STRATEGIC FRAMEWORK FOR PREVENTION OF PARENT TO CHILD TRANSMISSION (PPTCT) OF HIV IN PAKISTAN

January 2017

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FOREWORD

Government of Pakistan is committed towards elimination of mother to child transmission of HIV. Towards this end, keeping national challenges and constraints in view, we hope to eliminate, with the support of our partners, at least 50% new HIV infections among children by 2021 and move towards complete elimination of mother to child transmission by 2030.

Pakistan has a concentrated HIV epidemic, where identifying HIV-positive pregnant women and linking them to prevention services and needed ART, to prevent the risk of mother to child transmission, has proven extremely challenging. Low ANC rates, although improving, has remained a challenge (currently 24.3% have no ANC at last birth, 13.3% have one visit), especially for high risk, marginalised women less likely to access public services. But the good news is that those HIV+ pregnant women who reached the Prevention of Parent to Child Transmission (PPTCT) Centres and received complete PPTCT services have been able to give birth to infants free of HIV, in more than 99% of cases.

There are currently 11 PPTCT Centres working in Pakistan, while the provinces have plans to decentralize and scale-up these services over the next 5 years.

This strategic framework provides a road map to scale-up PPTCT services in the most efficient manner, where value for money is achieved with the promise that no infected mother will be missed and no child will be born with HIV, where every HIV exposed infant will receive the much needed HIV test at 6 weeks of age, and linked to treatment where required.

Pakistan has a unique opportunity for an AIDS-free generation. Let's make it possible!

Dr Asad Hafeez
Direct General
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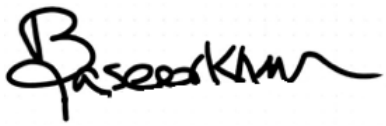
Government of Pakistan

ACKNOWLEDGEMENTS

The current review of the PPTCT Strategic Framework in Pakistan was organized by the National AIDS Control Programme in collaboration with the Provincial AIDS Control Programmes with the support of UNICEF Pakistan. It had the objective to review the last (2007 PPTCT Strategic) Framework, draw lessons learnt from its implementation and revise it to reflect the changing needs and new developments.

NACP would like to thank the consultant, Dr Ayesha Khan, who led this exercise; the Provincial AIDS Control Programme Managers and their teams for sharing key insights, honest opinions on the PPTCT experience, and directions for future programming. National Technical Working Group and UNICEF HIV Section provided continuous guidance and facilitation throughout the review process. This document has benefitted greatly from their inputs and comments, particularly contribution of Dr Sofia Furqan, Senior Programme Officer at NACP, Dr Quaid Saeed and Dr Nasir Sarfraz, UNICEF HIV/AIDS Specialist is appreciated.

Special thanks are due to the NGO staff working with key population sections and PLHIV, and those who took time out and travelled considerable distances to meet with the review team.



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AUTHOR'S NOTE

This review process was an independent exercise conducted between August – November 2016 and the proposed findings or recommendations do not necessarily reflect the views of UNICEF Pakistan, UNICEF Regional or Head Quarters office, any individual, organisation or institution unless explicitly stated so. All references are listed in the footnotes.

The revision of the PPTCT Strategic Framework has been a participatory process and reflects inputs from a number of key stakeholders in government, NGOs, civil society, PLHIV, donors/UN agencies and review of national/provincial HIV and MNCH strategic documents in order to be relevant and responsive to the needs of HIV programming in Pakistan. For any comments or errors please contact the corresponding author via email given below.

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ABBREVIATIONS / ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AJK	Azad Jammu & Kashmir
AKU	Aga Khan University
ANC	Ante-Natal Care
ARV	Anti-Retroviral
ART	Anti-Retroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behaviour Change Communication
BHUs	Basic Health Unit
CBOs	Community Based Organizations
CCM	Country Coordinating Mechanism
CD4	Cluster Differentiation of CD4 T lymphocyte
CEDAW	Convention on the Elimination of all Forms of Discrimination
CHBC	Community Home Based Care
CHW	Community Health Workers
CMWs	Community Midwives
CoC	Continuum of Care
CPR	Contraception Prevalence Rate
CSO	Civil Society Organizations
CSW	Commercial Sex Worker
DBS	Dried Blood Sample
DHD	District Health Day
DHM	District Health Model
DHIS	District Health Information System
DHMT	District Health Management Team
EDO	Executive District Officer
EID	Early Infant Diagnosis
EmONC	Emergency Obstetric and Newborn Care
FHC	Family Health Centre
FGD	Focus Group Discussion
FLCF	First Level Care Facility
FP	Family Planning
FP & PHC	Family Planning and Primary Health Care Programme
FSW	Female Sex Worker
GB	Gilgit-Baltistan
GBV	Gender Based Violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoP	Government of Pakistan
HAART	High Active Anti-Retroviral Therapy
HACT	Harmonized Approach to Cash Transfer
HIV	Human Immunodeficiency Virus
HIV VL	HIV Viral Load Testing
HSW	Hijra (Transgender) Sex Worker

