with a PWID were highest amongst brothel-based FSW at 7.2per cent and 15.8per cent, respectively.

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

Figure 7: Interactions between PWID, MSW, HSW and FSW populations (Source: HASP 2011)



Adolescent and Young Key Populations: Estimated new HIV infections among 15-24 year olds have more than tripled in Pakistan from 2005 (n=995) to 2014 (n=3390).[55]From the 2011 IBBS R IV, adolescent prevalence among overall key populations was estimated as follows: PWID: 1 per cent of PWID were 18-20 years and HIV positive; 0.3 per cent of HSW and 0.1 per cent of FSW were 15-19 years old and HIV positive; and 0.7 per cent of MSW were 13-19 years old and HIV positive - *one third of all MSW HIV infections in 2011*.[56]In IBBS R IV safe injection practices among adolescent PWID in 2011 was low with only 1.9 percent reporting using sterile injecting equipment the last time they injected.[57]Condom use at last sex act with regular partners amongst adolescent PWID was 22.6 per cent in IBBS R IV.[58] Among adolescent *hijra* who engaged in selling sex 18 per cent reported consistent condom use with clients.[59] Of adolescent males who sell sex, only 9.5 per cent in 2011 reported consistent

[55]Spectrum Data Summary 2014 (final20Mar).
[56] Reported in GARPR 2014.
[57] IBBS variable: The last time you injected did you inject with a used syringe/needle? (Optional answers: yes, no, don't know, no response)
[58]Registration Analysis (Client) 18-20 years, Nai Zindagi. 104/635 respondents 1st Jan 2011 through 16th Oct 2014.
[59]HIV second generation surveillance in Pakistan: National Report Round IV. 2011.

condom use with clients.[60]HIV testing among adolescent key populations remains a challenge with particularly low uptake rates. In 2011 the percentage of PWID <20 years of age who received an HIV test in the past12 months and knew their results was 12.4 per cent; among adolescent *hijra* who sell sex it was 13.9 per cent; 2.7 per cent among males 13-19 years who sell sex, and 5.7 per cent among females who sell sex.[61]

Female Intimate Partners of Male Key Populations: As in other partners of Asia, female intimate partners of males who inject drugs, have sex with other men or are clients of sex workers are considered very vulnerable.[62]For example, a research study conducted in Punjab by the NGO Nai Zindagi found up to 15 per cent HIV prevalence among spouses and female partners of male PWID. Transmission of HIV from PWID to their wives is enhanced by the fact that around 80 per cent of the former engage in unprotected sex.[63]Given a lack of programme data on intimate partners of HIV positive MSW and HSW, population estimates are speculative at best: 306 partners of HIV positive MSW (63 732 MSW[64], 15.5% married[65] and 3.1% HIV positive) and 474 partners of HIV positive HSW (50 598 HSW[66], 13% married[67] and 7.2% HIV positive).Of women living with HIV surveyed through a study on community access to treatment, 61.4 per cent were married, followed by widowed (28.5%).[68] The source of the majority of new infections among low risk women (n=844) in Punjab and in Sindh (n=566) at the end of 2013, were their spouses or regular partners.[69]

Returned Migrant Workers: There has been significant migration from rural areas of all Provinces to the Gulf States. The net outward migration rate from Pakistan is estimated at 3.3 per 1000 inhabitants.[70]Significant numbers of HIV cases reported to the health care services, especially in Khyber Pakhtunkhwa, have been and continue to be among returning migrants deported from the Gulf States when found to be HIV positive.[71] Spectrum estimated over 51 000 deported migrants at the end of 2014 (and over 290 HIV positive).[72] The risks of onward HIV transmission to spouses and to children have been documented upon the return of migrant workers from abroad. In KP for example, at the end of 2013, among the 1257 PLHIV ever-

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[60]Ibid.
[61] GARPR Pakistan 2014.
[62]Evidence from many countries in Asia indicate majority of HIV infections in women are sexually acquired by intimate partners or spouses, and exacerbated by the presence of certain sexually transmitted infections (STIs). UNAIDS. 2009. HIV Transmission in Intimate Partner Relationships in Asia.
[63] The Hidden Truth' Report by Nai Zindagi and PACP, Punjab 2008
[64]Populations Estimation exercise: Pakistan National AIDS Programme and UNAIDS Asia Pacific Regional Support Team, February, 2015, Bangkok, Thailand.
[65]HIV second generation surveillance in Pakistan: National Report Round IV. 2011.
[66]Populations Estimation exercise: Pakistan National AIDS Programme and UNAIDS Asia Pacific Regional Support Team, February, 2015, Bangkok, Thailand.
[67]HIV second generation surveillance in Pakistan: National Report Round IV. 2011.
[68] Country Report on National Research Study on HIV Community Access to Treatment, Care and Support Services In Pakistan, Association of People Living with HIV, 2013.
[69] AEM in Pakistan 2013. Fig 5 'Where are the infections coming from?' (Punjab 2013 & Sindh 2013
[70]Source: Mapping of HIV Risk and Vulnerabilities of Temporary Contractual Workers from Pakistan to GCC Countries 2011, Government of Pakistan, IOM and UNAIDS.
[71] At the end of 2013, 0f the 526 migrants registered at Hayatabad Medical Complex in Peshawar, 60% were from UAE and 23% from Saudi Arabia.
[72]Spectrum Data Summary 2014 (final20Mar).

registered (includes dead and missing) 41.8 per cent (526) were migrants. Among the 819 on ART at the end of 2013, 28.9 per cent were migrants (237). In the last quarter of 2014 a total of 27 returned migrant men were registered at the HIV Clinic in KP. All were married and of 27 spouses 6 were found to be HIV positive and none of the children.

Prisoners: Prisoners, including female[73] and juvenile, are considered a key vulnerable population in Pakistan given the prevalence found in sample cohorts to date. At the end of 2013 there were over 77 500prisoners in Pakistan either under trial or already convicted.[74] There has been limited HIV testing in prisons, however sporadic testing has taken place. In 2009 almost 5000 jail inmates were voluntarily tested across nine jails in Sindh, with an overall HIV prevalence of 1 per cent;[75]in 2009 Camp Jail in Lahore over 1000 inmates were tested with a prevalence of 2.4 per cent;[76] and in District and Central Jails of Lahore almost 5000 prisoners were tested with an overall HIV prevalence of 2.0 per cent and 77.8 per cent of them had co-infections. HIV/HCV co-infection was detected in 73.7 per cent of HIV positive inmates.[77] Even earlier studies showed a similar prevalence. In Camp Jail in Lahore from January to June 2008, 261 inmates were tested for HIV and 6 (2.3%) were found to be HIV positive.[78]

Clients of Sex Workers: Clients of sex workers are considered a vulnerable population in Pakistan. Considering the prevalence rates among sex workers alone, male clients of both MSW and HSW may be considered most at risk among clients, however they overlap with the MSM population and may be addressed through MSM programming. Clients of female sex workers are also considered a vulnerable population, given the low overall prevalence rate of FSW, their risk may not be as high. While there has been no formal studies on, nor services provided to clients of sex workers, a 2008 Population Council STI study in six major urban cities across Pakistan showed that 5.8 per cent (141/2400 men surveyed, median age 23 years) had visited a female sex worker during the last 12 months.[79] Spectrum (2014) estimates 3434 infections among an estimated population of 6 048 254 clients of sex workers (clients of which group of SW not indicated, however, all male).[80]

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

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

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

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

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

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

[79] Study of Sexually Transmitted Infections Among Urban Men in Pakistan: Identifying the Bridging Population. Population Council, 2008.

[80]Spectrum Data Summary 2014 (final20Mar).

PLHIV: According to programme data at the end of 2014 there were 5019 PLHIV on ART, out of whom201 were paediatric clients. Relative to the estimated number of PLHIV in the country, the number of registered PLHIV within the health care system remains low and ART coverage for those eligible remains low at 9.08 per cent end 2014 for both adults and children.[81]At the end of 2014 HIV treatment and care facilities were available through 16 hospitals[82], 5 of which have paediatric HIV management capacity and 11 offering PPTCT/PMTCT[83] services (safe delivery of an HIV positive mother). The majority of the treatment, care and support facilities are confined to larger cities[84].

II.4. National responses to the HIV epidemic

II.4.a. Programming response

In 2001 GoP developed its first five-year National Strategic Framework (NSF-I). The NSF-I identified nine broad priorities areas including Priority Area 3: Women, Children and Youth.[85] Following the Declaration of Commitment (DoC) in the 2001 UNGASS session the GoP approved the 'Enhanced HIV/AIDS Control Project' (EHACP) for 2003-8 funded by the World Bank (soft loan and grant), DFID and Government. The strategy of EHACP partially decentralized the program to five provincial (PACP) programmes[86] and followed a more strategic investment approach for the concentrated epidemic.[87]The 2nd National Strategic Framework completed its five-year timeframe in December 2011.[88]It had four Strategic Objectives including: A) Scale Up Programme Delivery; B) Create and Enabling Environment; C) Build the Right Capacity; and D) Strengthen Institutional Framework.[89]Currently the provinces are guided by their own Provincial AIDS Strategies 2012 – 2016. The PAS III is aligned with the Provincial Strategies and expands upon them for a coherent, inclusive National response. Efforts to implement a multi-sectoral response to Pakistan's epidemic, have been complicated over the last five years due to conflict, insecurity, natural disasters, capacity, competing priorities and funding gaps.

Out-sourcing health services to private sector organizations is a common delivery mechanism

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[81] Ibid.
[82] Taken from List of ART, PPTCT & Paeds Centers (New), submitted by UNICEF.
[83] Although both terms – PMTCT and PPTCT - are globally acceptable, Pakistan primarily uses PPTCT.
[84]http://www.nacp.gov.pk/programme_components/hiv_prevention/hiv_care/
[85]Global AIDS Response Progress Report 2012: Country Progress Report Pakistan. National AIDS Control Program, Ministry of National Health Services Regulation and Coordination Government of Pakistan, Islamabad 2012.
[86] Including at that time the Azad Jammu Kashmir (AJK) Provincial AIDS Control Programme.
[87] EHACP addressed five principal components: 1) Interventions for most-at-risk populations; 2) Establishment of a Second Generation Surveillance System; 3) Preventing HIV transmission to the General Public through Blood and Blood Products; and 4) Treatment, Care and Support services for PLHIV and Capacity-Building.
[88] See http://www.nacp.gov.pk/introduction/NSF-NACP.pdf.
[89]Priority Areas included: 1) Expanded Response; 2) High-risk, Vulnerable & Bridge groups; 3) Women, Children, and Youth; 4) Surveillance and Research; 5) Transmitted Infections; 6) General Awareness; 7) Blood and Blood Products Safety; 8) Infection Control; 9) Treatment, Care, and Support; 10) Institutional Arrangements; 11) Commodities and Procurement; and 12) Management Information.

in Pakistan.[90]Private sector organizations, both for-profit or not for-profit,are critical partners in the roll-out of the HIV response in Pakistan. Since the implementation of EHACP, the NACP and PACPs have engaged in public-private partnership (PPP) arrangements with NGOs and CBOs through their PC-1s*(see III.7 Implementation arrangements)*.

Health System and expanded AIDS response

The expanded AIDS response has only managed to mainstream HIV related interventions into the health sector on a very limited basis, despite the fact that all the four Provincial AIDS Strategies (2012 to 2016) had stressed HIV mainstreaming within the health sector. Since 2006 the TB programme with Global Fund support has tested a limited number of TB positive persons for HIV in the public sector, with the onus of procurement on the National TB Programme. That number will further increase from 2015 onwards supported by a new grant from GF (New Funding Model). Currently HIV positive clients are being supported for TB management, including extra-pulmonary, through HIV Clinics, primarily in the same hospital, with less connection to DOTS programming in districts of origin. Provincial MNCH Programmes have integrated Prevention of Parent to Child Transmission activities to a limited extent, including PPTCT prophylaxis and outreach through Lady Health Workers to identify women and their families potentially at risk for HIV. Interventions introduced solely through a select few public sector facilities ANC departments have not been successful at identifying HIV positive women except in high burden districts. Linkages with the Prime Minister's Hepatitis Programme have had moderate success.[91] In hospitals where the PM Hepatitis Programme exists, patients have been more easily referred. There been, however, no formal attempt to link the HIV and Hepatitis Programmes, either to prioritise patients with HIV or on the preventative side (education, waste infection control, etc.), and as of the end of 2014 only interferon treatment was available to a limited number registered with the Prime Minister's Programme. The Blood Transfusion Authority runs blood banks across the country screening collected blood for HIV. Given the current policy of blind screening for blood products, in the case of an HIV positive blood sample, no referral is made for blood donors for confirmatory testing and further referral into the treatment care and support stream, although initiating a counselling and result dissemination policy is suggestedin PAS III and is under development with GIZ. Lastly, although not only a health sector response, public sector detoxification services where they exist (Psychiatry units and ANF setups) are far from adequate for HIV positive PWID. According to both PWID service providers and HIV Clinic physicians, most HIV positive PWID are not initiated on ART without a confirmed detoxification status. Formal linkages between the National and Provincial AIDS Control Programmes and the ANF and other health sector supported facilities for provision of detoxification of PWID has not been made, and there is currently no budget from the HIV sector side.

II.4.b. Funding response

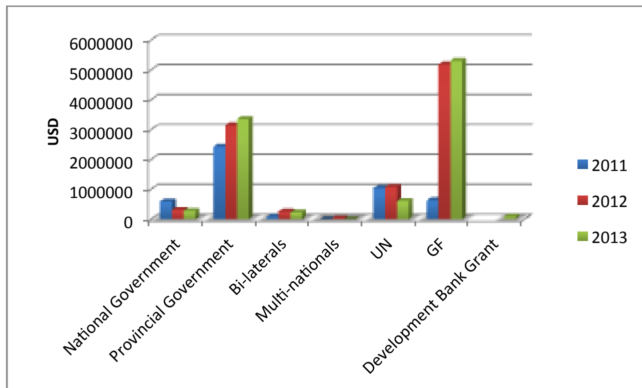
[90]Ahmed F, Nisar N. Public–private partnership scenario in the health care system of Pakistan. Eastern Mediterranean Health Journal La Revue de Santé de la Méditerranée orientale (EMHJ). Vol. 16, No. 8, 2010. http://applications.emro.who.int/emhj/V16/08/16_8_2010_0910_0912.pdf

[91] Khyber Pakhtunkhwa has a planned combined PC-1 for HIV and Hepatitis.

"We can assure you on the Government of Pakistan's commitment to eradicate this issue and we will also look at other countries in the region to learn from each other and replicate the best practices in Pakistan. I assure you of a positive change in the coming years in Pakistan to deal with the HIV/AIDS issue."
Mamnoon Hussain, President of Pakistan

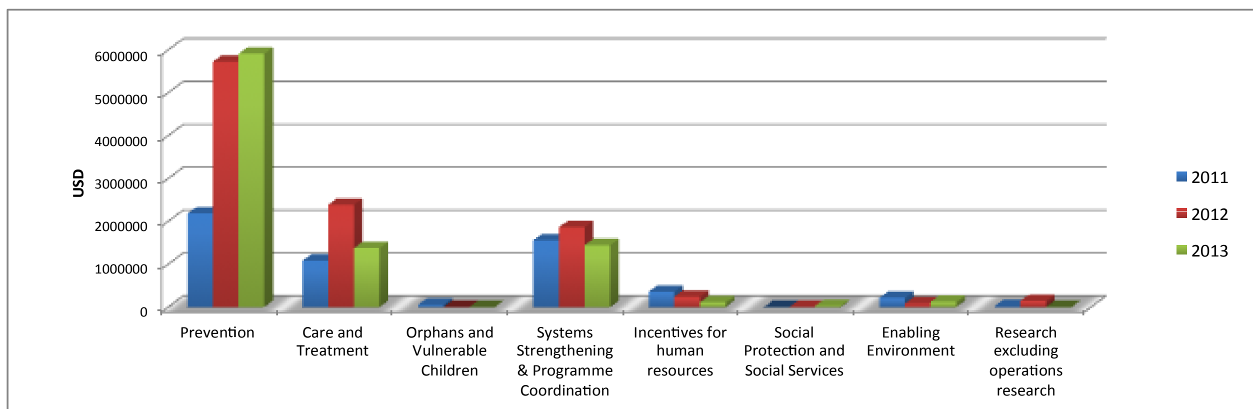
Using parallel financing arrangements, in partnership with the private sector, the United Nations and other donors have supported the HIV response since its inception.[92] The funding landscape has changed over the last several years, from primarily World Bank soft loan and grant funding, to increased domestic allocations through PC-1s and strengthened GF support. In 2013 GF (including regional grants) accounted for over 50 per cent of the total HIV response[93], Provincial Government 37 per cent, the UN 7 per cent[94], other external donors 3 per cent and National Government 3 per cent. From 2011 through 2013, expenditures by the National Government decreased given Devolution, while expenditures by Provincial governments and Global Fund increased, primarily due to the World Bank loan contribution to the Punjab Government for Health Systems Strengthening, which includes HIV.

Figure 8: Financing sources of the HIV response in Pakistan for 2011-13 (Source: GARPR 2014)



Looking at the eight areas of expenditure outlined by the Global AIDS Reporting system,

Expenditures in prevention have gone up over the past 3 years. Given the low ART coverage rates, expenditures need to be strengthened in care and treatment, dependent on PLHIV being

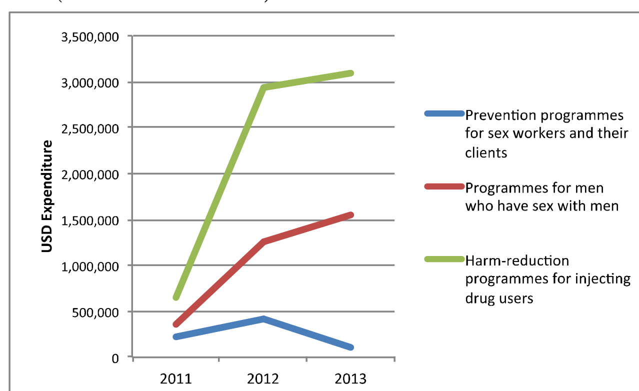


[92]Key bilateral and multilateral donors to date include: The Global Fund to fight AIDS, Tuberculosis and Malaria; UN agencies (through the Joint Team on AIDS); World Bank (grant); CIDA, EU, DFID/UK Aid, USAID, GTZ/GIZ, Netherlands Ministry of Foreign Affairs, Norwegian Embassy.
[93]In 2000, the GFATM, with a commitment of USD 18.4 million till March 2013 to 2016.
[94]The UN Joint Team on AIDS had committed 1 396 169 USD for 2014-2017. Draft 'Delivering as One UN,' The Joint UN Programme of Support on AIDS2014-2017. November 2014.

identified for care (HTC, under prevention) which needs to continue to be strengthened. There is meagre expenditure on enabling the environment, key for a successful HIV response in a concentrated epidemic, or development synergies e.g. social protection and services.

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

Figure 10: Expenditure by key populations 2011 through 2013(Source: GARPR 2014)



PC-1 Summary

The table below presents the financial commitment landscape for the overall HIV response at the end of 2014. While the NACP and all PACPs have indicated a commitment to the HIV response through the development of PC-1s specifically for HIV, as of the end of 2014 only Punjab's was implemented (with a loan from the World Bank); while Balochistan's is approved but not yet implemented, Sindh is operating on a 1-year extension of their previous PC-1 only for operational expenses (primarily salaries); and the NACP PC-1 is under approval. Khyber Paktunkhwa's PACP was dissolved in 2013 and their PC-1 along with it; the Department of Public Health has yet to commit funds through any mechanism specifically for HIV.

Table 1. PC-1 Commitments (Pakistan Rupees)

	PC-1s (planned and committed funding)				
	NACP	PACP	SACP	BACP	KP DoPH
Year	July 2014 to June 2016	July 2013 to June 2017	July 2014 to June 2017	July 2014 to June 2018	July 2012 to June 2017
	• Coordination : 4.08% • Salaries: 60.14% • Operating Costs: 33.8%	• Key Populations: 74.11% • Surveillance & Operational Research: 5.88% • M&E: 0.4% • A/C: 4.78% • Treatment & Care: 6.28% • Program Management: 8.51%	• Interventions: 72.72% • Advocacy & Communication & Social Mobilization: 3.41% • Governance and the Institutional Framework of the Response: 23.86%	• Targeted Interventions: 69.3% • Awareness: 3.6% • Governance and the Institutional Framework of the Response: 26.97% *(HR: 37.76%; Capacity Building: 3.05%; Operational Expenses: 59.18%)*	• HIV Prevention and Treatment Services 33% *(targeted interventions: 85.1%; VCCT & STI Clinics At DHQ 12.35%; MARA 0.065%; Migrant Workers 1.79%)* • HIV Care & Support 31% *(FCC at HMC 82.2%; FCC at Kohat 1.6%; Blood Safety 16.14%)* • Policy Environment and AIDS Program Response 36% *(Governance 0.08%; PMU 16.5%; A/C & Mobilization 78.7%; CB 3.9%; M&E and Research 0.7%)*
PKR	422,000,000	1,638,132,000	1,248,736,000	279,320,000	241,790,000

Part III:
Pakistan AIDS Strategy III

III.1. Purpose of the PAS III

The purpose of the PAS III is to guide Pakistan's overall national HIV and AIDS response through 2020. It is a reflection of the national and provincial governments' commitment to implement a strategic, targeted and expanded multi-sectoral response to address turn around Pakistan's HIV epidemic.

III.2. Development of the PAS III

The PAS III was developed through interactive and participatory consensus building through Provincial Dialogues in each of the four provinces as part of the mid-term review of the Provincial AIDS Strategies 2012-2016, and two Country Dialogues for the PAS III development. An expanded Technical Working Group for HIV under the Country Coordination Mechanism[95] (henceforth referred to as TWG) provided technical support and oversight for the process led by National AIDS Control Programme. A team of consultants comprised of one Lead Consultant, one National Consultant, one Costing Consultant and one Gender Consultant was hired to conduct the MTR, and to develop the PAS III. Direct supervision of the team was conducted by the National AIDS Control Programme, UNAIDS Pakistan and by the Technical Support Facility. The Technical Working Group's responsibilities for the development of the PAS III were primarily to provide technical feedback on the Results Strategy and the drafts and final version of this PAS III.

The PAS III is a consolidation of the Provincial AIDS Strategies, recommendations for strengthening those strategies, and consideration of the territories of Gilgit-Baltistan, Azad Jammu Kashmir, the Federally Administered Tribal Areas and the Islamabad capital Territory. It is the third national strategy; the first National Strategic Framework was from 2001-2006 and the second from 2007-2012. Following the NSF II, the Federal Ministry of Health was dissolved and the NSF III delayed as provinces developed their own Provincial AIDS Strategies.

Contributions to Provincial and Country Dialogues were made by Ministry and Departments of Health and other non-health sectors, UN agencies, international and national non-government organisations, community-based organisations, representatives from people who inject drugs, males who have sex with males, transgender persons, female sex workers, and people living with HIV and AIDS. Focus Group Discussions and Key Informant Interviews were held as part of the Provincial AIDS Strategies MTR with additional meetings held as part of the PAS III development. Provincial Dialogues and Country Dialogues at Federal level were held as part of the MTR process and PAS III development respectively (*see Table 1 below*). The Strategic

[95] As the national response is broader than the Global Fund and the activities they support, the constituted inclusive group of both members and observers was expanded slightly to include the National and Provincial AIDS Control Programmes, KP Health Directorate (as there is no more KP Provincial AIDS Control Programme) relevant UN agencies (namely, UNAIDS, UNICEF, WHO, UNDP, UNFPA and UNODC), civil society organizations including for PLHIV, MSM and *hijra* and people who inject drugs, private sector, and educational institutions.

