



KHYBER PAKHTUNKHWA AIDS STRATEGY 2021-2025

June 2020

Foreword

Khyber Pakhtunkhwa has been on the forefront in the war on terror. The province's limited resources were stretched to the limit to meet this challenge. Only recently the province has seen life returning to normalcy. Therefore, the Khyber Pakhtunkhwa AIDS Strategy 2021-2025, comes at the right time, which will help us in reaching those, who so far were not reached by the provincial AIDS response. Though in the beginning of this year we were met with yet another challenge of COVID-19. But I have confidence in the capacity of our health workforce, and I am hopeful that the Department of Health will continue to serve the population of the province to the best of its ability.

The strategy aims to reach the 90–90–90 treatment targets by closing the testing and treatment gap so that the health of people living with HIV in the province is protected and promoted. The strategy focuses on reducing new infections to alter the trajectory of the epidemic. Ending the AIDS epidemic will involve reaching children, women, young people, men who have sex with men, people who inject drugs, sex workers and clients, transgender people, migrants and prisoners with critical, testing, prevention and treatment services. This strategy provides a roadmap to ensure that no one is left behind, by addressing the low treatment coverage for children living with HIV, expecting mothers and adults living with HIV.

The strategy was developed based on WHO recommendations, UNAIDS technical support on epidemic modelling and target setting, and with the involvement of all relevant stakeholders, including people living with HIV and affected communities, the Joint UN Team on AIDS, UNAIDS and bilateral partners.

The principal objective of this strategy is to strengthen the provincial AIDS response so that by 2030, 90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and 90% of all people receiving antiretroviral therapy will have viral suppression.

June 2020

Acknowledgements

This AIDS strategy was developed based on a broad consultation process at provincial and national level. The strategy writing team would like to thank all those who have participated in this process by sharing their insights, experiences and feedback on presentations and draft documents. These inputs have been a great help in tailoring the approach to the context of Khyber Pakhtunkhwa. Ongoing dialogue has been an especially challenging process on this occasion because the COVID-19 pandemic has forced us to try new ways of communicating with each other. The quality of participation has been exemplary, nonetheless.

Special thanks to the Khyber Pakhtunkhwa AIDS Control Programme, the National AIDS Control Programme, the programme implementers, the communities (PLHIV and key populations), Association of PLHIV and CBOs whose active engagement was a critical part of the process. Technical inputs from development partners (Joint UN Team on AIDS, UNAIDS and bilaterals) have provided much guidance and we are particularly grateful to the UNAIDS Regional Support Team-Asia Pacific for their work on epidemic modelling, scenario planning, and target setting.

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Acronyms

AAU	ART Adherence Unit
AIDS	Acquired Immune Deficiency Syndrome
ADR	Acquired Drug Resistance
AEM	AIDS Epidemic Model
ANC	Antenatal Care
APLHIV	Association of People Living with HIV
ART	Antiretroviral Therapy
ARV	Antiretroviral (drugs/medication)
BHU	Basic Health Unit
CBO	Community-Based Organization
CCM	Country Coordination Mechanism
CD4	Cluster of Differentiation 4
CNIC	Computerised National ID Cards
COVID-19	Corona Virus Disease 2019
DOTS	Directly Observed Treatment Short-course (for TB)
DoH	Department of Health
DSD	Differentiated Service Delivery
EID	Early Infant Diagnosis
FSW	Female Sex Worker
GARPR	Global AIDS Response Progress Report
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GSM	Greenstar Social Marketing
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HIVDR	HIV Drug Resistance
HIVST	HIV Self-Testing
HTS	HIV Testing Service
IBBS	Integrated Biological and Behavioural Surveillance
KP	Key Population
M&E	Monitoring and Evaluation
MNCH	Maternal, Newborn and Child Health
MIS	Management Information System
MSM	Men who have Sex with Men
MSM (non-SW)	Men who have Sex with Men who are not sex workers
MSW	Male Sex Worker
NACP	National AIDS Control Program

NGO	Non-Governmental Organization
NIH	National Institute for Health
NMD	Newly Merged Districts (of Khyber Pakhtunkhwa)
NSEP	Needle Syringe Exchange Program
NZT	Nai Zindagi Trust
OST	Opiate Substitution Therapy
PACP	Provincial AIDS Control Programme
PAS	Pakistan AIDS Strategy
PAS III	Pakistan AIDS Strategy III (2017-2021)
PAS IV	Pakistan AIDS Strategy IV (2021-2025)
PC-1	Planning Commission Proforma – One (Project Document)
PDR	Pre-treatment Drug Resistance
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PPTCT	Prevention of Parent-to-Child Transmission (of HIV)
PR	Principal Recipients (for GFATM grant)
PrEP	Pre-Exposure Prophylaxis
PSE	Population Size Estimate
PWID	People who Inject Drugs
SDG	Sustainable Development Goals
SDP	Service Delivery Package
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TG	Transgender person
TSU	Technical Support Unit
TWG	Technical Working Group
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

1. Introduction

Khyber Pakhtunkhwa along with its newly merged districts (NMD) constitute 17% of the total population of Pakistan but they contribute only 6% to the total HIV burden with an estimated 12,127¹ PLHIV in the province.

Though Khyber Pakhtunkhwa has made progress in identifying and bringing new PLHIV on treatment, much more needs to be done to bring the epidemic under control, where annual HIV infections continue to rise. This is an opportune time for Khyber Pakhtunkhwa AIDS Control Programme to have an impact on the course of the epidemic by using this strategy in a meaningful way to design, govern and oversee the (domestically funded and foreign funded) provincial AIDS response.

Strategy 2020-25

Khyber Pakhtunkhwa AIDS Strategy covers the period from 2021 to 2025. It cuts short by one year the timeframe of Khyber Pakhtunkhwa AIDS Strategy 2017-21 for two important reasons:

- Recent programme reviews indicate a significant under-performance against the targets of Khyber Pakhtunkhwa AIDS Strategy 2017-21
- By developing the strategies now there is a significant opportunity to ensure that domestic planning and budgeting processes (PC-1) are aligned with strategy targets

Inputs

Khyber Pakhtunkhwa AIDS Strategy was revised in 2017 based on new information from round (V) of Integrated Biological and Behavioural Surveillance (IBBS)² data. This provided revised population size estimates (PSE) for key populations (KP), new prevalence estimates and epidemic models that showed how the epidemic was likely to progress given the baseline revealed by the IBBS data. There has been no further round of IBBS since 2016 so the epidemic analysis presented in Khyber Pakhtunkhwa AIDS Strategy 2017-21 still stands, which stated that HIV had established in people who inject drugs (PWID) and among transgenders (TG). Among female sex workers (FSW) in particular the IBBS showed early sign of infections.

Process

The Khyber Pakhtunkhwa AIDS strategy has been developed through a consultative process, which unfortunately had to be adjusted due to the COVID-19 pandemic, with discussions moving online after the advent of restrictions on face to face meetings. These consultations included face-to-face meetings with the Program Manager for Newly merged districts (NMD) AIDS Control Programme, key populations and people living with HIV (PLHIV) stakeholders as well as a virtual (online meetings) with the Khyber Pakhtunkhwa AIDS control programme, and the Department of Health (DoH), Khyber Pakhtunkhwa. A full list of meetings and consultations that took place to develop the strategies is annexed.

Structure

The strategies take their structure from a standard approach to strategic planning:

- An analysis of where we are now

¹ Annex 4: Baseline Data

² NACP, *Pakistan IBBS Round V*, April 2017

- A decision about where we want to be at the end of the strategy period
- A plan for how we will get there

In what follows Section 3 covers the current situation, Section 4 the decision about where we want to be in 2025 and, Section 5 the strategic approach to achieving the desired impact. The strategic approach is further supported by a monitoring and evaluation framework (Section 6), a budget (Section 7) and an implementation plan.

Ownership

Khyber Pakhtunkhwa AIDS strategy 2021-25 is designed to guide the entire AIDS response at provincial level. This guides what the programme as a whole needs to do in order to gain control of the epidemic. The funding sources for the various activities will vary, part international, part domestic. But it is important to understand that the budgets, targets, M&E framework and implementation plans are for the AIDS response as a whole regardless of funding source.

The strategy, therefore, sits above both the Global Fund resourced portion of the response, and the PC-1 resourced portion of the programme, and bind them together into a single response with overall budgets, targets, and indicators. It is assumed that the strategy is, therefore, owned by the Khyber Pakhtunkhwa AIDS control programme, Department of Health (DoH), Khyber Pakhtunkhwa and is used to ensure complementarity between differently funded interventions. Put simply, PC-1 budgets/targets plus the Global Fund budget/targets should aim to equal strategy targets. Any deficit should be identified as a resource gap and efforts be made to mobilise resources to address the shortfall.

2. Provincial Context

Khyber Pakhtunkhwa province is situated in the north west region of Pakistan, it has a long porous border with Afghanistan, with some tribes living across border areas of both countries. In 2018 federally administered tribal areas (FATA), which consisted of seven tribal agencies and six frontier regions that were directly governed by the federal government through a special set of laws, were merged into Khyber Pakhtunkhwa province. Due to the extremely under-developed nature of this region and difficult terrain, it still retains a special status in the province, and is now referred to as the newly merged districts (NMD), with provincial government and international development partners allocating ear marked funds to assist in the development of this region. Before the merger Khyber Pakhtunkhwa had a population of 30.5 million³, which is now 35.5 million after the inclusion of NMD in the province. Peshawar is the provincial capital and only metropolitan city with a population of just over 4.0 million. Other main districts of the province include, Mardan, Charsadda, Dera Ismail Khan, Abbotabad, Haripur, Kohat and Swat.

In Khyber Pakhtunkhwa, the HIV epidemic is mainly concentrated among PWID, TG and FSW, infection was also found among MSM/MSW but to a lesser extent⁴. The country has not conducted a new round of IBBS since 2017. The 2017 IBBS data estimated the following HIV prevalence among key populations in the province.

Table 1: HIV prevalence among key populations in Khyber Pakhtunkhwa

City	PWID	TG SW	MSW/MSM	FSW
Peshawar	9.9%	1.3%	0.7%	3.0%
Bannu	3.4%	15.4%	0.9%	1.5%

Table 2: AEM based PSE of key populations for Pakistan and Khyber Pakhtunkhwa

Key population	PSE for Pakistan	PSE for Khyber Pakhtunkhwa	% Proportion
MSM (non-SW)	848,423	104,464	74%
MSW	74,409	6,518	5%
TG	60,924	5,989	4%
FSW	203,277	17,657	12%
PWID	111,330	7,149	5%
Total KP	1,298,363	141,777	11%
PLHIV	183,705	12,127	7%

It is clear from the table above that highest prevalence of HIV in key populations is among PWID and TG SW, but the combined population size estimate of MSW and MSM in Khyber Pakhtunkhwa is 15 times the population size estimate of PWID and TG. This sheer number of MSW and MSM makes HIV prevention programmes for MSM/MSW extremely critical for controlling the epidemic. Unfortunately, no Global Fund supported service delivery programme or domestically funded programme for these populations has exists in Khyber Pakhtunkhwa.

³ Pakistan Population Census 2017

⁴ Integrated Biological & Behavioural Surveillance in Pakistan 2016-17, Round V

Khyber Pakhtunkhwa has an integrated PC-1 for HIV, Hepatitis and Thalassemia, of PKR 500 million that was approved for the period July 2016 - June 30, 2019. A no cost extension was granted to the project for a year till June 2020. Information gathered from Khyber Pakhtunkhwa AIDS Control Programme revealed that 48% of the budget of PC-1 released for HIV was spent. NMDs also had a separate HIV prevention PC-1 of PKR 182.572 million for the period 2017-19 that was mostly for advocacy and communication.

There are two treatment centers in Peshawar and one in Kohat, which are dispensing ARVs. As of Dec 2016, there were 2,502⁵ PLHIV receiving ART in Khyber Pakhtunkhwa out of which 257 (10%) were migrant workers and 57 (2.3%) were Afghan nationals. Prevention and treatment programme in Khyber Pakhtunkhwa need to take these two important factors into consideration. For prevention, special efforts need to be made for counselling of males to ensure HTC of their wives, (a) to ensure primary prevention of wives, here PrEP would play an important role, and (b) to offer prevention of mother to child transmission of HIV, where pregnant women are infected.

There are more than 700⁶ PLHIV taking treatment at the three treatment centers in Khyber Pakhtunkhwa who belong to the newly merged districts. These patients have to travel long distances (NMDs cover an area of 27,220 km²) as there is no proper treatment center in this whole region. Though there are three centers in NMD, at Bajaur, South Waziristan and Kurram District but they provide only counselling and referral services, not ART. This means that PLHIV in NMD have to travel long distances to receive treatment and even follow-up, this distance and associated cost is a huge barrier to the people of this area, which determines their HTC, HIV treatment uptake and adherence.

⁵ NACP Treatment MIS data

⁶ NMP AIDS Control Programme data

3. Critical Issues

In 2017, Khyber Pakhtunkhwa AIDS Strategy underwent a major revision to take account of new IBBS data,⁷ epidemic modelling based on that data,⁸ and the (then) recent global guidance⁹ on how to fast-track HIV/AIDS responses in order to achieve ambitious 90-90-90 treatment targets. Since Khyber Pakhtunkhwa's HIV epidemic was (and still is) concentrated, with an estimated prevalence rate of less than 0.1% among the adult (15-49 years) general population, it was important to reconfigure and focus the response. The aim was to gain control of the epidemic among the key populations whose HIV prevalence was significant and rising.

The resulting 2017-21 Khyber Pakhtunkhwa AIDS strategy followed the global guidance in proposing four key (strategic) directions to Khyber Pakhtunkhwa's AIDS response:

Increased testing among key populations:	New CBO-led, outreach prevention programmes for MSM, HSW and FSW, to be implemented in cities prioritised on the basis of epidemiological evidence.
Increased treatment coverage among key populations:	Testing for key populations shifted from clinics into community-settings, phasing in treatment for all, expanding community-based treatment preparedness support for PWID, addressing long-standing treatment access barriers.
Addressing loss to follow Up:	Intensified clinic-to-community-and-back case management with particular focus on key populations with active involvement of community-based case managers.
Keeping Track of Progress:	Introducing an integrated tracking system to monitor events prior to clinic entry all the way through to treatment and adherence.

These key directions were framed around the need to address four critical issues which were challenging the province's ability to control the HIV epidemic. Three of these were constraining the flow of PLHIV into, and on through, the testing and treatment service cascade, and the fourth was making it impossible to track individuals as they moved through it. These issues were as follows:

1. Low prevention and testing programme coverage among key populations
2. The continued existence of barriers to treatment access and initiation
3. High treatment attrition rates
4. A weak monitoring and evaluation system

⁷ NACP, *Pakistan IBBS Round V*, April 2017

⁸ NACP, *AIDS Epidemic Modelling Exercise for Pakistan*, 2017

⁹ UNAIDS, *Fast Track Commitments to End AIDS by 2030*, UNAIDS Strategy 2016-2021, *On the Fast-Track to End AIDS*, Global Fund Strategy 2017-2022: *Investing to End Epidemics*, WHO Global Health Sector Strategy on HIV 2016-2021

The main thrust of the 2017-21 strategy was that in order to gain control of Khyber Pakhtunkhwa's AIDS epidemic these four critical issues had to be addressed.

This section will revisit each of the critical issues identified in 2017-21 strategy and show that they remain critical and unresolved. It will also highlight an additional critical issue that appears to be preventing the programme from effectively addressing the original four critical issues.

Critical Issue 1. Low prevention and testing programme coverage among key populations

Table 3

Khyber Pakhtunkhwa AIDS Strategy (2017-21) Indicators	2019 Target ¹⁰	2019 Result ¹¹
% PWID that received an HIV test within the last 12 months and know the results	35%	7%
% Non-SW MSM that received an HIV test within the last 12 months & know the results	25%	0%
% MSW that received an HIV test within the last 12 months and know the results	35%	0%
% HSW that received an HIV test within the last 12 months and know the results	35%	0%
% FSW that received an HIV test within the last 12 months and know the results	35%	0%

Table above demonstrates that the testing coverage targets set in 2017-21 strategy for increasing coverage have been significantly underachieved. The UNAIDS Global AIDS Update 2019 judged key population prevention programmes in Pakistan to be "faltering"¹² on account of the fact that prevention programme coverage is at less than 10% for more than one key population.¹³ The extremely low testing coverage for MSM and MSW is of particular concern given their combined estimated population size (83,940), which is 80% of all key population populations size estimate in the province, and their projected proportion of disease burden as the epidemic progresses.¹⁴ Though TG make up only 4% of Khyber Pakhtunkhwa's key populations size epidemic but over 15% prevalence of HIV among TG in Bannu requires urgent attention.