IBBS	Integrated Behavioural and Biological Survey
IDU	Injecting Drug User
IEC	Information, Education and Communication
KP	Key Populations
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
MARP	Most At Risk Population
MDG	Millennium Development Goal
MICS	Multi Indicator Cluster Survey
MISP	Minimal Information Service Package
MNCH	Maternal, Newborn and Child Health
MSU	Mobile Service Unit
MSM	Men Having Sex with Men
MSW	Male Sex Worker
NHSRC	Ministry of National Health Services, Regulation and Coordination
MoU	Memorandum of Understanding
NACP	National AIDS Control Programme
NGO	Non-Government Organization
NICC	National Inter-agency Coordination Committee
OI	Opportunistic Infection
PACP	Provincial AIDS Control Programme
PDHS	Pakistan Demographic Health Survey
PLHIV	People Living with HIV
PPTCT	Prevention of Parent to Child Transmission (of HIV)
PWD	Population Welfare Department
PWID	People with Injecting Drugs
RG	Reference Group
RMNCAH	Reproductive Maternal Neonatal Child Adolescent Health
RSPN	Rural Support Programme Network
SBA	Skilled Birth Attendant
SD	Service Delivery
SDG	Sustainable Development Goal
SRH	Sexual Reproductive Health
SSFA	Small Scale Funding Agreement
STI	Sexually Transmitted Infection
THQ	Taluka/Tehsil Headquarter Hospital
UC	Union Council
UNCT	UN Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United State Agency for International Development
VAW	Violence Against Women
VHC	Village Health Committee
WHO	World Health Organization

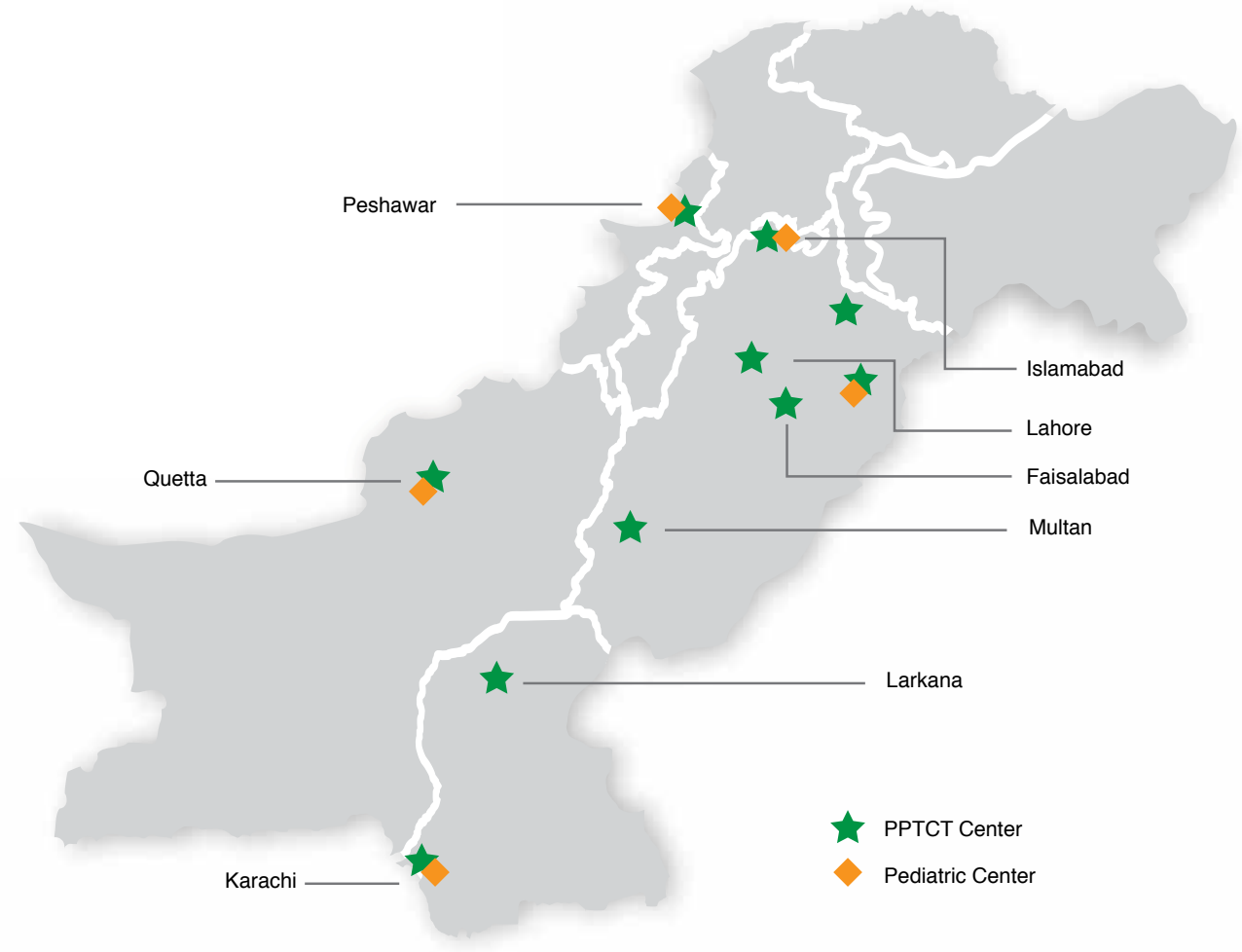
Pakistan: Facts and Figures

Key Facts and Figures		Source
Population:	191,715,847 (estimated 2015)	Pakistan Economic and Labour Survey 2014-15
Population Growth Rate	2.15 % (2016)	
Urban Population	74,987, 621	UN world Urbanisation Prospects 2014
Type of Government:	Democratic Parliamentary Federal Public	National Assembly 2016, FAFEN 2015 , Aurat Foundation
Seats held by women in national assembly (%)	60/342 (17.2%) and 60/256 in Provincial Assembly (23.4%)	
Economy		
GDP per capita (PPP US$)	1512 (2014-15)	Pakistan Economic Survey 2014-15
GDP growth rate	4.2 % (2014-15)	
Unemployment rates	5.32 % (2014-15)	
Labour force participation rates	50.46% (Total) 67.85% (Male) 32.58% (Female)	