Framework initially consolidated Provincial AIDS Strategies Results Frameworks adding recommendations based on Provincial FGDs, KIIs and Dialogues. It was streamlined and revised prior to the 1st PAS III Country Dialogue and revised afterwards based on feedback received both at the 1stCountry Dialogue and afterwards electronically, and revised finally after the 2nd Country Dialogue for the PAS III development.

Table 2. Meetings with stakeholders related to the Provincial AIDS Strategies Mid-Term Review and Pakistan AIDS Strategy III development

Meeting	Date	Participants	Location
Technical Working Group	24th Oct 2014	Expanded Technical Working Group	**Islamabad**
KIIs, FGDs & Provincial Dialogue	18th – 20thNov, 21st Nov	Key Stakeholders	**Peshawar**
KIIs, FGDs & Provincial Dialogue	25th – 28th Nov, 3rd Dec 2014	Key Stakeholders	**Karachi**
KIIs, FGDs & Provincial Dialogue	1st – 3rd Dec 2014	Key Stakeholders	**Quetta**
KIIs, FGDs & Provincial Dialogue	4th, 8th – 12th Dec 2014	Key Stakeholders	**Lahore**
KIIs, FGDs & Provincial Dialogue	1st, 5th-6th, 8th - 9th Dec 2014	KIIs, FGDs	**Islamabad**
Technical Working Group	14th Jan 2015	Expanded Technical Working Group	**Islamabad**
Endorsement meeting	15th Jan 2015	Representatives of Provincial Health Secretaries and Planning Departments	**Islamabad**
1st Country Dialogue	20th Jan 2015	Key Stakeholders	**Islamabad**
Technical Working Group	16th Feb 2015	Expanded Technical Working Group	**Islamabad**
2nd Country Dialogue	17th Feb 2015	Key Stakeholders	**Islamabad**

The mid-term review of the Provincial AIDS Strategies, the backbone of the Pakistan AIDS Strategy, were endorsed by representatives of the provincial Health Secretaries and Planning Commissions January 15th 2015. The PAS III was endorsed through the 2nd Country Dialogue held 17th February 2015.

III.3. Goal

The overall goal of the PAS III is to halt new HIV infections and improve the health andquality of life of people living with and affected by HIV in Pakistan over the next six years.

JANS Tool (Joint Assessment of National Health Strategies and Plans)[96]

The JANS tool criteria and their attributes were considered during the formulation of the PAS III to ensure a comprehensive national strategy: 1) Situation analysis and programming: clarity and relevance of strategies, based on sound situation analysis; 2) Process: soundness and inclusiveness of development and endorsement processes for the national strategy; 3) Costs and Budgetary Framework for the Strategy: soundness and feasibility; 4) Implementation and Management: soundness of arrangements and systems for implementing and managing the programmes contained in the national strategy; 5) Monitoring, evaluation and review: soundness of review and evaluation mechanisms and how their results are used.[97]

III.4. Objectives

The Objectives of the PAS III set the implementation direction of the Strategy in order to achieve the goal.

1. To target first and foremost the epidemic among People who Inject Drugs; followed by key populations where HIV prevalence or risk of transmission is highest;

2. To provide high impact services in cities and peripheries with evidence of rising or emerging HIV prevalence, particularly where there is documented and sizable presence of Key Populations and *focusing on HTC uptake for all key populations and treatment for all needing it*;

3. To strengthen capacities and coordination of, and referral between, Government, civil society, communities and people living with HIV for a more effective and sustained response; and

4. To increase cost-effectiveness of programs through innovation, systems strengthening and mainstreaming HIV in health and other sectoral work-plans and budgets where relevant and possible.

III.5. Guiding Principles

[96]Joint Assessment of National Health Strategies, or JANS, is a shared approach to assessing the strengths and weaknesses of a national health strategy or plan. http://www.internationalhealthpartnership.net/en/tools/jans-tool-and-guidelines/.

[97]Joint Assessment of National Health Strategies and Plans Joint Assessment Tool: the attributes of a sound national strategy. International Health Strategies and related initiatives, Version 2: September 2011.

Pakistan's AIDS Strategy III identifies the following Guiding Principles as critical to ensuring a more effective HIV response. These principles are based on lessons learned about what works best in the Pakistan context. The Guiding Principles will underpin effective national and provincial responses to achieve the Strategic Outcomes.

1. Prioritization: high impact interventions with key populations are prioritized. Priorities are weighted; meaning implementation of certain strategies and greater coverage will be conditional on the availability of additional resources.

2. Evidence and results-based: existing strategic information from epidemiological, public health and social research including programme data, will guide priorities responsive to changing incidence and prevalence trends with specific, measurable and realistic targets aligned with the goals of achieving Universal Access.

3. Efficiency and sustainability: as external resources are on the decline, the plan seeks cost effectiveness and cost efficiency through strengthened management systems, and greater integration, where feasible, into existing health and social support systems.

4. Participatory: the Strategy was developed with inputs from relevant stakeholders, including government, civil society, communities, and development partners and requires the meaningful participation of concerned communities to increase the chances that planned outputs are achieved.

5. Gender and age-responsive: the Strategy recognizes gender and age cut across prevention, treatment, care, and support strategies and are important determinants of vulnerability and access; and implies an understanding of how social and cultural norms affect vulnerabilities of people of different sexual orientations potentially requiring different interventions.

6. Quality of interventions: the Strategy recognizes that performance of implementers shall not be judged on quantitative achievement alone and quality of services and client satisfaction will have major consideration. The principle will remain the basis of scaling up or down the services once the strategic information is available for the continuation or scaling up of the services.

III.6. Targets for Key Populations

PWID: Optimal targets vary on the intervention for PWID, however the PAS III aligns the coverage target of PWID "regularly reached by Needle and syringe programmes" (regularly

reached defined here as at least once a month[98]) with global targets at 80 per cent.[99] However while the global target is 80 per cent for needle exchange programme enrolment, Pakistan's target is 80 per cent of PWID reached by NSEP services at least once in the last month.

Transgender persons: The access to services and condom use coverage target for transgender persons and HSW are60 per cent. While UNAIDS 2020 global targets[100]are for 80%, given Pakistan's limited resources, and unknown number of TG, the 2020 target is set at 60% but can be revisited after the 2015 IBBS R V. National and global reporting on access to services will be based on the two IBBS variables: 1) know where to get an HIV test, and 2) free condom in last 12 months. As baselines for transgender persons will only be available after the completion of the IBBS Round V end 2015, targets for transgender were set based on *hijra* baselines from the IBBS RIV.

MSM: Like with transgender persons, baselines for MSM and MSW will be set after the completion of the IBBS Round V end 2015. While global coverage rate for MSM are set at 70 per cent for condom use and 85 per cent for access to services coverage, as prevalence rates and potential numbers are unknown, both condom use and access to services targets are set at 60 per cent. National and global reporting on access to services will be based on the two IBBS variables: 1) know where to get an HIV test; and 2) free condom in last 12 months.

FSW: Like with male sex workers, the global targets for FSW are set at 90 per cent for condom coverage and 85 per cent for access to services coverage. In Pakistan, however, the targets are set at 50 per cent for both condom coverage and access as HIV prevalence of FSW is the lowest among all key populations at 0.8 per cent. National and global reporting non-access to services will be based on the two IBBS variables: 1) know where to get an HIV test; and 2) free condom in last 12 months. Baselines for FSW targets are taken from the Round IV IBBS.

Prisoners: There is no global target for prisoners. The estimated prevalence among prisoners has been around 2 per cent at different points in time and locations. The PAS III sets the target for prisoners at 60 per cent of the 75 000 estimated prison inmates have received an HIV test in the last 12 months and know their result. Priority should be those who have been imprisoned based on a drug offence as most of the HIV positive prisoners are PWID.

III.7. Implementation Arrangements

[98]*WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users, World Health Organisation 2012*

[99]UNAIDS. Update: Setting New Targets for the AIDS Response: 2015 and Beyond. UNAIDS 2014.

[100]Ibid.

The implementation of PAS III requires each stakeholder play their designated role (*see Annex 1. Stakeholders Roles and Responsibilities).* It is envisioned that the NACP with PACPs and related stakeholders will drive the implementation of the Strategy through a public private partnership approach with multi-sectoral support and funds received from Government and Donor sources with resource mobilisation efforts led by Government.

Federal Level

At Federal level, NACP with its technical partners including UN agencies will be responsible for providing guidance to stakeholders through development of guidelines, frameworks, standardized MIS, financial and supply management reporting system and technical assistance. Moreover NACP will lead the implementation of PAS III in Gilgit-Baltistan, AJK and FATA till these regions develop their respective AIDS strategies and capacity(s) to implement with required, secured, funds (PC-1 or donor grants). Procurement of pharmaceuticals and diagnostics is centralised through the procurement supply chain management system of NACP. NACP will manage national trainings, federal level multi sectoral meetings, monitoring and surveillance. While the NACP is responsible for managing newly introduced systems on Quality Assurance (diagnostics), Pharmaco-Vigilance, and ARV drug resistance, the development and day to day operations of these systems will be outsourced. PPPs or other public-partnership models will also be formed to support the HIV research agenda at national level respectively through leading institutes such as PMRC, HSA etc.

Moreover at Federal level, private sector partners (national or international) will manage the donor-funded projects with their partner(s) at Federal and sub levels. They will contribute in national progress on PAS III through stakeholder coordination, compliance to established referral system, joint monitoring and national surveillance through data sharing on standardized MIS and research activities. Lastly, NACP will develop periodic and Annual/GARP reports based on periodic surveillance, MIS reporting and research. They will also present the national response toward HIV and AIDS in national and international forums to bring improvement in response and policy changes (national) and leverage funding (international).

Provincial Level

At Provincial level PACPs (DoPH in KPK) will implement PAS III, aligned with Provincial AIDS Strategy(s) which will be revised to align with the PAS III, including extension through 2016. The implementation will be dependent on timely securing of funds from existing and new PC-1 for HIV interventions in the province with public sector support or through management of donor funded grants, like GFATM. The fully functional Programme Management, Financial, PSM, M&E units, will be regularly assessed and assisted for their capacity development, will help in management of civil society(s) implementing service delivery project(s) for key populations (PC-1 funded and donor funded grants). Further PACPs (DoPH in KPK) will

manage provincial trainings, procurement of diagnostic and pharmaceuticals (non-ARVs), referral systems, coordination and meetings with stakeholders (including Provincial Ministries, Donors and UN Agencies), development of periodic and annual reports based on periodic surveillance, MIS reporting and research. Whereas in the past PACPs were mandated to directly report to NACP but in the post devolution scenario the reporting will be for data consolidation at national level and to help ensure availability of strategic information for improvement. They will also present the provincial response for HIV and AIDS in provincial, national and international forums to improve the response and leverage funding. PACPs will also be responsible for implementing the Quality Assurance system for pharmaceuticals and HIV testing services and provide certification to sites qualifying based on the required criteria.[101]

District Level

Service Delivery Packages for key and vulnerable populations will be supported by District AIDS Councils where there is a need to facilitate intervention implementation and access. PACs are headed by the Deputy Commissioner's Office (the highest administrative office in the district). DACs were first established in districts under GF Round 9 support and will be expanded now to districts where SDPs under GF and PC-1s are operating. DACs will facilitate coordination of local efforts to ensure that services are properly delivered and monitored for effectiveness. A coherent strategy and action plan from DAC will help to support HIV interventions in the district, when to use its area of influence to advocate with individuals, the community and local government institutions accordingly. The DAC will play an important role in building referral linkages for the betterment of HIV positive people and their families, including with relevant social protection mechanisms e.g. Bait ul Maal or BISP.

Public-Private Partnerships

Public: The public sector at regional, provincial and district level will provide services related to HIV testing, medical management of PLHIV, formal referral to services in public sector for detoxification of PWIDs (Psychiatric units) and social services. Services will be provided either in public or private sector (depending on availability) for increased access to (ART adherence centred) rehabilitation, social services for vocational training and/or income generating opportunities. NACP and PACPs will ensure that the public private partnerships (PPP) contracts are awarded and renewed based on results-based performance with public-sector defining basic standards of service, leaving the private-sector party with the choice as to how to meet and possibly improve upon these basic standards. PPP contracts will be based on the principles of transparency, confidentiality, close monitoring and governance.[102] They will be

[101] In 2015 WHO Pakistan with key stakeholders will adapt their Service Availability and Readiness Assessment tool specifically for Pakistan and for HIV. The tool will be used to assess and monitor clinical facility sites including HIV Clinics, HIV satellite Sites, HTC Sites, as well as private sector service delivery sites as needed. The tool will include a PLHIV service satisfaction component.

[102]The availability of preventive services for Key Populations is the responsibility of the public sector whereas due to extensive outreach and confidence among communities, the delivery of HIV services is taken care of by NGOs and CBOs.

monitored both at the quantitative level (e.g. numbers provided services) and at the quality level against internationally accepted norms and standards for effective programming. The Bid Evaluation Committees for contracts will be formed at National and Provincial levels under the National and Provincial AIDS Control Programmes. They will meet on regular basis or when required to award service delivery contracts and to review progress on the PC-1. They will include representatives from Key Populations (including those not aligned with current service providers).

Private: PAS III will be implemented through regional and district offices of civil societies (supported either through PC-1 or Donor grant) and will manage the awarded grant through a fully functional Programme Management, Financial, PSM (where required) and M&E staff. The SDP will coordinate with relevant Provincial and District administration for capacity building, service provision and for addressing the issues of implementation. The service provision will be followed up by a multi-sectoral referral system reporting through a standardized MIS and sharing of reports and field research with provincial surveillance system.

See Section IV Strategic Priority Outcomes and Outputs, Key Strategy 3.3.3: Improve Management and Implementation Arrangements for further details.

III.7. Risk Mitigation

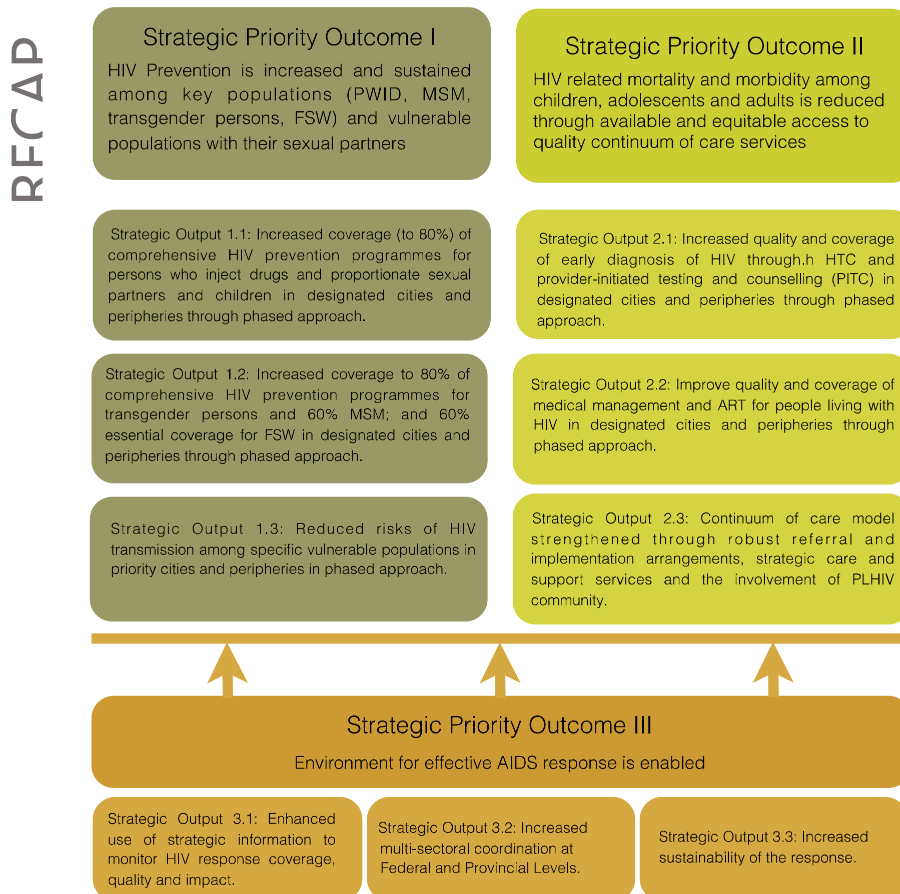
The major risks to the Pakistan AIDS Strategy III emanate out of political, administrative, financial, security and emergency factors, which are likely to negatively affect the implementation of the HIV response in the country. The risk categories have been identified on the challenges encountered by the HIV response in Pakistan during the last ten years. Political and administrative interference on critical appointments and transfers, especially of Programme Managers and in hiring of technical staff, has resulted in diminished capacities of teams managing the HIV response. The placement of senior management at national and provincial levels has to be strengthened through the introduction of policy to ensure fixed term, open, competitive and merit based appointments. Likewise an uncertain financial environment, where significant delays in PC-1 development, approval, and release of funds creates obstacles, delays and sometimes even cessation of critical prevention and care activities being supported by National and Provincial AIDS Control Programmes. In recent years the deterioration in the security situation in FATA, KP, Balochistan, Southern Punjab and Karachi is making it difficult to extend and monitor HIV related services, especially for key populations, in the absence of a system to track their displacement to different areas of the country. Similarly natural disasters and other health campaigns, especially polio, have frequently affected service delivery. In addition to the major risks listed above, stigma and discrimination, including enforcement of punitive laws for key risk behaviours, are critical risk factors in the successful achievements of Outcomes I and II of the PAS III. While Outcome III addresses risks to a large

extent through an enabled environment, persistent risks have to be countered through development of a comprehensive and sound risk mitigation strategy.

Part IV: Strategic Priority Outcomes and Outputs

Introduction

This section articulates the Strategic Priority Outcomes and Outputs, Key Implementation Strategies, Guidelines or Protocols to be developed, Key Partners and Linkages within the Strategy. Outputs call for implementation in cities and peripheries and through a phased approach to be decided by the Provinces.



Age and gender sensitive interventions to be revised as needed based on strategic information inputs such as programme evaluations (public and private), operational research, IBBS, and routine monitoring through a coherent MIS; including lessons learned and relevant programming material (e.g. modules of training, implementation and monitoring and evaluation of services) developed under Pakistan's Global Single Stream Funding for HIV. Initial and periodic capacity assessments of service providers should be conducted for inputs into capacity building plans and their implementation.

IV.1. Strategic Priority Outcome I

Outcome I: HIV Prevention is increased and sustained among key populations (PWID, MSM, transgender persons, FSW) and vulnerable populations with their sexual partners		
Strategic Output 1.1: Increased coverage (to 80%) of comprehensive HIV prevention programmes for persons who inject drugs and intimate partners (70%) and children in designated cities and peripheries through phased approach.	**Strategic Output 1.2: Increased coverage to 80% of comprehensive HIV prevention programmes for transgender persons and 60% MSM; and 60% essential coverage for FSW in designated cities and peripheries through phased approach.**	**Strategic Output 1.3: Reduced risks of HIV transmission among specific vulnerable populations in priority cities and peripheries in phased approach.**
Key Output Strategy 1.1.1: Expanded access to core preventive harm reduction services for PWID	Key Output Strategy 1.2.1: Increased coverage of comprehensive HIV prevention interventions for transgender people and MSM (including sex workers) through community-based or driven.	Key Output Strategy 1.3.1: Develop pre-departure prevention education for intending migrant workers, and a referral system to HTC, ART and PPTCT for returning migrants and their families in priority cities and peripheries in step-wise, phased approach
Key Output Strategy 1.1.2: Expanded essential HIV prevention interventions for 70% of IP of HIV positive PWID and 100% of their children meeting National Testing Criteria for HIV Affected Children in priority citiesand peripheries through phased approach.	Key Output Strategy 1.2.2: Increased coverage of targeted HIV interventions for Female Sex Workers through community-based or driven	Key Output Strategy 1.3.2: Establish and expand HIV services across priority prisons (including women and juveniles) to reach 60% of the prison population from baseline in a step-wise phased approach
	Key Output Strategy 1.2.3: Establish and expand essential HIV prevention interventions for 50% of Intimate Partners of HIV positive TG and MSM, and 100% children of HIV positive IP and FSW meeting testing criteria for children	Key Output Strategy 1.3.3: Scaled up PPTCT[103] services in prioritized cities and peripheries for women of child bearing age at risk for or living with HIV

Outcome I: HIV Prevention is increased and sustained among key populations (PWID, MSM, transgender persons, FSW) and vulnerable populations with their sexual partners.

[103] In Pakistan PMTCT is referred to as PPTCT, which stands for Prevention-of-Parent-to-Child-Transmission, because most women get HIV infection from their husbands, to ensure that prevention efforts start from prevention of HIV transmission from husband to wife.

Strategic Output 1.1 — Increased coverage (to 80%) of comprehensive HIV prevention programmes for persons who inject drugs and intimate partners (50%) and children in designated cities and peripheries through phased approach.

Key Output Strategy 1.1.1 — Expanded access to core preventive harm reduction services for PWID.

Key Implementation Strategies

Ensure comprehensive programming for *street-based* PWID (including females and adolescents) through private (NGO) service delivery. Comprehensive programming includes the nine core intervention components for the prevention, treatment and care of HIV among people who inject drugs suggested by WHO, UNODC and UNAIDS.[104] While NSP, HTC, BCC, and condoms are provided directly by SDPs, STI management, detoxification and/or OST, may be referred out.

NSP targets are currently set at a medium level of 200 per PWID per year by 2016 and maintaining through 2020.[105,106] Referrals for Hepatitis and TB are referred to the relevant programmes, however given the diminishing scale of the Prime Minister's Hepatitis Programme and the out-of-pocket expense for clients that are able to access treatment, the PAS III recommends provision of interferon Hepatitis treatment by the HIV Clinics themselves until the Government's programme is strengthened. It is estimated that over 90% of PWID are currently co-infected with HIV and Hepatitis C.[107] Once a PWID tests HIV positive, their CD4 level with either be checked through the SDP (GF R9 recipient provides mobile CD4 to their clients and their intimate partners) or they will be referred into an HIV Clinic or satellite site.[108]ART initiation will be from HIV Clinics.