2017-21 strategy short-listed 5 priority cities for key populations in Khyber Pakhtunkhwa, based on where the available evidence (IBBS mapping) suggested that most PLHIV were likely to be found. With the exception of PWID programming, which is currently present in one of the 3 cities and other two are in pipeline, priority city coverage for other key populations has

¹⁰ Annex 4: Baseline Data

¹¹ Annex 4: Baseline Data

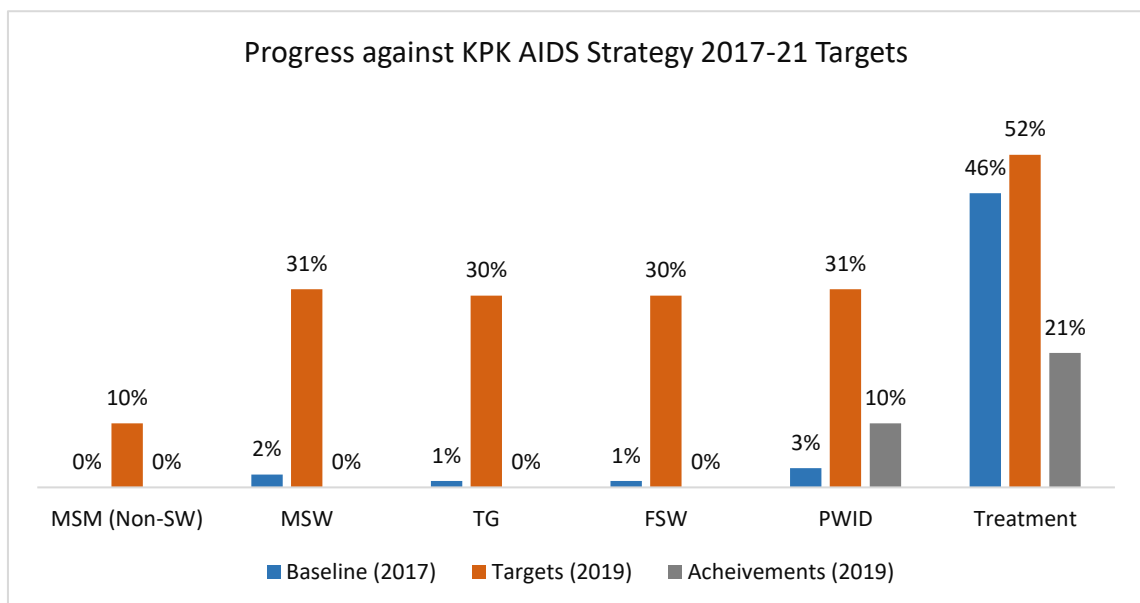
¹² p216, UNAIDS Global AIDS Update 2019, <https://www.unaids.org/en/resources/documents/2019/2019-global-AIDS-update>

¹³ p38, UNAIDS Global AIDS Update 2019, <https://www.unaids.org/en/resources/documents/2019/2019-global-AIDS-update>

¹⁴ P18 KPK AIDS Strategy 2017-21

failed to materialise, as no prevention programmes for MSM, TG or FSW, are being implemented in any of the prioritized cities.

Graph 1 – Key Population Programme Coverage¹⁵



The PWID programme coverage that exists, is wholly supported by the Global Fund. Domestically funded Khyber Pakhtunkhwa PC-1 programme has been largely inactive and significantly underspent.¹⁶ Domestic funds are not being used to fill the gaps between Global Fund key population programme coverage and the overall strategy targets.

Critical Issue 2. The continued existence of barriers to treatment access and initiation

Table 4

Khyber Pakhtunkhwa AIDS Strategy (2017-21) Indicator	2016 Baseline	2019 Target	2019 Result ¹⁷
# People living with HIV initiating treatment within the last year	40	386	951

2017-21 strategy identified 3 types of constraints that were affecting treatment access, the CD4 count eligibility requirement, insufficient treatment preparedness services for PWID, and treatment service model issues. The first has been effectively dealt with by the implementation of treatment for all regardless of CD4 count with the result that the target for the number of people newly initiating ART in 2019 in Khyber Pakhtunkhwa was over-achieved. But the point to note is that key populations are significantly under-represented in this number. Reaching key populations is critical to the overall control of the epidemic.

The recent programme review notes that distance to travel is a main barrier for key populations.¹⁸ Travel distances to ART centres also came out as one of the barriers to access

¹⁵ NACP MIS Data

¹⁶ National HIV Programme Review 2019

¹⁷ Results data from NACP, June 2020

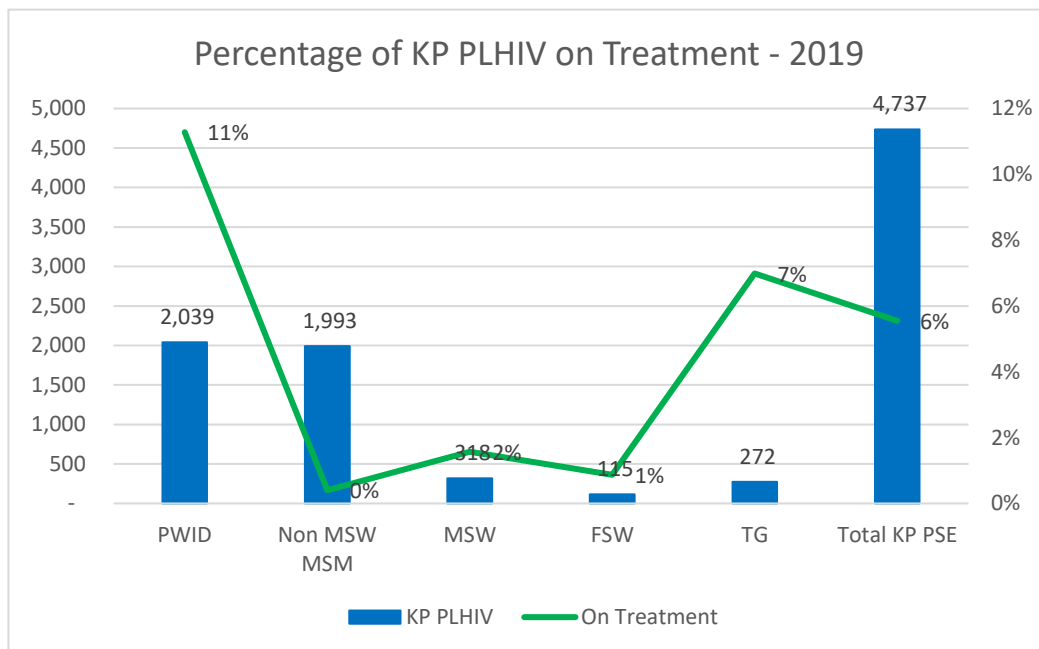
¹⁸ National HIV Programme Review 2019

treatment in community consultations, which results in PLHIV initiating treatment, but then not returning for follow-up visits (discussed further in next section).

The consequence of inadequately addressing critical issues 1 and 2 is that the 2,502 people currently on treatment in Khyber Pakhtunkhwa represent only 21% of the estimated number of PLHIV in the province. Though this percentage is better than other provinces but still is far from satisfactory. Graph 1 shows that the treatment coverage for PLHIV has gone down instead of improving, this is because of the recalculation of the denominator, which led to an increase in the estimated number of PLHIV in Khyber Pakhtunkhwa, it should be noted that actual number of people on treatment has increased from 1,410 (in 2016) to 2,502 (in 2019).

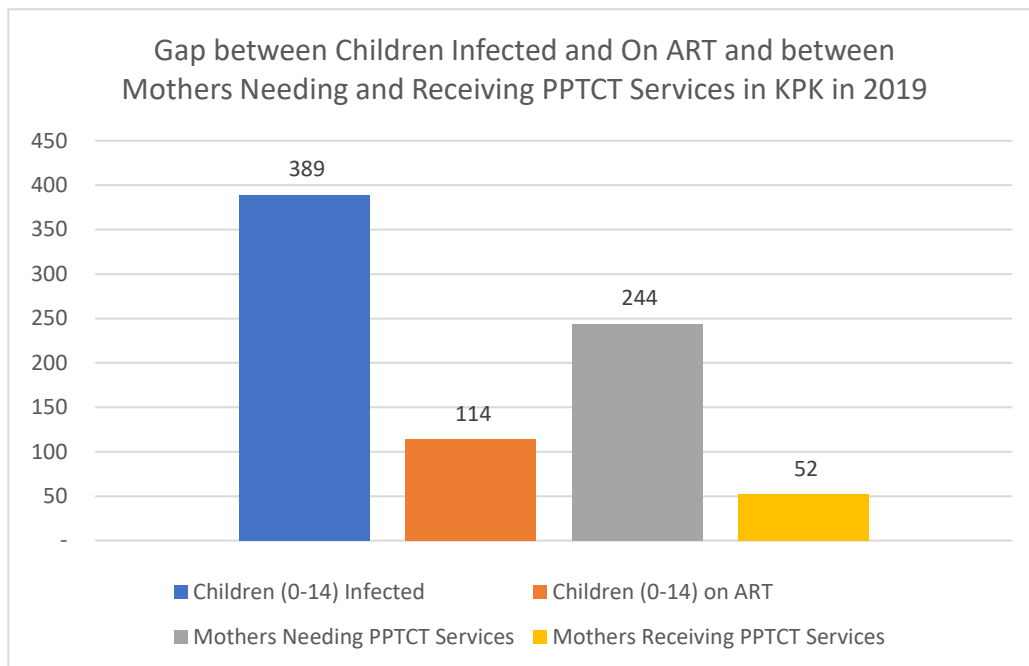
For key population PLHIV (who are estimated to account for 39% of the total number of PLHIV in the province), the treatment coverage is even lower, at 6%. Of concern, from the point of view of epidemic control, is the almost no treatment coverage for MSM PLHIV, who are currently estimated to account for 16% of the total number of PLHIV in Khyber Pakhtunkhwa.¹⁹

Graph 2²⁰



¹⁹ Treatment coverage data from NACP MIS 2019, KP PLHA PSEs derived from IBBS 2017 data.

²⁰ Annex 4: Baseline Data

Graph 3 – Paediatric AIDS Treatment and PPTCT²¹

Major consequence of the non-addressal of issues 1 and 2 is that vulnerable populations, like children of key populations and wives of key populations are not being captured by the system and not being linked to treatment services. The result is that only 29% of children living with HIV received treatment, while only 21% of pregnant women living with HIV received PPTCT services in Khyber Pakhtunkhwa in 2019.

Critical Issue 3. High treatment attrition rates

In 2019, with Global Fund support, NACP conducted a retrospective cohort study²² to assess patient retention. By analysing data from two patient cohorts, one 12-month cohort, and one 24-month cohort, a clear picture of just how serious the treatment programme's retention problem is, has emerged. In both cohorts (nationally) more than one third of patients initiating treatment in month one did not return in month two. Only 9% of patients in Khyber Pakhtunkhwa were retained at the end of the 12-month cohort, and only 11% (nationally) at the end of the 24-month cohort. In both cohorts the number of fully retained patients declined every month that was tracked. The study admits that the patient numbers in Khyber Pakhtunkhwa were small, which limited the analysis.

The study concludes that (nationally) “while there was an improvement in retention among the patients who started treatment in 2018, the overall loss factor in both cohorts was massive.”²³

Critical Issue 4. Weak monitoring and evaluation system

The need to capacitate the provincial monitoring and evaluation system was a key strategic action proposed in 2017-21 strategy. As with the treatment access barriers, the strategy

²¹ Annex 4: Baseline Data

²² Pakistan ART Outcome Study, NACP, February 2020

²³ Pakistan ART Outcome Study, NACP, February 2020

noted that this was not a new issue. Systems fragmentation, parallel systems, lack of interconnectivity between systems, and uncoordinated data flows are all historical issues.

The results of the 2019 Programme Review suggest that any efforts to address this critical issue, they have been largely unsuccessful. The review notes that there is a “lack of a reliable interconnected MIS across HIV programme streams” with parallel systems run by “federal (NACP), provincial (PACP), and non- governmental (NZA, APLHIV), without interfaces connecting them.”²⁴ This gap between various MIS’ results in discrepancies in data between the various systems and mutual suspicions about the accuracy of data from systems owned by other parties. There is little evidence that data is being used for real-time programme management.

Both the Programme Review and the ART Outcomes Study make key recommendations around the need to improve HIV-related data systems. The outcomes study singles out the issues of data quality in ART centres, the integration of the national MIS and the provincial MIS, and the flow of viral load testing data from the third-party provider into the national MIS.²⁵ The Programme Review recommends that the MIS should be maintained and guided by a clear strategy and structure that ensures that data are correctly and timely captured, validated, reported upward and horizontally, analysed and used for feedback and planning.”²⁶

New Critical Issues

Considering the above analysis, it is clear that the same set of critical issues that 2017-21 Khyber Pakhtunkhwa AIDS Strategy was designed to resolve, will need to inform the content of 2021-25 strategy. Unless these issues are urgently addressed the provincial AIDS programme in will continue to be ineffective in controlling the province’s epidemic.

It is also clear that only those aspects of the strategy tend to get implemented which fall within the remit of the Global Fund grants. Domestically funded AIDS control programme struggles to absorb the funds allocated it. E.g., out of the PKR 500 million allocated to the integrated PC-1 for HIV, Hepatitis and Thalassemia for the period July 2016 - June 30, 2019, PKR 307.994 was earmarked for HIV, out of which PKR 92.500 were released. And 48%²⁷ of the released amount was spent on HIV related activities. The review identifies the “lack of results-based management that provides for accountability and transparency”²⁸ as a root cause of this inefficient spending.

In view of the above, this strategy has been designed to address an additional critical issue as follows:

Critical Issue 5. Lack of strategic programme oversight and effective implementation management

The strategy should be actively used to govern and manage the combined performance of domestically and internationally funded programme components towards the achievement of strategy targets. Unless this happens, long-standing systems and implementing model

²⁴ National HIV Programme Review 2019

²⁵ Pakistan ART Outcome Study, NACP, February 2020

²⁶ National HIV Programme Review 2019

²⁷ KPK AIDS Control Programme information

²⁸ p48 National HIV Programme Review 2019

problems will continue to be unaddressed, domestically funded programmes will continue to underspend and fail to reach targets, and the epidemic will remain uncontrolled.

In particular, the following need to be addresses:

- Strengthening of programme oversight mechanisms at provincial level to oversee progress towards achieving strategy targets
- Strengthening of programme governance capacity at provincial level to regularly monitor progress towards achieving programme targets and do evidence informed course correction, if required
- Alignment between domestically and internationally funded programme plans to ensure optimisation of their respective coverage contributions towards achieving strategy targets
- Results-based management of domestically funded programmes to ensure proposed targets are achieved and unspent funds are used to address programmatic gaps
- Transparency and accountability-mechanisms to ensure that non-performing projects can be identified and improved in a timely manner, and for ensuring follow-through on the resolution of long-standing systems and programme model problems
- Standardisation of programme components across domestically and internationally funded programmes so that complementarity can be better planned and tracked
- Oversight of geographic allocation of different programme components to ensure optimal coverage of cities prioritised for each key population
- A common M&E framework and MIS for all programmes

To address these issues this current iteration of strategy has undergone significant reworking of Outcome 3²⁹ concerning the enabling of an environment for an effective AIDS response. Unless programme governance and management issues are properly addressed the rest of the strategy is unlikely to be adequately implemented.

Summary of Critical Issues

Based on the analysis presented in this section, the table below summarises the critical issues that this strategy has been designed to address and highlights the consequences of failing to address them.

	Critical Issue	Results in
1	Low prevention and testing programme coverage among key populations	<ul style="list-style-type: none"> • Most PLHIV not knowing their status or accessing treatment • Failure to reduce the occurrence of risk behaviours • Rising HIV incidence
2	Unaddressed barriers to treatment access and initiation	<ul style="list-style-type: none"> • Significant cascade leakage between testing and treatment • Poor treatment coverage
3	High treatment attrition rates	<ul style="list-style-type: none"> • Failure to achieve viral suppression • Failure to achieve prevention benefit of treatment

²⁹ KPK AIDS Strategy 2017-21 has a three-pillar structure. Put simply these are 1. prevention/testing, 2. treatment and 3. enabling environment. 2017 strategy significantly rewrote 1. and 2. but only made minor modifications to 3. This strategy significantly rewrites 3.