HIV/AIDS, Maternal Health and Fertility Indicators		Source
HIV/AIDS in general population (prevalence)	< 0.1% (estimated 100,000 people)	Spectrum 2014 (UNAIDS-NACP) Pakistan Demographic and Health Survey 2012-13 Integrated Biological and Behavioural Survey 2011 Demographic and Health Survey 2012-13 Integrated Biological and Behavioural Survey 2011
Estimated number (%prevalence) of women aged 15-49 living with HIV/AIDS	<0.1% (estimated 30,000)	
Number and % of young people aged 15-24 who are living with HIV	<0.1% (estimated 7,275)	
% of sex workers reached with HIV prevention programmes	FSWs = 5% MSWs= 9% HSWs= 20%	
% of sex workers reporting the use of a condom with their most recent client	FSWs = 41% MSWs= 26% HSWs= 36%	
% of people who inject drugs that have received an HIV test in the past 12 months and know their results	6.7 %	
% of people who inject drugs who report the use of a condom at last sexual intercourse	22.6%	
% of HIV+ pregnant women who receive ART to reduce the risk of mother to child transmission	4%	Programme data 2007-2015
Percentage of infants born to HIV positive women receiving a HIV PCR virological test for HIV within 2 months of birth	87%	Evaluation Report 2015 – PPTCT Programme (www.unicef.org)
Estimated transmission of HIV from HIV+ mothers to their child	3.2% vs. 42% (Spectrum 2014 estimations)	Programme Data 2007-2015
Total Fertility rate	3.8%	PDHS 2012-13
Adolescent fertility rate (births per 1000 women aged 15-19)	44	Pakistan Demographic and Health Survey 20012-13
Contraception Prevalence Rate	35% (Any method) 26% (Modern method includes Lactational amenorrhea)	
Unmet need (married couples unable to access family planning):	20% (approximately 6 million married women of reproductive age)	

1 Free and Fair Election Network www.fafen.org

Figure 1. Map of Pakistan with PPTCT and Paediatric Treatment and Care Sites



CHAPTER 1: PREVENTION OF PARENT TO CHILD TRANSMISSION (PPTCT) OF HIV IN PAKISTAN

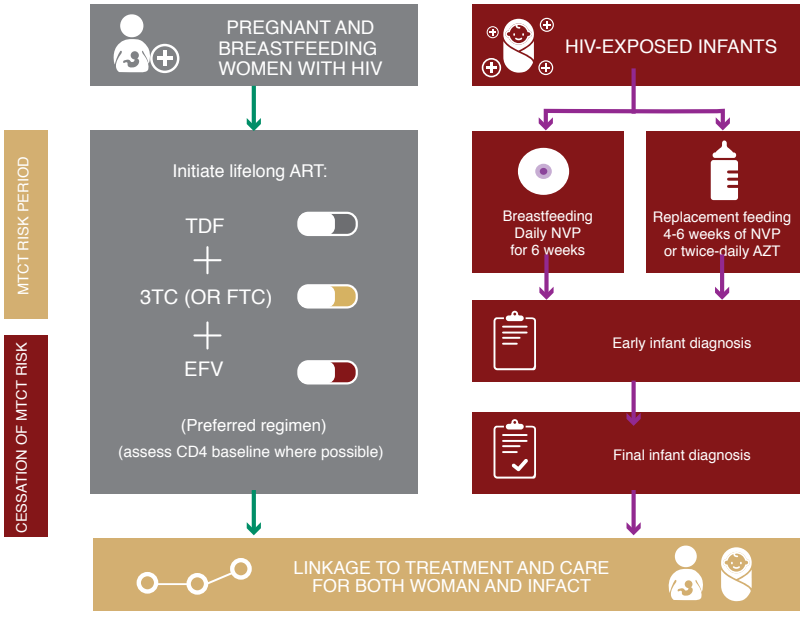
1.1 Background and Rationale for PPTCT

HIV can be transmitted from an HIV-positive woman to her unborn child during pregnancy, childbirth and breastfeeding. Mother-to-child transmission (MTCT) accounts for over 90% of new HIV infections among children and can be easily prevented by providing antiretroviral treatment (ART) to HIV-positive pregnant women. Without treatment, the likelihood of HIV transmission from mother to child is 15%-45% with 5%-10% risk during pregnancy, 10%-20% during labour and delivery, and 10%-20% during breast feeding. ART plus proper prevention of MTCT interventions like safe delivery, infant prophylaxis can reduce this risk to less than 2%[1].

In Pakistan, it was a policy decision to consider MTCT as prevention of Parent to Child transmission (PPTCT) of HIV in order to reflect shared responsibility of prevention efforts between both parents and not just the mother. Effective PPTCT programmes require women and their infants to have access to and uptake of a cascade of PPTCT interventions – timely identification of HIV, antenatal care, ART, safe birthing and breastfeeding practices, and early infant diagnosis (EID), including options for healthy spacing and family planning (FP) choices.

The two recent most WHO HIV Treatment Guidelines (2013 and 2016), recommend putting all HIV+ pregnant and breast feeding women on lifelong ART regardless of CD4 count or WHO clinical stage (Figure 2: Option B+). Treatment should be maintained after delivery and completion of breastfeeding for life. *These guidelines differ from the previous (2010) guidelines that recommended Option B, where treatment was only continued after the completion of breastfeeding if the mother was eligible for antiretroviral*

Figure 2: Option B+ Lifelong ART for All Pregnant and Breastfeeding Women with HIV



1 153 Bryson Y. Perinatal HIV-1 transmission: recent advances and therapeutic interventions. AIDS, 1996, 10(Suppl 3):S33-S42.

treatment for her own health. This is consistent with the new approach of "Treatment as Prevention (TasP)[2] where ART can reduce the risk of HIV transmission to a negative partner by 96%.