OST and Other Drug Treatment Interventions

WHO, UNODC and UNAIDS have documented that OST, such as use of methadone or Buprenorphine for maintenance, is highly effective in reducing injecting behaviours that put

[104]*WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users, World Health Organisation 2012.*
[105]WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision.
[106] NSP should be un-rationed with supply determined by need and not limited by cost or other considerations; e.g. NSPs with strict limits on the number of syringes provided to each client are less successful than those that do not impose such restrictions. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision.
[107] Verbal communication with the Association of People Living with HIV and AIDS. Formal dissemination of report is 5th May 2015.
[108] The PAS III recommends a satellite ART distribution and patient monitoring system (see below under Outcome II).

opioid-dependent injectors at risk for HIV and hepatitis C.[109]In addition, OST has been demonstrated to improve access to and adherence to ART as well as to reduce mortality among HIV positive injectors.[110]The global evidence base points to a substantial reduction in illicit use of opiates, injection drug use and deaths from overdose among those on OST. In view of the evidence base the WHO has included Buprenorphine and Methadone in the WHO Model List of Essential Medicines[111] and WHO, UNODC and UNAIDS recommend that countries with large scale use of opiates make available OST, an important component of a comprehensive package of HIV prevention, treatment and care services for PWID.[112]

People who inject drugs account for a significant proportion of all PLHIV in need of HIV treatment in Pakistan. Yet available data indicate that adherence to ART is significantly lower among PWID compared with PLHIV who do not inject drugs (19.8% vs 46.9%).[113] Leading HIV physicians in the country report that absence of agonist opioid substitution treatment (OST) is one of the main barriers to uptake of and adherence to HIV treatment amongst HIV positive PWID. The PAS III recognizes the critical link between OST and health and HIV outcomes for PWID, including adherence to ART. An OST strategy[114] has been developed by the NACP with technical assistance from UNODC, WHO and UNAIDS. The Strategy proposes a phased approach aimed at introduction and expansion of OST in Pakistan during 2015-2020 cognizant of the fact that introduction of pharmacologically assisted treatment of opioid dependence in Pakistan will require a number of processes as per relevant international treaties and national regulatory frameworks. These include, among other, processes involved in enabling availability of Buprenorphine in the 2mg, 4mg, 8mg and 10mg sub-lingual tablet form and putting in place a stringent procurement and supply chain mechanism systems to prevent unintended use of the medicine. The three phases are:

Phase 1- Preparatory phase (2015 through to mid 2016)
Phase 2 - Implementation of OST service delivery (mid 2016 - December 2017)
Phase 3 - Scale-up and implementation of OST service delivery in an additional 13 cities (2018 - 2020)

Phase 1 (2015- mid 2016) is considered as the preparatory phase. The preparatory steps will include, but are not limited to, the following:

[109]WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users: 2012 Revision.
[110]WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users: 2012 Revision.
[111]World Health Organization. WHO 18th Model List of Essential Medicines (April 2013). Geneva, World Health Organization, April 2013. http://www.who.int/medicines/publications/essentialmedicines/en/index.html
[112]WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users: 2012 Revision.
[113]Daud MY, Qazi RA, Bashir N. Anti-retroviral drugs compliance in intravenous and non intravenous drug abusers. Journal of Ayub Medical College Abbottabad. 2014;26(4):437-40.
[114]For detailed OST strategy see Annex V Strategy for introduction and expansion of opioid substitution treatment in Pakistan.

- Revitalization of Technical Steering Committee for OST and/or formation of a National Advisory Group on OST;
- Securing limited use permission from Drug Regulatory Authority of Pakistan;
- Logistics related to transport, medicine, DOT etc.;
- Supply chain management;
- Review and updating of existing national drug dependence treatment guidelines;
- Management arrangements, including contracting of OST sites and human resources, budget, M & E system; and
- Development of a national policy on OST

Responsibility for obtaining necessary approvals, establishment of required administrative, logistics and management processes and procedures procurement and supply chain management systems, development of guidelines and standard operating procedures, recruitment and training of human resources required for the programme and establishment of the M&E system as well as other preparatory steps in the Phase 1 of the programme rests with the National AIDS Control Programme (NACP) in coordination with the PACPs and the licensed hospitals.

Phase 2 (mid 2016 - December 2017) will consist of OST service delivery for an estimated 1000 PWID as part of a comprehensive HIV prevention, treatment and care response by the public health sector in Pakistan. A total of 1=000 eligible individuals will be enrolled onto the OST programme from mid 2016 onwards, or earlier, provided that all the necessary preparatory arrangements have been accomplished. The planned number of patients reached through each OST site will be divided proportionate to the estimated population of PWID in the four main provinces so as to reach the total target of 1000 PWID. Standard Operating Procedures (SOPs), developed by the NACP with support from technical partners, will guide the service delivery during Phase 1.

Phase 3 (2018 - 2020)

Phase 3 will consist of development and implementation of a national implementation and scale-up plan which will be informed by the lessons learned from implementation of OST service delivery during Phase 2 as well as be guided by international normative guidance with regard to optimal levels of programme coverage by WHO, UNODC and UNAIDS.[115]It is envisaged that during Phase III the OST programme will be further scaled up and implemented in additional 13 major cities, including, but not limited to cities detailed in below table (see separate attachment for Table). The OST programme will focus on cities that have a high prevalence of injection drug use, leading to a large overall number of PWID, and high prevalence of HIV amongst PWID. The number of OST service delivery sites will be determined

[115]As per WHO, UNODC, UNAIDS 2012 Revision of the Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users high level of coverage of OST would equal having at least 40% of opioid dependent individuals on OST, while 20-40% equals medium level of coverage and < 20% equals low level of programmatic coverage.

based on available data on the estimated total population in each city, estimated population size of PWID and HIV prevalence amongst PWID according to data as of 2017.

In the absence of OST, the PAS III recommends to provide detox and rehabilitative adherence support for a limited number of PWID.[116] Although detox is currently for HIV positive PWID with a CD4 of <500, the PAS III recommends to provide it to all PWID detoxification services, prioritizing HIV positive PWID, based on SOPs in line with international standards and guidance developed by key partners including civil society currently providing services to PWID, UNAIDS, UNODC and the WHO. Although many ultimately relapse after detox, the time away from potentially sharing, and the subsequent injecting-free period (as long as it may be) ensures the virus is not shared from that individual to other HIV-negative injecting individuals. Coverage targets for detoxification and linked rehabilitation services are expected to go down as OST becomes available and coverage targets are scaled up. Rehabilitative adherence support for PWID refers to a residential program for HIV positive PWID taking ARV medication, providing therapeutic safe learning environment with drug, HIV and AIDS specific health and psychosocial care.[117] The PAS III recommends providing rehabilitative support to 40 per cent of PWID.[118]To support mitigation of chaotic lifestyles and long-term ART retention goals, linkages to vocational training and employment opportunities will be made where possible.

The majority of opiate users smoke, chase or sniff heroin (oral use), however many shift between oral use and injecting depending on multiple factors including cost of heroin. As regular non-injectors co-exist with injectors, the potential of co infections (HIV, Hepatitis C etc.) exist due to sporadic exchange of used syringes and needles. Service delivery for PWID should incorporate a portion of budget for non-injecting drug users (male, female and adolescent) found in same service delivery geographical areas to provide a minimal package of services to mitigate shift to injecting and reach those who may only sporadically inject. Essential services include the same services as for PWID except NSP and wound dressing.

A note about reaching women who inject drugs: While reaching PWID is most efficient through the existing PWID SDPs, specific gender responsive programmatic components need to be in place such as: female outreach workers; facilitation for clinical and other appointments (including STI diagnosis and treatment); contraception (other than condoms) and pregnancy tests; prioritization of pregnant FWID for OST; risk reduction (including vertical transmission) and GBV counselling and prevention services.

[116] This is currently being provided by Nai Zindagi under GF Round 9, however, the PAS III recommends to scale both interventions up.

[117] See Nai Zindagi model currently supported by the Dutch Ministry of Foreign Affairs through Mainline Foundation at*http://www.naizindagi.org/#!mainline-foundation/c10c2*). Currently this is the only rehabilitation programming model in Pakistan for PWID with an HIV-related focus.

[118]As provision of rehabilitative ART adherence support is recommended primarily in the absence of OST, recommended coverage targets are the same as global OST targets.

Key Output Strategy 1.1.2 **Expanded essential HIV prevention interventions for 50% of Intimate Partners of HIV positive PWID and 100% of their children meeting National Testing Criteria for HIV Affected Children.**

Key Implementation Strategies

Intimate partners[119] of HIV positive PWID and their children meeting criteria for testing[120] will be reached through the service delivery packages reaching PWID. Intimate partners will be reached primarily through a female outreach worker to the home with essential services including targeted IEC (including screening for gender-based violence), condoms, HTC (including couple counselling[121]), and CD4 if available.[122] Referrals will be made for CD4, HIV Clinic registration and ART if needed. Although ART is only provided through the public sector, where feasible NGO service delivery providers to provide point of care CD4 and access to ART; and care and support including women development schemes. Referrals to sexual and reproductive services for HIV positive IPs would be facilitated, including for gynaecological problems, STI syndromic management, and family planning, i.e. those seeking to avoid pregnancy and those who are sexually active and planning a pregnancy.

Children of HIV positive children meeting the following testing criteria will also receive HTC and referred if needed: 1) mother is HIV positive; mother was infected before the birth of the child; and child is under 12 years. If the mother feels an older child is at risk of having injected drugs, they should also receive HTC.

Key Partners: National and Provincial Governments, Non-Governmental Organisations, CBOs, APLHIV, UNODC, UNAIDS, WHO, UNICEF, Narcotics Control Division, Drug Regulatory Authority, NADRA, social welfare schemes (including women's schemes)

Linkages within the Strategy:

- 1.3 Reduced risks of HIV transmission among specific vulnerable populations in priority cities and peripheries in phased approach
- 2.2 Improve quality and coverage of medical management and ART for people living with HIV in designated cities and peripheries through phased approach
- 2.3 Continuum of care model strengthened through robust referral and implementation arrangements, strategic care and support services and the involvement of PLHIV community
- 3.1: Monitoring & Evaluation system strengthened for improved programme implementation

Strategic Output 1.2 Increased coverage to 60% of comprehensive HIV prevention programmes for transgender

[119] Defined as in a current sexually active relationship with their male PWID partner.

[120] HIV Testing Criteria for Children affected by HIV and AIDS, NACP 2008.

[121] Couple counselling should include condom distribution and education emphasizing: (1) the need to protect oneself from disease progression, co-infection, super-infection and treatment failure; and (2) to prevent onward transmission.

[122] If intimate partners are injecting with their male PWID partners, referrals into detox, rehabilitation and OST services are covered as part of Output Strategy 1.1.1.

persons and MSM; and 50% essential coverage for FSW in designated cities and peripheries through phased approach.

Key Output Strategy 1.2.1 **Increased coverage of comprehensive HIV prevention interventions for transgender people and MSM (including sex workers) through community-based or driven approaches.**

Key Output Strategy 1.2.2: **Increased coverage of targeted HIV interventions for Female Sex Workers through community-based or driven approaches.**

Key Implementation Strategies

Transgender persons, MSM and FSW receive a similar comprehensive package of services including targeted IEC, condom programming including lubricants, and HTC.[123] STI management may be provided directly by SDPs or referred out. Transgender persons, MSM and FSW testing HIV positive will be referred out for CD4 and treatment initiation. Care and support services will be provided by the SDPs serving these key populations. Services for these communities would be community based or community driven interventions,[124] and wherever relevant and feasible, the capacity of communities would be built to provide services.[125] Given the large proportion of young key populations, age-sensitive implementation and programming adaptations for adolescents is critical; e.g. BCC and self-risk identification terminology used by MSM and TG adolescent populations, as well as specific outreach strategies. Specific strategies for FSW will be employed for sub-categories of adult and adolescent sex workers, e.g. street based and brothel based. Sex workers outside *deras*, brothels or *kothikhanas* are dispersed and difficult to access given recent improvements in communication technology, especially the easy and wide availability of cell phones. Street-based sex work is diminishing as sex workers and clients can now directly interact without the need of going through a third person.Given the primary mode of attracting clients by all sex workers is outside of a fixed establishment, services will be provided through outreach with access to a static site for STI identification and treatment (if provided), HRC (if unable to provide through outreach), to provide a safe space to avoid harassment or violence and community building.

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[123] If TG, MSM or FSW are injecting drugs, referrals into detox, rehabilitation and OST services are covered as part of Output Strategy 1.1.1.

[124] Community based indicates the organisation's management structure is from the community and that only community members take decisions within the organisation. Community driven indicates community members are involved in decision-making and one or more components of the programming, e.g. outreach, is led and implemented by community members.

[125]Interventions for MSM should be designed and run by the Community so as to provide without any kind of prejudice and with a socially/culturally sensitive approach to reach those who may not identify themselves with specific way of living or expression. Understanding the nexus between sexual identities and meanings of masculinities is critical to build a gendered understanding of the difference between homosexual practices with that of homosexual identities.

As prevalence among FSW is still very low, efficient service delivery mechanisms will be explored such as service delivery to FSW by existing MSM, TG or PWID service providers and scaled up if effective (including community acceptance).

Key Output Strategy 1.2.3: Establish and expand[126] essential HIV prevention interventions for 50% of Intimate Partners of HIV positive TG and MSM, and 100% children of HIV positive IP and FSW meeting testing criteria for children[127]

Key Implementation Strategies

Intimate partners[128] of HIV positive PWID, MSM and transgender persons and their children meeting criteria for testing[129] will be reached through the service delivery packages reaching those key populations. Intimate partners will be reached primarily through outreach to the home for targeted IEC, condoms, STI referrals, rapid testing and for CD4 if available.[130] Referrals will be made for CD4, HIV Clinic registration and ART if needed, as well as care and support including women development schemes. Referrals to sexual and reproductive services for HIV positive IPs will be facilitated, including for gynaecological problems, STI syndromic management, and family planning, i.e. those seeking to avoid pregnancy and those who are sexually active and planning a pregnancy.

Children of HIV positive TG, MSM and FSW meeting the following testing criteria will also receive HTC and referred if needed: 1) mother is HIV positive; mother was infected before the birth of the child; and child is under 12 years. If the mother feels an older child is at risk of having injected drugs, they should also receive HTC.[131]

Key Partners: National and Provincial Governments, Non-Governmental Organisations, UNDP, UNAIDS, UNFPA, UNICEF, WHO, APLHIV, Action Aid, Oxfam, social welfare schemes (including women's schemes)

Linkages within the Strategy:

- 1.3 Reduced risks of HIV transmission among specific vulnerable populations in priority cities and peripheries in phased approach
- 2.2 Improve quality and coverage of medical management and ART for people living with HIV in designated cities and peripheries through phased approach
- 2.3 Continuum of care model strengthened through robust referral and implementation arrangements, strategic care and support services and the involvement of PLHIV community
- 3.1: Monitoring & Evaluation system strengthened for improved programme implementation

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[126] Should match phased approach expansion of (male) key populations programming.
[127]HIV Testing Criteria for Children affected by HIV and AIDS, NACP 2008.
[128] Defined as in a current sexually active relationship with their male PWID partner.
[129]HIV Testing Criteria for Children affected by HIV and AIDS, NACP 2008.
[130] If intimate partners are injecting drugs, referrals into detox, rehabilitation and OST services are covered as part of Output Strategy 1.1.1.
[131] FSW have very low levels of awareness of PMTCT: only 13.4% knew about mother-to-child transmission, reported in a study of 540 FSW (91% married and 98% with children) (Hawkes S. et al. 2012. HIV and other sexually transmitted infections among men, transgender persons and women selling sex in two cities in Pakistan: a cross-sectional prevalence survey).

Strategic Output 1.3 — Reduced risks of HIV transmission among specific vulnerable populations in priority cities and peripheries in phased approach.

Key Output Strategy 1.3.1: Develop pre-departure prevention education for intending migrant workers, and a referral system to HTC, ART and PPTCT for returning migrants and their families in priority cities and peripheries in step-wise, phased approach

Key Implementation Strategies

Services to departing and returned HIV migrant workers will be provided in close collaboration between NGOs (SDPs), the HIV sector, and Government sectors serving migrant workers. Preventative education and referral information will be provided to outgoing migrants through 1) BEOE Regional Training Centres, 2) immigration processing services/travel agents serving intending migrants; 3) private laboratories used for mandatory visa-related HIV testing (including Gulf Cooperation Council GCC Approved Medical Center's Associations [GAMCA]); 4) airports that have direct international flights (through Civil Aviation Authority); and 5) in cities and peripheries with a defined percentage of the male adult population working overseas and identified by the Provincial AIDS Control Programmes including through LHW programme. Referrals into treatment, care and support will be made for deported migrant workers in cooperation with the Federal Investigation Authority, the agency in charge of facilitating medical and other deportations through Immigration.

Capacity building of implementing partners is necessary to strengthen referrals for returned HIV positive migrants and their families.Capacity building priorities include a) HTC training (initial and refresher) for all laboratories undertaking HIV testing for intending migrant workers; b) training (initial and refresher) FIA staff at airports with international flights on HIV and how to refer deported migrants and their families to HTC, treatment centres and NGOs/CBOs providing care and support.

Key Output Strategy 1.3.2: Establish and expand HIV services across priority prisons (including women and juveniles) to reach 60% of the prison population from baseline in a step-wise phased approach

Key Implementation Strategies

As with migrant workers, services for prisoners will be provided in close collaboration between NGOs (SDPs), the HIV sector, and Government sectors managing prisons. Services for prisoners include targeted IEC and HTC. For those testing HIV positive, satellite services within prisons will be provided for CD4 and ART initiation from the nearest HIV Clinic to the prison. Referrals into SDPs[132],treatment care and support will continue following release. Intimate partners of HIV positive prisoners will be traced, tested and referred into treatment care and support, as well as children of HIV positive IPs.

Provincial-level SOPs for providing HIV services in prisons will be developed with relevant partners to ensure consistency and quality of service provision. SoPs will include targeted HIV information, HIV testing protocol, blood collection/confirmatory testing, CD4, ART initiation, partner tracing, HIV treatment monitoring information, emergency treatment protocols and referrals system for released prisoners who inject drugs and/or are HIV positive.

Technical Assistance, capacity building and infrastructural support will be provided in step-wise manner to ensure timely and sustainable hand over of identified services to the prison health services where feasible.

Key Output Strategy 1.3.3: Scaled up PPTCT[133] services in prioritized cities and peripheries for women of child bearing age at risk for or living with HIV

Key Implementation Strategies

Current PPTCT outcomes are quite poor, although they have improved in the last years. Coverage of PPTCT services[134] increased from 4.1 per cent in 2012[135] to 8.1 per cent in 2013, based on estimated HIV positive pregnant women, while coverage of identified HIV positive pregnant women was 100 per cent. The generated estimated percentage of child HIV infections from HIV-positive women delivering in 2013 barely decreased from 2012 34.6 per cent to 34.4 per cent(534/1554).[136]Of infants born to women receiving PPTCT services early infant diagnosis at 6-8 weeks increased from 16.3 per cent in 2012 to 23.8 per cent in 2013.

Challenges in reaching HIV positive pregnant women in a concentrated epidemic require coordinated efforts with key population prevention programmes to bring these figures closer to the estimated need. In the PAS III Prevention of Parent to Child Transmission services will be

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[132] If prisoners are injecting drugs, referrals into detox, rehabilitation and OST services are covered through PWID service providers as part of Output Strategy 1.1.1.

[133]In Pakistan PMTCT is referred to as PPTCT, which stands for Prevention-of-Parent-to-Child-Transmission, because most women get HIV infection from their husbands, to ensure that prevention efforts start from prevention of HIV transmission from husband to wife.

[134]Availed or are still availing prophylaxis or treatment for their own health.

[135]Pakistan EPP Projections, Spectrum Modelling, GoP/UNAIDS, 11th March 2013.

[136] Spectrum modelled data = child new infections 0-14 years.

focused on reaching intimate partners of men already known to be HIV positive (through SDPs, including CoPC+ and CHBC sites, and HIV Clinics), FSW and women living in districts or areas with a high burden of HIV disease through SDPs and broader health initiatives. Information on GBV will be made available with referral for those who report intimate partner violence. Capacity to manage HIV positive pregnancies will be built in identified HIV Clinic facilities (*see Outcome 2, Output 2.1.1*) simultaneous with initiation of ART and paediatric service provision. Successful outreach strategies, e.g. Lady Health Workers referring identified at-risk families into testing facilities through a broader health initiative in high burden areas will continue. As Pakistan is implementing Option B+, treatment will be initiated at the HIV Clinics and pregnant women referred to MNCH services for pre- and post-natal services and delivery, while HIV-related clinical monitoring and service provision will be implemented by HIV Clinics, and later routine ARV provision potentially by Satellite services.[137] Safe delivery will be ensured through provision of kits placed at ART Centres and allocated to positive pregnant women either directly or through OB/Gyn departments.

The PPTCT service strategy will be refined following an evaluation of the PPTCT programme (*planned in 2015 under Outcome 3*) to increase identification and reduce lost-to-follow up along the PPTCT cascade with special attention to 1) the particular migrant workers situation in the province; 2) reaching spouses/female partners of males in key and vulnerable populations; 3) implementation consequences of Option B+ on HIV Clinics. Contingent on the evaluation, the strategy will adapt current HTC interventions for at-risk women and families promoted through the LHW programme; and HTC uptake in selected Districts with higher risk and vulnerability factors.

Guidelines or Protocols to be developed:

- SOPs for providing HIV services in prisons
- PPTCT Strategy

Key Partners: National and Provincial Governments, UNAIDS, UNICEF, WHO, UNHCR, NGOs/CBOs, APLHIV.
(*in addition for Migrants*: BEOE, FIA, CAA, ILO, IOM, private labs)
(*in addition for Prisons*: Home Department, Prison Authorities, UNODC)

Linkages within the Strategy:

- 1.1 Increased coverage (to 80%) of comprehensive HIV prevention programmes for persons who inject drugs and proportionate sexual partners and children in designated cities and peripheries through phased approach.
- 1.2 Increased coverage to 80% of comprehensive HIV prevention programmes for transgender persons and 60% MSM; and 60% essential coverage for FSW in designated cities and peripheries through phased approach.
- 2.2 Improve quality and coverage of medical management and ART for people living with HIV in designated cities and peripheries through phased approach
- 2.3 Continuum of care model strengthened through robust referral and implementation arrangements, strategic care and support services and the involvement of PLHIV community
- 3.1 Monitoring & Evaluation system strengthened for improved programme implementation

[137]With Option B+ PPTCT regimen protocol, pregnant women will be immediately initiated onto ART for life; their clinical management will be supported through the HIV Clinics, while their pregnancies will be managed through MNCH as with other pregnant women.

IV.2. Strategic Priority Outcome II

Outcome II: HIV related mortality and morbidity among children, adolescents and adults is reduced through available and equitable access to quality continuum of care services		
Strategic Output 2.1: Increased quality and coverage of early diagnosis of HIV through HTC and provider-initiated testing and counselling (PITC) in designated cities and peripheries through phased approach.	**Strategic Output 2.2: Improve quality and coverage of medical management and ART for people living with HIV in designated cities and peripheries through phased approach.**	**Strategic Output 2.3: Continuum of care model strengthened through robust referral and implementation arrangements, strategic care and support services and the involvement of PLHIV community.**
Key Output Strategy 2.1.1: Increase availability and uptake of HTC for Key and other vulnerable populations	Key Strategy 2.2.1: Scaled up quality HIV management and treatment services (children, adolescents and adults) for improved access and adherence	Key Strategy 2.3.1: Scaled up quality HIV management and treatment services (children, adolescents and adults) for improved access and adherence
Key Output Strategy 2.1.2: Mainstream and support critical HIV related risk-reduction interventions138 in general health services	Key Strategy 2.2.2: Ensure sustainability of procurement and supply chain management of ART and HIV related medicines	

Outcome II: HIV related mortality and morbidity among children, adolescents and adults is reduced through available and equitable access to quality continuum of care services[139]

Strategic Output 2.1 **Increased quality and coverage of early diagnosis of HIV through HTC and provider-initiated testing and counselling (PITC) in designated cities and peripheries through phased approach.**

Key Output Strategy 2.1.1 **Increase availability and uptake of HTC for Key and other vulnerable populations.**

Key Implementation Strategies

[138] Interventions that reduce the risk of HIV acquisition and transmission.
[139] Continuum of Care refers to HTC, HIV treatment related services and care and support for people living with HIV.