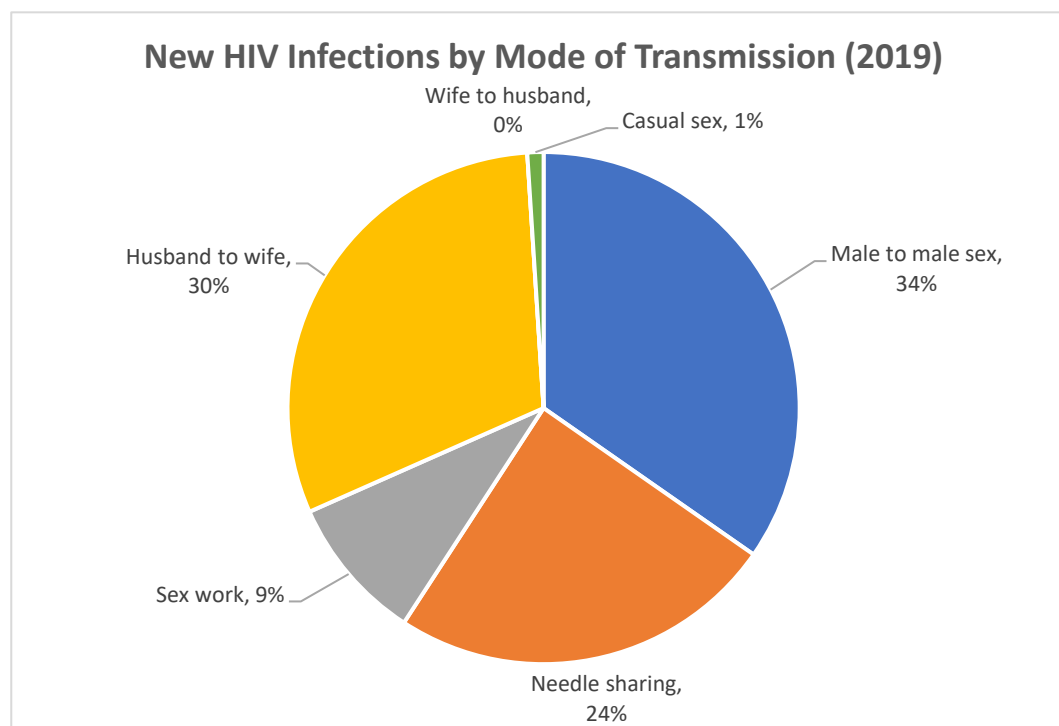
4	Weak monitoring and evaluation system	<ul style="list-style-type: none"> • Inability to effectively manage programme performance • Lack of coordination • Inefficient resource allocation and utilization • Limited understanding of service cascade weak points
5	Lack of strategic programme oversight and weak implementation management	<ul style="list-style-type: none"> • Significant underperformance of domestically funded programmes • Failure to resolve long-standing systems and implementation barriers • Failure to optimise the respective contribution of internationally and domestically funded programmes towards the achievement of strategy targets

4. Gaining Control of the Epidemic

This strategy aims to reverse the trends of rising incidence of HIV infections, and mortality from AIDS in Khyber Pakhtunkhwa province. Previous sections have discussed our starting point; the current situation in 2020. This section looks forward to our end point; to the impact we want to have on the epidemic by the end of our strategy timeframe in 2025. Based on projections from AEM modelling, and using current programmatic data for baselines, two futures are considered; one where we continue programmes at the current level of coverage - “business as usual” - and one where we scale up our coverage to achieve targets that have been set through a consultative dialogue process with the province.

The targeting rationale of this strategy, and its emphasis on scaling up prevention programme coverage of key populations, is based on what the AEM model³⁰ tells us about how most new HIV transmissions are currently occurring. In 2019, 67% of new infections occurred through, male to male sex (34%), needle sharing among PWID (24%), and sex work (9%). Therefore, the programme targets MSM, PWID, and male, female, and transgendered sex workers to try to influence their risk behaviours. A further 30% of new infections were likely transmitted from married MSM, PWID and clients of sex workers to their female spouses. This means in effect that according to the model: (a) currently over 90% of transmissions are coming from key populations and sex worker clients (b) the majority of these transmissions are occurring in the context of needle-sharing for drug use and male to male sex.

Graph 4³¹



AEM modelling enables us to project how the epidemic would progress under a “business as usual” scenario (where prevention programme coverage remains at current levels). We know,

³⁰ It is a combined model for Balochistan and KPK

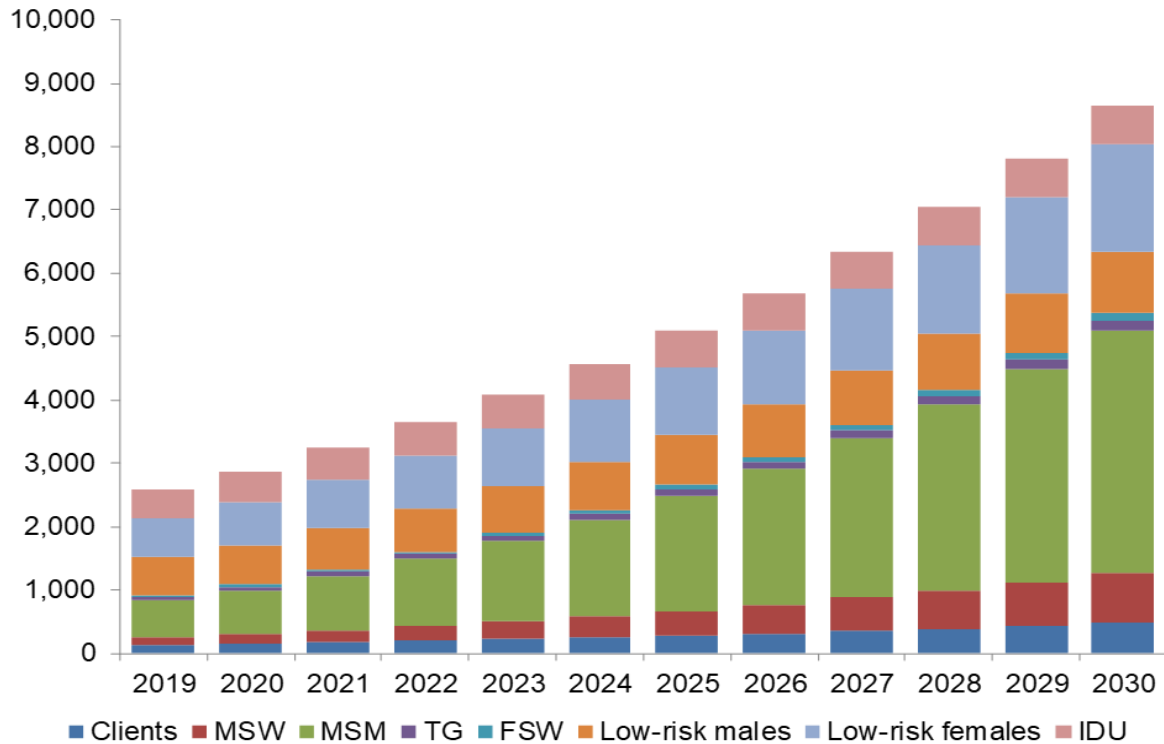
³¹ Based on AEM Modelling

based on programmatic data from 2019, that programme coverage levels for key populations are not meeting the scale up targets set in the 2017-21 strategy (Section 3, Graph 1).

Given this coverage, and without any new effort to achieve key population programme scale up, the model projects the distribution of new infections to increase as follows:

Graph 5

Annual New HIV Infections: by Risk Population, 2019-2030



It can be seen that the portion of new infections accounted for by MSM increases significantly. This is why the extremely low coverage of this population is of such concern. Getting a better understanding of this population (its sub-groups, their risk behaviour frequencies and distributions, the best ways to reach them, and how to tailor intervention packages to their needs) is an intended outcome of a number of key outputs of this strategy.³²

In order to facilitate a target setting process at provincial level, AEM modelling was used to project the impact of a range of different intervention scenarios with differing levels of key population and treatment programme coverage. Three options were considered:

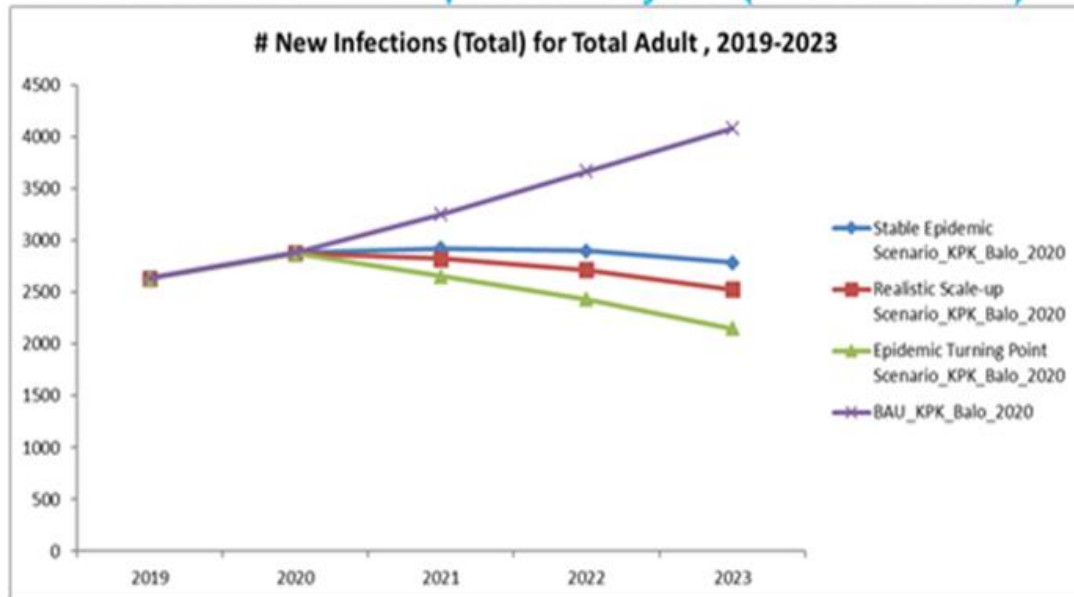
- A stable epidemic scenario (minimal impact)
- A realistic scale-up scenario (moderate impact)
- An epidemic turning point scenario (highest impact)

The scenarios are differentiated by the level of investment they require, and the level of coverage they achieve – the higher the investment, the greater the coverage and the bigger the impact. Each scenario was compared with a business as usual approach. The following graph illustrates various approaches and their outcomes:

³² Outputs 1.1.3, 1.2.3, 3.1.1 and 3.5.2 in the following section all aim to inform a better evidenced and differentiated approach for MSM.

Graph 6

KP-Balochistan – Impact analysis (4 Scenarios)

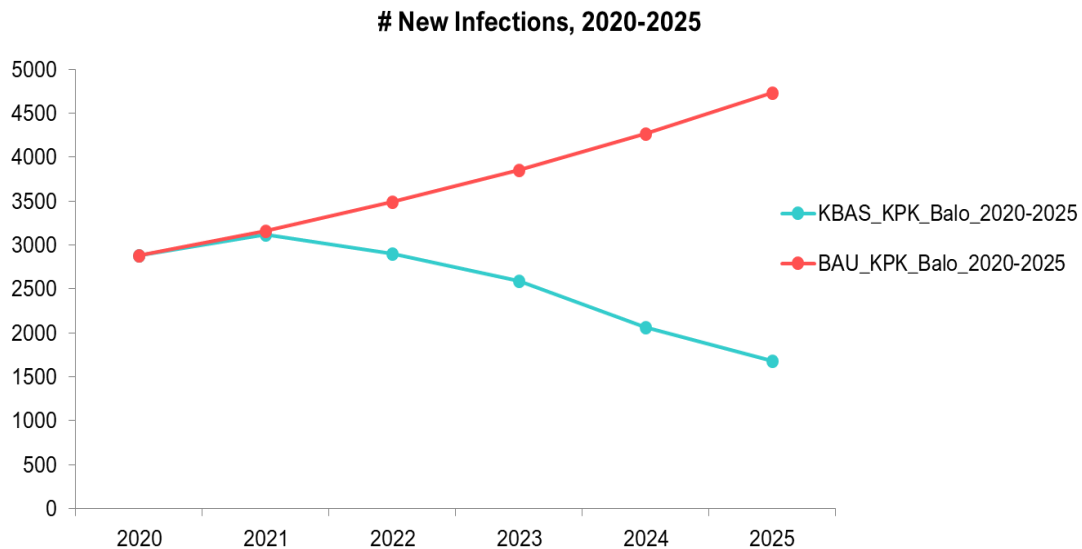


Each scenario option and its associated set of annual coverage targets for prevention and treatment, were put through a consultation process with the province. Khyber Pakhtunkhwa programme management opted for a mixed model, it selected realistic scale up scenario for key population prevention programmes, and for treatment a scenario it selected epidemic turning point scenario. Based on the feedback received the scenarios were redesigned by adjusting annual prevention and treatment programme targets to levels that province found workable.

The resulting selected scenario is, therefore, a hybrid version of the original models depicted above. A key feature of the revised final scenario is that it allows for the lead time the programme felt were necessary to bring key population programmes for MSM, male and female sex workers and transgendered sex workers to scale.³³

³³ This is discussed further in the next section. When programming in new cities CBOs for key populations have to be created, organised and capacitated. Key population involvement in HIV prevention and testing programming is in its nascent stages in Pakistan.

Graph 7: Impact Analysis – Proposed Strategy vs Business as Usual Scenario



The model shows that the achieving the targets for this scenario would result in a 42% decline in new HIV infections in the country between 2020 and 2025.

The achievement of this impact is conditional on the achievement of the coverage targets that have been set for the Khyber Pakhtunkhwa AIDS strategy 2021-25. The table below summarises a core set of the coverage targets for 2025.

Table 5

Key Indicators	Baseline ³⁴	2025 Target
% PWID reached with HIV prevention	11%	60%
% MSM (High-Risk Non-SW) reached with HIV prevention	0% ³⁵	60%
% MSW reached with HIV prevention	0%	60%
% TG reached with HIV prevention	0%	60%
% FSW reached with HIV prevention	0%	60%
% People living with HIV currently receiving ART	20% ³⁶	81%

A significant difference between this strategy (2021-25) and previous (2017-21) strategy indicators is that for MSM (High-Risk Non-SW) a smaller denominator is being used in this

³⁴ Annex 4: Baseline Data

³⁵ Since High-Risk Non-SW MSM is a new construct, we do not have any data on which to assess whether the Non-SW MSM the programmes are currently reaching have a higher risk profile than the rest of the Non-SW MSM population. For convenience only, we have assumed that all those reached fell into this category. This is clearly a generous assumption. More evidence is required to ensure programmes track and target sub-groups with higher risk behavioural profiles. Outputs 1.1.3, 1.2.3, 3.1.1 and 3.5.2 in the following section all aim to inform a better evidenced and differentiated approach for MSM.

³⁶ This baseline is slightly less (20%) than ART coverage for 2019 (21%) because previous (2017-21) strategy clumped all PLHIV (adults + children) together, while for this (2021-25) strategy PLHIV have been disaggregated by age. This indicator is for Adult PLHIV (15 and above), therefore, baseline has been adjusted. There is a separate baseline and target for Children (0-14) receiving ART in this (2021-25) strategy

strategy. The rationale for this assumes that risk behaviours and their frequencies are not distributed evenly across the entire population of non-SW MSM. The denominator for the targets for High-Risk Non-SW MSM has been calculated by the AEM team as 35% of the total Non-SW MSM in any given year. Evidence collected while implementing this strategy, both through programme implementation and the proposed surveys, should provide data to inform more accurate assessments of the risk-profiles of subsets of the non-SW MSM population.

5. The Strategy

Previous sections analysed the current situation and selected an intervention scenario, with programme targets, based on a decision about the impact we want to have on the epidemic by 2025. We now know where we are, and where we want to get to. This section answers the question “How do we get there?”

As with previous strategy, this strategy is designed in a framework with three pillars each with a different target outcome. The pillars group thematically into: (1) prevention and testing, (2) treatment and care, and (3) enabling environment and sustainability. The three outcomes they aim at are as follows:

Outcome 1: Increased testing coverage and reduced risk behaviours among key populations and their partners

Outcome 2: Increased ART initiation and retention, with key populations and their spouses/partners and children proportionally covered

Outcome 3: Environment is enabled for an effective and sustainable AIDS response

Each of these outcomes aims to address at least one of the critical issues identified in Section 3. Together the three Outcomes aim at achieving the impact selected in Section 4.

Under each Outcome is a set of Outputs that detail what will be done to achieve the Outcome. More specifics about the implementation of these Outputs can be found in the Implementation Plan that accompanies this strategy. A summary table of the overall framework of this strategy is annexed.

Outcome 1: Increased testing coverage and reduced risk behaviours among key populations and their partners

Rationale: This outcome is designed to address the critical issue of low prevention and testing programme coverage among key populations. The current programs are limited to few of the selected cities in Khyber Pakhtunkhwa and where they exist, they lack scale. Prevention aims to change the risk behaviours among key populations. It is here that the strategy aims to have an impact on Khyber Pakhtunkhwa’s increasing incidence rates. Testing aims to ensure that those with HIV are aware of their status, have access to treatment and therefore, less likely to spread the virus. The strategy aims to increase prevention coverage to the following levels by 2025:

Table 6

Key Population	2019 Coverage ³⁷	2025 Coverage
PWID	11%	60%
MSM	0%	60%
MSW	0%	60%
TG	0%	60%
FSW	0%	60%

There are three key Outputs for Outcome 1. These outputs cover: (1.1) key population testing scale up; (1.2) high-impact key population prevention roll-out; and (1.3) interventions for

³⁷ Annex 4: Baseline Data

other vulnerable populations and pregnant women, respectively. Each output breaks further into sub-outputs, described below.

Output 1.1 Accelerated scale-up of community-based HTS for all key populations (coverage aligned with epidemic burden)

Khyber Pakhtunkhwa, like other provinces has a well-established community-based service delivery model for HIV testing services for PWID, while community-based service delivery model for other key populations (MSM, MSW, TG and FSW) is evolving and requires support to get established, before it can be scaled-up. The key challenge in this case is the mobilisation, organisation, capacitation, and supervision of key population CBOs, especially in cities where such groups currently do not exist.