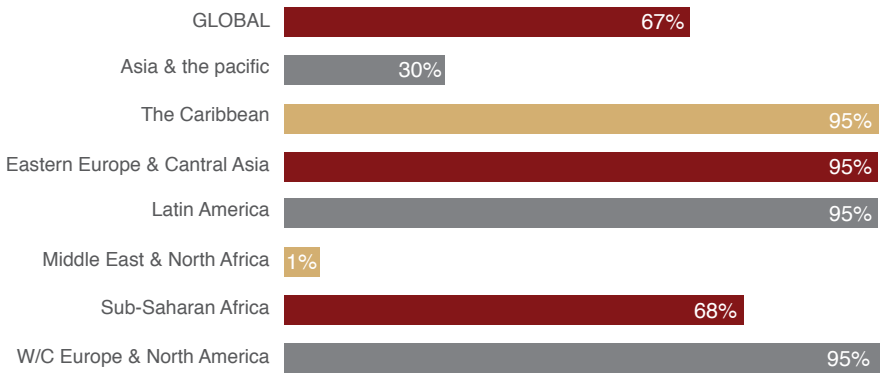
For infants, the new guidelines recommend a course of antiretroviral treatment as soon as possible after birth with once daily Nevirapine or twice daily Zidovudine for six weeks. At six weeks after birth, all infants who are born to HIV-positive mothers should be given an early infant diagnosis using HIV virological test and a repeat HIV test should be done at 18 months and/or when breastfeeding ends to provide the final infant diagnosis.

1.2 Global PPTCT Targets and Progress

The Global Plan (UNAIDS 2011-2015) aimed to reduce new HIV infections from mother-to-child transmission by 90% by 2015 through targeting 10 out of the 22 priority countries that accounted for 75% of PMTCT service needs. It was estimated that the effective scaling up of interventions in these countries would prevent over 250,000 new infections annually[3].

In 2016, UNAIDS with PEPFAR among others launched Start Free, Stay Free, AIDS Free – a framework calling for a worldwide sprint towards "*super fast-track targets*" to end AIDS among children, adolescents and young women by 2020.

Figure 3. Current Coverage of HIV Coverage



The current global commitments and targets are to reduce new HIV infections among children to fewer than 40,000 by 2018 and fewer than 20,000 by 2020. This framework also sets targets to reduce HIV infection in 10-24 year old girls/women to less than 100,000 by 2020. There is also a commitment to ensure that 95% of pregnant women living with HIV are reached and receiving lifelong HIV treatment by 2018. As shown in Figure-3, the coverage in Asia is currently 30%.

It is encouraging that considerable progress has been made in terms of PPTCT services – doubling in ART coverage from 36% in 2009 to nearly 80% in 2015; decline of AIDS related deaths by 43% from 2009 to 2015; and a 60% decline in new infections among children equating to 1.2 million averted infections. However, countries need to accelerate efforts to reduce new infections among women and girls who missed the 50% reduction target and

2 Cohen, MS et al. Prevention of HIV with early ART. NEJM 365(5)493-505

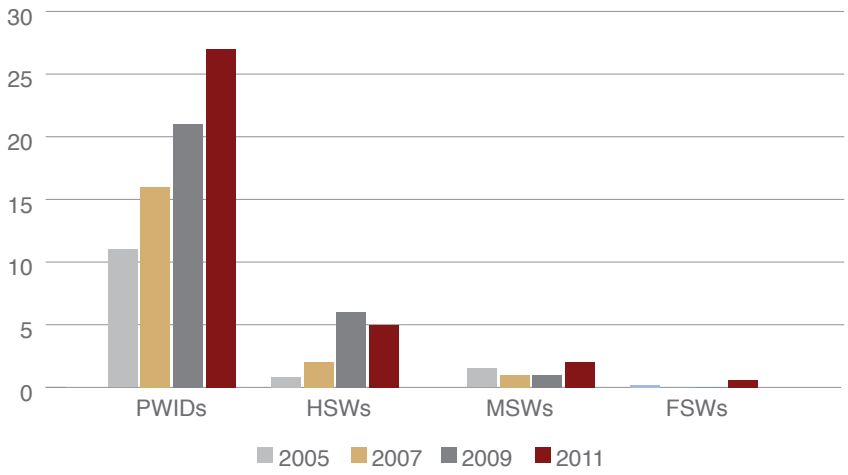
3 WHO Global Report 2013 PMTCT Progress

where infections declined by just 5% between 2009 and 2015, resulting in 4.5 million new infections among this group.

1.3 HIV Epidemiology

In Pakistan, the HIV epidemic is concentrated[4] mainly amongst the key populations, such as people who inject drugs (PWID 27%) and their sexual contacts, male (MSW 1.6%) and transgender (HSW 5.2%) sex workers, and FSW (0.6%) (Figure 4), with a general population prevalence of less than 0.1%. Of the estimated 368,245 key populations, there are 104,248 PWID, 50,598 HSW, 149,111 FSW, and 63,732 MSW, based on extrapolation data from the 2011 Integrated Biological and Behavioural Surveillance (an ongoing IBBS 2016 will be available later in the year with updated findings).

Figure 4. HIV Prevalence Among Key Populations



In the general population there are an estimated 100,000 (77,000 - 169,000) HIV+ cases in Pakistan, with 30,000 (22,000 - 47,000) women, 2,500 (1900 – 3,900) children (ages 0 - 14 years), and 7,275 youth (aged 15 - 24 years[5]). Deaths reported due to AIDS were 3,300 (2100 - 5500[6]), mostly men (98%). Approximately 17,584[7] patients are registered in government supported HIV Treatment Centres (ART Centres), of those registered and on ART there is a 60% men and 40% women disaggregation. There are 8,381 patients receiving anti-retroviral therapy (ART) nationwide.