HTC focus is primarily on increasing uptake among key populations and specific vulnerable populations. Innovative testing strategies with standardized SOPs will be developed with key partners for HIV testing uptake including PoC rapid HIV testing using 3-rapid test algorithm. This will be ensured through home/community-based testing including through task-shifting finger-prick testing to trained, non-medical staff. Consistent provision of WHO approved rapid test kits is critical to achieving the HTC uptake levels needed to close the gap between estimate prevalence and identified cases, and those needing treatment and those receiving it.[140]To achieve closing this gap HTC is to be scaled up with SoPs for testing sites; regulation of test kits and testing algorithms for public and private testing facilities (including labs); and a cadre of master trainers identified and trained at provincial level to build the capacity of service providers in public and private sectors on revised guidelines.[141]

For key populations Point of Care (PoC) testing will be scaled up beyond the limited scale currently achieved. While principles of adequate preparatory counselling, confidentiality and consent will be respected and adhered to, provision of HTC to homes, work establishments and street-based hot spots will be strengthened for key populations and their intimate partners. SDPs will increase provision of HTC to 100 per cent of registered clients.

To identify vulnerable persons potentially infected not receiving services through SDPs, capacities will be built of key health services for vulnerable populations to make referrals into HTC. Vulnerable populations may include migrant workers, prisoners, populations in high burden districts (e.g. Gujrat), TB patients, STI patients, persons receiving multiple blood transfusions (e.g. thalassemia and transplant patients) and chronic infection patients e.g. in paediatrics and dermatology. Public and/or private HTC sites are proposed to be available across every Division in Pakistan by 2020.

One-Stop Shop: HTC site/facility will be established, free of cost, with standardised SOPs in targeted facilities (coherent with scaling up ART, and paediatric services in same facilities). The capacities will be built of relevant departments, in the same facilities, on potential HIV case referrals for HTC from Dermatology, Urology, Paediatrics and Gynaecology, using revised relevant module/s in National District HIV Training curricula (NACP 2010).[142]Capacity of one-stop service provision will be reinforced where feasible through inclusion of HIV and where to refer for HTC into district and provincial level schools training healthcare providers (in-service).

If evidence of a break-out in a particular location, efforts will be made for large-scale community volunteer testing.

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[140]WHO approved tests and kits to be sustained, including rapid test kits for 3-rapid test algorithm based on appropriate forecasting for 1st, 2nd and 3rd tests, and ELISA and Western Blot diagnostic kits.
[141] Aligned with Pakistan Country Strategy for HIV Testing & Counselling 2013.
[142] District Health Training (NACP 2010) to be adapted based on new Pakistan Treatment Guidelines (2014).

Key Output Strategy 2.1.2: Mainstream and support critical HIV related risk-reduction interventions[143] in general health services.

Key Implementation Strategies

Infection Control and Waste Management SOPs and material support specifically for HIV programme implementation partners (public and private) at Federal and Provincial levels developed and disseminated.

PEP will be introduced through the HIV clinics for HIV related health care service providers either at the SDP level or in health facilities. As the regimen is slight different than the prioritized first-line[144] regimen in fixed dose combination, ARV orders will have to include respective PEP regimen ARVs. A PEP guide will be produced and disseminated to relevant HCP in both public and private sectors and will include potential transmission cases through GBV.[145]

The HIV sector along with other partners (e.g. GIZ) will provide technical support to National Blood Transfusion Authority to adapt and implement at Federal and Provincial levels a routine counselling and notification system to link those testing positive with treatment and care.[146]

Guidelines or Protocols to be developed:

- Revised HTC Guidelines
- SOPs for HTC sites
- Quality assurance system for test kits and testing protocol
- HTC training developed with ToT plan and certification
- Revised HIV Training (NACP 2010)

Key Partners: National and Provincial Governments, Health departments and clinical facilities, NGOs/CBOs, APLHIV, UNAIDS, WHO, UNICEF, UNODC, UNDP, UNHCR, UNFPA, private labs and clinical facilities

Linkages within the Strategy:

- 1.1 Increased coverage (to 80%) of comprehensive HIV prevention programmes for persons who inject drugs and proportionate sexual partners and children in designated cities and peripheries through phased approach.
- 1.2 Increased coverage to 80% of comprehensive HIV prevention programmes for transgender persons and 60% MSM; and 60% essential coverage for FSW in designated cities and peripheries through phased approach.
- 1.3 Reduced risks of HIV transmission among specific vulnerable populations in priority cities and peripheries in phased approach.
- 3.1Monitoring & Evaluation system strengthened for improved programme implementation

[143] Interventions that reduce the risk of HIV acquisition and transmission.

[144] TDF + 3TC (or FTC) and LPV/r or ATV/r. Efavirenz is also recommended as an alternative third drug for post-exposure prophylaxis. Guidelines on post-exposure prophylaxis for HIV and the use of cotrimoxazole prophylaxis for HIV-related infections among adults, adolescents and children: recommendations for a public health approach: December 2014 supplement to the 2013 consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection.

[145]WHO (2006), "Addressing Violence Against Women in HIV Testing and Counselling: A Meeting Report"; www.who.int/gender/documents/VCT_addressing_violence.pdf. See also WHO and UNAIDS (2007), "Guidance on Provider Initiated HIV Testing and Counselling in Health Facilities.

[146] Reference WHO (with CDC & IFRC) Blood donor counselling: implementation guidelines (2014).

Strategic Output 2.2 — Improve quality and coverage of medical management and ART for people living with HIV in designated cities and peripheries through phased approach.

Key Strategy 2.2.1 — Scaled up quality HIV management and treatment services (children, adolescents and adults) for improved access and adherence.

Key Implementation Strategies

Treatment coverage at the end of 2014 was estimated at a critically low level at 7 per cent of all PLHIV: 11 per cent of adults eligible (<500 CD4) and 5% of eligible children. Increasing this coverage to even 60% by the end of 2020 will require system strengthening and innovative interventions to exponentially increase HTC uptake and plug the treatment cascade.

HIV Clinical Management and Treatment Services will continue to be provided by the HIV Clinics (formally known as ART Centres) located in the four provinces and Islamabad Capital Territory, free of cost and with standardised management and care.[147] Additional HIV Clinics will be added through 2020 (coherent with scaling up of HTC, paediatric and HTC services in the same facilities). TB testing and treatment will be provided through the National TB Programme. Where geographically indicated, mobile CD4 machines will be introduced to Clinics not already having them and new Clinics as they open. Not all HIV Clinics will have the same level of services. Tertiarycare facilities, mostly located in provincial capitals, will have specialised services for complicated case management including initiation (e.g. hepatitis co-infection) and regimen switch (e.g. resistance). HIV Clinics at the District (or Divisional) level will have a minimum levels of investigative capacity including Ultra-Sound and X-ray. Where available and feasible, existing PCR machines will be optimized for viral load for tracking adherence and disease progression. Where indicated, PCR machines will be placed at facilities housing HIV Clinics.

> Facilities where HIV Clinics are housed are expected to provide:
> - CD and Viral Load tests at a schedule recommended in the 2014 Pakistan Treatment Guideline
> - Baseline investigations
> - General HIV clinical management including diagnosis and treatment of opportunistic infections
> - STI diagnosis and treatment
> - Hepatitis identification and treatment (through the Prime Minster's Hepatitis Programme)
> - HIV treatment

[147] Standardised SoPs for HIV Clinics developed including confidentiality; specific actions to plug leaky treatment cascades, minimum qualifications for technical staff [function-specific] and define minimum staffing levels. Minimum staffing levels to include a client tracing function from PLHIV community.

To **mitigate loss-to-follow-up** and retention of clients for viral load suppression, innovative and adapted HIV treatment strategies are needed, especially given distances in Pakistan between urban centres. Where district or tertiary facilities are not available (or where there is an overburden on existing HIV Clinics) and where the number of persons living with HIV is at least >50, satellite HIV services will be provided from district/tertiary HIV Clinics either solely by Government, or in partnership with NGOs serving PLHIV in those communities, or eventually directly through NGOs themselves. A trained physician, nurse or paramedic (mobile ART service provider) will provide services in satellite locations.[148] Once the specific HIV Clinic has stabilised a client on their medications (expected after 3 months) the referral to the satellite site could be made for follow up monitoring and to receive ARVs. The mobile ART service provider will be linked with a specific (usually closest) HIV Clinic and will rely on the attending physician at the HIV Clinic for technical back-stopping, including through web-based and interactive technology where available. Clients will continue to get VL, CD4, and other more specialised services at the identified "parent" HIV clinic or through mobile services. Given limited resources in remote areas and the placement of satellite sites in areas with a substantial number of PLHIV, SDPs in those areas will facilitate the physician (nurse or paramedic) to reach clients, either in their homes or a static site of the SDP if so arranged with the client. Figure 12below indicates the current and planned HIV Clinic and Satellite sites.

Figure 11. HIV Clinics and Satellite ARV provision arrangements

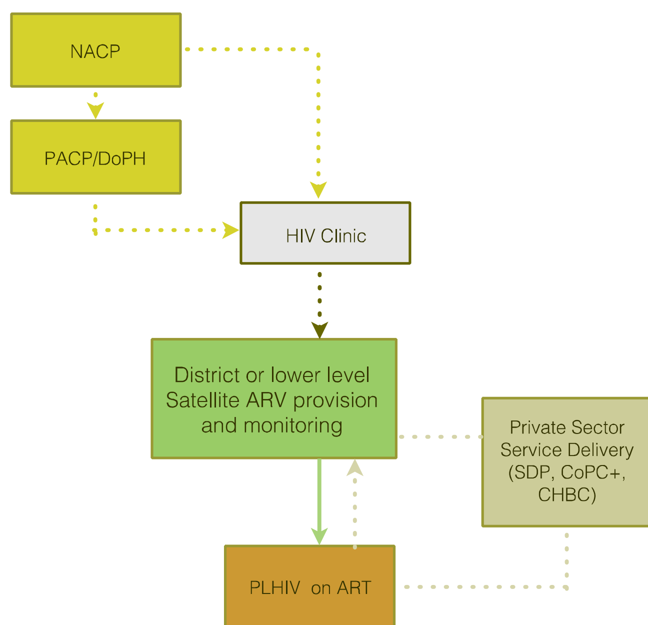
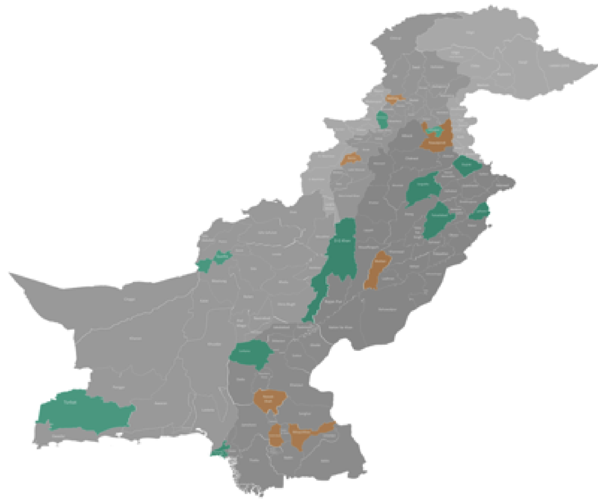
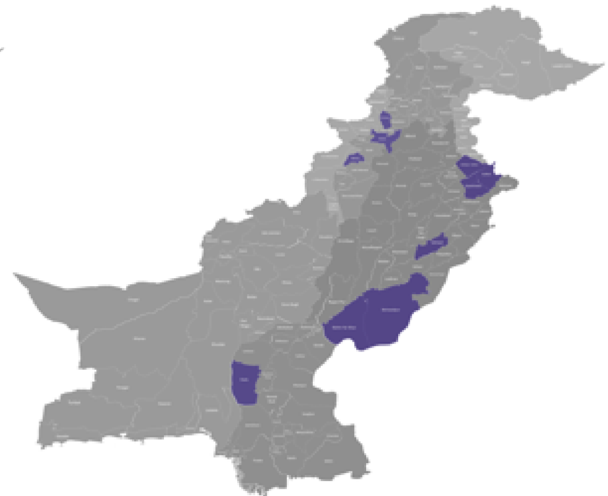


Figure 12. HIV Clinics (current and planned) and planned HIV Satellite Sites from 2015

[148]Reliance on a physician-driven model for satellite sites may become unfeasible. In this situation, task shifting—the reallocation of clinical tasks between cadres—is a potential alternative to Pakistan's current physician-centred service delivery models and may provide the best approach for increasing human resources quickly enough to match the continuing scale-up of treatment programs. World Health Organization. Task shifting: global recommendations and guidelines. Geneva: World Health Organization; 2007. Available at: http://data.unaids.org/pub/Manual/2007/ttr_taskshifting_en.pdf.



HIV Clinics



HIV Satellite Sites

HIV Clinic Sites and Satellite Sites

Clinics

Islamabad Capital Territory

1. Pakistan Institute of Medical Sciences, Islamabad

Punjab

2. Mayo Hospital, Lahore
3. Services Hospital (includes paediatrics), Lahore
4. Jinnah Hospital, Lahore
5. Shaukat Khanum Memorial Cancer Hospital, Lahore
6. Allied Hospital, Faisalabad
7. DHQ Hospital, Sargodha
8. DHQ Hospital, DG Khan
9. DHQ Hospital, Gujrat
10. Combined Military Hospital, Rawalpindi
11. TBD (new), Multan

Sindh

12. Indus Hospital, Karachi
13. Civil Hospital (includes paediatrics), Karachi
14. Abbaasi Shahid Hospital (new), Karachi
15. Aga Khan Hospital (paediatrics), Karachi
16. Larkana, Karachi
17. Jinnah Hospital (new),
18. DHQ Hospital (new), Mirkhur Pas
19. Sh. Benazirabad Nawabshah (new), Nawabshah
20. Hyderabad (new), Hyderabad

Khyber Pakhtunkhwa

21. Hayatabad Medical Complex, Peshawar
22. DHQ Hospital, Batkhela
23. DHQ Hospital, Bannu

Balochistan

24. Bolan Medical Complex, Quetta
25. DHQ Hospital, Turbat

Satellite Sites

Punjab

1. Jallalpur Jatta (parent HIV Clinic: Gujrat)
2. R.Y. Khan (parent HIV Clinic: Multan)

3. Sialkot (parent HIV Clinic: Lahore)
4. Gujranwala (parent HIV Clinic: Lahore)
5. Sahiwal (parent HIV Clinic: Multan)
6. Bahawalpur (parent HIV Clinic: Multan)

Sindh

7. Dadu (parent HIV Clinic: Larkana)

Khyber Pakhtunkhwa (parent HIV Clinic: Hayatabad Medical Complex)

8. Kohat (parent HIV Clinic: Hayatabad Medical Complex)
9. Lady Reading Hospital (parent HIV Clinic: Hayatabad Medical Complex)

Federally Administered Tribal Areas

10. Bannu FR (parent HIV Clinic: Bannu)

Standards in service provision need to strengthened including:

- **Standards of Care** for HIV Clinics to plan, develop and audit service quality including minimum staffing levels and qualifications of staff.
- To ensure quality clinical management of HIV and co-infections, **capacity** of HIV infectious disease physicians and paediatricians**will be built** on Pakistan 2014 National Treatment Guidelines (including case holding). Physicians and other relevant medical and para-medical staff of identified district/tertiary sites will be trained on revised District Health Training.[149] In addition, given the high level of hepatitis (2.5% hepatitis B and 4.8% hepatitis C in the general population,[150] and 85% hepatitis C prevalence[151]and 6.8% hepatitis B[152]among PWID) and TB (Pakistan ranks fifth amongst TB high-burden countries worldwide[153]) co-infection guidelines will be strengthened/ developed within the HIV training.
- To ensure patient safety a **pharmaco-vigilance system**will be established at Federal level inclusive of implementation of Consolidated Prevention and Treatment Guidelines (prescribing and regimen recommendations), MIS, timely procurement and maintained quality supply chain.
- Mitigation measures for extended treatment failure through **drug resistance tracking** (survey developed with SIUT for optimal regimen adjustments).

To ensure **viral load suppression**, several components will be added or strengthened, e.g., adherence support will be provided at multiple levels including HIV Clinics, satellite sites and SDPs, including *mhealth*[154] technology for adherence, as well as increasing access to ART adherence centred rehabilitation for all HIV positive PWID on ART (with linkages to vocational training and/or income generating opportunities for sustained outcomes). In addition, ART

[149] District Health Training (NACP 2010) to be adapted based on new Pakistan Treatment Guidelines (2014).

[150]Qureshi H, Bile KM, Jooma R, et al. Prevalence of hepatitis B and C viral infections in Pakistan: findings of a national survey appealing for effective prevention and control measures. East Mediterr Health J. 2010;16.

[151]Nelson PK, Mathers BM, Cowie B, Hagan H, Des Jarlais D, Horyniak D, et al. Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews. *Lancet.* 2011;378(9791):571-83 in The Global State of Harm Reduction 2014. Harm Reduction International, 2014.

[152] Ibid.

[153] http://www.emro.who.int/pak/programmes/stop-tuberculosis.html

[154] Use of mobile devices in rolling out medical and public health interventions.

adherence guidance, plans and treatment literacy materials will be developed for clients in HIV Clinics, SDPs, CHBC and CoPC+ sites, and awareness of ART services (incl. PEP) built among public & private health care providers, and vulnerable and key populations in coordination with APLHIV.[155]

In addition other strategic uses of ART to be implemented where relevant such as putting key populations on treatment irrespective of CD4 count (already Pakistan includes sero-discordant couples, pregnant or lactating HIV positive women, active HIV and HBV co-infected with TB co-infected, those with chronic active hepatitis), and potentially oral PrEP for specific persons or populations.[156]

Key Strategy 2.2.2 Ensure sustainability of procurement and supply chain management of ART and HIV related medicines

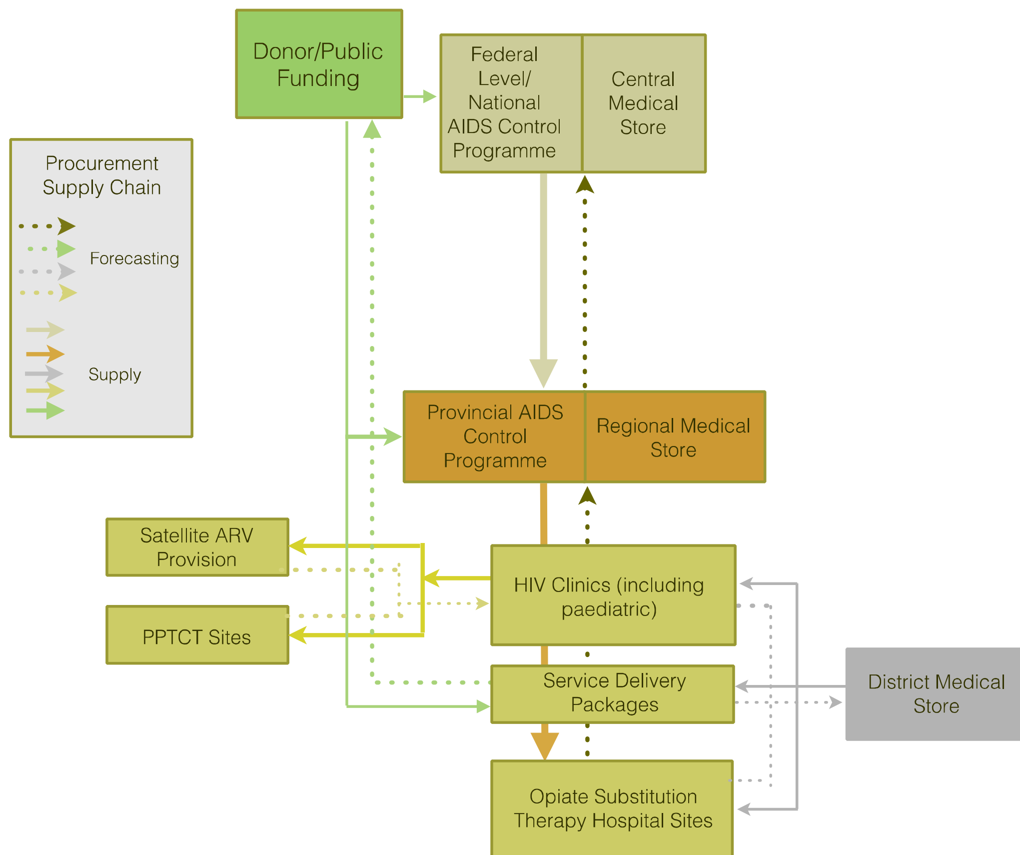
Key Implementation Strategies

Procurement and supply strengthening is a key element in the PAS III.

Currently procurement and supply is managed at different levels including National, provincial and directly by NGOs. It is expected that under the Global Fund, the Government procurement and supply systems of the HIV, TB and Malaria Programmes will be integrated into a central system. Whether all procurement remains vertical or if to some extent systems are integrated or centralised, the public sector HIV PSM system needs to be strengthened to accommodate an increase in HTC and resultant HIV infected persons becoming eligible for ART.

[155]GF R9 trainer on CoC for service providers.
[156] The daily use of ARVs by HIV-unifected persons to block the acquisition of HIV.

Figure 13. Forecasting and Supply Chain



Pharmaceuticals and health products in PAS III will be procured based on appropriate forecasting through a standardized drug management Information system from field up to provincial level to PACP (DoPH KPK) through to federal level to NACP if relevant. Forecasting starts at service delivery sites including **HIV clinics** (for Adult and Paediatric ARVs, CD4, Viral load and Rapid and Eliza and Western Blot test kits), **HIV Satellite sites** (for Adult and Paediatric ARVs), **PPTCT sites** (for Safe Delivery and Caesarian kits), **OST hospital sites** (for Buprenorphine) and **service delivery package (SDP) projects** (for HIV Rapid kits, STI drugs, mobile CD4 kits). *Figure 12. Forecasting and Supply Chain* indicates both a vertical programme and a centralized arrangement with Federal, Regional and District level Medical Stores. Procurements taking place at provincial level through PC-1s or other sources of Government or donor funds will be managed through provincial medical stores for onward supply direct to service delivery packages.

In case of centralized procurement, a central medical store will manage purchase orders, and distribute supplies to either regional or provincial medical stores for onwards distribution to district medical stores or direct toimplementing partners (e.g. AIDS Control Programmes). The distribution to service delivery points will be through district medical stores on regular and need basis. Service delivery sites will update the status of their stocks in the standardized drug

management Information system and ensure no stock out of pharmaceuticals or health products is encountered.

To ensure timely and consistent access to HIV-related medicines, the National and Provincial AIDS Control Programmes in coordination with the WHO Essential Medicines Unit, will ensure inclusion of HIV and other medications related to the HIV response (e.g. Buprenorphine in 2mg, 4mg, 8mg and 12mg) on Federal and Provincial essential drug lists, and provincial procurement lists.