1.1.1 Initiation of community-based outreach testing programmes for key populations in all priority cities not yet covered

In the absence of new IBBS data this strategy is using the same list of priority cities used in the Khyber Pakhtunkhwa AIDS Strategy 2017-21. Based on IBBS Round V and AEM analysis, each key population has its own set of priority cities (prioritisation was based on estimated PLHIV among the key populations in each city – the aim was to maximise the yield of testing services). 2017-21 strategy short-listed 5 priority cities for key populations in Khyber Pakhtunkhwa. Only PWID programme is currently present in 1 of the 3 cities and other two are in pipeline, while there are no prevention programmes for MSM, TG, or FSW, in any of the prioritized cities.

Scaling up CBO model to the remaining cities prioritised for key populations require substantial technical support to effectively manage intervention models which necessitate the creation, capacitation, and supervision of organisations among marginalised communities. The management capacity and technical support dimensions of this output are addressed under Outcome 3.

Given that there are already PWID interventions in all priority cities, the key issues for PWID testing scale up are:

- Whether more PWID can be reached with testing services in existing programmes sites.
- Whether there are potentially new programme sites within cities where more PWID can be reached with existing interventions.
- Whether there are additional cities not on the prioritized list where significant numbers of PWID are likely to be found.

These questions can be answered through mapping activities with targeting adjusted according to the results.

1.1.2 Scale up and precision targeting of existing community-based testing programmes for key populations in priority cities where such programmes already exist

Objective here is to optimise the testing coverage of the interventions that have already been established. Two aspects will need attention; one is the capacity of the existing intervention set-up; ensuring it is sufficiently well-resourced (number and type of staff, and their technical capacity) to reach more people. The other is the methods deployed for expanding geographic and virtual reach.

Intervention set-up should ensure:

- that CBOs delivering programmes are scaled in relation to the estimated target population in their city (no one-size fits all approach)
- frontline workers have the requisite technical capacity for their roles (knowledge and skills)
- key organisational support functions are staffed and performing (M&E, finance and administration, management, and supervision)
- the intervention models are tailored to the particular groups or sub-groups they serve

Geographic programme reach will likely be specific to particular populations in particular cities and will need to be highly flexible based on community intelligence about where people can be best accessed at any given point in time. Likewise, service delivery time schedules need to be adapted to accommodate the social and professional lives of the targeted population (e.g. sex worker working hours). Whether physical or virtual, the use of social-network-based HIV testing approaches to expanding coverage will be a key dimension of the service strategy for key populations.³⁸ Technical support³⁹ and capacity building will be required on the use of particular approaches to online outreach.⁴⁰

Delivering this output will require a strategic approach if key population testing yield is to be optimised. There will be a managed sequence approach to scale up existing interventions (1.1.2) versus the establishment of new interventions in additional cities (1.1.1). These sequencing choices will be guided initially by the available data from IBBS Round V (estimated population size for a given key populations in a particular city and estimated number of PLHIV among that population). The guiding question will be “where are more cases likely to be found?” As programmes become more established, as with the PWID programme, programmatic data can be triangulated with IBBS data to make more informed choices about where to locate and expand interventions.

Particular attention will be given to programme scale in relation to the MSM population where a significant number of cases are expected to be found. The modelling conducted for this strategy (Section 6) has highlighted the need to precision target subsections of the non-SW MSM population where high-risk behaviours are occurring at a higher level of frequency. The evidence on where to find, and how to reach, these subsections will come first through programmatic experience. Online approaches may prove particularly productive here, but this will first be tested. The critical next step for the MSM (non-SW) and MSW programmes will be to develop differentiated interventions for these two populations and for subsets within them. The current model treats them as a single population and does not disaggregate its coverage between them. Outputs 1.1.3, 1.2.3, 3.1.1 and 3.5.2 all aim to inform a better evidenced and differentiated approach for MSW and MSM (non-SW). This is essential to increase the efficiency and impact of the respective interventions.

1.1.3 Pilot promotion of HIV self-test kits for MSM in high burden cities

Low testing and need to explore various options for HIV testing demand generation among hard to reach key populations provides an opportunity to explore HIV self-testing (HIVST) approach. Where there is a significantly under-diagnosed HIV epidemic among MSM, HIVST

³⁸ Policy Brief, WHO recommends social network-based HIV testing approaches for key populations as part of partner services package, November 2019

³⁹ PAS IV, Outcome 3.3.3

⁴⁰ Resources such as Going Online to Accelerate the Impact of HIV Programs could be used: <https://www.fhi360.org/resource/going-online-accelerate-impact-hiv-programs>

may prove a game changer, which comes with a strong recommendation from the WHO⁴¹ and was also endorsed in a national consultation.⁴²

Key steps will include the establishment of a technical working group to oversee the pilot, the securing of regulatory approval for the use of the kits, the development of a pilot project monitoring and evaluation framework, the selection of cities for the pilot (guided by IBBS data and technical support unit (TSU)⁴³, pilot will be initiated in two high burden cities in the country), implementation and evaluation. The monitoring and evaluation framework will be designed so as to enable the pilot to distinguish between MSW and non-SW MSM participating in the programme. Social network-based approaches can be considered for self-test kit distribution as per recent WHO guidance.⁴⁴ Scale up plans will be developed on the basis of the pilot outcomes.

Considering the urgency of the need for testing scale-up, the pilot will need to be effectively managed and technically supported. Full use should be made of WHO guidance on self-testing. Results of the pilot and plans for scale up should be available by the strategic framework's mid-point.

1.1.4 Integration of partner notification and HTS for key population partners/spouses/family members into targeted key population programming where consent can be obtained

An evaluation of PPTCT in Pakistan conducted by UNICEF in 2016 concluded that there is an “urgent need” to integrate PPTCT skills and services in outreach and service delivery programmes for PWID, SWs and other bridging populations rather than the general population.”⁴⁵ The integration of partner notification and HTS for key population partners and spouses is an important step towards achieving this. It is also important for increasing the uptake of HTS and case finding.

The existing prevention and testing service model for PWID includes spousal services, which include voluntary assisted partner notification. The model has demonstrated the viability of securing consent from PWID for partner notification services. This programme will continue to be scaled as an integral part of the PWID testing/prevention service model, and will include testing for children where risks are obvious (e.g., spouse of PWID/mother of children is found positive).

For other key populations, especially MSM, where the bulk of key population female spouses are to be found, partner notification services for those testing HIV positive may face challenges around people's willingness to identify partners. WHO guidance stresses that HIV partner notification is a “voluntary process” that can only take place “with the consent of the HIV-positive client.”

The viability of different methods of partner notification is not yet known in relation to particular key populations in the provincial context. During this strategy period the various

⁴¹ Guidelines on HIV Self-Testing and Partner Notification, WHO December 2016

⁴² National Consultation on HIV Self Testing (HIVST) and Pre-Exposure Prophylaxis (PrEP) among Key Populations in Pakistan, 10-11 May 2018

⁴³ PAS IV, Output 3.3.3

⁴⁴ Policy Brief, WHO recommends social network-based HIV testing approaches for key populations as part of partner services package, November 2019

⁴⁵ Evaluation of the Prevention of Parent to Child Transmission (PPTCT) of HIV Programme in Pakistan, March 2016, UNICEF

methods⁴⁶ need to be trialled within established key population programmes and the results documented so that higher yield models can be taken to scale. Trials will be conducted in the first year of the strategy with successful models being scale up across the programme in the remaining strategy period.

Output 1.2 High-Impact, age-tailored, HIV prevention services for key populations taken to scale

Three of the five prevention pillars⁴⁷ in the Global HIV Prevention Roadmap are relevant to the Khyber Pakhtunkhwa context:

- Combination prevention with key populations
- Comprehensive condom programmes
- Rapid introduction of pre-exposure prophylaxis

Prevention services for key populations in Khyber Pakhtunkhwa are delivered through the same models as the testing services in 1.1. Therefore, the strategic approach to scale-up is largely the same; for non-PWID key populations the aim is to: (a) bring existing programmes to scale with a focus on cities with higher estimated numbers KP PLHIV, (b) secure a programming presence in all priority cities currently without programme presence, and (c) evolve the MSM programme so that it is able to develop differentiated intervention models for MSW and non-SW MSM. For PWID the aim is to: (a) scale the newer city programmes to saturation and (b) reach out to surrounding districts to assess the potential to reach more PWID.

1.2.1 Expansion and fine-tuning of coverage of community-based combination harm reduction/HIV prevention for PWID in accordance with validated programmatic data about where unreached PWID with high prevalence can be found

Scale up of prevention programmes for PWID can be guided by the evidence coming up from an already well-established programme. The combination prevention package will continue to include NSEP as a critical component for this population. Issues around the low return rate of syringes need to be investigated and programme adjustments made accordingly.⁴⁸ More emphasis can be placed on condom promotion and STI screening for PWID.

OST, which has a well-documented impact on reducing risk behaviours among PWID is a critical missing prevention programme component in the country. There is a risk to the programme that the continued absence of this drug dependence treatment results in significant drop-outs between prevention/testing services and treatment services. This will undermine the efficiency and effectiveness of efforts to scale up prevention and testing programmes for this PWID.

This strategy proposes that OST be urgently implemented. It is dealt with further under 2.1.2 below because it also has a significant role to play in improving ART initiation and adherence for PWID.

⁴⁶ Guidelines on HIV Self-Testing and Partner Notification, WHO December 2016

⁴⁷ pp14-15, HIV Prevention 2020 Roadmap, UNAIDS

⁴⁸ p26, National HIV Programme Review, 2019

1.2.2 Ambitious expansion of coverage of community-based prevention programmes for MSM (High-Risk Non-SW)/MSW/HSW/FSW making full use of social media to expand programme reach

To date prevention programmes for these key populations have been very small in scale and of limited impact. The practicalities of taking the model to scale have been referred to under Output 1.1 and are discussed further below under Outcome 3.

Members of key populations should be able to experience full, pleasurable sexual lives and have access to a range of sexual and reproductive health (SRH) options. For many women from key populations, their main concerns often are not just HIV and STIs, but also other reproductive health issues. Women from key populations should enjoy the same reproductive health rights as all other women; it is important that they have access to family planning and other reproductive health services, including STI screening and treatment.⁴⁹

Therefore, two critical components of the package should include condom availability/promotion and STI screening and treatment. Reducing the frequency of unprotected intercourse and the prevalence of untreated STIs are critical outcomes for the success of the prevention initiative for these populations.

The condom component of key population programmes should include behavioural change communication and demand creation, and free distribution of adequate supplies of condoms and lubricant. Commodities distribution will need to be tailored (volume and type) to the specific needs of particular key population groups based on their particular sexual practices.

Using the 2019 National STI Case Management Guidelines, STI screening and syndromic management services need to be brought to the fore as a core prevention programme component for key populations with specific tailoring to the needs of the three genders of the target populations. There is ample guidance available on how to design comprehensive programmes to the particular needs of each key population group.⁵⁰ Programme monitoring and evaluation frameworks should be tracking the prevalence and type of STIs found among clients so that services can be developed to address emerging needs.

Age and gender dimensions relevant to particular key populations will be an important consideration for this output. Higher numbers of youth are likely to be found in the male and female sex worker populations in particular. Therefore, outreach workers will need to be sufficiently skilled to support younger sex workers to build skills in negotiating safer sex in the context of the power imbalances inherent in intergenerational transactional sex.

As with 1.1.2 above, social network-based approaches and the strategic use of online outreach will be critical to expanding programme coverage. Technical support (see Outcome 3) may be required to ensure that these approaches are developed in a methodical way and that evidence of their impact on expanding programme coverage is captured and analysed for further programme development.

1.2.3 Roll-out of PrEP for MSM, TG and sero-discordant couples in high burden cities

⁴⁹ Consolidated Guidelines HIV Prevention, Diagnosis Treatment and Care for Key Populations, WHO, July 2014

⁵⁰ *Implementing comprehensive HIV and STI programmes with sex workers: practical guidance from collaborative interventions* (WHO, 2013) – informally known as the SWIT; *Implementing comprehensive HIV and STI programmes with men who have sex with men: practical guidance for collaborative interventions* (UNFPA, 2015) – the MSMIT; *Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions* (UNDP, 2016) – the TRANSIT

The HIV Prevention Roadmap 2020 calls for **rapid** roll out of PrEP. PrEP is currently being informally provided through a couple of treatment centres to sero-discordant couples and possibly some MSM and TG referred through social networks. The failure to formalise this service prevents strategic scale up and systematic monitoring to guide its development. The absence of leadership and effective programme management appear to be key missing ingredients (see Outcome 3).

PrEP offers a significant strategic opportunity to precision target prevention programmes for MSM. For the administering of PrEP to sero-discordant couples formal links should be established between the ART Centres and the spousal outreach component of the current PWID programme. When the planned partner-notification services for other key population programmes become established, these should be linked in too.

Responsibility for formal PrEP implementation needs to be clearly established within the programme structure. TSU⁵¹ established at national level will provide technical assistance for roll out of PrEP for MSM, TG and sero-discordant couples initially in two high burden cities in the country. A monitoring and evaluation framework and a technical working group for oversight will be required. The framework will enable the monitoring of the PrEP programme's coverage of both sero-discordant couples MSM and TG, with the latter being disaggregated into MSW and MSM (Non-SW). Targets and deadlines will be agreed upon and tracked. PrEP roll-out for TG and MSM will be implemented in partnership with local CBOs with full engagement of members of the target communities.

1.2.4 Integrate prevention programme coverage of partners/spouses/family members into targeted key population programming where consent can be obtained

This output links directly to Output 1.1.4. Spousal/family-member coverage is well-established in the PWID programme but not yet initiated within the other KP programmes. These latter programmes will trial different approaches to securing referral to family members, all of which will be non-coercive and with voluntary client consent. As with testing services, social network-based approaches will be utilised for reaching non-family sexual partners of key populations.⁵²

Output 1.3 Selective prevention and testing programme coverage of pregnant women and vulnerable populations

Epidemic modelling shows that the majority of HIV infections in 2019 in Khyber Pakhtunkhwa and Balochistan were to be found among key populations (67%) and their intimate partners (30%) Khyber Pakhtunkhwa also has a number of vulnerable populations whose vulnerability is determined by their association with key populations or by circumstances and environment beyond their control, like prison settings and migration for work. It makes strategic sense to expand the HTS programmes for the key populations where the epidemic is concentrated to reach vulnerable populations.

1.3.1 Targeted HTS for at-risk pregnant women

⁵¹ PAS IV, Output 3.3.3

⁵² Policy Brief, WHO recommends social network-based HIV testing approaches for key populations as part of partner services package, November 2019

Provider-initiated testing and counselling (PITC)⁵³ denotes an HIV testing service (HTS) that is routinely offered in a health facility. It includes providing pre-test information and obtaining consent, with the option for individuals to decline testing. This is contrary to the general (yet false) perception that PITC is only offered based on the healthcare provider's selection criteria to selected persons. Although PITC involves the routine offering of HTS, it should not develop into mandatory testing or testing people without first informing them that they can decline.

WHO considers that in low prevalence settings routine PITC will most likely not be cost-effective. However, HIV testing should still be made available for people who request testing or who exhibit clinical signs and symptoms indicative of HIV.⁵⁴

HTS as early as possible during pregnancy enables pregnant women with HIV to obtain and benefit most from prevention, treatment, and care and to reduce the risk of HIV transmission to their infants. According to WHO, in low prevalence settings, such as Pakistan's, PITC can be considered but the primary recommendation for such epidemic contexts is for HIV testing for all pregnant women from key populations or who have partners with HIV or from a key population group.⁵⁵

Recent WHO guidelines on HIV testing recommend that all pregnant women should be tested for HIV, syphilis and hepatitis B surface antigen (HBsAg) at least once and as early as possible.⁵⁶ However, the same guidelines point out that in some resource-limited settings, particularly those with low HIV burden, programmes may need to prioritize resources by focusing HTS in pregnancy on geographical areas with higher prevalence or among women with high ongoing risk such as members of key populations.

Therefore, under this strategy, in Khyber Pakhtunkhwa HTS will be offered at designated antenatal care (ANC) sites, to pregnant women from key populations or who have partners with HIV or from a key population group or who request testing or who exhibit clinical signs and symptoms indicative of HIV will be offered HTS.

The effectiveness and efficiency of this strategy will depend upon its ability to reach pregnant women from among key populations such as FSW, female spouses of male key population members, and especially also female spouses of returning migrant workers and link them to HTS.

For the successful implementation of this output, collaboration with the maternal, neonatal and child health (MNCH) programme will be ensured. Standard Operating Procedures (SOP) and training guidelines will be developed (with the support of UNICEF and WHO) and ANC staff at all government facilities will be trained to offer HTS. SOPs will include guidelines and arrangements for assisted referral to the nearest PPTCT/Treatment centre will be ensured. The TSU⁵⁷ will assist with the required SOPs and arrangement of trainings. As per WHO guidelines all HIV testing, including PITC must be voluntary, confidential, and undertaken with the patient's consent.