In the general population there have also been some “mini-HIV outbreaks” in rural communities like, Jalal-pur Jattan (Gujrat), and Larkana as a result of poor infection control practices and unsafe therapeutic injection re-use[8] by practicing medical (and non-doctor) providers.

ART Centre[9] data (Figure-5) shows that People Who Inject Drugs (PWID) and their wives constitute only 20% of the patients receiving ART at the treatment centres (the remaining

4 Prevalence greater than 5%

5 Pakistan Global HIV/AID Response Progress Report 2015

6 Pakistan Global HIV/AID Response Progress Report 2015

7 Programme Data (till October 2016)

8 Jalalpur Jattan Outbreak Investigation Report 2009.NACP and FELTP/CDC.

9 Programme data from 2007-2015 from ART centres nationwide

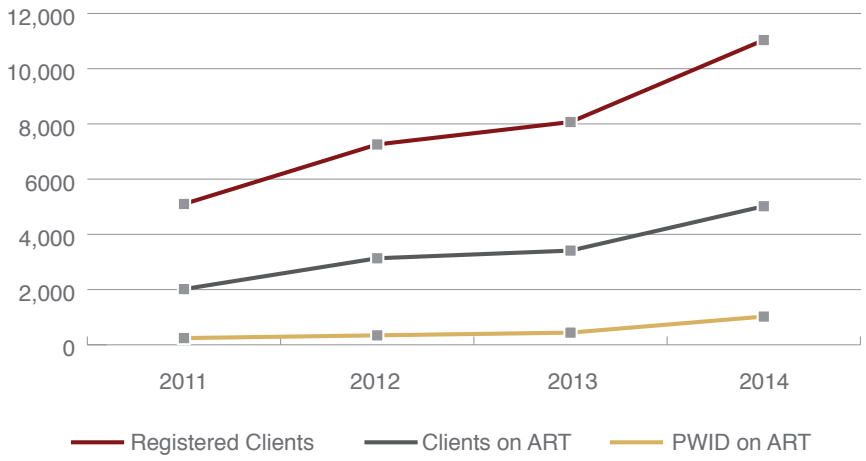
80% are mostly migrant workers and their spouses). This number is disproportionately low, considering that Pakistan's HIV epidemic is driven predominantly by PWID, among whom the prevalence of HIV is approximately 27% in major cities of Pakistan. Remaining of the 80% People Living with HIV (PLHIV) accessing treatment are from general population, including migrant workers and their spouses and children.

In contrast to other countries, a key bridging population in Pakistan are wives of PWID who are sexually active with their drug user spouses, and on occasion even engage in commercial sex or share drugs and equipment with their husbands. In fact after PWID, their wives have the highest prevalence of HIV of all groups making them the next important group to intervene with. In a recent study in Punjab[10] 101/1,896 wives of PWID were found to be HIV positive (5% prevalence) and 7/74 children (9%) tested positive in a home based outreach model of HIV testing and counselling.

Migrant workers characterised by nearly 400,000 or so low-medium skilled male migrants that formally go every year for employment to Middle East and Gulf countries[11], represent a vulnerable and bridge population due to high rates of unprotected sex with sex workers or casual partners while abroad and high risks of HIV transmission to their wives back home in Pakistan. Although theoretically the migration policy of Pakistan requires that all migrant workers travelling overseas should receive HIV and STI counselling and knowledge at the time of departure/arrival, this practice is rarely followed in 83% of cases[12]. Discussions with ART centre staff shows that nearly 30% - 40% of the women receiving care were infected through their male spouses working abroad in the Middle East and Gulf States[13] and had no other identifiable risk factor for HIV[14].

Unsafe infection control practices (i.e., iatrogenic factors in health facilities/ small clinics) and re-use of syringes by community-level private (and at times public) sector providers are another significant concern for transmission of HIV in general population settings and is independent

Figure 5. Number of PWIDs on ART



10 Home Based Testing and Counselling with spouses of IDUs (Faisalabad, Sargodha, and Lahore 2015). Punjab AIDS Control Programme.

11 Bureau of Emigration and Overseas Employment. www.beoe.gov.pk. Country and Category-wise employment emigration 2015

12 UNDP 2008

13 PIMS ART centre

14 Risk Screening study NACP-UNICEF 2008

of individual level risk factors[15]. For example, Pakistan has high rates of unscreened blood transfusions[16] and a very high demand for therapeutic injections and poor infection control practices in hospitals and clinics nationwide[17].

1.4 Overview of PPTCT and Paediatric Programme in Pakistan

PPTCT and Paediatric Treatment and Care Programme

Started in 2005, the National HIV Treatment and Care programme was mainly funded by the World Bank (Enhanced HIV/AIDS Control Programme 2004 - 2008), WHO and the Global Fund (Round 2, 3 and 9). The initial five treatment and centres (ART centres) were established in public sector, tertiary-care teaching hospitals in the federal and provincial capitals to provide management of antiretroviral therapy (ART), opportunistic infections, acute and chronic HIV care, STI management, counselling, in-patient admissions, and referral/specialty services to people living with HIV and their families.

In 2007, with support from UNICEF and WHO (technical capacity building and financial), the NACP in collaboration with the PACPs initiated 5 prevention of parent to child transmission (PPTCT) and 5 Paediatric care sites mainly in the same public sector tertiary hospitals to provide a comprehensive "family-centred" package of services. Later, in 2012 responding to emerging demands and greater patient convenience, additional PPTCT centres were added in District Head Quarter (DHQ) hospitals of Larkana, Gujrat, Dera Ghazi Khan, Faisalabad, and Sargodha. Currently there are 16 ART centres, 11 PPTCT centres, and 7 Paediatric treatment centres – with many of the centres located within the same hospital facility.