Guidelines or Protocols to be developed:

- Standards of Care for HIV Clinics
- Guidelines on TB/HIV to be reviewed and/or revised
- Guidelines on Hepatitis/HIV
- LMIS tools and procedures

Key Partners: National and Provincial Governments, Health departments and clinical facilities, NGOs/CBOs, APLHIV, UNAIDS, WHO, UNICEF, UNODC, UNDP, UNHCR, UNFPA, private labs and clinical facilities

Linkages within the Strategy:

- 1.1 Increased coverage (to 80%) of comprehensive HIV prevention programmes for persons who inject drugs and proportionate sexual partners and children in designated cities and peripheries through phased approach.
- 1.2 Increased coverage to 80% of comprehensive HIV prevention programmes for transgender persons and 60% MSM; and 60% essential coverage for FSW in designated cities and peripheries through phased approach.
- 1.3 Reduced risks of HIV transmission among specific vulnerable populations in priority cities and peripheries in phased approach.
- 2.1 Increased quality and coverage of early diagnosis of HIV through HTC and provider-initiated testing and counselling (PITC) in designated cities and peripheries through phased approach.
- 3.1 Enhanced use of strategic information to monitor HIV response coverage, quality and impact.

Strategic Output 2.3 Continuum of care model strengthened through robust referral and implementation arrangements, strategic care and support services and the involvement of PLHIV community.

Key Strategy 2.3.1 Scaled up quality HIV management and treatment services (children, adolescents and adults) for improved access and adherence.

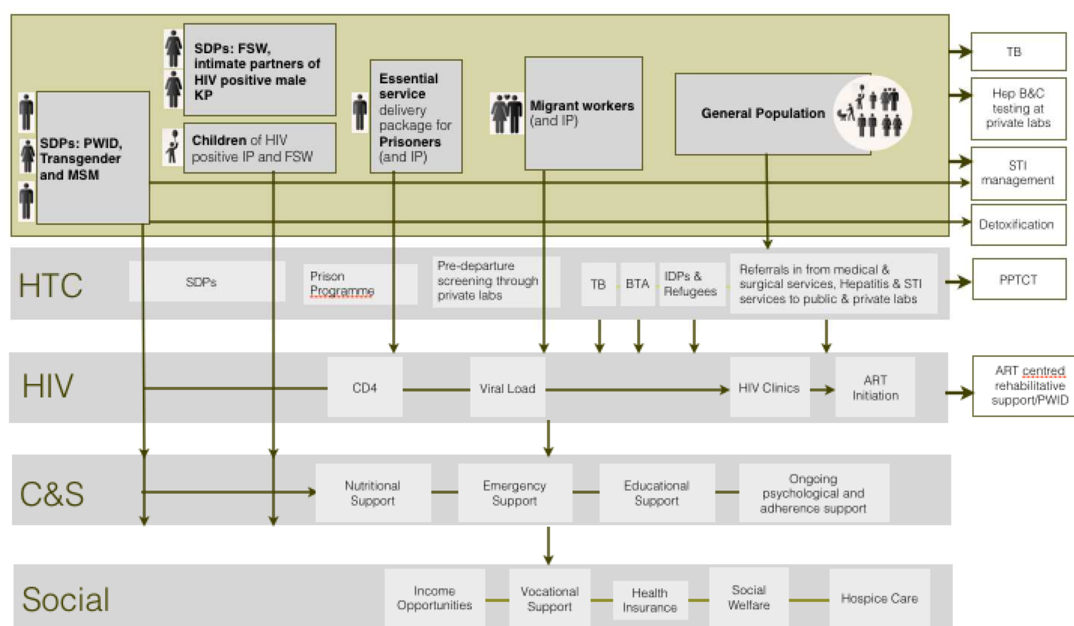
Key Implementation Strategies

To ensure a robust Continuum of Care from HTC through care and support, a formal referral system between public and private service providers will be developed. Currently attrition of clients is very high at all points along the continuum due to factors such as stigma and

discrimination, transport costs, service points located in multiple facilities, and a lack of a formal, traceable, referral system, integral to a coherent MIS.

SDPs and other services for vulnerable populations will provide HTC, as well as referring out for TB, hepatitis, STI management, and detoxification services. For those testing HIV positive, CD4 and baselines investigations will be conducted by SDPs or referred out, ART initiation, VL and other complicated prognostic investigations will be referred. Clients seen at the HIV Clinics will be referred to care and support services either through SDPs or stand alone services. PWID completing detoxification will be referred to ART-centred rehabilitation services to ensure adherence and mitigate relapse. Referrals into social support mechanisms will take place from care and support services.

Figure 14. CoC Referral Schematic



Continuum of Care Implementation Guide will be developed with implementation arrangements of Continuum of Care model from community through tertiary levels[157] including formal referral system, referral forms and reporting formats for public and private services. To ensure maximum efficiency, relevant multi-sectoral stakeholders e.g. health and social service providers, PLHIV organisations, private hospitals in high HIV burden districts orientated on CoC referral system through multi-sectoral meetings and referral system promoted through PLHIV community through help-lines[158] and community awareness raising.

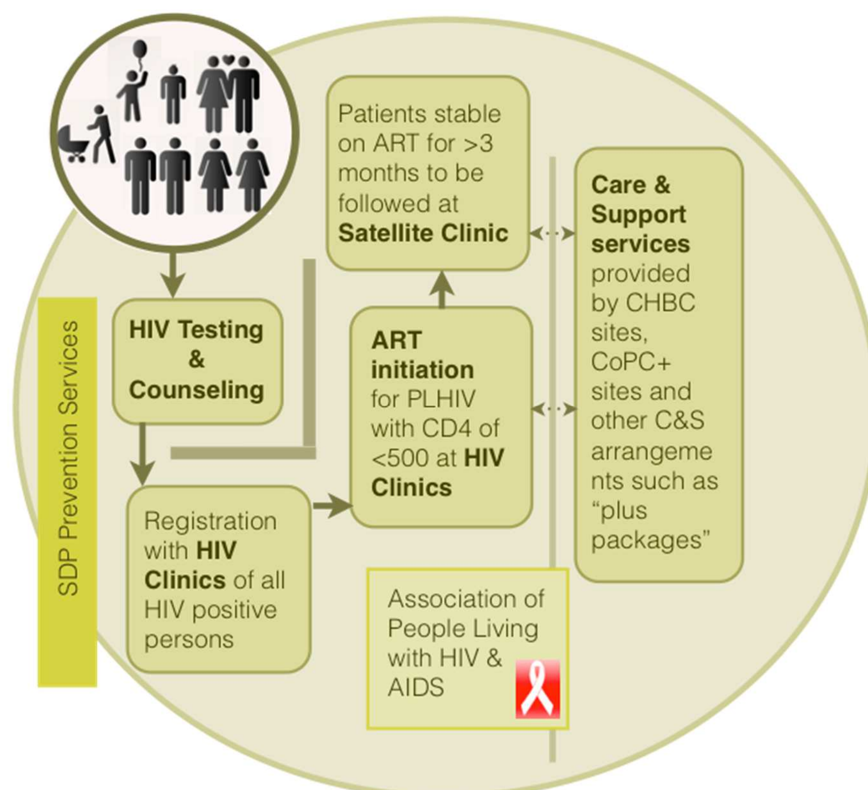
Key Strategy 2.3.2 **Targeted care and support services provided to registered PLHIV meeting criteria[159]**

[157] The National (draft) Continuum of Care Model (NACP, WHO 2012) will be considered in development.
[158] Current helpline services implemented by APLHIV: Telephone: 0800-22209
[159] Criteria to be determined through either clinical (nutritional) or social criteria (all care and support services).

Key Implementation Strategies

Essential care and support services will be provided primarily through NGOs and CBOs. Existing Community Home Based Care Centres will continue to provide care and support services their clients, focused primarily on vulnerable and other populations and key populations in areas where there is no service delivery, or for clients not linked already with

Figure 15. Referrals in Treatment, Care & Support



an SDP. Service Delivery Packages providing services for key populations will facilitate transport and other support for their HIV positive clients. Support would include emergency support (including but not limited to emergency transport facilitation, burial expenses, legal or administrative related expenses[160]) as a priority, adding nutritional support[161], educational support for school-going children, on-going psycho-social and adherence support as feasible as well as HTC for those the seeking service, such as intimate partners and children (>18 months). Where relevant, linkages with vocational training/income generation should be made. To ensure linkages to vocational and income generation are made and social welfare services

[160] Some Legal Aid resources include: Insaf (Justice) Network Pakistan Country-wide (http://inp.org.pk); AGHS Legal Aid Cell in Lahore (https://aghsblog.wordpress.com); and Legal Aid Society in Karachi (http://co.lao.org.pk/).

[161]Criteria for nutritional support to be set on clinical indications. Due to their chaotic street-based lifestyle, nutritional support for PWID will be provided through spouses and intimate partners where feasible.

accessed, a mapping and referral directory to be developed, including how and where to access public health insurance for PLHIV for in-patient services where available.[162]

Guidelines or Protocols to be developed:

- Care and Support

Key Partners: All involved in the HIV response

Linkages within the Strategy:

- 1.1 Increased coverage (to 80%) of comprehensive HIV prevention programmes for persons who inject drugs and proportionate sexual partners and children in designated cities and peripheries through phased approach.
- 1.2 Increased coverage to 80% of comprehensive HIV prevention programmes for transgender persons and 60% MSM; and 60% essential coverage for FSW in designated cities and peripheries through phased approach.
- 1.3 Reduced risks of HIV transmission among specific vulnerable populations in priority cities and peripheries in phased approach.
- 2.1 Increased quality and coverage of early diagnosis of HIV through HTC and provider-initiated testing and counselling (PITC) in designated cities and peripheries through phased approach.
- 2.2 Improve quality and coverage of medical management and ART for people living with HIV in designated cities and peripheries through phased approach

.

[162] As of beginning 2015, The National Health Insurance Scheme has allocated 12 Billion Pak rupees overall. In Phase I 2.6 billion Pak rupees have been allocated for the following districts will be covered Districts: Punjab: Narowal; Khanewal; Sargodha; Rahim Yar Khan; Sindh: Shikarpur; Badin; Shaheed Banazirabad; Sanghar; KPK: Swabi; Nawshera; D.I. Khan; Haripur; Baluchistan: Quetta; Loralai; Lasbela; Kech; AJK: MuzafarabadKotli; GilgitBaltistan:Diamer; Sakardu; FATA: Bajaur Agency; Mohmand agency; ICT.

IV.3. Strategic Priority Outcome III

Outcome III : Environment for effective AIDS Response is Enabled		
Strategic Output 3.1: Enhanced use of strategic information to monitor HIV response coverage, quality and impact.	**Strategic Output 3.2: Increased multi-sectoral coordination at Federal and Provincial Levels.**	**Output 3.3 Increased sustainability of the response.**
Key Strategy 3.1.1: Monitoring & Evaluation system strengthened for improved programme implementation	Key Strategy 3.2.1: Implement targeted and sustained advocacy actions for policy reform, HIV integration and addressing stigma and discrimination.	Key Strategy 3.3.1: Reduce costs of the HIV response through mainstreaming and efficiency improvements.
Key Strategy 3.1.2: Support and disseminate HIV-related substantive and operational research.	Key Strategy 3.2.2: Enhanced participation of multi-sectoral partners to increase service provision and uptake.	Key Strategy 3.3.2: Increase domestic resource allocation and mobilise and align additional external resources for sustainability of the Response.
		Key Strategy 3.3.3: Improve Management and Implementation Arrangements.

Outcome III: Environment for effective[163] AIDS Response is Enabled

Strategic Outcome III supports both Strategic Outcomes I and II.

Strategic Output 3.1	**Enhanced use of strategic information to monitor HIV response coverage, quality and impact.**

Key Strategy 3.1.1: **Monitoring & Evaluation system strengthened for improved programme implementation**

Key Implementation Strategies

The PAS III Monitoring and Evaluation Framework was developed through consolidation of the Provincial AIDS Strategies M&E Frameworks and consensus among stakeholders on targets to be set in the Monitoring Framework. PAS III recommends enhanced use of strategic evidence to monitor service coverage, quality and impact. Many challenges exist in the current M&E system including incomplete data reports, lack of coherence among different MIS, lack of standardization of indicators across service providers, lack of age and sex disaggregated data, lack of systematic way to collate and validate data at the provincial level and absence of

[163] Effective indicates the ability to reach targets outlined in the *Monitoring & Evaluation Framework*.

recent studies for key populations (except the IBBS 2011 and UNODC prison study of 2012). As a result, PAS III M&E Framework relies on various sources of data for baselines, target setting, monitoring and evaluation, while laying out concrete plans to strengthen a coherent MIS system.

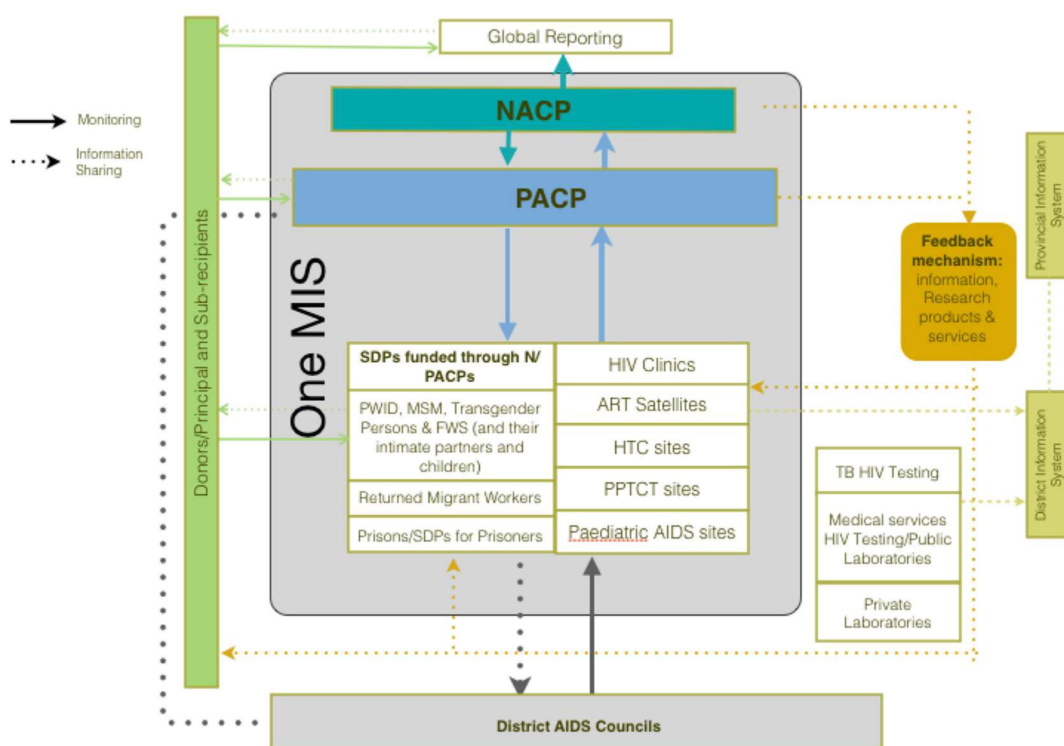
Effective implementation of the Pakistan AIDS Strategy depends on fully functional M&E Units at Federal and Provincial AIDS Control Programme levels staffed with an M&E Manager, Epidemiologist, M&E Officer and data entry operator. Similar units in private sector service providers will contribute towards a centralized MIS system collating and producing information at provincial and national levels. Output monitoring relevant to both programme monitoring and national level reporting will be done on quarterly basis and progress reports generated on quarterly and annual basis. Global reporting to UNAIDS is done on an annual basis through the Global AIDS Response Progress Report (GARPR). Most GARPR indicators are included in the PAS III Monitoring Framework, however, those we do not have information for will be reported on when and if information becomes available.[164] Further, Integrated Biological and Behavioural Surveillance (IBBS) will be conducted every two to three years to monitor the trend and emerging threats. Periodic research (according to pre-set agenda), conducted at provincial level will also help in measuring outcomes and impact.

The coherent national electronic MIS will collate data from service delivery points e.g., HIV clinics, ART satellite, HTC, PPTCT, and Paediatric AIDS sites, as well as SDP service sites for key and vulnerable populations, e.g. prisons), based on standardized MIS data collection and reporting tools.

The NACP and PACPs (including DoPH KPK) will directly monitor the SDPs (Key and vulnerable populations) and sites providing HTC and ART services funded through public sector funds. PAPCs will monitor privately funded services in collaboration with service providers and District AIDS Councils. The federal (NACP) will not only monitor sampled sites offering services in the four provinces but also the 3 regions of GB, AJK and FATA under its management. At the same time Donors, principal or primary Implementing partners and their partners managing SDPs will also be monitoring the implementers and service delivery points. Meanwhile efforts will be made by PACPs to transfer monitoring responsibilities to their district counterparts (members of DAC) for increasing frequency but without compromising the quality.

[164] The following GARPR Indicators are not asked in Pakistan and it is unlikely they will as they are for generalised epidemics and difficult to ask in Pakistan's conservative cultural context: Percentage of young women and menaged 15-24 who have had sexual intercourse before the age of 15; Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months; Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse; and Percentage of women and men aged 15-49 who received an HIV test in the past12 months and know their result. MSM indicators will be reported on after the 2015 National IBBS R V.

Figure 16. Monitoring and Reporting Lines



Data (and SI) will be reviewed at district level with District EDO and service providers (irrespective of funding source) through District AIDS Council meetings on a quarterly basis (*see Implementation Arrangements below for more Information of DACs*). Inputs into the data and SI may be received at District, Provincial (through PACPs and DoPH) and national levels through monitoring visits and data validation exercises as laid out in the Pakistan PAS III Monitoring and Evaluation Guide. At the same time, public sector sites providing testing and treatment services (HIV clinics, ART satellites, HTC sites, PPTCT sites, Paediatric AIDS sites) will provide data on select indicators to the district HMIS, and data from MIS at PACP level will provide data on select indicators to the provincial HMIS.

A gender-responsive M&E system will track gender-responsive activities, strategies and programmes to monitor funds allocation and to understand and analyse outcomes of these activities on uptake of services and HIV prevalence by age and gender. It will also aim to identify, integrate and track a standard set of indicators (such as violence, sexual behaviour, and use of family planning) to measure gender outcomes across districts over a period of time; should collect and use gender–disaggregated data at all levels; and should examine existing indicators to identify those that are useful to disaggregate by gender for decision making and programme modification.

Key Strategy 3.1.2: **Support and disseminate HIV-related substantive and operational research.**

Key Implementation Strategies

While Pakistan's sentinel surveillance system has been robust and fairly consistent, other formative and operational research has been lacking, as have programme model evaluations or cost-effectiveness research. To facilitate and evaluate operational research, an HIV Strategic Information Technical Advisory Unit is to be formed at federal level to guide the HIV surveillance and research agenda at Federal and Provincial levels including: 1) guide coherent Nationwide IBBS every two to three years supported at the provincial level for designing, managing, analysing and reporting on rounds; 2) guide population research in AJK, Gilgit-Baltistan and ICT to determine populations most affected in those areas; 3) guide external National and Provincial programme evaluations to be conducted in 2018 (mid-term) & end 2020 including efficiency and cost effectiveness reviews; 4) identify research needs and opportunities, potential research bodies (for conducting and/or managing research); and guide analysis and dissemination of research, and programme/MIS data for programmatic improvement. Potential areas for research and subsequent dissemination of good practices may include the following:

- Evaluate current service delivery models for key populations including existing community-based comprehensive service models for MSM and *hijra* populations(including adolescents), impact of both public and private detoxification services on injecting practicesand impact of rehabilitation for PWID on ART retention;
- Evaluate and adapt PPTCT approach;
- Nexus between HIV andgender based violence experienced by individuals (females, transgender persons and feminised males)[165] as well as institutionalised violence[166]to better understand violence as a risk factor for the transmission of HIV, and HIV as a risk factor for violence against women living with HIV, and how it can be translated into interventions;
- Dynamics of sex work for strengthened programme design including adapted approach for sub-categories of sex workers, including adolescent sex workers; and understand profiles of paying and non-paying partners;
- Assessment of adolescent key populations and subsequent revision of *The National HIV Prevention Strategy for Adolescents and Young People* (2006);
- Map numbers and locations of returned and overseas migrants in KP and generate evidence with the community on adapted approaches to reducing HIV vulnerability and provision of services for migrants; and

[165] According to the PDHS 2012-13, 1 in 5 women experienced physical violence in the past 12 months; one-third of ever-married women have ever experienced physical violence since age 15- most commonly by the current husband (79%); and overall 16% men (15-49 years), 9% urban and 20% rural men agree that a husband is justified in hitting or beating his wife if she refuses to have sex with him (2009-2013). In 2013, 18% of women in Pakistan experienced sexual violence by spouse or intimate partner, (2005-2013) (Prepared by www.aidsdatahub.org based on Demographic and Health Surveys).

[166] In Pakistan, 22% of women living with HIV who had a desire to have children reported being coerced to undergo sterilization, 2012-2013 (HIV and AIDS Data Hubs for Asia-Pacific Review in Slides. Regional overview slides).

- Community-based research conducted for improving quality of services for PLHIVincluding assessing socio-economic needs of PLHIV and current access to social welfare services.

Key Partners: National and Provincial Governments, Health departments and clinical facilities, NGOs/CBOs providing services to key and vulnerable populations, APLHIV, private labs and clinical facilities, prisons, FIA, UNAIDS, WHO, UNICEF, UNDP, UNODC, UNHCR, UNFPA and NCSW.

Linkages within the Strategy:

- Outcomes I and II

Strategic Output 3.2: Increased multi-sectoral coordination at Federal and Provincial Levels.

Key Strategy 3.2.1: Implement targeted and sustained advocacy actions for policy reform, HIV integration and addressing stigma and discrimination.

Key Implementation Strategies

Implement targeted and sustained advocacy actions for policy reform, HIV integration and addressing stigma and discrimination to enable high impact interventions and protection of rights. Advocacy and communication units should be established at federal and provincial levels to support advocacy, communications, including programme, as well as support resource mobilisation efforts. Coherent, clear and focused HIV advocacy strategies to be developed at federal and provincial levels. Key advocacy themes include:

- OST, specifically registration and local production, or import of Buprenorphine in 2mg, 4mg, 8mg and 12mg dosages, and approval to use it for treatment of opioid dependent individuals, especially PWID;
- Mitigating stigma and discrimination of key, vulnerable and affected populations and increasing access through parliamentary-supported provincial legislation (Sindh[167] and ICT[168] are in process of enacting legislation to mitigate stigma and discrimination) and revision of current punitive legislation[169];

[167]The Sindh HIV and AIDS Control, Treatment and Protection Bill 2013 passed on September 20, 2013. The bill says no person shall discriminate against another on the basis of other person's HIV status in healthcare services, education, employment or provision of utilities or services and accommodation for lease, rent, hire or purchase. The bill indicates the government would establish the Sindh AIDS Commission within 15 days from the date of promulgation of the Act but to date the Commission has not been established.

[168]HIV/AIDS Prevention and Treatment, Care and Support Act, 2013 was presented to the presented before the National Assembly Standing Committee on Health on 22nd January 2015.

[169]Inclusive of the operational plan of the *Scan of laws and policies impacting human rights, discrimination and access to HIV services by key populations in Pakistan*.

- Mitigating punitive actions against key populations by law enforcement officials and increasing access to services through increased awareness of public health consequences and on the CRC for <18 adolescents engaging in drug use and selling sex;
- Regulation of HIV testing (HTC sites, SDPs, public labs, private labs, BTA and blood transfusion services) including use of WHO pre-qualified kits.
- Information sharing with the Federal Investigation Agency to ensure HIV positive deported returned migrant workers are linked to HIV treatment and care interventions upon arrival in Pakistan.