1.3.2 Introduce and ensure Early Infant Diagnosis for all infants born to HIV positive mothers

⁵³ p46 WHO Consolidated Guidelines on HTS, July 2015

⁵⁴ p46 WHO Consolidated Guidelines on HTS, July 2015

⁵⁵ p68 WHO Consolidated Guidelines on HTS, July 2015

⁵⁶ p7, Policy Brief, Consolidated Guidelines on HIV Testing Services for a Changing epidemic, Nov 2019

⁵⁷ PAS Output 3.3.3

WHO recommends virological testing for HIV for all HIV-exposed infants (those born to HIV+ mothers) at 4 to 6 weeks of age, or as soon as possible thereafter, so that ART can be started immediately, and morbidity and mortality prevented.⁵⁸

In the public health sector in Pakistan, early infant diagnosis is available only at Islamabad, Lahore or Karachi that requires mothers to travel long distances with their young infants.⁵⁹ UNICEF sponsored PPTCT evaluation found that a high proportion of HIV+ mothers do take their young children for EID, but because of the long journey involved for many, most infants are taken for the test much later than the recommended time of 6 weeks.⁶⁰ If the infant is infected this will delay the start of treatment and increase the risk of the infant or child dying. To address these logistical issues, testing for EID will be integrated with available mechanisms for viral load testing.

NACP has outsource the viral load testing to Agha Khan Laboratories, where patients are able to give their blood samples to Agha Khan Labs' collection centres that are widely distributed across the country. These tests and results are provided free of the cost to the patients upon recommendation of the treating physician. Issues with this model are dealt with further under Output 2.3 below. This provides an opportunity for the same model to be used for EID. Similar integrative approaches will be made by the provincial AIDS Control Programmes or NACP to initiate EID for HIV-exposed infants.

1.3.3 Consistent screening for HIV for all persons admitted to prisons with links to treatment for those testing positive

Key population behaviours, such as sex work, men having sex with men, and drug use are criminalised, with the result that prisons represent an additional entry point where a range of key population members can be found.⁶¹ There is also evidence of risk behaviours taking place within prisons.⁶² HIV prevalence rates in prisons are higher than among the general public.⁶³ The prison programming in this strategy, therefore, aims to both identify positive prisoners, and link them to treatment, and also to reduce onward transmission within prisons.

The first step will be to ensure consistent screening for all people entering prisons.⁶⁴ This requires adjustments in both policy and practice, and would require training to ensure prison medical staff are equipped with the skills they need and are then themselves involved in routine screening of prisoners. This also needs defined linkages to treatment to ensure that all prisoners testing positive have continued access to it. Co-infection is a particularly important issue for treatment services to be capacitated to address. The recent prison surveillance study found 10.3% prevalence of HCV and 1.2% were co-infected with HIV and HCV. TB coinfection is also highly likely to be an issue.

⁵⁸ Consolidated Guidelines on HIV Testing Services, WHO, July 2017

⁵⁹ Opportunities for strengthening and expanding availability of early infant diagnosis (EID) of HIV infection in Pakistan, UNICEF 2016

⁶⁰ Evaluation of the PPTCT Programme in Pakistan, UNICEF 2016

⁶¹ 28% of prisoners surveyed in Sindh and KPK prisons had been arrested at least once for a drug related offence, Integrated Biological & Behavioural Surveillance among Prisoners in Prisons of Sindh and Khyber Pakhtunkhwa Provinces, February 2020.

⁶² *ibid.*

⁶³ The same survey among prisoners in Sindh and KPK found an overall prevalence rate of 2%, with some prisons having rates as high as 6%.

⁶⁴ The IBBS in prisons found that only 25% of prisoners interviewed had been tested for HIV.

Effective prison testing and treatment services will require strong intersectoral coordination between the health and prison departments. This is especially important to ensure that: (a) people already on treatment who are subsequently given prisons sentences are not lost to follow up when incarcerated, and (b) prisoners put on treatment whilst in prison are not lost to follow up upon discharge. The strengthened management and governance systems (under Output 3.2) of this strategy have an important role to play in making this coordination and service linking work.⁶⁵

1.3.4 Develop pre-departure prevention education for intending migrant workers, and a referral system to HTC, ART and PPTCT for returning migrants and their families

Most migrants are young unskilled males, and their potential vulnerability arises from their increased engagement in risk taking behaviours such as purchasing commercial sex, when they are away from homes for longer periods of time.⁶⁶ This issue is of particular concern for Khyber Pakhtunkhwa and its newly merged districts where a large proportion (11%)⁶⁷ of PLHIV are from migrant worker population. Strategically, prevention will focus on intended migrants and testing on those returning. Coverage efficiency will be achieved by integrating services into systems, services and venues through which the outflowing and inflowing migrants would already be obliged to pass. This will require strengthening the partnership with the immigration and other authorities (see 3.2.2). For returning migrants testing positive assisted partner notification services will be established to facilitate spousal testing. Where needed (i.e. when pregnant spouses also test positive) PPTCT services will be linked in. For Sero-discordant couples PrEP will be offered in accordance with the roll-out of Output 1.2.3 above.

The PLHIV community and/or the Association of People Living with PLHIV can play an important role here as peer educators and supporters, especially for returning migrants who have been diagnosed as living with HIV. Collaborative interventions, such as help desks/referral points promoting HIV awareness, education and information sharing for returning migrants, will be trialled with the support of ILO/IOM, relevant government offices and airport management.

Outcome 2: Increased ART initiation and retention, with key populations and their spouses/partners and children proportionally covered

Rationale: This second outcome is designed to address the critical issues of unaddressed barriers to treatment access and initiation and high treatment attrition rates both of which result in poor treatment coverage. The strategy aims to increase treatment coverage from 21% in 2019 to 81% in 2025.

Broadly speaking there are three key strategic approaches to boosting treatment coverage rates:

- Identifying new positive cases
- Ensuring that all those who have tested positive are started on treatment
- Ensuring that those who initiate treatment are retained in the treatment programme

⁶⁵ Strengthened coordination between health and prisons services is a key recommendation of the recent prison IBBS report.

⁶⁶ p22 Health Vulnerabilities of Migrants from Pakistan, Baseline Assessment, IOM, August 2015.

⁶⁷ NACP MIS Data

The first approach has already been addressed under Outcome 1. The remaining two are the concern of Outcome 2.

There are three key outputs for Outcome 2. These outputs cover the removal of barriers to treatment initiation (2.1), the intensification of treatment adherence support (2.2), and the scaling up of viral load testing (2.3) respectively. Each output breaks down into a cluster of sub-outputs which are detailed in the narrative below.

Output 2.1 Removal of key treatment initiation barriers for key populations and their partners/spouses and children

There is still significant cascade leakage between testing and treatment. The UNAIDS country scorecard for Pakistan 2019 shows almost a third of those testing positive not being on treatment.⁶⁸ Effectively addressing treatment initiation barriers, therefore, offers a strategic “quick-win” in terms of increasing numbers on treatment by up to a third.

2.1.1 Reconfiguration of ART Centre model to one-stop-shop model, inclusive of PPTCT and paediatric services, to address long-standing barriers to treatment access.

Pakistan’s HIV programme review concluded that fragmented and non-integrated health care infrastructure hampers effective HIV control measures and recommended a one-stop-shop approach at ART centres.⁶⁹ The WHO also recommends three overarching strategies that can improve service delivery: 1) integration, 2) decentralization and 3) task shifting. These strategies, separately or in combination, can improve the accessibility of care.⁷⁰

Barriers to accessing treatment due to the fragmentation of services was a recurring theme in provincial consultations with communities and civil society. An integrated, one-stop-shop model has been tried successfully at the Family Care Center at Hayatabad Medical Complex Peshawar, where adult, PPTCT, paediatric and diagnostic services are provided at the same set up. This model has already been replicated at Ratodero, Sindh. This integrated, one-stop-shop approach will be replicated, to the extent possible, in existing ART and all new locations.

A key aspect to the reconfiguration of the ART Centre model will be the simplification of the patient pathway and related processes for testing and ART initiation. This will include simplifying testing algorithms to allow for same-day diagnosis and ART initiation, multi-month dispensing of ART (especially for those with long distance to travel), and patient literacy support with active involvement of PLHIV. Issues with the limited physical space of the treatment centres will be addressed to guarantee privacy and confidentiality. Registration procedures will be simplified. The community-facility interface will be enhanced to ensure full accountability for patients across the community and facility divide – with clear specifications of the respective roles of clinic staff, key population CBOs, NGOs and PLHIV-led adherence support groups.

Another critical step to ensure patient satisfaction and retention is to configure human resources at the ART centres according to patient load. Centres serving larger numbers of PLHIV should have additional staff (both for treatment and for follow-up support). Currently resources are not configured in relation to patient load with the result that there is extra

⁶⁸ Snapshot 2019, Pakistan, UNAIDS

⁶⁹ National HIV Programme Pakistan, Review 2019

⁷⁰ WHO Consolidated guidelines on HIV prevention, treatment and care for key populations, July 2014.

pressure at Family Care Centre, Hayatabad Medical Complex. Opening of new integrated centres in the newly merged districts will help to address this issue to a great extent.

2.1.2 Implementation of an OST programme specifically designed to generate evidence of its impact on ART initiation and adherence for PWID

The challenges of getting PWID who have tested positive into treatment have been well documented.⁷¹ A key factor is the motivation of the positive PWID to pursue treatment in the absence of any effective treatment for his opioid dependency. There is strong scientific evidence that OST would be a game changer for addressing the problems of PWID recruitment into treatment.⁷² Moreover, there is also strong scientific evidence that OST significantly increases treatment adherence and viral suppression, and significantly decreases ART discontinuation among PWID.⁷³ A third, and equally important scientifically evidenced benefit of OST is its impacts on reducing risk for HIV and HCV infection and mortality from overdose.⁷⁴

Actions to be taken to implement an OST programme under this strategy include securing regulatory approval for the requisite doses of opioid substitute drugs, securing policy commitment to the approach, establishment of a technical/advisory committee to oversee implementation, selection for sites for initial implementation, development of a monitoring and evaluation framework, identification and capacitation of the implementor(s), and sourcing of technical support to design systems and train programme managers/clinic staff.

2.1.3 Continue to scale up comprehensive treatment preparedness services for PWID

In the absence of OST detoxification and rehabilitation support services are clearly needed to address the treatment initiation problem for PWID. For the purposes of this strategy 'treatment preparedness support' for PWID is defined as opioid dependent treatment services that stabilise an HIV positive PWID's lifestyle to the extent that (a) that individual is motivated to pursue treatment for HIV and (b) clinicians at treatment centres feel confident of the possibility of successful treatment outcomes with respect to that patient.

Currently the only tailored service model available is the ART Adherence Units run with support from the Global Fund.⁷⁵ The service model integrates drug detoxification support

⁷¹ pp51-52 PAS III (2017)

⁷² A systematic review and meta-analysis of evidence of the effect of OST on ART outcomes among PWID living with HIV found strong evidence that OST increased recruitment onto ART by 87%. See "Impact of Opioid Substitution Therapy on Antiretroviral Therapy Outcomes: A Systematic review and Meta-Analysis", AJ Low et al., Clin Infect Dis (2016) 63 (8): 1094-1104. June 2016.

⁷³ There is strong evidence that OST increases "ART adherence 2-fold, viral suppression by 45%, and reduces ART discontinuation by 23%." See "Impact of Opioid Substitution Therapy on Antiretroviral Therapy Outcomes: A Systematic review and Meta-Analysis", AJ Low et al., Clin Infect Dis (2016) 63 (8): 1094-1104. June 2016.

⁷⁴ MacArthur GJ, Minozzi S, Martin N, Vickerman P, Deren S, Bruneau J et al. Opiate substitution treatment and HIV transmission in people who inject drugs: systematic review and meta-analysis. BMJ. 2012;345:e5945. Platt L, Minozzi S, Reed J, Vickerman P, Hagan H, French C et al. Needle and syringe programmes and opioid substitution therapy for preventing HCV transmission among people who inject drugs: findings from a Cochrane Review and meta-analysis. Addiction. 2018;113(3):545-63. Ma J, Bao YP, Wang RJ, Su MF, Liu MX, Li JQ et al. Effects of medication-assisted treatment on mortality among opioids users: a systematic review and meta-analysis. Mol Psychiatry. 2018 Jun 22. Epub ahead of print (<https://www.nature.com/articles/s41380-018-0094-5>, accessed 4 March 2019).

⁷⁵ PAS III (2017) notes that for other drug rehabilitation services in Pakistan "service quality is highly variable and can, at the worse extreme, involve involuntary incarceration and other inhumane approaches. Private services predominate and are beyond the means of most drug users. A small number of government facilities are available without charge for enrolment though they do require payment for drugs and other incidentals. The demand (among PWID and their family members) for affordable quality drug rehabilitation significantly outstrips the supply. Clinicians in HIV treatment centres have also cited the lack of availability of such services as a problem." p51.

with ART initiation and adherence support. In order to prevent a treatment access bottleneck for PWID these services will be scaled up in relation to the scale up of the testing programme. Scale up includes the expansion of bed capacity of the existing service units and the expansion of the model into new sites where large numbers of new positive PWID are being found. The role of the service in the programme will be reassessed once OST services come online.

2.1.4 Proactive case finding to enable equitable access to and uptake of PPTCT services by vulnerable and marginalized women.

The success of this Output is directly related to Output 1.1.4 (Integration of partner notification and HTS for key population partners/spouses/family members into targeted key population programming where consent can be obtained) discussed earlier.

All the prevention programmes for key populations will integrate partner notification and HTS for key population partners and spouses. This step will increase the uptake of HTS among pregnant women who are most vulnerable and marginalized, and lead to increased case finding, the cases will then be linked to the PPTCT programme.

Community-based or home-based HTS services will be trialled for spouses of HIV+ KP, with their consent. This proactive case finding approach has already been successfully demonstrated among PWID in Punjab.⁷⁶

Output 2.2 Intensified treatment adherence support differentiated by key population

Cascade leakage after treatment initiation is having a major impact on the overall effectiveness of the treatment programme. It also represents a significant strategic opportunity to boost treatment coverage by better retaining those that initiate. This output is designed to bring about the systematic and better professionalized treatment centre service model that is required to resolve this long-standing problem.

2.2.1 Immediate initiation of proactive case management for people newly initiating treatment

The evidence shows us that the largest drop off of patients after treatment initiation occurs within the first month.⁷⁷ To address this proactive case management will commence immediately upon patient registration. A designated staff member/group of staff members within the ART Centre will be responsible for proactively maintaining the communication link the patient in the first months.⁷⁸ ART Centres resourced to do this in relation to their patient load.

Service protocols for this support will be drawn up inclusive of guidance on frequency of follow-up, communications with family members and/or members of CBOs/NGOs bringing the patient in, involvement of PLHIV, logging of interactions, on-going updating of records of contact numbers and addresses for each patient and their key support persons, and reasonable actions to be taken if the patient becomes uncontactable for any reason.

⁷⁶ Expanding access to HIV testing and counselling and exploring vulnerabilities among spouses of HIV-positive men who inject drugs in Pakistan. https://journals.lww.com/co-hivandaids/FullText/2016/03001/Expanding_access_to_HIV_testing_and_counseling_and.2.aspx

⁷⁷ Pakistan ART Outcome Study, NACP, February 2020

⁷⁸ Frequency of contact can be tailored according to the patients' circumstances and their evolving compliance. It should be born in mind that current evidence shows that PLHIV on treatment in Pakistan are not reaching a stabilization point within the first 24 months.

There will be a regular case review process at clinic level whereby documented decisions are made about which cases are no longer to be considered active and in need of continued proactive follow up.

2.2.2 Rethinking/consolidation and capacitation of existing case management/adherence counselling model.

The introduction of the Case Manager position to a small number of ART Centres does not appear to have been a success. Going forward three things will be changed:

1. Scale: each treatment centre with a significant number of patients will have at least one designated staff member responsible for proactive patient follow up between appointments.
2. Case load distribution: centres with a very high number of cases and/or a higher proportion of cases coming from populations with lifestyles and circumstances that make it more challenging for them to stay in the treatment programme, will have more resources for patient follow up.
3. Recruitment: Persons responsible for case follow up will be appointed based on having an appropriate skill set inclusive of the counselling skills needed to interact with marginalised populations from diverse backgrounds.

Proactive case management will be developed as an integral part of the ART Centre service model. It will be managed by the head of the Centre and accountable to them for performance. It will be professionalised with adequate training, supervision and support provided to the individuals appointed. A standard SOP for the function will be developed as per 2.2.1. The role is not only the main link between the clinic and the patient but also with the patient's support network in the communities they come from whether that be their families or the CBOs/NGOs that have linked them to the treatment centres.