While the numbers of people enrolled in care have significantly increased to more than 10,000 patients (approximately 60% men and 40% women) and 411 women in PPTCT services (Table-1), there remain a number of challenges particularly in terms of coverage of PPTCT services. According to Spectrum 2015 estimations by UNAIDS-NACP there are 30,000 HIV+ women in Pakistan with an estimated 1,720 pregnancies per annum that should be identified through health facilities (i.e., ART centres) or through community outreach (i.e. NGOs working with PLHIV or District outreach model using Lady Health Workers). Based on these extrapolations the PPTCT programme coverage for the last seven years has been below 1.5% - 3.4%, which is extremely low.

Findings of the PPTCT Programme Evaluation (2015)

1. **PPTCT Programme Functioning (process level) –** PPTCT centres are functioning (moderately well) and focus mainly on Prong-3 (prevention of HIV transmission from mother to child), with very little attention to Prong-1 (prevention of infections in girls and women), and Prong-2 (availability of family planning choices for birth spacing and preventing

15 Janjua NZ et al. Towards Safe Injection Practices in Pakistan. JPMA 2006 (Nov)

16 NACP 2007 Assessment of Blood Banks.

17 WHO Injection Safety 2013 Report

pregnancies). Centres are starting to follow new WHO guidelines for Option B+ and majority of babies are delivered by elective C-sections by trained PPTCT providers (Ob-GYN doctors). PPTCT centres are located within ANC clinics in large tertiary-care or district hospitals, and have on average 3-4 staff, and 1-2 rooms.

Table 1: PPTCT Clients and Transmission

PPTCT Centre	Women in PPTCT	On ART	Infants Born	Infant ARV Prophylaxis
PIMS, Islamabad (2007)	98	89	68	68
Services Hospital, Lahore (2007)	25	25	21	21
FPAP, Lahore (2015)	5	5	1	1
DHQ (ABSH) Gujrat (2011)	75	75	75	75
Allied Hospital Faisalabad (2012)	14	13	10	10
DHQ DG Khan (2010)	54	52	37	37
Civil Hospital, Karachi (2007)	23	23	22	22
Sheikh Zayed Hospital Larkana (2011)	22	22	19	19
HMC, Peshawar (2007)	53	51	43	41
BMC Quetta (2007)	42	36	38	36
Total	411	391(95% were on ART)	334 (81% live births) 4 infants HIV + (1.35 transmission rate)	330 (99%)

Gaps were found in counselling content, short duration, poor documentation of learning, lack of clarity on infant feeding practices, and weak emphasis on early infant testing and diagnosis. PPTCT centres (5/8) lacked counsellors and/or case managers (due to funding constraints or withdrawal of support from UNICEF or provincial Health Departments), leading to deficiencies in documentation, missing patient tracking of appointments and follow up, and incomplete patient chart notes or register information (these were tasks previously done by or assigned to case managers).

Implementation of Prong-2 is non-existent even though 80% or more of the HIV-positive women are of childbearing age. FGDs with PLHIV reported unintended pregnancies due to lack of knowledge or inability to access longer term FP methods. This is important point of action for Pakistan's PPTCT programme, since a well-designed women-centred contraceptive strategy would prevents 28.6% more HIV-positive births than Nevirapine[18].

PPTCT programme has successfully managed to reduce transmission from 30% - 45% (no intervention) to 1.35% with no maternal deaths reported in the eight year time period. An estimated 86 - 116 infections were averted due to direct PPTCT interventions.

18 Human Reproductive Health Programme Research 2013 www.who.int.org/RH/linkages in FP

2. **Provider Knowledge Is Good** – PPTCT centre staff and providers are well versed in Prong-3 management, and somewhat deficient in Prong-2 family planning counselling and rapport building (<6/10 scoring). PPTCT providers have a narrow clinical perspective on the implementation of PPTCT services versus a holistic continuum of care approach.

3. **District Family Health Day (FHD) Model is Not Cost Effective for the HIV Epidemiology of Pakistan –** Utilising LHWs for HIV awareness and detection through family health days is a reasonable strategy for increasing HIV awareness in the general population. However, cost effectiveness analysis (CEA) i.e., comparison of costs incurred for testing versus HIV+ cases identified reveals low cost-effectiveness at 0.8% or US$ 4,636/- per HIV infection averted in mother-baby pairs. The FHD model needs to be revised in the context of the HIV epidemiology, targeted to at risk populations, and using the upcoming IBBS 2016 for selection of districts/areas to ensure value for money.

4. **Participation of PLHIV Association(s) –** This is still very rudimentary in actual programme activities and implementation. None of the PPTCT centres visited are employing peer counsellors or PLHIV case managers, and rarely do centres have a NGO staff workers present on-site on clinic days. From the PPTCT programme perspective there are legitimate concerns of encouraging NGOs domination, violating patient confidentiality, and lack of capacity to serve in PPTCT centres. However, these need to be addressed to encourage a greater role and empowerment of PLHIV.

5. **Stigma and Discrimination –** Despite considerable progress in the last decade, there are still ongoing incidents of stigma and discrimination amongst PPTCT centre staff, hospital management, and lower staff for PLHIV. This stigma and discrimination appears to be HIV associated rather than gender directed against women. Regardless, this harms the credibility of the PPTCT programme service delivery and quality of care perceptions by end beneficiaries and NGOs working with PLHIV, and needs to be urgently addressed.