The outcome of key advocacy efforts would contribute to consistent norms and standards within the HIV response including domestic manufacture, or import, of appropriate OST medications, mitigation of stigma and discrimination through legislation (HIV Acts and Ordinances), non-punitive enforcement around drug use and sex work, consistent reliable HIV diagnoses and access to treatment and care for deported migrant workers.

Advocacy efforts with planners and managers in the executive arm of the government will focus on critical enabling advocacy efforts such as: notifying multi-sectoral coordination at national, provincial and district levels; Increasing the resource allocation for HIV both within the Health sector and outside among other public multi-sectoral stakeholders e.g. the Home Department that oversees prisons; ensuring social protection under Zakat, Bait ul Maal, National Insurance, and women's development schemes, legal partners (including LHRA, Coffey, and private law firms) to provide legal aid/pro-bono support; and other schemes for people affected by HIV (including irrespective of age or gender [including transgender people]); HIV-related work-place policies for the private sector; and inclusion of age-appropriate, gender-equitable sexual and reproductive health and rights education in extra and/or core curricula. Additionally, advocacy on social enablers would include efforts with religious leaders to facilitate HIV prevention education and implementation of HIV services for key and vulnerable populations and at-risk adolescents, women's machinery to link on issues that impact vulnerability access to services such as child marriage, and GBV[170] – including men's engagement, while media (print and electronic) will ensure that target of PAS III are achieved through a conducive environment.

A key function of advocacy in Pakistan's concentrated epidemic is to work towards removing human rights barriers to health services for key populations and other vulnerable groups and mitigating discrimination and criminalization which reduce access to health, and undermine

[170]Pakistan voted without reservation for the Asian and Pacific Ministerial Declaration on Population and Development (2013), at the Sixth Asian and Pacific Population Conference held in Bangkok, 16-20 September 2013. Article 81 includes "to take to take all possible preventive and remedial measures, by all relevant stakeholders at all levels, to end all forms of violence and discrimination against women and girls, including by empowering women and girls and protecting them against all forms of violence."

efforts toward effective responses to HIV.

See Annex III. Strategic Checklist for Monitoring Integration of Human Rights into HIV & AIDS

Key Strategy 3.2.2: Enhanced participation of multi-sectoral partners to increase service provision and uptake

Key Implementation Strategies

While it is not guaranteed that multi-sectoral partners will engage in the HIV response agenda, to facilitate their participation at least two meetings per year to be organized with all relevant stakeholders and service providers, (including DoH, community-based and PLHIV organizations and multi-sectoral partners such as TB, Hepatitis, Social Welfare, CPA, IG Prisons, Home Department, Law Enforcement Agencies, Education, NCSW, BOEO). Reports on progress of the response will be made to the partners, and address re-occurring or new coordination challenges. Provincial AIDS Control Programmes to facilitate smaller meetings as needed on specific issues related to prevention, treatment and care access.See Annex I. for suggested stakeholders roles and responsibilities.

To mitigate the impact of natural and humanitarian disasters (including Earthquake and recent floods, IDPs) on the HIV response, with the National Health Emergency Preparedness and Response Network, Pakistan Institute of Medical Sciences, analyse HIV related vulnerability and access issues in emergencies, internationally recommended responses and the response to date in Pakistan and develop SOPs for HIV in emergencies.

To ensure relevant and appropriate information on HIV reaches the general and vulnerable populations, Media to undertake mass communication campaign (gender sensitive including transgender sensitive) focused on self-identification of risk behaviour and information where to get tested and treated; and stigma reduction.

Guidelines or Protocols to be developed:

- SOPs for emergencies

Key Partners: National and Provincial Governments, public clinical facilities, NGOs/CBOs providing services, APLHIV, private labs and clinical facilities, prisons, UNAIDS, WHO, UNICEF, UNDP, UNODC, UNHCR, UNFPA, ILO, IOM, BEOE, FIA, CAA, Education, Social Welfare and other social protection partners, NCCWD/PCCWD, Child Protection authorities, religious leaders, legal aid providers, media, legislators, policy makers

Linkages within the Strategy:

- Outcomes I and II

Output 3.3 Increased sustainability of the response.

Key Strategy 3.3.1: Reduce costs of the HIV response through mainstreaming and efficiency improvements.

Key Implementation Strategies

Mainstreaming and efficiency improvements are indicated in all Outcomes. For example innovative a more prioritized response, PoC diagnostics and satellite ARV provision, Consolidated Guidelines promoting fixed dose combination, strengthened systems including MIS, LMIS, QA and referrals, SoPs, and adapted programme implementation based on findings from operational research and efficiency and cost effectiveness reviews. In addition to improvements within the HIV sector, it is critical that with reduced global funding opportunities for HIV and competing domestic priorities such as security and disaster response, health and other sectors should address HIV in their PC-1s including narcotics control, social welfare, overseas employment, and education.

Key Strategy 3.3.2: Increase domestic resource allocation and mobilise and align additional external resources for sustainability of the Response.

Key Implementation Strategies

The PAS III calls for a Resource Mobilization Strategy to be developed at Provincial and National levels to ensure domestic resources are increased for the HIV response and external funds are mobilised and aligned. Specific strategic Actions to include:

- N/PACPs ensure timely PC-1 development, release and expenditure for increased budgets in subsequent PC-1s;
- N/PACPs ensure availability of evidence (research, MIS) for scaling up interventions resulting to enhance budget proposals for HIV services;
- Innovative mechanisms for private and philanthropic contributions to HIV sector response;
- N/PACPs to revise or align their PC-1s with the costed National AIDS Strategy to mobilise resources;
- CBOs and PLHIV networks to be supported with programme design and proposal writing support to access domestic resources from private and public sectors;
- N/PACPs to circulate biannual reports including epi summaries summary of programmatic intervention progress, and have regular meetings with international organisations and funders, with priority focus on the World Bank, and key bilateral partners such as DFID

and USAID.

Key Strategy 3.3.3: Improve Management and Implementation Arrangements

Key Implementation Strategies

The PAS III calls for management and implementation arrangements to be significantly strengthened at both National and Provincial levels, and at the private sector service provision level and between Government and private sector.

Implementation arrangements for management capacity building will be spelled out in a detailed action plan at both Federal and Provincial levels,which will be updated as needed. Management capacities of the National and Provincial AIDS Control Programmes as well as service providers to be strengthened through specific management training and refresher trainings to be rolled out through internal arrangements or external institutions including:

1. Financial Management
2. Project Management
3. Procurement
4. Human Resource Management (HRM)
5. Surveillance and Epidemiology
6. Management Information Systems (including Logistics)

National and Provincial AIDS Control Programmes will ensure minimum qualified staff relevant to programme implementation levels with clear ToRs and regular performance assessments. Staff functions suggested to include at the minimum:

- Health Programme Specialist as part of Management Team
- Epidemiologist/researcher; Monitoring/Assessment specialist/officer; Statistician (Federal level); as part of M&E Unit
- Procurement/supply management specialist; Logistics officer; and storekeepers part of Procurement Supply Management Unit[171]
- Advocacy Communications Specialist; Programme Communication Specialist as part of Communication and Fundraising Unit;
- Training Coordinator (Federal level)

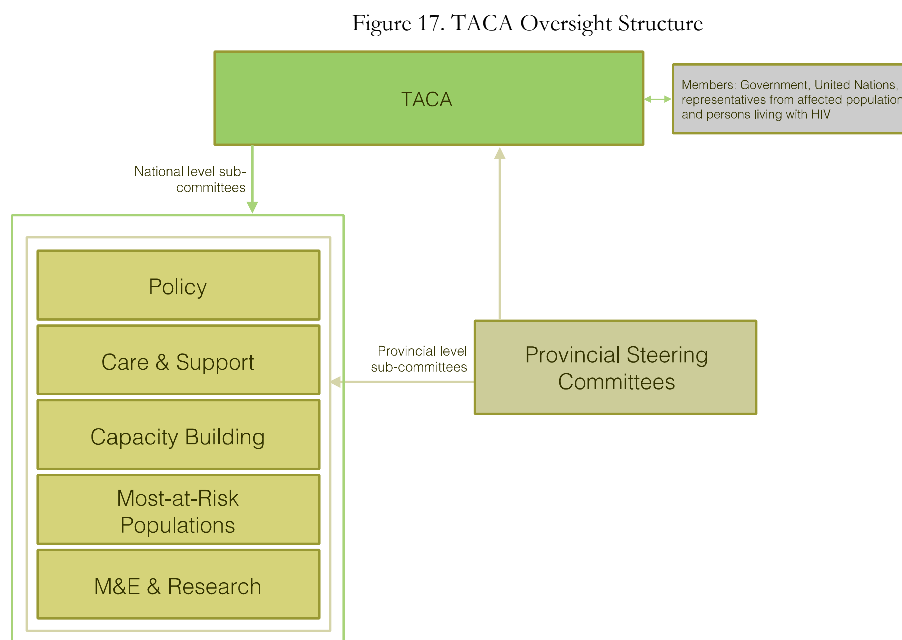
Persistent risks will be countered through development of a comprehensive and sound risk mitigation strategy at Federal and Provincial levels.*SeeIII.7. Risk Mitigation.*

Oversight

[171] At Federal and Punjab levels there should also be a Pharmacist as part of the PSM Team.

Oversight is critical to good management and is to be achieved in part through the re-establishment of the Technical Advisory Committee on AIDS (TACA)[172] originally established in 2004,and Provincial level Steering Committees.

Figure 17. TACA Oversight Structure



The role of TACA has expanded from a previous primary policy role to one that includes assessment, review and programme guidance. Specific ToRs are as follows:

i. Provide overall policy guidelines including areas to advocacy, BCC, and use of NGO/private sector institutions for delivery of services to the identified vulnerable population sub-groups;
ii. Review overall program performance of all implementing agencies, both technical & financial, on the basis of their implementation plans;
iii. Provide guidance and suggest options to overcome implementation bottlenecks
iv. Review periodic assessment reports and accord approval for changes in implementation modalities, if any;
v. Provide support for approval of new laws and regulations at National level, if and when needed;
vi. Its members create enabling environment for implementation of the project.

TACA Members include:

1.	Minister, Ministry of NHSR&C	Chairperson
2.	Secretary, Ministry of NHSR&C	Member
3.	Secretary, Ministry of Finance	Member
4.	Secretary, Ministry of Religious Affairs	Member
5.	Secretary, Economic Affairs Division	Member

[172]The TACA comprises of 5 sub-committees that includes: policy, care and support, capacity building, most at-risk populations, and M&E and research.

6.	D G,, Ministry of NHSR&C	Member
7.	Director General, Ministry of Technical Education & Training	Member
8.	Director General, Ministry of Overseas & HRD	Member
9.	Chief Health Planning and Development	Member
10.	Director General, Ministry of Information	Member
11.	Program Manager Provincial AIDS Control Program Punjab,	Members
12.	Sind, Baluchistan, Focal Person KP.	Members
13.	Country Representative UNAIDS,	Members
14.	Country Representative UNDP,	Members
15.	Country Representative UNICEF,	Members
16.	Country Representative WHO,	Members
17.	Country Director USAID,	Members
18.	Country Director DFID,	Members
19.	Chief Health Advisor, the World Bank.	Members
20.	Representative of PLHIVs.	Member
21.	National Program Manager National AIDS Control Programme	Member Secretary

The Provincial Steering Committees provide technical oversight and are responsible for overseeing the implementation of the PAS III. They will support in preparation of provincial operational plans, M&E Framework, development of guidelines and mechanisms for public private partnerships (based on lessons learnt) when services for KPs are outsourced, development of coordination mechanisms for working with PLHIV, CBOs, development partners, and public sector line departments, extend support to NACP for carrying out IBBS and other HIV-related research and development of standards, liaise with development partners funding agencies at both domestic and international levels, and help develop a risk mitigation strategy.

District AIDS Councils

Under GF Round 9 District AIDS Councils were initiated in five select districts by PR 1 for enhanced coordination with and among government departments at the local level for service provision to injecting drug users. Under PAS III DACs will be adapted to include representatives of other key populations in districts where they exist, and expanded to additional districts as needed. DAC support oversight by developing a coherent strategy and action plan to deal with HIV and AIDS in the district. They coordinate local efforts to ensure that services are properly delivered and to monitor effectiveness.

District AIDS Councils work as advisory bodies to provide advice, information, and recommendations on the problems faced by communities as a result of HIV and AIDS and to make useful suggestions to the ways to control HIV & AIDS effectively in the respective districts. DACs suggest ways to reduce the risk, fear, and incidence of HIV infection, encourage the independence of people living with or affected by HIV and AIDS, and promote understanding of their needs. DACs promote communication and information sharing and

mobilize broader involvement. They ensure that available resources are used as efficiently as possible. On-going monitoring and assessment will be part of its work.

Guidelines or Protocols to be developed:

- Management capacity building action plan
- Staffing plan for NACPs and PACPs with minimum staff qualifications and ToRs
- Risk Mitigation Strategy
- TACA and Steering Committee ToRs

Key Partners: All partners in the HIV response.

Linkages within the Strategy:

- Outcomes I and II

IV.4. Summary Budget

Target 2015	Target 2016	Target 2017	Target 2018	Target 2019	Target 2020	TOTAL PAS III 2015-2020
TOTAL PAS III						
13,402,204	***21,454,231***	***27,508,176***	***37,690,740***	***43,777,224***	***51,908,709***	**195,741,284**
Outcome I: HIV Prevention is increased and sustained among key populations (PWID, MSM, transgender persons, FSW) and vulnerable populations with their sexual partners and children						
9,916,209	**15,918,543**	**21,922,796**	**30,055,668**	**36,092,460**	**41,437,951**	**155,343,627**
Output 1.1 Increased quality coverage (to 80%) of prioritized HIV prevention programmes for persons who inject drugs and proportionate sexual partners and children in designated cities and peripheries.						
5,421,892	7,921,123	10,420,354	15,048,205	17,579,975	19,891,657	**76,283,206**
Output 1.2: Increased phased coverage (to 85% by 2020) of effective HIV prevention programmes for Transgender persons and MSM (including sex workers) and (60% coverage) FSW						
3,926,527	7,381,840	10,839,072	14,296,304	17,753,535	20,739,554	**74,936,832**
Output 1.3: Reduced risks of HIV transmission among vulnerable populations in priority cities and peripheries in phased approach.						
567,790	615,580	663,370	711,160	758,950	806,740	**4,123,590**
Outcome II: HIV related mortality and morbidity is reduced through available and equitable access to quality continuum of care services						
1,785,995	**2,835,687**	**3,885,379**	**4,935,071**	**5,984,763**	**7,770,759**	**27,197,654**
Output 2.1: Increased quality and coverage of early diagnosis of HIV through HTC and provider-initiated testing and counselling (PITC).						
35,493	70,987	106,480	141,974	177,467	212,961	**745,362**
Output 2.2: Improve quality and coverage of medical management and ART for people living with HIV.						
1,522,152	2,308,001	3,093,849	3,879,698	4,665,546	6,187,698	**21,656,944**
Output 2.3: Continuum of care model strengthened through robust referral and implementation arrangements, strategic care and support services and the involvement of PLHIV community						
228,350	456,700	685,050	913,400	1,141,750	1,370,100	**4,795,350**
Outcome III: Environment for effective AIDS Response is Enabled						
200,000	**1,200,000**	**200,000**	**1,200,000**	**200,000**	**1,200,000**	**4,200,000**
Output 3.1: Enhanced use of strategic information to monitor HIV response coverage, quality and impact.						
-	1,000,000	-	1,000,000	-	1,000,000	**3,000,000**
Output 3.2. Increased multi-sectoral coordination at Federal and Provincial Levels						
100,000	100,000	100,000	100,000	100,000	100,000	**600,000**
Output 3.3: Increased sustainability of the response						
100,000	100,000	100,000	100,000	100,000	100,000	**600,000**
Contingency (to be refined)						

1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	9,000,000

Annex I: Stakeholders Roles and Responsibilities

Stakeholder	Expected Roles and Responsibilities	Level
Federal		
NACP	• Develop, seek approval and manage PC-1 funds and Donor grants on HIV • Develop/Revise National guidelines and its related strategies for implementation by provinces • Coordinate with Federal Ministries, Donors, UN Agencies and relevant stakeholders • Manage international procurements for diagnostic and pharmaceuticals on behalf of provinces • Develop/improve and manage national MIS, surveillance and research • Develop and manage National Quality Assurance and Pharmaco-vigilance systems • Develop and manage national trainings • Developing Annual/GARP Reports • Convene multi sectoral meetings according to schedule • Represent Pakistan's response toward HIV and AIDS in national and international forums	National
Ministry of National Health Services Regulation and Coordination	• Facilitate early approval of national PC-1 funds and Donor grants for HIV program • Ensure prompt approvals of Staff hiring at NACP • Ensure prompt approvals procurements at NACP • Facilitate coordination with Federal Ministries, Donors, UN Agencies and relevant stakeholders • Represent Pakistan's response toward HIV and AIDS in national and international forums • Facilitate Detoxification services based on SOPs in	National

	line with international standards and guidance	
Ministry of Planning and Development	• Facilitate early approval of national PC-1 funds for HIV and other relevant programs complementing HIV interventions • Facilitate coordination with Federal Ministries, Donors, UN Agencies and relevant stakeholders for complementing HIV program	National
Ministry of Finance, Revenue, Economic Affairs, Statistics and Privatization	• Facilitate earmarking of funds for PC-1 in annual development plan • Facilitate early approval of national PC-1 funds and Donor grants • Ensure timely and complete release and funds for implementation of grants • Ensure participation in multi sectoral meetings	National
Ministry of Interior and Narcotics Control	• Facilitate approval of National OST Strategy • Facilitate import/manufacture of oral substitute drugs • Participate in joint monitoring of OST service delivery sites and storage facilities • Facilitate advocacy efforts to bring policy and legislations for relevant harm reduction interventions • Facilitate trainings (initial and refresher) FIA staff at airports with international flights on HIV and how to refer deported migrants and their families to HTC, treatment centres and NGOs/CBOs providing care and support. • Ensure participation in multi sectoral meetings	National
Ministry of Law, Justice and Human Rights	• Facilitate advocacy efforts to bring policy and legislations for HIV interventions • Ensure participation in multi sectoral meetings • Advise, lead and enhance the implementation of women empowerment commitments across line ministries and institution	National

	• Advocate and leverage support to strengthen alliances and collaboration between the HIV response and institutions and organizations working to promote gender equality at the national, district, and local levels to enable greater coordination of a gendered HIV response. • Strengthen the linkages and collaborative works of Ministry of Law, Justice and Human rights (MOLJ & HR) National Commitment and Policy instrument (NCPI), and Provincial Commission on the Status of Women (PCSW), Ministry of Health, and Social Welfare Departments (SWD) with the National and Provincial AIDS Control programme. • Build the capacity of district level authorities to effectively plan, implement, monitor and evaluate activities that address the gender specific dimensions of the epidemic • Strengthen the capacity and involve the affected communities, particularly key affected women and girls and the Hijra community who face significant barriers that prevent their participation.	
Ministry of Parliamentary Affairs	• Facilitate advocacy efforts to bring policy and legislations for HIV interventions • Ensure participation in multi sectoral meetings	National
Ministry of Overseas Pakistanis and Human Resource Development	• Facilitate private sector organization on intervention for intending migrants • Facilitate complete and sustained coverage of HIV risk identification and referral information to airports with international flights (through Civil Aviation Authority) • Facilitate strengthening of referral system for returned HIV positive migrants and their families • Ensure participation in multi sectoral meetings	National

Ministry of States and Frontier Regions	• Facilitate NACP and private sector organization(s) for HIV intervention in Frontier Regions • Facilitate monitoring of HIV interventions in Frontier Regions • Facilitate strengthening of referral system for beneficiaries of HIV intervention for relevant services • Ensure participation in multi sectoral meetings	National / Regional
Ministry of Kashmir Affairs and Gilgit Baltistan	• Facilitate NACP and private sector organization(s) for HIV intervention in Gilgit/Baltistan and AJK • Facilitate monitoring of HIV interventions in Gilgit/Baltistan and AJK • Facilitate strengthening of referral system for beneficiaries of HIV intervention for relevant services • Ensure participation in multi sectoral meetings	National / Regional
National TB Program	• Facilitate the revision of TB/HIV guidelines when required • Facilitate provision of Anti Tubercular drugs and INH prophylaxis treatment for PLHIV, diagnosed with TB, in HIV clinics • Ensure participation in multi sectoral meetings	National/ Provincial
Drug Regulatory Authority	• Facilitate inclusion of HIV related drugs in essential drug list • Facilitate approval for manufacturing of oral substitute drugs suggested in National OST Strategy • Ensure participation in multi sectoral meetings	National
Anti-Narcotic Force	• Facilitate OST intervention in the country • Facilitate development of IEC material for OST strategy • Joint monitoring of OST intervention sites including storage facilities	National / Provincial

	• Ensure participation in multi sectoral meetings	
Bureau of Employment and Overseas Emigration	• Facilitate development of IEC material for intending migrant workers • Facilitate private sector organization on intervention for intending migrants • Facilitate strengthening of referral system for returned HIV positive migrants and their families • Ensure participation in multi sectoral meetings	National / Provincial
National Health Emergency Preparedness and Response Network, Pakistan Institute of Medical Sciences	• Facilitate development of SOPs for HIV in emergencies • Ensure participation of public and private key HIV stakeholders in the Clusters and other coordination mechanisms during emergencies	National/Provincial/District
CAA	• Facilitate complete and sustained coverage of HIV risk identification and referral information to airports with international flights (through Civil Aviation Authority) • Ensure participation in multi sectoral meetings	National/ Provincial
UNAIDS	• Facilitate development/revision of relevant national guidelines and strategies • Provide technical assistance to NACP/PACP on HIV interventions, trainings and research • Facilitate NACP for Global reporting • Provide support to PLHIV association • Facilitate initiatives with parliamentarians, media and religious leaders and women groups. • Ensure participation in multi sectoral meetings	National/ Provincial
WHO	• Facilitate development /revision of relevant national guidelines and strategies • Provide technical assistance to NACP/PACP on HIV	National/ Provincial

	interventions, trainings and research • Facilitate technical assistance to undertake Epidemiological analysis of HIV in the country • Ensure participation in multi sectoral meetings	
UNICEF	• Facilitate development /revision of relevant national strategy and guidelines on PPTCT • Provide technical assistance to NACP/PACP on HIV interventions and research on pre and postal natal management of HIV positive women • Facilitate capacity building of identified divisional level hospitals in the country (with ART and paediatric treatment) • Ensure participation in multi sectoral meetings	National/ Provincial
UNODC	• Facilitate approval of National OST Strategy • Facilitate in manufacture of oral substitute drugs in the country • Participate in joint monitoring of OST service delivery sites and storage facilities • Facilitate advocacy efforts to bring policy and legislations for relevant harm reduction interventions • Ensure participation in multi sectoral meetings	National/ Provincial
UNDP	• Facilitate development /revision of relevant national HIV strategy and guidelines on MSM/TG interventions • Ensure participation in multi sectoral meetings	National/ Provincial
UNHCR	• Facilitate private sector organization on intervention for refugees and internally displaced persons • Facilitate strengthening of referral system for returned HIV positive refugees, internally displaced persons and their families • Ensure participation in multi sectoral meetings	National/ Provincial