2.2.3 Decentralization of ART supply for stable HIV patients down to district level.

“Decentralization aims to deliver all HIV services closer to the individual. In many settings transport costs and long waiting times in central hospitals are significant barriers to access to services and retention in care. Particularly in rural areas, decentralization can reduce the difficulty and cost of travel and shorten waiting times. For key populations decentralizing HIV care and treatment can further strengthen community engagement, can link community-based interventions with health facilities, and may improve access to services, care-seeking behaviour and retention in care.”⁷⁹

The option that the WHO recommends for the decentralization for ART that best suits the Pakistan context is the initiation of ART in hospitals, with maintenance of ART in peripheral health facilities.⁸

The establishment of a differentiated service delivery (DSD) model for ART came out as a strong recommendation during consultations held for this strategy with healthcare professionals and communities. DSD is a client-centred approach, simplifying and adapting services to better meet the needs of people living with HIV and reducing unnecessary burdens on the health care system.⁸⁰

⁷⁹ Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations, WHO 2014

⁸⁰ Children Surviving Working Group – Policy Brief: Providing differentiated delivery to children and adolescents.
<http://childrenandaids.org/node/565>

Features of the DSD model will include: (a) initiation of ART at the main/established ART centre; (b) shifting of stable patients to a satellite clinic near his home, where the patient will receive refills of ARVs; (c) the patient will check-in at the main clinic every 6 months.

At present there are only three (03) functional HIV treatment (ART) centres in Khyber Pakhtunkhwa, and all three are situated in the settled districts (Hayatabad Medical Complex at Peshawar District; Lady Reading Hospital at Peshawar District; and District Headquarter Hospital at Kohat district). During the implementation of this strategy 5 more ART centres will be added. HTS centres, one each at Abbottabad (Abbottabad District) and Batkhela (Malakand District) will be upgraded to ART Centres, leading to 2 additional centres. Another 3 ART Centres will be added by establishing one each at Bannu District, Dera Ismail Khan District, and Saidu Shareef (Swat District). With the inclusion of newly merged districts (NMD) in Khyber Pakhtunkhwa it has become critical to decentralize ART services so that needs of vast population of NMD can be addressed. As a first step the three treatment centres in NMDs, at Bajaur, South Waziristan and Kurram Districts (that so far were only providing HTS and referral services) will be transformed into satellite clinics, where stable patients will be shifted and where they will get their refills. In the next phase, private clinics (in cities) or Basic Health Unit (BHU) in rural areas will be considered for satellite clinics. Khyber Pakhtunkhwa AIDS Control Programme will have to undertake an extensive mapping exercise to identify the clinics and BHUs and enter into public-private partnership for the implementation of this model.

Private practitioners or hospitals already engaged in the provision of TB services can be engaged to provide ART refills PLHIV facilitating better management and increasing access to treatment at the decentralised level. DOTS Centres can be used to dispense ARV drugs to stable cases of HIV and while also providing TB treatment. There will be efficiency gains from the utilization of staff who are trained in counselling and treatment of TB to manage PLHIV on ART as well as provide counselling services.

Decentralization model can also be implemented through an established CSO/CBO working with the AIDS Control Programme) serving any key population. A clear SOP (with specified operational scope and scale) will be developed and agreed between the provincial AIDS Control Programme, the treating physicians, and the organization for this to proceed efficiently.

2.2.4 Re-design of care and support package, its allocation and delivery mechanism, to ensure adequate patient access and equitable distribution

The recent National HIV Programme Review found the existing mechanism for distribution of support packages to PLHIV to be “few and not cost effective” with “systems failures” leading to inadequate distribution.⁸¹

This Output takes place in conjunction with 2.1.1 (one-stop-shop reconfiguration) above and is largely based on recommendations in the National Programme Review. The physician in charge of the ART Centre will have the nutritional support, emergency medicines support and travel charges funds readily available for disbursement to clients through a committee as per an agreed set of eligibility criteria. Disbursement will take place when ARTs are collected from the centre. The CBOs working in the jurisdiction of the ART Centre will be members of the committee that approves the list of PLHIV for living support. The Centre’s Case Managers (or equivalent) will act as secretary for the committee under the supervision of the physician in

⁸¹ p50, National HIV Programme Pakistan, Review 2019

charge. The aim is to ensure that more PLHIV benefit and the support packages are distributed more frequently.

2.2.5 Scale-up of paediatric AIDS treatment coverage in proportion to growing case numbers

The success of this output depends upon how well prevention programme coverage of partners/spouses/family members is integrated into targeted key population programming (1.2.4) and the effectiveness of EID (1.3.2). It will also be ensured that children of adult patients enrolled in ART are not missed; patients will be actively counselled to bring their children for HIV testing and counselling, and children testing positive will be linked to treatment.

The scale-up of paediatric AIDS treatment coverage has so far been challenging because of the small scale of prevention programmes for key populations other than PWID. Where such programmes do exist, they have yet to develop a viable and systematic approach to assisted partner notification services.

A family-centred approach is vital, and all key population prevention programs must build models that are inclusive of their children and partners/spouses.⁸² Where a child is identified to be living with HIV, the child must be put on treatment immediately. As outlined in 2.1.1 one-stop-shop treatment model must be implemented to cater to the needs of increasing adult and children PLHIV identified through routine scale-up of HTS.

Output 2.3 Reconfiguration of viral load testing mechanism to remove barriers

Viral load testing is critical for assessing progress towards the 3rd 90: the percentage of people receiving ART who have achieved viral suppression. Current guidelines in Pakistan require an initial viral load test three months after initiating treatment with follow up tests every 6 months. Roughly three quarters of viral load testing in Pakistan is done by a third-party provider. The system as it currently operates “erects multiple barriers for patients”. There are also data flow issues which prevent test results getting reported into the ART centre. The outcome of these issues is that “the number and percentage of patients ...with a viral load test record at the ART Centre is very low.”⁸³ With no more than 4-7% of patients having a baseline viral load test result Pakistan is unable to properly assess progress towards the 3rd 90.

2.3.1 Removal of patient perspective barriers from viral load testing process

The current set up requires patients to:

- (a) Go to a separate facility for the viral load test
- (b) Go back to that facility to get the result
- (c) Take the test results to the ART Centre and report the result

⁸² Children Surviving Working Group – Policy Brief: Addressing service delivery needs of children of key populations <http://childrenandaids.org/node/562>

⁸³ p16, Pakistan ART Outcome Study, February 2019. The study found that only 1 in 23 patients in the 24-month cohort and 1 in 15 patients in the 12-month cohort had a viral load test result in their record. There were improvements in the percentage among patients starting treatment in the later 2018 cohort.

As is well-known in the context of Khyber Pakhtunkhwa's treatment programme, travel requirements place a particular burden on patients, especially PWID,⁸⁴ and are a significant cause of the service's coverage and retention problems. A testing mechanism which adds to this burden by complicating the patient pathway, causes more problems than it resolves.

These barriers will be addressed in the context of 2.1.1 above (reconfiguration of ART Centre model to one-stop-shop). The viral load testing process will be specifically reconfigured to eliminate the additional travel requirement on patients.

2.3.2 Removal of data-flow obstacles from viral load test result reporting process

The viral load test result data-flow issue will be addressed in conjunction with 2.3.1. There will be direct transfer of results from the third-party provider to the ART Centres. ART Centres will carry the responsibility of entering the result into the patient record. The data will be entered as soon as the results are received, and made available to the provincial and national AIDS Control programmes through regular reporting processes.

Outcome 3: Environment is enabled for an effective and sustainable AIDS response

Rationale: This third Outcome is designed to address the critical issues of lack of strategic programme oversight, weak implementation management, and fragmented monitoring and evaluation systems. Effective delivery of the Outputs for Outcomes 1 and 2 in this strategy will be to a large extent dependent on successful implementation of the activities in this section. They are critical programme performance enablers.

There are seven key Outputs for Outcome 3. These Outputs cover the capacitation of critical service delivery models, which to date have struggled to perform effectively (3.1), the enhancement of programme governance (3.2), strengthening programme management (3.3), addressing stigma and discrimination (3.4), institutionalising surveillance and filling critical data gaps on key and vulnerable populations (3.5), integrating monitoring and evaluation systems (3.6), and building a sustainable response (3.7).

Each output breaks down into a cluster of sub-outputs, which are detailed in the narrative below.

Output 3.1 Capacitation of critical service delivery models to ensure adequate coverage, quality and effectiveness

Both the treatment programme and the community-based prevention programme for non-PWID key populations are struggling to perform effectively.⁸⁵ For the treatment the capacity issues are particularly acute around effective case management. For the latter there was a steep learning curve when these programmes were initiated under the current Global Fund grant. Achieving the prevention and treatment coverage targets agreed for this strategy will require a significant investment in capacity building for these two critical service delivery models.

3.1.1 Capacitation of community-based key population prevention/testing model

⁸⁴ p16, Pakistan ART Outcome Study, February 2019. In contrast to other patient groups, the study found a small decline in the percentage of PWID who had a viral load test result in their record in the later (2018) cohort, suggesting that viral load access issues were particularly problematic for this group.

⁸⁵ National HIV Programme Review, 2019, Pakistan ART Outcome Study, NACP, February 2020

The key capacities required to achieve effective implementation of these programmes at scale include:

- Expertise on establishing CBOs within marginalised communities, where such organisations do not exist – this includes both community mobilisation and organisational development
- Expertise on specific key populations and their issues: male and female sex workers, transgendered people, men who have sex with men, clients of sex workers, and young people within these populations
- Service-specific skills and knowledge; testing, counselling, outreach, safer sex and condom/lube promotion, STI screening and management, online intervention techniques
- Expertise on results-based programme management and the organisational systems and capacities required (management, finance, monitoring and evaluation) to make it work

The approach assumed by this strategy is that of optimal and empowered involvement of members of the community whom the programmes are intended to reach. This is to ensure, among other things, the acceptability and appropriateness of the interventions to their target audience. In addition to community know-how the strategy will deliver additional capacity building technical support by the following means:

- Through full capitalisation and sharing of knowledge and lessons learned in establishing the programmes thus far
- Through sharing of intervention protocols, systems and experience between the newer programme models and the more established intervention model for PWID
- Through adequate and consistent supervision arrangements
- Through on-going dialogue with the targeted communities including community-based monitoring mechanisms
- Through programme coordination meetings
- Through the TSU⁸⁶ established at national level

Specific outputs of the capacitation process will include:

- A standard CBO-start-up support package inclusive of guidance on how to address registration issues, and how to establish interim operational arrangements whilst registration is pending
- Adequate frontline staffing, training, and supervision support (both service-delivery and organisational development)
- Standardised mechanisms for ensuring cooperation of law enforcement
- The development of differentiated service delivery models tailored to target populations
- Differentiated intervention models for MSW and MSM (non-SW)
- Programme monitoring and evaluation frameworks that enable coverage to be disaggregated between MSM (non-SW) and MSW.

⁸⁶ PAS IV, Output 3.3.3

- Training to integrate sexual and reproductive health services into HIV prevention services
- Youth-specific prevention service protocols for key populations with higher numbers of youth at risk, inclusive of sexual and reproductive health
- Defined referral processes and linkages between community-based testing and ART centres
- Cross-programme training sessions covering critical technical and management areas

The Khyber Pakhtunkhwa AIDS Control Programme, implementing organisations, and TSU⁸⁷ will collaborate to design and implement the capacity building agenda, and related training materials, for this service model.

3.1.2 Capacitation of treatment model

The evolving of the treatment centres into a one-stop shop model will require a significant programme of capacity building to ensure that the existing weaknesses in the service are properly address. Capacity-building for the treatment programme will focus on ensuring:

- The development of expertise on treating people with opioid dependency
- The provision of training and support on working with key populations⁸⁸
- The re-conceptualisation of the case-management role to make it work (adequate patient counselling skills, proactive and aggressive⁸⁹ follow-up, strong collaboration with CBOs bringing clients in). This will be inclusive of a revision of the technical specification of the case-management role to ensure appropriately qualified individuals are appointed
- Regular and adequate supervisory and training support to ensure the patient follow up system is being adhered to and efforts to reach patients are properly logged
- The effective implementation of a reconfigured mechanism for implementing viral load testing and early infant diagnosis
- Proper adherence to confidentiality protocols and adequate physical space to achieve this
- Training to integrate paediatric care into new one-stop-shop model
- The availability and functionality of skills and systems for adequate data capture and reporting
- The effective delivery and equitable distribution of patient support packages
- The strengthening of community-based monitoring of patient treatment and support services

As with 3.1.1 the AIDS Control Programme, implementing organisations and TSU⁹⁰ will collaborate to design and implement the capacity building agenda, and related training materials for this service model.

⁸⁷ PAS IV, Output 3.3.3

⁸⁸ The recent ART Outcomes study, p21, makes this recommendation for all ART Centre frontline staff.

⁸⁹ "Aggressive patient-tracing" is a key recommendation of the recent ART Outcomes Study, p 21.

⁹⁰ PAS IV, Output 3.3.3

3.1.3 Protocols and standards for screening and treatment in prisons and provision of training to prison doctors

In consultation with the provinces the National AIDS Control Programme will develop service guidelines/protocols/standards for prisons to ensure consistent screening and linkages to treatment for infected prisoners. Based on these standard guidelines, the provincial AIDS control programme will either itself provide or arrange trainings for the prison healthcare staff, so that regular screenings of prisoners are conducted, infected prisoners are linked to treatment, and continuous follow-up is ensured. Particular attention will be paid to treatment continuity as the patient moves in and out of the justice system.

Output 3.2 Enhanced strategic governance of programmes

Two key governance issues addressed in this strategy are the need for strategic programme oversight and the need to develop strong linkages between AIDS programme, the broader health portfolio and beyond. Effective oversight is critical to ensure that the provincial strategy is actively used in real-time to guide programmes toward the achievement of targets. In this way risks and bottlenecks can be identified and addressed in a timely manner. Linkages are critical to address the more complex and broader systemic issues that inhibit effective programming; the need for coordination between public health and law-enforcement, between different disease programmes to address co-infections, and between HIV and sexual and reproductive health, the blood safety programme, and the infection prevention and control programme, for example.

3.2.1 Use of provincial AIDS strategy to develop targets and budgets for domestically funded AIDS control programme

The provincial AIDS Control strategy will be used to ensure that PC-1 programme targets are set with reference to strategy targets to ensure optimal coverage of key population prevention programmes and the implementation of the “treatment for all” policy. The strategy will serve as a reference point to ensure complementarity between the parts of the overall programme funded from different sources. AIDS Control Programme management will be aware of the portion of the strategy targets and budgets being covered by both domestically funded and internationally funded programmes. Strategy will be proactively used by the AIDS Control programme to track and address programmatic gaps (i.e. where the combines totals of internationally and domestically funded programme targets fall short of strategy targets).

3.2.2 Establishment of intersectoral/interdepartmental coordination mechanisms to advocate for adequate programme support

The WHO recommends the setting up and strengthening of a coordinating body for collaborative TB/HIV activities that is functional at regional, district, local and facility levels (sensitive to country-specific factors).⁹¹ Like the country coordinating mechanism (CCM) at the federal/national level, a coordinating mechanism will be introduced at the provincial level, led by the Department of Health (or Planning & Development department) with involvement of AIDS, TB and Malaria programmes, and membership from key stakeholders, including civil society, PLHIV, key population representatives, SRH, MNCH, nutrition, blood

⁹¹ WHO policy on collaborative TB/HIV activities guidelines for national programmes and other stakeholders, 2012. https://www.who.int/tb/publications/2012/tb_hiv_policy_9789241503006/en/

safety, hepatitis programmes, law enforcement and prison departments. The coordinating body will have clear and consensus-based terms of reference. The important areas of responsibility will include:

- Governance and coordination at provincial – inter-sectoral, inter-departmental and district levels
- Resource mobilization
- Provision of general policy and programme direction for the management of activities
- Capacity-building needs identification
- Ensuring coherence of communications about HIV, TB, SRH, MNCH, blood safety and hepatitis
- Ensuring the involvement of civil society non-governmental and community-based organizations, and individuals

This is not the same entity as the oversight committee in 3.2.2, which has a much leaner expertise-based membership and a very specific programme performance oversight function. The oversight committee could, however, report into the coordinating body if that makes structural sense in a particular provincial context.⁹²

Output 3.3 Strengthened programme management

This strategy addresses the need for programme management strengthening in three key ways; identifying and addressing management capacity building needs, ensuring that the data flows essential for effective programme management are in place, and taking advantage from the establishment of a TSU⁹³ at national level, to manage the provision of technical assistance across the various systems development activities that will take place under the strategy.

3.3.1 Management audit of provincial AIDS programmes to identify capacity building needs around results-based management and procurement management

One of the findings of the National HIV Programme Review was that AIDS control programmes have low capacity to absorb and spend resources, and that the structure, capacity, operational efficiency and effectiveness of the provincial AIDS programmes are also weak.⁹⁴

Improving institutional capacity and efficiency is critical to scale-up the HIV response in the province. To address this, a management audit of the provincial AIDS control programme will be conducted. The audit will map the critical gaps in capacities and recommend contextualized capacity building measures. Based on the findings and needs identified, tailored capacity building of the AIDS control programme staff will be conducted, which will include trainings on results-based management and procurement. The TSU⁹⁵ will help with sourcing and fielding expertise to address specific capacity building needs.

⁹² The distinction is similar to that between the CCM and its oversight committee at national level. It is important that the Oversight Committee membership does not become bloated, remains technically focused and devoid of conflict of interest. The Global Fund defines oversight in relation to grants: https://www.theglobalfund.org/media/5412/ccm_ccmoversightguidance_paper_en.pdf?u=637233411520000000. In this context it is being defined in relation to the whole AIDS programme at provincial level. The principles would be broadly the same.