6. **Gender Equity and Engagement of Men –** The primary beneficiaries of PPTCT programme are women-infants, with fairly limited involvement of men (increasing to some extent in the last 1-2 years). Directly and indirectly the programme activities have increased women's access to information and somewhat towards decision making (limited assessment in this evaluation). While the role of men has been recognized in the context of promoting effective PPTCT uptake, there are Pakistan specific biases that remain, such as male spouses not being encouraged or allowed to be in the labour room or delivery wards with their wives, counselling regarding breast feeding specifically directed only to women, with exclusion of the fathers.

7. **Rights Based Approach –** The PPTCT programme was established on the premise of upholding the rights of PLHIV, especially HIV+ women and their families. However, despite considerable progress over the last eight years there are significant gaps in the understanding of programme managers and PPTCT centres regarding the concept. RBA is restricted to a narrow domain of patient privacy, confidentiality and trying to minimise discrimination. The broader concepts of PLHIV empowerment, accountability, access and options to quality services, and integrated policies and programmes are still missing in practice, particularly for women. The PLHIV Association and NGOs working with PLHIV can play an instrumental role, but that needs to be actively realised in the next phase of PPTCT programming.

8. **Output Based Monitoring –** Monitoring is regularly undertaken and data is compiled into provincial level information on a monthly basis. However, PPTCT data or monitoring itself are not being used for strategic decision making or improvements in policies or programming.

9. **Sustainability –** It remains variable with some provinces faring better than others. A better participatory approach and planning by NACP/PACPs and relevant partners such as Department of Health (DoH), MCH programmes, and PPTCT centres/hospital management along with technical guidance from UNICEF would help streamline the financial resource limitations and mobilization issues that are hampering programme activities and effectiveness. Some provinces have taken on the programmatic responsibility early on (2011 onwards) while others are still planning or waiting for pending PC 1, and seeking support from other donors like GFATM, UNAIDS for bridge funding.

PPTCT Strategic Framework 2007 – An Overview

Developed in 2007, the PPTCT Strategic Framework is evidence based and covers all 4 prongs. The framework addresses all 4 prongs with well-defined objectives, activities and key strategies for MTCT prevention in Pakistan. It also included global and local lessons to improve quality of MCH services, integration and linkages with PLHIV and vulnerable populations for enhancing the efficacy of PPTCT interventions – many of which have been neglected in the implementation plans and activities.

An initial desk review of the Strategic Framework shows the following demand-supply side challenges based on eight years of programme implementation experience:

Table 2: Gaps in the PPTCT Strategic Framework 2007

Demand Side	Supply Side
Prong 1: Primary prevention of HIV infection among (men) women and girls	
■ Socio-cultural barriers and inhibitions limit girls and women most at risk of HIV infection from voluntarily seeking HIV testing and counselling. ■ Spouses and partners of KP do not seek HIV prevention services due to lack of information, fear of stigma and discrimination, and financial barriers. ■ Disclosure of HIV status remains low by HIV+ men to their spouses and partners.	■ Low coverage of HIV testing and counselling in key populations (KP), youth with risk behaviours, or in spouses of migrant men. ■ Low emphasis on prong 1 by programme planners and implementers – action plans miss out on prong 1 activities in the context of PPTCT ■ Limited or absent debate on policies and safeguard mechanisms for women/wives of HIV+ men

Demand Side	Supply Side
Prong 2: Preventing unwanted pregnancies in HIV+ women	
■ Women are not aware of FP and RH services in PPTCT centres. ■ Demand creation by PLHIV Association and NGOs is a weak component of the PPTCT programme. ■ Socio-cultural beliefs and practices that limit FP uptake in couples such as planning pregnancies, and deciding on the number of children to have	■ FP counselling and supplies not available in PPTCT centres ■ Low emphasis on prong 2 activities by programme planners and implementers – FP is considered outside of the domain of PPTCT programmes (other than condom provision) ■ Myths among PPTCT centre staff on safety and feasibility of IUCDs (Intra-uterine Contraceptive Device) in HIV+ women
Prong 3: Preventing transmission of HIV from HIV+ mothers to their child	
■ HIV+ women and couples remain passive recipients of services – very little empowerment through information and decision making which represent great missed opportunities. ■ Community linkages have not strengthened the role of non-doctor providers – i.e. demand generation in PLHIV remains doctor centred ■ Weak identification by PLHIV networks of women at risk and in need of services (411 in 8 years) ■ C-section scares away some HIV+ women from delivering in facilities (particularly KP, Sindh) ■ Clients are confused on breast feeding vs. formula feeding risks ■ HIV + men still are not actively involved in the PPTCT programme due to individual inhibitions and structural barriers in the programme implementation.	■ Counselling protocols are ad hoc and do not document learning, stage of PPTCT client, and mixed messages on breast feeding ■ Provider bias is towards C-section for fear of HIV transmission in vaginal deliveries and does not take into account new evidence. ■ Some areas of non-compliance in PPTCT centres with Option B (this is now being rigorously addressed) ■ Stigma and discrimination in non-PPTCT trained staff – limits availability and acceptability of HIV+ women in health facilities
Prong 4: Providing a comprehensive package of care, support and treatment services to women and mothers	
■ PLHIV are not aware of CHBC services and there are low linkages between local CBOs in PPTCT care and support in terms of early infant diagnosis (EID) and testing referrals/ facilitation, home-based care services, and guidance ■ Ingrained Socio-cultural behaviours and understanding of the importance of post-natal follow up leads to delays in EID and follow up testing.	■ Low linkages of PPTCT centres with community organisations/CBOs for referrals and facilitation ■ Absence of DBS (Dried Blood Spot) sample for remote areas where patients/ mothers cannot travel to health facilities. ■ Infant prophylaxis for Cotrimoxazole is often missed ■ Integration with MCH programming is low

Demand Side	Supply Side
Monitoring and Tracking Progress	
■ High rates of loss to follow up from identification to treatment centres (PPTCT cascade shows drop outs at every stage) ■ Low numbers of cases registered with NGOs and frequent duplications	■ Programme data is not being used for decision making, planning and advocacy. ■ Absence of trend analysis and resource mobilisation according to need/numbers. ■ Costing of PPTCT programme is absent ■ Absence of key operational research – issues of research quality and representation

In addition, changed international recommendations on integration, health systems strengthening and cost-effectiveness (public health vs. universal provision approach) in low burden countries requires a re-alignment of PPTCT and MCH planners in Pakistan.