UNFPA	• Facilitate development /revision of relevant national strategy and guidelines on STI management • Provide technical assistance to NACP/PACP on HIV interventions STI management • Facilitate capacity building of identified divisional level hospitals in the country on STI management • Ensure participation in multi sectoral meetings	National/ Provincial
ILO	• Facilitate private sector organization on intervention for intending migrants • Facilitate strengthening of referral system for returned HIV positive migrants and their families • Ensure participation in multi sectoral meetings	National/ Provincial
IOM	• Facilitate private sector organization on intervention for intending migrants • Facilitate complete and sustained coverage of HIV risk identification and referral information to airports with international flights (through Civil Aviation Authority) • Facilitate strengthening of referral system for returned HIV positive migrants and their families • Ensure participation in multi sectoral meetings	National
Zakat and Bait ul Mal	• Facilitate introduction of the policy for Zakat and Bait ul Mal services in the country to extend assistance to PLHIV and their families • Jointly develop guidelines and protocols with NACP / PACPs for extension of Zakat and Bait ul Mal services to PLHIC and their families • Ensure participation in multi sectoral meetings	National/ Provincial
International/National NGO	• Establish fully functional Programme Management, Financial, PSM, M&E units to manage HIV grants	National/ Provincial/ District

	• Coordinate with relevant Ministries, Donors, UN Agencies and relevant stakeholders • Organize initial and refresher trainings • Institutionalize and develop capacity of stakeholders on programme and multi-sectoral referral system • Manage procurements of commodities not provided by public sector • Implement standardized MIS and share reports and research with national surveillance system • Developing Annual Reports • Participate in multi sectoral meetings • Represent Pakistan's response toward HIV and AIDS in national and international forums	
Association of People Living with HIV and AIDS	• *All functions mentioned above* • Ensure the participation of PLHIV in all related HIV programming and policy development and implementation – both within and outside of the PAS III	National/Provincial/District
Provincial		
PACPs / Department of Health KPK	• Develop/Revise Provincial AIDS Strategy in 2016 • Develop, seek approval PC-1 funds and Donor grants on HIV in the province • Establish fully functional Programme Management, Financial, PSM, M&E units to manage HIV grants in the province • Coordinate with Provincial Ministries, Donors, UN Agencies and relevant stakeholders • Organize initial and refresher trainings on consolidated guidelines (and including case holding) implemented for HIV infectious disease physicians, paediatricians and other relevant medical and para-medical staff of each divisional hospital	Provincial/ District

	• Institutionalize and develop capacity of stakeholders on programme and multi-sectoral referral system • Facilitate referral for increased access to (ART adherence centred) rehabilitation for all HIV positive PWID on ART with linkages to vocational training and/or income generating opportunities • Manage procurements of diagnostic and pharmaceuticals in the province • Manage MIS, surveillance and research • Manage National Quality Assurance and Pharmaco-vigilance systems in the province • Develop plans and manage provincial trainings • Developing Annual Provincial Reports • Convene multi sectoral meetings according to schedule • Represent Pakistan's response toward HIV and AIDS in national and international forums	
Health Department	• Facilitate early approval of Provincial PC-1 funds and Donor grants for HIV program • Ensure prompt approvals of Staff hiring at NACP • Ensure prompt approvals procurements at NACP • Facilitate coordination with Federal Ministries, Donors, UN Agencies and relevant stakeholders • Represent Pakistan's response toward HIV and AIDS in national and international forums • Facilitate Detoxification services based on SOPs in line with international standards and guidance • Ensure participation in multi sectoral meetings	Provincial/ District

Planning and Development Department	• Facilitate early approval of national PC-1 funds for HIV and other relevant programs complementing HIV interventions • Facilitate coordination with Federal Ministries, Donors, UN Agencies and relevant stakeholders for complementing HIV program	Provincial
Finance Department	• Facilitate earmarking of funds for PC-1 in annual development plan • Facilitate early approval of national PC-1 funds and Donor grants • Ensure timely and complete release and funds for implementation of grants • Ensure participation in multi sectoral meetings	Provincial
Home Department	• Facilitate approval of National OST Strategy • Participate in joint monitoring of OST service delivery sites and storage facilities • Facilitate advocacy efforts to bring policy and legislations for relevant harm reduction interventions • Facilitate trainings (initial and refresher) FIA staff at airports with international flights on HIV and how to refer deported migrants and their families to HTC, treatment centres and NGOs/CBOs providing care and support. • Facilitate complete and sustained coverage of HIV risk identification and referral information to airports with international flights (through Civil Aviation Authority) • Facilitate private sector organization on intervention for intending migrants • Facilitate strengthening of referral system for returned HIV positive migrants and their families • Ensure participation in multi sectoral meetings	Provincial/ District
Law and Parliamentary Affair Department	• Facilitate advocacy efforts to bring policy and legislations for HIV interventions	Provincial

	• Ensure participation in multi sectoral meetings	
Inspectorate of Prisons	• Facilitate revision of Prison Manual for HIV intervention • Facilitate implementation of HIV intervention in the Prison • Facilitate the capacity building efforts for prison staff to assume the management of HIV interventions in the prisons • Facilitate the private sector organization for contacting the families/intimate partners of the HIV positive prisoners • Ensure participation in multi sectoral meetings	Provincial/ District
Anti-Narcotic Force	• Facilitate OST intervention in the province • Joint monitoring of OST intervention sites including storage facilities • Ensure participation in multi sectoral meetings	Provincial/ District
Bureau of Employment and Overseas Emigration	• Facilitate distribution of IEC material for intending migrant workers • Facilitate private sector organization on intervention for intending migrants • Facilitate strengthening of referral system for returned HIV positive migrants and their families • Ensure participation in multi sectoral meetings	Provincial
CAA	• Facilitate complete and sustained coverage of HIV risk identification and referral information to airports with international flights (through Civil Aviation Authority) • Ensure participation in multi sectoral meetings	Provincial
Health Care Commission / Health Regulatory Authority	• Facilitate policy introduction on regulating HIV testing in the Province according to WHO guidelines • Ensure Blood Transfusion Authority is screening blood based on the WHO approved HIV Rapid testing kits • Ensure Public and Private Laboratories/Health facilities are following the national	Provincial

	VCCT guidelines for HIV testing	
Prevention and Control of Hepatitis Programme	• Contribute in development/revision of Continuum of Care guidelines for integration of Hepatitis Prevention and Control Programme with AIDS control programme in the Province. • Contribute in clinical management of PLHIV for prevention and control of Hepatitis through provision of vaccines for Hepatitis B and Interferon for treatment of Hepatitis B and C to SDPs serving PWIDs and PLHIV on ART respectively	Provincial
Service Delivery Package implementers	• Manage the awarded HIV grant • Establish fully functional Programme Management, Financial, PSM (where required) and M&E units • Coordinate with relevant Provincial and District Administration for addressing the issues in implementation • Organize initial and refresher trainings • Institutionalize and develop capacity on programme and multi-sectoral referral system • Manage procurements of commodities not provided by public sector • Implement standardized MIS and share reports and research with provincial surveillance system • Develop Annual Reports and represent Pakistan's response toward HIV and AIDS in national forums • Participate in multi sectoral meetings	Provincial/ District

Annex II Monitoring & Evaluation Framework

All indicators should be disaggregated by age cohorts (e.g. 15-19, 20-24, >24)

Impact/Goal Statement: Halt New Infections and Improve the Quality of Life for People Living with HIV and AIDS

Type of Indicator	*Indicator*	*Global/National*	*MoV*	*Baseline*	*Target 2015*	*Target 2016*	*Target 2017*	*Target 2018*	*Target 2019*	*Target 2020*	*Assumptions*
Impact 1.	AIDS mortality per 100,000	GF HIV I-4	Spectrum	1.71	<1.7	<1.6	<1.5	<1.3	<1.1	<1	Baseline: Pakistan 2015MAR18
Impact 2.	Percentage of young women and men aged 15–24 years who are HIV infected	GARP 1.6, GF HIV I-1	Spectrum	0.03%	<0.03%	<0.03%	<0.03%	<0.03%	<0.03%	<0.03%	Baseline: Pakistan 2015MAR18
Impact 3.	Estimated percentage of child infections from HIV-infected women delivering in the past 12 months - estimated mother-to-child transmission	GARP 3.3, HIV I-6	Spectrum	35.77%	<35%	<34%	<32%	<30%	<25%	<20%	Baseline: Pakistan 2015MAR18
Impact 4.	Percentage of men who have sex with men who are living with HIV - *(at a provincial level projects should track incidence of their own clients)*	GARP, UA, GF HIV I-9a	IBBS	TBD	TBD	TBD	TBD	TBD	TBD	TBD	Baseline: TBD IBBS R V 2015
Impact 5.	Percentage of transgender people who are living with HIV - *(at a provincial level projects should track incidence of their own clients)*	GF HIV I-9b	IBBS	TBD	TBD	TBD	TBD	TBD	TBD	TBD	Baseline: TBD IBBS R V 2015
Impact 6.	Percentage of sex workers (disaggregated) who are living with HIV [IBBS 2011 weighted: MSW: 3.1%; HSW 7.2%; FSW: 0.8%] - (2 LEVELS) *(at a provincial level projects should track incidence of their own clients)*	GARP, UA, GF HIV I-10	IBBS								Baseline: IBBS R IV 2011
Impact 6.a			MSW	3.10%	3.10%	3.10%	3.10%	3.10%	3.10%	3.10%	N/A
Impact 6.b			HSW	7.20%	7.20%	7.20%	7.20%	7.20%	7.20%	7.20%	N/A
Impact 6.c			FSW	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	0.80%	N/A
Impact 7.	Percentage of people who inject drugs who are living with HIV [IBBS 2011: weighted 37.8%] - *(at a provincial level projects should track incidence of their own clients)*	GARP, GF HIV I-11	IBBS	37.8%	37.8%	37.8%	37.8%	37.8%	37.8%	37.8%	Baseline: IBBS R IV 2011
Impact 8.	Modelled (Spectrum) Infections averted based on latest epidemiological data (among KP: PWID, TG, MSW, FSW, Deported Migrant Worker (new populations to be added as Spectrum infections by population is further disaggregated)	GARP Goal (reduction in transmission by 50%	Spectrum	Baseline	10.0%	20.0%	30.0%	40.0%	45.0%	50.0%	Baseline: Pakistan 2015MAR18. As incidence is not measured in Pakistan at a programme level, Spectrum provides the only national estimates for incidence.
Impact 8.a	PWID			7061	6355	5649	4943	4237	3884	3531	N/A
Impact 8.b	Transgender			279	251	223	195	167	153	140	N/A
Impact 8.c	MSW			134	121	107	94	80	74	67	N/A
Impact 8.d	FSW			1289	1160	1031	902	773	709	645	N/A
Impact 8.e	Deported Migrant Worker			32	29	26	22	19	18	16	N/A
Outcome I: HIV Prevention is increased and sustained among key populations (PWID, MSM, transgender persons, FSW) and vulnerable populations with their sexual partners and children											
Outcome I.1	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse [IBBS 2011 regular partner: 25.8%]	GARP, UA	IBBS	25.8%	30%	40%	45%	50%	55%	60%	Baseline: IBBS R IV 2011
Outcome I.2	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	GARP 2.3, UA, GF HIV O-6	IBBS	38.6%	40%	45%	50%	60%	70%	80%	Baseline: IBBS R IV 2011 (pg. 24)
Outcome I.3	Percentage of sex workers reporting the use of a condom with their most recent client (disaggregated)	GARP 1.8, UA, GF HIV O-5	IBBS								Baseline: IBBS R IV 2011
Outcome I.3.a			MSW	9.7%	15%	25%	35%	45%	55%	60%	Baseline: IBBS R IV 2011 For Asia's epidemic to stabilize, interventions for MSM should cover between 60 and 80 percent of individuals considered high risk.*
Outcome I.3.b			HSW	19.8%	20%	25%	35%	45%	55%	60%	
Outcome I.3.c			FSW	41.5%	42%	42%	44%	46%	48%	50%	50% target for FSW given lower prevalence, financial and other capacity to address
Outcome I.4	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	GARP 1.12, UA, GF HIV O-4a	IBBS	N/A	10%	20%	30%	40%	50%	60%	Baseline: TBD IBBS R V 2015
Outcome I.5	Percentage of transgender people reporting the use of a condom the last time they had anal sex	National	IBBS	N/A	10%	20%	30%	40%	50%	60%	Baseline: TBD IBBS R V 2015

Output 1.1 Increased quality coverage (to 80%) of prioritized HIV prevention programmes for persons who inject drugs and proportionate sexual partners and children in designated cities and peripheries.											
Output 1.1.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programs	GARP 2.1, UA, GF KP-4	Programme Data	131	150	200	200	200	200	200	Baseline: 131/yr GARPR 2014. Aggregated number of syringes is measured against the Output 1.1.2 target "Percentage of PWID reached by prevention programs" by year.
Output 1.1.2	Percentage of PWID reached by prevention programs	GF KP-1d	IBBS	45.1%	55%	60%	65%	70%	75%	80%	Baseline: IBBS R IV 2011. Proxy indicator (GF): #/% estimated pop - PWID reached by NSEP at least once in the last month. Definition PAS III: % receiving free syringe in past one month [IBBS R IV]).
Output 1.1.3	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	GARP, UA	IBBS	9.1%	30%	40%	50%	60%	70%	80%	Baseline: IBBS R IV 2011
Output 1.1.4	Percentage of individuals receiving OST who received treatment for at least 6 months.	UA, GF KP-5, WHO Target setting guide for PWID, 2012 revision	Programme Data	0.0%	0.0%	0.5%	0.5%	1.0%	3.0%	5.0%	Baseline: 2014 no OST. 2016 & 2017 targets based on opreations research).
Output 1.1.5	Percentage of PWID receiving detoxification services	National	Programme Data	1.2%	2.0%	5.0%	7%	10%	12%	15%	Baseline: NZ 2014 programme data. Target correlated with HIV positive PWID (37.8% = 39 616) with CD4 <500 (47% of HIV positive PWID [n=18 620]- NZ programme data 2014) given link between drug dependence programmes and initiation of and retention on ART.
Output 1.1.6	#/% of co-habitating intimate partners of identified HIV+ PWID reached by HTC -	National	Programme Data	9.8%	10%	15%	20%	30%	40%	50%	Baseline: Nai Zindagi 2014 programme data (n=1300 by end 2015)/13 232 (IBBS married PWID)
Output 1.2: Increased phased coverage (to 85% by 2020) of effective HIV prevention programmes for Transgender persons and MSM (including sex workers) and (60% coverage) FSW											
Output 1.2.1	Percentage of sex workers reached with HIV prevention programs	GARP 1.7, GF KP-1c	IBBS								Baseline: IBBS R IV 2011. GARP definition 2 variables: 1) Know where to get an HIV test; and 2) free condom in last 12 months
Output 1.2.1.a			MSW	9.7%	10%	25%	35%	45%	55%	60%	N/A
Output 1.2.1.b			HSW	19.8%	20%	25%	35%	45%	55%	60%	N/A
Output 1.2.1.c			FSW	10.8%	10%	15%	20%	30%	40%	50%	N/A
Output 1.2.2	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	GARP 1.9, UA, KP-3c	IBBS								Baseline: IBBS R IV 2011
Output 1.2.2.a			MSW	4.8%	15%	30%	40%	50%	55%	60%	Baseline established during decreased MSW and HSW programming. Since 2012 the GF multi-country South Asia grant for MSM & TG has increased access to HTC for MSM & TG
Output 1.2.2.b			HSW	13.9%	15%	30%	40%	50%	55%	60%	Baseline established during decreased MSW and HSW programming. Since 2012 the GF multi-country South Asia grant for MSM & TG has increased access to HTC for MSM & TG
Output 1.2.2.c			FSW	5.7%	10%	15%	20%	30%	40%	60%	N/A
Output 1.2.3	Percentage of men who have sex with men reached with HIV prevention programs	GARP 1.11, KP-1a	IBBS	N/A	10%	20%	30%	40%	50%	60%	Baseline: TBD IBBS R V 2015. Consider increasing after 2015 IBBS
Output 1.2.4	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	GARP 1.13, UA, GF KP-3a	IBBS	N/A	10%	20%	30%	40%	50%	60%	Baseline: TBD IBBS R V 2015
Output 1.2.5	Percentage of transgender people reached with HIV prevention programs	Disaggregation category for GARP 1.7, GF KP-1b	IBBS	N/A	10%	20%	30%	40%	50%	60%	Baseline: TBD IBBS R V 2015
Output 1.2.6	Percentage of transgender people that have received an HIV test in the past 12 months and know their results	Disaggregation category for GARP 1.9, GF KP-3b	IBBS	N/A	10%	20%	30%	40%	50%	60%	Baseline: TBD IBBS R V 2015. Consider increasing after 2015 IBBS
Output 1.2.7	% of co-habitating intimate partners of identified HIV+ MSM reached by HTC	National	Programme Data	N/A	N/A	10%	20%	30%	40%	50%	Baseline: TBD IBBS R V 2015
Output 1.2.8	% of co-habitating intimate partners of identified HIV+ Transgender persons reached by HTC	National	Programme Data	N/A	N/A	10%	20%	30%	40%	50%	Baseline: TBD IBBS R V 2015

Output 1.3: Reduced risks of HIV transmission among vulnerable populations in priority cities and peripheries in phased approach.											
Output 1.3.1	Percentage of infants born to HIV positive women receiving a virological test for HIV within 2 months of birth	GARP 3.2, UA, GF PMTCT-3	Programme Data/Spectrum estimates	1.86%	5%	10%	20%	30%	40%	50%	Numerator: GARPR 2015; Denominator: (Baseline: Pakistan2015MAR09_Final2
Output 1.3.1.a	*# Based on identified HIV positive pregnant women*	*National*	Programme Data	86.8%	87%	88%	89%	90%	90%	90%	Baseline: GARPR 2014
Output 1.3.2	Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding (includes only women selecting to exclusively breastfeed)	GARP, UA	Programme Data/Spectrum estimates	1.86%	5%	10%	20%	30%	40%	50%	Numerator: GARPR 2015; Denominator: Baseline: Pakistan2015MAR09_Final2
Output 1.3.2.a	*# Based on identified HIV positive pregnant women (100% of those breastfeeding used ARVs)*	*National*	Programme Data	100%	100%	100%	100%	100%	100%	100%	Baseline: GARPR 2014
Output 1.3.3	Percentage of HIV-positive pregnant women who received antiretroviral drugs to reduce the risk of mother-to-child transmission	GARP 3.1, UA, GF PMTCT-2	Spectrum	3.88%	5%	10%	20%	30%	40%	50%	Baseline: Pakistan2015MAR09_Final2
Output 1.3.3.a	*# Based on identified HIV positive pregnant women*	*National*	Programme Data	100%	100%	100%	100%	100%	100%	100%	Baseline: GARPR 2014
Output 1.3.4	Percentage of pre-departure orientation sessions that include HIV at targeted BEOE Centres	National	Programme Data	N/A	75%	80%	85%	90%	95%	100%	N/A
Outcome II: HIV related mortality and morbidity is reduced through available and equitable access to quality continuum of care services											
Outcome II.1	Percentage of adults with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	GARP 4.2, UA, HIV O-1	Programme Data	N/A	65%	70%	75%	80%	85%	90%	N/A
Outcome II.2	Percentage of children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	GARP 4.2, UA, HIV O-1	Programme Dat	N/A	65%	70%	75%	80%	85%	90%	N/A
Output 2.1: Increased quality and coverage of early diagnosis of HIV through HTC and provider-initiated testing and counselling (PITC).											
Output 2.1.1	Percentage of prison inmates in target prisons have received HIV test in last month and know their result	National	Programme Data	77500	10%	20%	30%	40%	50%	60%	N/A
Output 2.2: Improve quality and coverage of medical management and ART for people living with HIV.											
Output 2.2.1	Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV (non-cumulative)	GARP 4.1, UA, GF TCS-1	Spectrum (Baseline: Pakistan2015MAR09_Final2)	9.08%	12%	15%	20%	25%	30%	40%	Coverage based on expected HTC scale-up, capacity to absorb, and financial support.
Output 2.2.2	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	GARP, GF TB/HIV-2	Programme Data	50%	55%	60%	70%	80%	90%	90%	Baseline: The APLHIV ART study in 2013 reported on PLHIV on ART receiving TB treatment. Rates of receiving and completing treatment were similar (>50%).
Output 2.2.3	Percentage of adults living with HIV that initiated ART, with an undetectable viral load at 9 months (<1000 copies/ml)	GF TCS-3 (indicator is 12 months but Pakistan tests at 3, 9, then 15 months	Programme Data	N/A	10%	20%	30%	40%	50%	60%	Global and GF indicator is 12 months but in Pakistan HIV positive clients are recommended to have VL test at 3 and 9 months (ART Guidelines 2014).
Output 2.2.4	Percentage of health facilities dispensing antiretroviral therapy that experienced a stock-out of at least one required antiretroviral drug in the last 12 month	Health sector response indicator 4.4, GF TCS-4	Programme Data	N/A	<2%	<1%	<1%	<1%	<1%	<1%	Collected annually as part of GARPR.