⁹³ PAS IV, Output 3.3.3

⁹⁴ National HIV Programme Pakistan Review, 2019

⁹⁵ PAS IV, Output 3.3.3

3.3.2 Reconfiguration of reporting processes to ensure that data essential for effective provincial AIDS programme management is systematically available

The integration of HIV MIS systems is covered more extensively under Output 3.6 below. Here the point is to ensure that the provincial AIDS control programme has access to the data it needs to manage programme towards the achievement of the provincial strategy targets.

All programmatic data (treatment and prevention) from both internationally and domestically funded programmes, will report into the provincial AIDS control programme so that there can be effective oversight of progress towards achieving provincial strategy targets. National and provincial level reporting mechanisms will be configured to ensure complementarity (see also 3.7.1). Quarterly programme reports into the provinces will be reviewed by the oversight committees established under 3.2.2. This will enable the adjustment of programme to address shortfalls, and the identification of risks and bottlenecks so that solutions can be devised to address them.

Output 3.4 Critical stigma and discrimination issues addressed

Stigma and discrimination are a recurring theme in all the key documents reviewed for this strategy. There is clear evidence of stigma and discrimination affecting PLHIV's access to healthcare.⁹⁶ Several of the documents reviewed make recommendations for more comprehensive stigma reduction programmes. This strategy takes a two-pronged approach due to the complex and widespread nature of the problem. The first prong (3.4.1) is designed to be targeted at two specific points where stigma and discrimination are known to directly impact programme performance. The second prong (3.4.2) has a much broader purview of the social context and addresses stigma across the whole spectrum.

3.4.1 Targeted sensitivity trainings where service access and programme effectiveness are being directly impacted

This output addresses two specific points where stigma and discrimination have a very direct impact on the prevention and treatment programming this strategy is designed to deliver. These are the attitudes and behaviours of healthcare workers in the healthcare facilities most frequently used by PLHIV (ART and PPTCT Centres) and the attitudes and behaviours within law enforcement departments that interact with/come into contact with key population outreach prevention and testing programmes. There will be a more intense effort to address stigma and discrimination within these setups inclusive of:

- Regular trainings/refreshers for ART/PPTCT centre staff (including those involved in paediatric HIV care) and other healthcare workers as appropriate
- Sensitivity trainings for law enforcement officials and judiciary
- The development of outreach worker protection protocols to ensure key population CBO staff can deliver programmes without interruption from police

Governance mechanisms such as the coordination mechanism in 3.2.3 above will be used to strengthen the coordination between the AIDS programme and the law enforcement system. The TSU⁹⁷ will be used as needed to assist with the design and delivery of the stigma and discrimination/key population sensitivity training programmes.

⁹⁶ Country Research on Community Access to treatment, Care and Support Services (Phase II), APLHIV, January 2019.

⁹⁷ PAS IV, Output 3.3.3

3.4.2 Nationally-led communication and advocacy programme

In Pakistan only 32% of women and 67% of men have heard of HIV/AIDS. Comprehensive knowledge about HIV is not widespread among either women (4%) or men (10%), and 60% of women and 61% of men have discriminatory attitudes towards people living with HIV.⁹⁸ This lack of knowledge, and high level of stigma and discrimination hampers prevention efforts for key populations and also acts as a barrier for PLHIV accessing treatment. The recent national AIDS programme review recommended stigma reduction in “society, in families, at workplaces, in schools, in hospitals, in police and justice departments and in the social media.”⁹⁹

To address these stigma related challenges a targeted communication and advocacy programme will be developed, that will include, anti-stigma and discrimination/myth-busting campaigns for various audiences such as religious scholars/leaders, media practitioners, parliamentarians, healthcare professionals (hospital staff particularly those providing surgical and obstetrics services) and the general public. Campaigns will include, but will not be limited to, special seminars with parliamentarians and religious leaders, women’s groups, youth leaders, and social media campaigns targeted at healthcare professionals and the general public.

Given the ubiquity of the stigma and discrimination issues across the country, the communication and advocacy programme will be designed and led at national level, with full collaboration from, and consultation with, the provinces.

Output 3.5 Institutionalised surveillance with more accurate key and vulnerable population data to facilitate precision targeting

The possession of quality data about the populations, and subsets of populations, engaging in high-risk behaviour is essential for a precision-targeted approach in a concentrated epidemic scenario. This is especially so where a key population is large and diverse. Resources will be used more effectively if prevention and testing programmes are targeted to where they are most likely to identify new cases and/or reduce the prevalence of high-risk behaviours. This output aims at strengthening surveillance systems and approaches to enable precision-targeting.

3.5.1 A new round of nationally led IBBS with quality issues of previous round properly addressed

The most recent round of IBBS was conducted in 2016. This strategy aims to institutionalise surveillance so that it takes place according to a fixed schedule and evolves its methodology on the basis of lessons learned from previous rounds. The next round will take place before the mid-point of this current strategy. The following issues will be addressed:

- All key data points (such as prevalence levels for specific populations) weighted at provincial as well as national level
- IBBS will be implemented from the national level with meaningful involvement of provinces in design and data collection. This is to ensure standardization and comparability of methodology and results across the country

⁹⁸ Pakistan Demographic & Health Survey (PDHS) 2017-18

⁹⁹ p50, National HIV Programme Review, 2019, Pakistan ART Outcome Study, NACP, February 2020

- Consistency in mapping sites to allow comparability between rounds
- Inclusion of Khyber Pakhtunkhwa's newly merged districts
- Improved methodologies for arriving at city-level PSEs
- Adequate sampling of non-SW MSM to better understand behavioural risk and prevalence, and inform revision of PSE

Consensus building around methodologies and results will be an integral part of the process. AEM projections will be revised based on the results.

3.5.2 Qualitative (pre-IBBS) field-assessments conducted of migrants, refugees, truckers, mine-workers and Non-SW MSM

This output is designed to address two persistent data gaps. One pertains to the MSM key population, the other pertains to populations that have an assumed but poorly evidenced vulnerability to HIV.

MSM are a large and diverse population and we do not currently have an accurate picture of the distribution of risk behaviours that would facilitate precision targeting. Nor do we understand how various subsets of the MSM population overlap or interact with each other. The MSM data gap is highly significant because the epidemic models we have, project this group becoming a key driver of the epidemic. Current data on this population from Round V IBBS is extrapolated from samples of MSM that were predominantly engaged in sex work. There is an urgent need for more concrete data on the population of MSM who are engaging in non-commercial sex with other men. This includes better evidenced population size estimates, behavioural data (inclusive of data on use of social media for sexual networking) and HIV prevalence data.

MSM programmes need to evolve so that they are using different service models and approaches for different for MSW and non-SW MSM. The field assessments will be designed to provide data that would inform this differentiation.

Several vulnerable populations (migrants, truckers, mine-workers) were frequently referred to in consultations held to develop the strategies. It has also been proposed that refugees be taken into consideration. There is no concrete data about the nature and extent of their behavioural vulnerability, their HIV prevalence rates, or their links and/or overlaps with the established set of key populations.

For both of these data gaps (non-SW MSM and other vulnerable populations) qualitative field assessments will be conducted to confirm whether the selected subpopulations are engaging in high-risk behaviour, and whether they exist in sufficient numbers to merit inclusion in the next round of IBBS. The assessments will explore the feasibility of collecting data among these populations by determining how and where they can be accessed and sampled systematically and their general willingness to participate in surveillance surveys.¹⁰⁰

For non-SW MSM the data collected will be used to inform their inclusion in IBBS Round VI. For the various vulnerable populations, the data will be used to decide whether to include

¹⁰⁰ The approach can be guided by *The Pre-Surveillance Assessment*, UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, WHO 2005, <https://www.who.int/hiv/pub/surveillance/sti/en/>

them in IBBS VI, or to conduct more specific follow on research. The TSU¹⁰¹ will be involved in sourcing expert support for these assessments.

3.5.3 Independent PWID programme saturation surveys in select cities

The PWID programme is reporting programme saturation in some cities, where the last round of IBBS estimated that a significant number of PWID still remain to be reached. Investing in scale up in these cities would not be cost effective if indeed saturation point has been reached. A new round of mapping for IBBS Round VI can address this issue, but decisions about where to scale up PWID programmes need to be taken in the short term. Programme saturation surveys in select cities (where the discrepancies between estimated numbers of PWID and numbers reached by programmes reporting saturation are particularly large) will be conducted by independent academic institutions not involved in programme implementation. These will take place in the first year of the strategy to inform scale up decisions.

Output 3.6 Integration of HIV M&E systems

UNAIDS recommends one national HIV monitoring and evaluation system as part of the ‘Three Ones’ principle.¹⁰² The National HIV Programme Review noted the absence of a reliable interconnected MIS across the HIV programme streams. Parallel monitoring systems exist – federal (NACP), provincial (PACP), non-governmental (NZA, GSM, APLHIV), without interfaces that connect them, with the result that required information is not being generated in a timely manner for efficient decisions and programme management. The review recommended the creation of an accountability and reporting system that is transparent, up to date and reliable.¹⁰³

The enhancement of HIV programme governance and management systems in this strategy is dependent on the resolution of long-standing monitoring and evaluation systems fragmentation. More effective governance and management decisions can only be made if the data to inform them is available (at the point in the system where the decision is to be taken), current, and accurate.

3.6.1 National and Provincial MIS reorganized to capture and report critical information for timely decision making

Here the objective is to reorganize the existing provincial and national MIS so that they are guided by a common and clear strategy that ensures timely collection, validation, analysis and reporting (upward, downward and horizontally), of data for planning and management (see also Outputs 3.2.2 and 3.3.2). To address this critical, longstanding issue, following steps will be taken:

- a) National and Provincial AIDS Control Programmes, along with partners, will be convened to agree on a core set of indicators with agreed definitions that all parts of the integrated system will track
- b) An integrated system data-flow map (with directionality and lag times) will be developed and endorsed at all levels

¹⁰¹ PAS IV, Output 3.3.3

¹⁰² Organizing Framework for a Functional National HIV Monitoring and Evaluation System, UNAIDS 2006

¹⁰³ National HIV Programme Pakistan Review, 2019

- c) Common interfaces will be developed to enable two-way data flow between provincial and national MIS, and also between implementing partners (PRs) and PACP/NACP
- d) The resulting integrated MIS will allow patient tracking from outreach testing into treatment and between treatment centres across provinces. This will include tracking and reporting of HIV positive pregnant women receiving PPTCT services and reporting of people on PrEP

This is a significant systems development initiative that will need a resource commitment, and an accompanying consultative consensus-building process. It is important that integrated platforms allow data to be visualized at the provincial level to facilitate the results-based management aimed at in 3.3 above. Technical support will be sourced through the TSU¹⁰⁴ inclusive of capacity building around effective data use.

Output 3.7 Increased sustainability of the response

Sustainability has many dimensions and is not just a question of the financial sustainability of HIV programmes as countries transition from international to domestic funding.¹⁰⁵ This strategy addresses sustainability at multiple points in the above framework. For example, moving towards epidemiological sustainability is addressed in the strategy's goal to turn an increasing incidence into a declining incidence, and many of the Outputs under Outcome 3 (Enabling Environment) have important implications for structural, political and programmatic sustainability. In addition to the sustainability-promoting outputs above the following two outputs are critical.

3.7.1 Strengthened coordination systems between national and provincial levels

The Outputs under Outcome 3 entail a strengthening of programme governance and management responsibility at provincial level. This is to ensure better ownership of the strategies and accountability towards delivering on the outputs. It is also better adapted to the devolved structure of Pakistan's health system. It is important, however, that the country still retains a national level overview of the epidemic and its response. This will be achieved by producing clear definitions of the roles and responsibilities of the national and provincial levels (especially with respect to programme supervision), the establishment of better coordination mechanisms and systems between national and provincial levels, and the integration of MIS systems under Output 3.6.

3.7.2 Improved mobilisation and absorption of the domestic resource allocation

Outputs 3.2. and 3.3 above, are intended to have an impact on the absorption issues with domestic funding. Strengthened management and governance should result in more efficient use of resources and effective implementation. The strategy also sets a framework and targets that will be used in the design of PC-1 programmes for the current funding application round.

The outstanding issue is the efficiency of the PC-1 approval process, which has historically led to significant programme implementation delays. There is a risk that the current COVID-19

¹⁰⁴ PAS IV, Output 3.3.3

¹⁰⁵ Oberth and Whiteside, What does sustainability mean in the HIV and AIDS response, AJAR 2016, 15: 1-9
<https://www.globalfundadvocatesnetwork.org/wp-content/uploads/2016/04/Oberth-Whiteside-2016-What-Does-Sustainability-Mean-in-the-HIV-and-AIDS-Response.pdf>

pandemic could divert attention and resources and lead to further delays. This can be addressed by sustained advocacy efforts from national and provincial stakeholders to keep the PC-1 application process on track.

One potential hinderance for the alignment of PC-1 budgets with strategy budgets is the historical underspend of the domestically funded programmes. Domestic funding allocation is typically based on historical spend-rate. Inactive programmes lead to underfunded programmes. To facilitate better evidenced funding allocation an allocative efficiency analysis will be conducted to inform programme prioritization and scale up.

3.7.3 Integrating HIV services into the national UHC program and social welfare program

The WHO defines Universal Health Coverage (UHC) as ensuring that all people in need have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that use of these services does not expose the user to financial hardship. The federal and provincial governments are advancing UHC as part of their commitment to achieving the SDGs by 2030. An essential package of services has been identified and is now being costed. HIV treatment and prevention services are part of it. Once this has been approved and to closely monitor progress on this the provincial intersectoral coordination mechanisms in this strategy (3.2.3) and CCM will have a key advocacy role in this regard, and key activities to implement this will be part of the Implementation Plan.

On the social welfare front the federal government has established a Division of Poverty Alleviation and Social Safety. Its purpose is to implement the umbrella initiative, Ehsaas (meaning empathy), launched in early 2019. The objective of Ehsaas is to reduce inequality and invest in people. It is meant to leverage the latest tools and approaches, such as the use of data and technology to create precision safety nets; promoting financial inclusion and access to digital services; supporting the economic empowerment of women; focusing on human capital formation; overcoming financial barriers to accessing health and education; and tackling malnutrition in all its forms.

It is critical that members of key populations, particularly FSW and TG (who are most marginalized), benefit from various programmes being offered by Ehsaas. The provincial AIDS Control programmes, with the involvement of APLHIV and the CBOs, will support key populations to get computerized national ID cards (CNIC), this is a requirement for registration with Ehsaas programmes, and will facilitate key populations with the registration process so that these marginalized communities can benefit from government initiatives to address inequality..

6. Monitoring and Evaluation Framework

The monitoring and evaluation framework comprises of two tiers:

1. A set of core indicators that use programme data to measure annual progress towards achieving prevention, testing and treatment targets.
2. A set of programme milestones that track key strategy outputs

The denominators for the tier 1 targets change annually in accordance with population growth estimates from the AEM and spectrum models. A complete set of denominators and numerators for the targets is annexed.

Table 7

	Indicator	2025
Impact	# New HIV infections among adults	42% reduction from 2020

Tier 1: Core indicators with annual targets measured by programmatic data

Table 8

	Indicator	Baseline (2019)	2021	2022	2023	2024	2025
Outcome 1	% PWID reached with HIV prevention programmes in the last 12 months	11%	23%	31%	40%	49%	60%
	% PWID that received an HIV test within the last 12 months and who know the results	7%	15%	22%	32%	42%	54%
	% MSM (High-Risk Non-SW) reached with HIV prevention programmes in the last 12 months	0%	7%	12%	28%	44%	60%
	% MSM (High-Risk Non-SW) MSM that received an HIV test within the last 12 months and who know the results	0%	4%	7%	19%	35%	53%
	% MSW reached with HIV prevention programmes in the last 12 months	0%	7%	12%	28%	44%	60%
	% MSW that received an HIV test within the last 12 months and who know the results	0%	4%	7%	19%	35%	54%
	% TG reached with HIV prevention programmes in the last 12 months	0%	7%	12%	28%	44%	60%
	% TG that received an HIV test within the last 12 months and who know the results	0%	4%	7%	19%	35%	54%
	% FSW reached with HIV prevention programmes in the last 12 months	0%	7%	12%	28%	44%	60%
	% FSW that received an HIV test within the last 12 months and who know the results	0%	4%	7%	19%	35%	54%

	Indicator	Baseline (2019)	2021	2022	2023	2024	2025
Outcome 2	% Adults living with HIV currently receiving ARV therapy	20%	33%	45%	57%	69%	81%
	% Children (0-14) living with HIV currently receiving ARV therapy	29%	39%	50%	60%	71%	81%
	% HIV-positive pregnant women who received ARVs to reduce the risk of mother-to-child transmission	15%	31%	47%	63%	79%	81%

Tier 2: Critical strategy milestones to be tracked in accordance with implementation plans

Table 9

	Milestone	Deadline
Outcome	Key population programme presence in all priority cities	2022
	OST programme launch	2021
Outcome 2	ART centre one-stop-shop model launch	2021
	Commencement of decentralized treatment	2021
	Deployment of case managers across treatment centres	2021
Outcome 3	Establishment of provincial oversight committees	2021
	Establishment of provincial intersectoral coordination mechanism	2021
	Commencement of communication and advocacy programme	2021
	Qualitative pre-IBBS field assessments & PWID programme saturation surveys	2021
	Mid-term review of the strategy	2023

7. Budget

Below is an indicative budget for the implementation of this strategy. Costs for specific activities, such as capacity building, have been built into the unit costs of the intervention packages. Unit costs for intervention packages for key populations are based on the existing service packages.