Output 2.3: Continuum of care model strengthened through robust referral and implementation arrangements, strategic care and support services and the involvement of PLHIV community											
Output 2.3.1	% PLHIV meeting inclusion criteria, receiving nutritional support (excluding MDR)	National	Programme Data	2.6%	3%	10%	10%	10%	10%	10%	Proxy for PLHIV receiving at least one C&S service. Inclusion criteria: nutritional deficiency at HIV Clinic or spouse of HIV+ PWID. Denominator: 56 377 (in need of ART, Pakistan 2015MAR18). Baseline: 2014: 1477 [n=613 NACP+864 NZ].
Output 2.3.2	Percentage of newly diagnosed adults linked to HIV care (individual linkage.	GF GP-2	Programme Data	N/A	N/A	70%	75%	80%	85%	90%	Numerator is newly registered at HIV Clinics within the last 12 months and denominator is total tested positive in the last 12 months. Measures effectiveness of referral. The system for tracking this is not expected to be in place until 2016.
Outcome III: Environment for effective AIDS Response is Enabled											
Outcome III.1	% HTC, MNCH/PPTCT, HIV treatment and Care facilities (existing and planned) meeting specific service readiness score for health facilities	GF HSS O-5	Programme Data	N/A	N/A	60%	70%	80%	90%	100%	Based on WHO SARA.
Outcome III.2	Increased score for supportive policy environment [GARP 2014 5%]	GARP	GARP	5%	6%	>7%	>8%	>8%	>8%	>8%	Part of NCPI (GARPR).
Output 3.1: Enhanced use of strategic information to monitor HIV response coverage, quality and impact.											
Output 3.1.1	At least 3 IBBS reports produced before 2020 (including 2015)	National	IBBS	(2011)		1		2		3	N/A
Output 3.2. Increased multi-sectoral coordination at Federal and Provincial Levels											
Output 3.2.1	At least 2 multi-sectoral coordination meetings held per year (National and 4 Provincial FATA to be included with Peshawar and AJK, GB and ICT with National)	National	Programme Data	N/A	10	10	10	10	10	10	N/A
Output 3.3: Increased sustainability of the response											
Output 3.3.1	Of the total needed resources, public sector allocation for HIV programs is proportionately increased by 10% annually	National	Programme Data	N/A	10% from 2014			30% from 2015		10% from 2019	N/A
Output 3.3.2	Quarterly M&E reports produced at NACP and PACP levels (National and Provincial)	GF M&E-1	Programme Data	N/A	10	20	20	20	20	20	N/A

Annex III Strategic Checklist for Monitoring Integration of Human Rights into HIV & AIDS

Human Rights	**HIV- related rights violations**	**Impact on Health, HIV and Human Rights**	**Key checklist**
Every person has the right to equality and non-discrimination	Key populations that are vulnerable to and at higher risk of exposure to HIV are discriminated against in access to healthcare	Discrimination denies key populations access to HIV prevention, treatment, care and support services, placing them at increased risk of HIV	Was meaningful involvement of KPs ensured during programme designing? Has a Stigma Index study been done that define key stigma and discrimination issues?
	Laws criminalizing key populations (e.g. laws criminalizing HIV transmission or sex between men) increase stigma and discrimination against key populations	Discrimination creates fear and forces key populations to remain 'invisible' in society, limiting their access to important services and negatively impacting on their health	Was legal and policy scan carried out? If yes, action plan developed and implemented? Advocacy carried out with parliamentarians and policy makers on removal of legal barriers? Train paralegals, law clinics and human rights organizations to provide HIV-related human rights services. Train networks of people living with HIV and other key populations to provide legal advice. Encourage private lawyers to provide pro bono (free) services. Support national human rights commissions, alternative dispute resolution mechanisms, and traditional and religious leaders to respond to HIV-related human rights violations

Every person has the right to liberty, security of the person and protection from cruel, inhuman or degrading treatment	People perceived to be at higher risk of HIV exposure (e.g. sex workers) may be subjected to mandatory HIV testing without their voluntary and informed consent	Mandatory HIV testing laws and policies create fear, discouraging pregnant women from accessing healthcare services and increasing their risk of HIV exposure	Are privacy and confidentiality appropriately respected and protected? Does the situation analysis include data disaggregated by sex, age, and other factors, as appropriate? Does the program design promote non-discrimination and equality for all beneficiaries? Does the program promote gender equality? Will women and children (both girls and boys) benefit directly from the program? Do communities participate in the human rights assessment to identify inequalities and imbalances, key issues, priorities and concerns?
Every person has the right to privacy	People living with HIV experience breaches of their right to confidentiality about their HIV status	Breaches of confidentiality create fear and discourage people living with HIV from seeking out health services	
Every person has the right to marry and found a family	People living with HIV are subjected to marital HIV testing in some countries, are denied access to reproductive healthcare services, pressured not to have children or to have sex, and even forcibly sterilized	Denying people living with HIV equal access to marriage and family rights is unfairly discriminatory	Education and training workshops on human rights and law. Facilitated dialogue between affected populations, service providers and law enforcement officials. Involvement of people living with HIV and other key populations
Every person has the right to fair labor practices	People living with HIV are discriminated against and unfairly dismissed in the workplace on the basis of their HIV status	Workplace discrimination denies employees with HIV the ability to earn a living when they may need income most. This increases the impact of HIV on their lives	Does the implementing organization have an adequate policy on HIV in the workplace?

Everyone has the right to freedom of assembly and association	In some countries people living with HIV and other key populations are denied the right to organize and form support organizations	Where laws or practices prevent key populations from organizing, they lose an important source of information and support to promote their health	Does implementation plan reflect removal or amendment of such discriminatory laws?
Every person has the right to freedom of movement	HIV should not be treated differently from other diseases with regard to immigration, long-term residency or short-term visits to any country	Countries that require information about HIV status, that deport people who are living with HIV, and who treat HIV differently from other diseases, can undermine access to healthcare, information and other human rights	Any plans for bringing overseas ministry on board and sensitize them? Awareness raising and information kiosks at land, sea and air routes for passengers on HIV
Every person has the right to access to information	Laws and policies in some countries prohibit adolescents, children and key populations (e.g. men who have sex with men) from getting appropriate HIV information and education	Laws and policies in some countries prohibit adolescents, children and key populations (e.g. men who have sex with men) from getting appropriate HIV information and education	Are there plans for TV and radio shows integrate non-stigmatizing messages into their programming? Mobilization of community, religious and traditional leaders to speak out against stigma and discrimination.

Annex IV. Strategy for introduction and expansion of opioid substitution treatment in Pakistan

Background

Pakistan is among three countries in Asia where, since 1990, the estimated number of new HIV infections has been increasing year by year. The Asian Epidemic Modeling (AEM), conducted in March 2015, reconfirmed that use of contaminated injection equipment among people who inject drugs (PWID) remains the main mode of HIV transmission in the country. The estimated number of PWID ranges from 104 804 (AEM, 2015) to 420 000 PWID (Pakistan Bureau of Statistics, 2013). HIV prevalence in this population is above 40 per cent in several cities, including Faisalabad (52.5%), D.G. Khan (49.6%), Gujrat (46.2%), Karachi (42.2%) and Sargodha (40.6%), respectively (HIV/AIDS Surveillance Project, Round IV in 2011, GoP).

WHO, UNODC and UNAIDS have documented that OST, such as use of methadone or Buprenorphine for maintenance, is highly effective in reducing injecting behaviours that put opioid-dependent injectors at risk for HIV and hepatitis C.[173] In addition, OST has been demonstrated to improve access to and adherence to ART as well as to reduce mortality among HIV positive injectors. The global evidence base points to a substantial reduction in illicit use of opiates, injection drug use and deaths from overdose among those on OST. OST has also been reported to be effective in decreasing self-reported petty crime. In view of the available evidence, WHO has included both methadone and Buprenorphine in the WHO Model List of Essential Medicines[174] and WHO, UNODC and UNAIDS recommend OST and other drug dependence treatment as a critical component of the comprehensive package of nine HIV prevention, treatment and care services for PWID.[175] This set of interventions has been endorsed by the Commission on Narcotic Drugs, the United Nations General Assembly and ECOSOC.

Uptake of and adherence to HIV treatment among people living with HIV in Pakistan is among lowest in Asia, with some 5121 people of the estimated 91 340 people (5.6%) living with HIV currently on treatment.[176] While the proportion of PWID of all PLHIV on HIV treatment is unknown it is expected that PWID account for a significant proportion of all PLHIV in need of HIV treatment in view of the large population of PWID (n= 104 804)[177] and high prevalence of HIV among PWID in Pakistan.

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[173]WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users: 2012 Revision.
[174]World Health Organization. WHO 18th Model List of Essential Medicines (April 2013). Geneva, World Health Organization, April 2013. http://www.who.int/medicines/publications/essentialmedicines/en/index.html
[175]Ibid.
[176]Spectrum, March 2015. Note: while PWID population size estimate is being used for national strategic planning purposes, including development of the HIV Concept Note, a national drug use survey estimated that 430,000 (range: 190,000 to 657,000), or 0.4 % (range 0.3% to 0.5%), people aged 15-64 inject drugs in the country. UNODC and Ministry of Interior and Narcotics Control, Narcotics Control Division, Government of Pakistan Drug Use in Pakistan 2013.UNODC, 2013.
[177]Spectrum, March 2015.

Once on anti-retroviral treatment (ART), adherence to HIV medicines among PWID remains a challenge and is increasingly raising concerns about possible resistance to ARVs, including second line ARVs. For example, a prospective study of 162 HIV positive male patients, including 81 men who injected drugs and 81 non drug users, in an ART centre in a major public hospital in Islamabad found that 41 (50.6%) per cent of the PWID were lost to follow-up compared with only two (2.5%) of the non-injection drug users who were lost to follow-up at the end of the five year study. Furthermore, adherence to ART ranged from 46.9 per cent among non-injection drug users to 19.8 per cent among injection drug users.[178]

Leading HIV treatment specialists in the country report that absence of agonist opioid substitution treatment (OST), which would help to stabilise HIV patients, a significant proportion of whom are people who inject drugs, is one of the main barriers to uptake of and adherence to HIV treatment among HIV positive PWID. Therefore, introduction and expansion of OST is critical, not only in terms of treating large numbers of opioid dependent individuals in Pakistan, but also in terms of its role in preventing transmission of HIV and other blood-borne viruses and its role in facilitating access and adherence to HIV treatment.

Progress in introducing OST in Pakistan so far

A Technical Steering Committee (TSC) for Opiate Substitution Therapy (OST) was established by the Ministry of National Health Services (M/o NHSR & C), Regulations and Coordination in 2013. The Chairman of the TSC was Secretary, M/o NHSR & C and Vice Chair was Director General, M/O NHSR & C. The National AIDS Control Programme was the designated Secretariat of the TSC. Members of the TSC included representatives of the Narcotics Control Division, Anti Narcotics Force, Drug Regulatory Authority, Managers of the Provincial AIDS Control Programmes, eminent psychiatrists, Nai Zindagi, representative of the drug user community, UNAIDS, UNODC and WHO. The TSC met frequently during 2013.

The ToR of the TSC included, among other, the following: development of operational plan and national guidelines, identification of health centres for OST, drug procurement plan and registration of drug.

With the aim of assessing the feasibility of use of Buprenorphine for treatment of opioid dependence, a pilot study was implemented by the Institute of Psychiatry and the Narcotics Control Division, in partnership with the National HIV/AIDS Control Programme, UNODC, WHO and UNAIDS under the auspices of the Technical Steering Committee on OST in 2013. The pilot study found a significant reduction in heroin use and injecting among patients receiving treatment as well as significant improvements in health and quality of life among those on treatment. One of the major challenges faced by the pilot project was unavailability of

[178]Daud MY, Qazi RA, Bashir N. Anti-retroviral drugs compliance in intravenous and non intravenous drug abusers. Journal of Ayub Medical College Abbottabad. 2014;26(4):437-40.

Buprenorphine in the required strength as absorption of a large number of crushed tables sublingually was a practical challenge for the patients. Despite this, 73 per cent of the patients were retained in treatment at 12 months.

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

Simultaneously, in November 2014 the NACP, technically guided by UNAIDS, submitted a request for limited use permission of Buprenorphine (for approximately 1,000 PWID) with the Drug Regulatory Authority of Pakistan (DRAP). The initial application was tabled for review by the Drug Registration Board (DRB) in a meeting held on 10 December 2014. The DRB agreed with the request in principle but asked NACP for some modifications. The NACP promptly complied to the requirements. At the time of writing of this document the application is under consideration by the DRAP and final decision is anticipated in the second quarter of 2015.

In addition to the processes adopted for availability of Buprenorphine in the required doses, a range of other initiatives are under way by concerned stakeholders to create a conducive environment. These include, among other, organization of a Dialogue on Pharmacologically Assisted Treatment of Opioid Dependence and Prevention of Blood-borne viruses by UNODC, in cooperation with the Narcotics Control Division and the National AIDS Control Programme in the second quarter of 2015. The objective of the Dialogue is to provide a platform for senior policy makers and experts in the field, including HIV physicians and psychiatrists, to discuss the role of OST in treatment of opioid dependence and prevention of HIV and hepatitis C. UNAIDS continues to support the NACP by engaging a national consultant to guide them through both the processes for availability of Buprenorphine as described above.

The purpose of this document is to detail a strategy aimed at introduction and scaling-up of OST, as part of a comprehensive national HIV response. The development of the proposed strategy has been led by the National AIDS Control Programme, with technical assistance from UNODC, WHO and UNAIDS.

Proposed roadmap for introduction and scale-up of OST

The Pakistan AIDS Strategy (PAS) III recognizes the critical link between opioid substitution treatment and health and HIV outcomes for PWID, including adherence to ART. This OST strategy proposes a phased approach aimed at introduction and expansion of OST in Pakistan during 2015-2017. Phase 1 in 2015-2016 is considered as the preparatory phase and the OST

service delivery will begin in Phase 2 in mid 2016 under the leadership of the National AIDS Control Programme as per the conditions set out in the limited use permission. A detailed implementation/operational plan and a national scale-up plan, informed by the lessons learned from the first two phases of implementation, will be developed during 2016-2017. The OST programme will focus on cities that have a high prevalence of injection drug use, leading to a large overall number of PWID, and high prevalence of HIV amongst PWID. Introduction of Buprenorphine for the purpose of treatment of opioid dependent individuals, especially those who inject opiates and who are either living with HIV or at high risk of HIV, requires a number of processes as per relevant international treaties and national regulatory frameworks. It is anticipated that in the second quarter of 2015 a "limited permission" will be granted by the Drug Regulatory Authority of Pakistan (DRAP) to NACP to procure Buprenorphine for purpose of treating approximately 800 - 1000 people who inject drugs.

This permission would be limited to five leading hospitals across Pakistan under a robust supply chain mechanism to prevent unintended use of the substance. OST delivery in these hospitals will be linked to ART service delivery so that patients from the OST site can be referred to an ART clinic and vice versa. It is anticipated that in 2018 or 2019 the DRAP would enable a substantial increase in the coverage, (through the process of regular registration) of Buprenorphine, making OST a sustainable intervention. After 2017 the OST will be scaled up nationwide, with focus on cities with large numbers of PWID, under the leadership of the NACP, PACPs, the Narcotics Control Division and the ANF (Ministry of Interior and Narcotics Control), and DRAP, with technical assistance from UNODC, WHO and UNAIDS.

Phase 1- Preparatory phase (2015 through to June 2016)

Responsibility for obtaining necessary approvals, establishment of required administrative, logistics and management processes and procedures, procurement and supply chain management systems, development of guidelines and standard operating procedures, recruitment and training of human resources required for the programme and establishment of the M&E system as well as other preparatory steps in the first phase of the programme rests with the National AIDS Control Programme (NACP) in coordination with the PACPs and the licensed hospitals. Key activities and milestones will include, but are not limited to the following:

Revitalization of Technical Steering Committee for OST / formation of a National Advisory Group on OST

Membership of the Technical Steering Committee for OST to be reviewed and the Steering Committee meetings held on a monthly basis from 2015 onwards under the leadership of the Ministry of National Health Services, Regulations & Coordination until members perceive that quarterly meetings of the TSC will suffice. The overall purpose of the OST Steering Committee will remain to provide a platform for senior policy makers, experts and representatives of the

affected community of PWID, CSOs and the UN, to plan and coordinate their respective efforts and activities with regard to the OST introduction and scale up. Possibility of a National Advisory Group on OST / a sub-group of the TSC, consisting of technical experts in the area of drug dependence treatment and HIV as well as members from the affected community of PWID, may be established in addition to provide technical inputs during the process of introduction and scaling-up of OST.

Securing limited use permission from Drug Regulatory Authority of Pakistan

As mentioned above, a formal request for limited use permission of Buprenorphine in the required dose by the DRAP is in process and the final decision is anticipated during the second quarter of 2015. Once the permission is granted by the DRAP, the NACP will be legally authorized to contact the specified manufacturer to produce Buprenorphine as given in the request. The procurement of Buprenorphine from the licensed pharmaceutical company will be undertaken by the NACP as per applicable drug rules and regulations. It is anticipated that the manufacture of Buprenorphine in the required strength will take place in the first quarter of 2016. The licensed manufacturer will distribute the finished product directly to the designated hospitals/OST sites as per the guidelines provided under supply chain management.

Logistics related to transport, medicine, DOT etc.;

Procurement of Buprenorphine would be done by the National AIDS Control Programme through its centralized procurement mechanism which is which is in place since last two years and where enough capacity is in place that could ensure the efficient, timely and quality assured transport of the drug from the national level to individual hospital sites with fool proof security. The system of procurement and supply chain will further improve with UNDP coming in as third PR and under the agreement the PSM system in the national and provincial programs would be further strengthened by them.

Supply chain management

Historically, most attempts to initiate the use of Buprenorphine as OST in Pakistan have failed because of the concerns of regulatory bodies regarding control mechanisms of unintended use. Therefore the preparatory phase will pay special attention to putting in place a robust procurement and supply chain management system in line with national rules and regulations. The designated Licensed Pharmaceutical Manufacturer will be responsible for complying to all national and international regulatory obligations. In addition to this the national supply chain management rules and regulations, applicable to other controlled medicines (e.g. morphine) will be followed. Further, the possibility of application of the same supply chain management system, which is currently being used for the TB and Malaria programmes, will be explored.

Buprenorphine will be manufactured in Pakistan by licensed Pharmaceutical Manufacturer, prescribed, dispensed or administered (furnished) by an individual legally qualified to do so in

accordance with Drug Rules 1976 of Pakistan. An efficient and fool-proof system of managing controlled drugs in the country already exist for production, procurement, distribution and secure administration from source to patients. The system exist in the country for use of other controlled medicines like morphine and pethidine which are used for critically ill patients in all tertiary care and secondary care hospitals. The system is designed to prevent unintended use of controlled medicines. The same would be used for procurement and distribution of Buprenorphine.

Review and updating of existing national drug dependence treatment guidelines

In 2012 Treatment Protocols for Drug Use in Pakistan were finalised by UNODC and the Government of Pakistan. The Treatment Protocols were drafted with support from the University of Adelaide and were reviewed by expert psychiatrists and psychologists prior to endorsement by the syndicate of the Dow University of Health Sciences, Karachi. The Treatment Protocols are aimed at facilitating standardized and enhanced delivery of drug treatment, including OST and rehabilitation services, in Pakistan as well as to improve monitoring and evaluation of drug treatment services. In addition, it is expected that the OST protocol[179] developed under Global Fund Round 9 will be reviewed, revised and updated as relevant during the first half of 2016. Furthermore, Standard Operating Procedures (SOPs) for OST service delivery, to accompany the existing Treatment Protocols, will be developed by the NACP, with technical assistance from UNODC and WHO.

Management arrangements, including contracting of OST sites and human resources, budget, M & E system

The National AIDS Control Programme (NACP) will be responsible for the overall planning, management, monitoring and evaluation of the OST programme, including contractual arrangements, human resources training and capacity building and establishment of an M & E system for the OST service delivery. The management, procurement and logistics arrangements will be completed in accordance of the governing management and procurement rules and regulations. The NACP will also be responsible for coordinating with the Drug Regulatory Authority of Pakistan (DRAP) to develop annual estimates for medicine in compliance with national rules and regulations.

Implementation of the service delivery will be through the Provincial AIDS Control Programmes (PACPs) with PWID service delivery partners and hospitals. The hospitals will be supported to establish dispensing units within or attached to psychiatric departments with linkages and referrals to and from the ART sites. The SDPs will be supported with staffing and logistical support. Tri-partite agreements will be signed between the NACP and PACPs and designated

[179]Opioid Substitution Therapy (OST) Protocol: Focused on Buprenorphine Maintenance Program (Modified version to comply with Pakistan current policies and regulations) Autumn 2013.

Hospitals. The PACPs in turn will sign agreements with respective SDPs. The OST service delivery in the first phase will be implemented in public hospitals/drug treatment facilities in five major cities of Pakistan (Karachi, Lahore, Peshawar, Quetta and Rawalpindi), with linkages to other relevant services, such as HIV treatment, care and support.

Identification of required human resources, training and capacity building of the treatment service staff will be by the NACP, PACPs in coordination with the hospitals. Ongoing institutional and human resources capacity building and development, including delivery of training courses by international / national drug dependence treatment experts as relevant will be conducted under the leadership of NACP and PACPs.

Budget for introduction of the OST service delivery will be sought from the following sources:

- Provincial government budget allocations for HIV (PC1s),
- GFATM and other potential donor partners.
- UN agencies such as UNODC, WHO, UNAIDS

M&E for OST

While targets for OST service delivery have already been reflected in the Monitoring Plan, the national M & E system will also be updated to reflect the OST intervention. The system of OST will be rigorously monitored by National and Provincial AIDS Control programs in collaboration with other sectors such as Ministry of Narcotics control. All centres will be audited on a regular basis. Monitoring visits will provide opportunity to evaluate the progress at each site and to identify potential problems and trends across sites. The monitoring staff will assure that procedures are being followed, that submitted data are accurate and in agreement with source documentation, verify that medications are properly stored and accounted for, and assure that all essential documentation required by national regulations is appropriately filed.

Routine monitoring visits by the monitors will be scheduled at appropriate intervals, more frequently at the beginning. All reports will be provided, in a timely manner. Program Manager, NACP and PACPs will review all monitoring reports and may offer additional training, or provide guidance to the sites. The Program Manager may take steps to terminate enrolment at any site that, after corrective procedures have been implemented, continues a pattern of serious violations. A detailed Monitoring and Evaluation Plan would be developed by the National AIDS Control Program agreed by all stakeholders with monitoring indicators to track progress.

Development of a national policy on OST

A national OST policy will be developed with the objective of establishing a set of standards for OST provision and address the needs of politicians, health administrators, program managers, clinicians and OST patients. Such policy would reflect a national agreement about the important strategic role of OST in reducing the adverse health, social and economic consequences of drug use, and outline objectives and procedures for nationwide roll-out.

Phase 2 - Implementation of OST service delivery (July 2016 - December 2017)

Phase 2 will consist of OST service delivery for an estimated 1000 PWID as part of a comprehensive HIV prevention, treatment and care response by the public health sector in Pakistan as envisaged in PAS III.A total of 1000 eligible individuals will be enrolled onto the OST programme from July 2016 onwards so that by December 2017 at least 1000 individuals will regularly be availing of the OST service. The planned number of patients reached through each OST site will be divided proportionate to the estimated population of PWID in the four main provinces so as to reach the total target of 1000 PWID.

Implementation and management arrangements

Potential OST patients will be referred directly through Service Delivery Packages (SDPs) providing services to people who inject drugs (PWID). This is to ensure that street-based injecting drug users, with the highest prevalence of HIV and the highest number of people on ART in Pakistan, are prioritised for OST to ensure retention of PWID living with HIV on ART, which also helps to prevent resistance to ARVs due to non-adherence.

SDPs will bring enrolled patients on a daily basis to the designated static dispensing unit for their Buprenorphine sublingual dose as a Directly Observed Therapy (DOT). While initially clients will come every day to collect their dose, over time as clients stabilize, and at the clinician's discretion, more than one day's dose may be given at a time. Weekly coordination meetings between the OST site and the service providers will be held and chaired by the PACP to review and document progress, issues, dose adjustments, etc. Eligible patients will receive Buprenorphine free of cost and possibility of provision of transport charges will be explored. The enrolment criteria will be detailed in the OST service delivery SOP.

Phase 3 - Scale-up and implementation of OST service delivery in an additional 13 cities (2018 - 2020)

Phase 3 will consist of development and implementation of a national scale-up which will be informed by the lessons learned from implementation of OST service delivery during Phases I and II as well as be guided by international normative guidance with regard to optimal levels of programme coverage by WHO, UNODC and UNAIDS.[180]It is envisaged that during Phase III the OST programme will be further scaled up and implemented in additional 13majorcities, including, but not limited to cities detailed in below table (see separate attachment for Table). The number of sites in below table is indicative and the final number of sites will be determined

[180]As per WHO, UNODC, UNAIDS 2012 Revision of the Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users high level of coverage of OST would equal having at least 40% of opioid dependent individuals on OST, while 20-40% equals medium level of coverage and < 20% equals low level of programmatic coverage.

based on available data on the estimated total population in each city, estimated population size of PWID and HIV prevalence amongst PWID according to data as of 2017. It is anticipated that by December 2019 an estimated 15 800 PWID could be availing of the OST services in Pakistan.