Khyber Pakhtunkhwa Strategy Costs (US\$)						
	2021	2022	2023	2024	2025	TOTAL
FSW	176,368	199,487	488,595	789,589	1,102,547	2,756,586
PWID	370,799	524,547	684,643	851,180	1,024,204	3,455,373
MSM (High-Risk Non-SW)	178,101	413,796	1,014,003	1,639,529	2,290,611	5,536,040
MSW	36,634	77,004	184,761	293,745	407,170	999,313
TG	29,172	67,778	166,090	268,549	375,193	906,783
Treatment Adults	1,131,000	1,786,828	2,606,450	3,616,469	4,848,666	13,989,413
Treatment Children	38,076	52,920	68,040	86,035	104,626	349,698
Programme Cost	100,000	150,000	200,000	250,000	300,000	1,000,000
TOTAL	2,060,151	3,272,360	5,412,581	7,795,095	10,453,018	28,993,205
Khyber Pakhtunkhwa Strategy Costs (%)						
	2021	2022	2023	2024	2025	TOTAL
FSW	8.56	6.10	9.03	10.13	10.55	9.51
PWID	18.00	16.03	12.65	10.92	9.80	11.92
MSM (High-Risk Non-SW)	8.65	12.65	18.73	21.03	21.91	19.09
MSW	1.78	2.35	3.41	3.77	3.90	3.45
TG	1.42	2.07	3.07	3.45	3.59	3.13
Treatment Adults	54.90	54.60	48.16	46.39	46.39	48.25
Treatment Children	1.85	1.62	1.26	1.10	1.00	1.21
Programme Cost	4.85	4.58	3.70	3.21	2.87	3.45

Annex 1: Strategic Framework for Khyber Pakhtunkhwa AIDS Strategy

Outcome 1: Increased testing coverage and reduced risk behaviours among key populations and their partners	
Output 1.1 Accelerated scale-up of community-based HTS for all key populations (coverage aligned with epidemic burden)	1.1.1 Initiation of community-based outreach testing programmes for key populations in all priority cities not yet covered
	1.1.2 Scale up and precision targeting of existing community-based testing programmes for key populations in priority cities where such programmes already exist
	1.1.3 Pilot promotion of HIV self-test kits for MSM in high burden cities
	1.1.4 Integration of partner notification and HTS for key population partners/spouses/family members into targeted key population programming where consent can be obtained
Output 1.2 High-impact, age-group tailored, HIV prevention services for key populations taken to scale	1.2.1 Expansion and fine-tuning of coverage of community-based combination harm reduction/HIV prevention for PWID in accordance with validated programmatic data about where unreached PWID with high prevalence can be found
	1.2.2 Ambitious expansion of coverage of community-based prevention programmes for MSM (High-Risk Non-SW)/MSW/HSW/FSW making full use of social media to optimise programme reach
	1.2.3 Roll-out of PrEP for MSM, TG and sero-discordant couples in high burden cities
	1.2.4 Integrate prevention programme coverage of partners/spouses/family members into targeted key population programming where consent can be obtained
Output 1.3 Selective prevention and testing programme coverage of pregnant women and vulnerable populations	1.3.1 Targeted HTS for at-risk pregnant women
	1.3.2 Introduce and ensure Early Infant Diagnosis for all infants born to HIV positive mothers
	1.3.3 Consistent screening for HIV for all persons admitted to prisons with links to treatment for those testing positive
	1.3.4 Pre-departure prevention education for intending migrant workers, and a referral system to HTC, ART and PPTCT for returning migrants and their families
Outcome 2: Increased ART initiation and retention, with key populations and their spouses/partners and children proportionally covered	
Output 2.1	2.1.1

Removal of key treatment initiation barriers for key populations and their partners/spouses and children	Reconfiguration of ART Centre model to one-stop-shop model, inclusive of PPTCT and paediatric services, to address long-standing barriers to treatment access.
	2.1.2 Implementation of an OST programme specifically designed to generate evidence of its impact on ART initiation and adherence for PWID
	2.1.3 Continue to scale up comprehensive treatment preparedness services for PWID
	2.1.4 Proactive case finding to enable equitable access to and uptake of PPTCT services by vulnerable and marginalized women.
Output 2.2 Intensified treatment adherence support differentiated by key population	2.2.1 Immediate initiation of proactive case management for people newly initiating treatment
	2.2.2 Rethinking/consolidation and capacitation of existing case management/adherence counselling model
	2.2.3 Decentralization of ART supply for stable HIV patients down to district level
	2.2.4 Re-design of care and support package, its allocation and delivery mechanism, to ensure adequate patient access and equitable distribution
	2.2.5 Scale-up of paediatric AIDS treatment coverage in proportion to growing case numbers
Output 2.3 Reconfiguration of viral load testing mechanism to remove barriers	2.3.1 Removal of patient perspective barriers from viral load testing process
	2.3.2 Removal of data-flow obstacles from viral load test result reporting process

Outcome 3: Environment is enabled for an effective and sustainable AIDS response	
Output 3.1 Capacitation of critical service delivery models to ensure adequate coverage, quality and effectiveness	3.1.1 Capacitation of community-based key population prevention/testing model
	3.1.2 Capacitation of treatment model
	3.1.3 Protocols and standards for screening and treatment in prisons and provision of training to prison doctors
Output 3.2 Enhanced strategic governance of programmes	3.2.1 Use of provincial AIDS strategies to develop targets and budgets for domestically funded AIDS control programmes
	3.2.2 Establishment of intersectoral/interdepartmental coordination mechanisms to advocate for adequate programme support
Output 3.3 Strengthened programme management	3.3.1 Management audit of provincial AIDS programmes to identify capacity building needs around results-based management and procurement management
	3.3.2

	Reconfiguration of reporting processes to ensure that data essential for effective provincial AIDS programme management is systematically available
Output 3.4 Critical stigma and discrimination issues addressed	3.4.1 Targeted sensitivity trainings where service access and programme effectiveness are being directly impacted
	3.4.2 Nationally-led communication and advocacy programme
Output 3.5 Institutionalised surveillance with more accurate key and vulnerable population data to facilitate precision targeting	3.5.1 A new round of IBBS with quality issues of previous round properly addressed
	3.5.2 Qualitative (pre-IBBS) field-assessments conducted of migrants, refugees, truckers, mine-workers and Non-SW MSM
	3.5.3 Independent PWID programme saturation surveys in select cities
Output 3.6 Integration of HIV M&E systems	3.6.1 National and Provincial MIS reorganized to capture and report critical information for timely decision making
Output 3.7 Increased sustainability of the response.	Output Strategy 3.7.1 Strengthened coordination systems between national and provincial levels
	Output Strategy 3.7.2 Improved mobilisation and absorption of the domestic resource allocation
	3.7.3 HIV services integrated into the national UHC and social welfare programmes

Annex 2: Priority Cities

2017 strategy revision proposed priority cities for rapid scale up of interventions based on IBBS/AEM analysis. Each KP had its own set of priority cities (prioritisation was based on estimated PLHIV among the KP in each city – the aim was to maximise yield of testing services. Below is an update on how programme presence is aligned with prioritised cities.

PWID			TG		
City	Programme		City	Programme	
	Yes	No		Yes	No
1. Peshawar	X		1. Haripur		X
2. Mardan		X	2. Peshawar		X
3. Swat		X			
MSM			FSW		
City	Programme		City	Programme	
	Yes	No		Yes	No
1. Haripur		X	1. Peshawar		X
2. Mardan		X			
3. Bannu		X			
4. Peshawar		X			

Annex 3: Strategy Targets

Strategy Targets

	Khyber Pakhtunkhwa							Khyber Pakhtunkhwa					
	2019 baseline	2021	2022	2023	2024	2025		2019 baseline	2021	2022	2023	2024	2025
Prevention FSW	0%	7%	12%	28%	44%	60%	Prevention FSW	-	1,200	2,168	5,311	8,582	11,984
Testing FSW	0%	4%	7%	19%	35%	54%	Testing FSW	-	660	1,301	3,718	6,866	10,786
Prevention PWID	11%	23%	31%	40%	49%	60%	Prevention PWID	800	1,701	2,406	3,141	3,904	4,888
Testing PWID	7%	15%	22%	32%	42%	54%	Testing PWID	475	1,106	1,684	2,512	3,319	4,399
Prevention MSM (higher risk non-SW)	0%	7%	12%	28%	44%	60%	Prevention MSM (higher risk non-SW)	-	2,487	4,498	11,022	17,821	24,898
Testing MSM (higher risk non-SW)	0%	4%	7%	19%	35%	54%	Testing MSM (higher risk non-SW)	-	1,368	2,699	7,715	14,257	22,408
Prevention MSW	0%	7%	12%	28%	44%	60%	Prevention MSW	-	512	837	2,008	3,193	4,426
Testing MSW	0%	4%	7%	20%	35%	54%	Testing MSW	-	281	502	1,406	2,554	3,983
Prevention TG	0%	7%	12%	28%	44%	60%	Prevention TG	-	407	737	1,805	2,919	4,078
Testing TG	0%	4%	7%	19%	35%	54%	Testing TG	-	224	442	1,264	2,335	3,670
Treatment (Adults)	20%	33%	45%	57%	69%	81%	Treatment (Adults)	2,388	5,236	8,272	12,067	16,743	22,448
Treatment (Children)	29%	39%	50%	60%	71%	81%	Treatment (Children)	114	176	245	315	398	484
Treatment (PPTCT)	15%	31%	47%	63%	79%	81%	Treatment (PPTCT)	36	118	203	299	412	464

Population Size Estimates (Denominators for Strategy Targets)

Khyber Pakhtunkhwa							
Population	2019	2021	2022	2023	2024	2025	
FSW	17,657	18,458	18,855	19,254	19,655	20,057	
PWID	7,149	7,482	7,647	7,812	7,979	8,147	
MSM (non-SW)	104,464	109,338	111,746	114,166	116,604	119,058	
MSM (High-Risk non-SW)	36,563	38,268	39,111	39,958	40,811	41,670	
MSW	6,518	6,822	6,972	7,123	7,275	7,428	
TG	5,989	6,268	6,406	6,545	6,685	6,825	
KP PLHIV	4,737	6,809	8,173	9,741	11,527	13,564	
PLHIV - KP Intimate Partners/Clients	6,992	9,058	10,210	11,429	12,738	14,149	
Adult PLHIV	11,729	15,867	18,383	21,170	24,265	27,713	
Children PLHIV	398	452	490	525	561	598	
Mothers needing PPTCT	244	381	431	475	522	572	

Notes

- Prevention and treatment targets were developed using AEM modelling with support from the UNAIDS Regional Support Team for Asia and the Pacific
- Targets (and the intervention scenarios on which they are based) were agreed at provincial
- Testing targets for each KP have been set in relation to the programmatic baseline % of those who receive prevention who get tested. The proportions are then progressed to 90% (of those reached with prevention) by 2025.
- PLHIV PSEs are based on Spectrum modelling
- KP PSEs are based on AEM modelling; the original source data is from IBBS Round V, 2017
- MSM (Non-SW) is not used as a denominator in the strategies; it is the PSE from which MSM (High-Risk Non-SW) is derived. The modellers have calculated MSM (High-Risk Non-SW) as 35% of MSM (non-SW)

Annex 4: Baseline Data

Khyber	KP	PSE	Prevention Coverage		Testing Coverage		PLHIV PSE	Prevalence	ART Coverage	
Pakhtunkhwa	PWID	7,149	800	11%	475	7%	2,039	29%	230	11%
	MSM (non-SW)	104,464	-	0%	-	0%	1,993	2%	8	0%
	MSM (higher risk non-SW)	36,562	-	0%	-	0%				
	MSW	6,518	-	0%	-	0%	318	5%	5	2%
	FSW	17,657	-	0%	-	0%	115	1%	1	1%
	TG	5,989	-	0%	-	0%	272	5%	19	7%
	Total Adult PLHIV						11,729		2,388	20%
	Children PLHIV						398		114	29%
	Total PLHIV						12,127		2,502	21%
	Mothers Needing PPTCT						244		52	21%

Notes

- All PLHIV PSEs based on Spectrum data
- All KP PSEs based on AEM data
- ART coverage data from NACP
- Prevention programme coverage data from NACP and Nai Zindagi
- Current treatment and prevention programmes do not bifurcate MSM data between non-SW MSM and MSW. Bifurcation has been done on a 60/40 allocation based on rough estimates from programme implementers. Considering the programme's historical challenge with reaching non-SW MSM there may be an overestimate of the numbers of non-SW MSM reached with a proportionate underestimate of the numbers of MSW reached
- KP PLHIV treatment coverage data is dependent on PLHIV revealing their KP status. Considering stigma and discrimination there is likely to be an underestimate of coverage of KPs whose identity is not apparent from appearance
- The AEM and Spectrum models have different methods for modelling disease progression and mortality rates. They, therefore, produce different PLHIV PSEs. The Spectrum estimates were used because their scientific methods represent the global standard. This has necessitated some proportional adjustment to the KP PLHIV PSE figures to ensure that the totals are aligned
- “MSM (High-Risk non-SW)” is a new construct being introduced in the strategy. It is based on the assumption that risk behaviours (type and frequency) are not evenly distributed across the entire population of non-SW MSM. Programmes need to target sub-groups engaged in higher risk behaviours. Non-SW MSM prevention targets for the strategy have been set with High-Risk MSM as the denominator. It has been assumed by the modellers that 35% of non-SW MSM are high-risk MSM. To derive a baseline for this sub-group of non-SW MSM it has been assumed that all non-SW MSM reached in 2019 were high-risk. The baseline highlighted in dark blue in the table is, therefore, the same coverage referenced in the line above it and is not included in the total KP coverage sum.
- Mothers needing PPTCT are not an additional group of PLHIV; they are subsets of KP PLHIV and non-KP PLHIV
- The strategy has separate treatment targets for Adults and children, so a baseline has been included for adult PLHIV treatment. Adults = Total PLHIV - Children PLHIV

Meetings and Consultations

The following meetings were held in support of the strategy development process.

Date	Type	Location	Participants
Mar 3, 2020	National community consultation	Islamabad	APCASO, UNAIDS, Key Populations
Mar 4 - 6, 2020	AEM workshop	Islamabad	UNAIDS, Implementers, KP CBOs, NACP, PACP*
Mar 5, 2020	TWG meeting	Islamabad	TWG members
Mar 8, 2020	KP community consultation	Balochistan	KPs, UNAIDS, BACP**
Mar 9 - 13, 2020	Meetings and consultations	Karachi	Multiple stakeholders (Sindh and Balochistan)
Mar 11, 2020	KP community consultation	Karachi	KPs (Sindh and Balochistan) UNAIDS, SACP***
Mar 12, 2020	Provincial stakeholders' consultation	Karachi	Multiple stakeholders (Sindh and Balochistan)
Mar 16 - 20, 2020	Meetings and consultations	Lahore	Multiple stakeholders
Mar 18, 2020	Provincial stakeholders' consultation	Lahore	Multiple stakeholders (Punjab)
Mar 19, 2020	KP Community consultation	Lahore	KPs (Punjab and Khyber Pakhtunkhwa) UNAIDS, PACP
Mar 30, 2020	Provincial stakeholders' consultation	Khyber Pakhtunkhwa (virtual)	Multiple stakeholders
Apr 13, 2020	Target setting consultation	Sindh and Punjab (virtual)	SACP, PACP, NACP, UNAIDS
Apr 17, 2020	Target setting consultation	Khyber Pakhtunkhwa (virtual)	Khyber Pakhtunkhwa AIDS Control Programme, NACP, UNAIDS
Apr 21, 2020	Small working group meeting on targets and scenarios	Virtual	UNAIDS, NACP
Apr 22, 2020	Target setting consultation	Balochistan (virtual)	BACP, NACP, UNAIDS
May 7, 2020	TWG meeting; progress update	Islamabad (Virtual)	Multiple stakeholders
Jun 16, 2020	Draft Punjab AIDS Strategy 2021-25 review meeting	Islamabad (virtual)	PACP, NACP, UNAIDS

Jun 17, 2020	Separate Draft Khyber Pakhtunkhwa AIDS Strategy 2021-25 and Sindh AIDS Strategy 2021-25 review meetings	Islamabad (virtual)	SACP, Khyber Pakhtunkhwa AIDS Control Programme, NACP, UNAIDS
June 18, 2020	Draft PAS IV (2012-25) review meeting	Islamabad (virtual)	NACP, UNAIDS, provincial programmes

*PACP = Punjab AIDS Control Programme

**BACP = Balochistan AIDS Control Programme

***SACP = Sindh AIDS Control Programme