Pakistan AIDS Strategy III (2015-2020)

The PAS III was developed in 2015 to guide Pakistan's overall national response for HIV and AIDS through focused interventions with set targets, costs, roles and responsibilities. The successful implementation of PAS-III involves multiple stakeholders to achieve priority outcomes as outlined in the Strategy. The strategy prioritises allocation of limited resources to scale up high-impact, high-value interventions, such as HTC and treatment to reduce AIDS-related deaths and new HIV infections. The key strategic outcomes are:

- Strategic Outcome I: HIV Prevention is increased and sustained among key populations: People who Inject Drugs (PWID), Males Who Have Sex with Males (MSM), Transgender Persons (TG), Female Sex Workers (FSW); and vulnerable populations with their sexual partners.
    - Output 1.3.3 - Scaled up PPTCT[19] services in prioritized cities and peripheries for women of child bearing age at risk for or living with HIV.

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

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

According to PAS-III Prevention of Parent to Child Transmission services will be focused on reaching intimate partners of men already known to be HIV-positive (through SDPs, CHBC sites, and ART centres), FSW and women living in districts or areas with a high burden of HIV disease through SDPs and broader health initiatives. Information on GBV will be made available with referral for those who report intimate partner violence. Capacity to manage HIV-positive pregnancies will be built in identified HIV Clinic facilities (see Outcome 2, Output 2.1.1) simultaneous with initiation of ART and paediatric service provision.

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

  trategic Outcome II focuses on increasing HTC uptake and getting those in need it into treatment, care and support. At the end of 2014, the gap between persons eligible for treatment and those who are receiving treatment was 90.8% for adults and 94.2 per cent for children.[20]

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

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

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

Provincial HIV Strategies and PPTCT Goals in the PC 1 Document

After devolution in 2011, health has become a provincial subject and the PACPs function independently from NACP under their own respective provincial Departments of Health (DoH). The NACP (under the Ministry of National Health Services, Regulation and Coordination) continues to serve as the principal recipient of the GFATM Round 9 grant and works closely with the provincial programmes in helping coordinate and implement the PPTCT programme activities within the overall HIV response.

20 Spectrum file Pakistan 2015MAR18.

In 2012-13, all four provinces developed their provincial HIV Strategies with specific PPTCT targets and objectives mentioned as below.

Balochistan

Low estimated numbers of HIV+ people i.e. 5000 people, nonetheless Balochistan has a relatively similar epidemiological profile to the rest of the country. The prevalence in PWIDs was 14%, MSWs/HSWs 1-3%, and no cases detected in FSWs, and amongst women seeking ante-natal care (not spouses of positive men).

Though PPTCT is not specifically mentioned in the HIV strategy, it is covered by the broad nature of the 3 key outcomes and outputs listed below:

- *Outcome 1: HIV prevalence is reduced in key populations and maintained to less than 0.1% in the general population (Outputs 1.1 – 1.3)*
- *Outcome 2: HIV morbidity and mortality is reduced and quality of life is improved for PLHIV (Output 2.2 - 2.3)*
- *Outcome 3: Policy environment and AIDS Programme response is enhanced and sustained for HIV prevention, treatment care and support (output 3.4: Increase resource by 10% per annum)*

The PC 1 of Balochistan is Pak Rupees 0.29 billion (2012-2016) and is currently in a state of uncertainty with bulk of the allocated funds transferred to non-HIV programming by the DoH. High level advocacy to DoH and Planning and Development is needed by UNICEF, Global Fund and the NACP to enable continuation of the planned programme activities by the PACP and return of the funds.

Khyber Pakhtunkhwa

Khyber Pakhtunkhwa has reported an increasing prevalence of HIV among PWID and to a lesser extent, among other key populations. Despite a prevalence of less than 0.1% in the general population, HIV positive cases are being reported through HTC centres amongst returning migrant workers, blood transfusion recipients etc. However, information on the extent of HIV prevalence among such vulnerable populations is scarce.

Khyber Pakhtunkhwa's HIV strategy specifically mentions PPTCT in the following outcomes and outputs:

- Outcome 1: HIV prevalence is reduced in key populations and maintained to less than 0.1% in the general population (Outputs 1.4: Improved uptake of PPTCT services by women who are vulnerable)
- Outcome 2: HIV morbidity and mortality is reduced and quality of life is improved for PLHIV (Output 2.2 - 2.3)
- Outcome 3: Policy environment and AIDS Programme response is enhanced and sustained for HIV prevention, treatment care and support (output 3.4: Increase sustainability and efficiency of the response, resource allocation and external resource mobilisation)

The PC-1 of Khyber Pakhtunkhwa is approximately PKR 0.5 billion (2015-2018) and integrated with Hepatitis B & C, Thalassemia programme. The PC 1 envisions opening of 4 additional Family Care centres geographically spread across KP and with easier access for FATA residents. SDPs programmes are aimed at the KPs with intention of reaching 65% coverage in these at risk groups. There is a strong emphasis on awareness raising campaigns for bridging and general population.

Punjab

Punjab has approximately half of the total estimated 100,000 people living with HIV in Pakistan, However only 6,865 PLHIV have been registered with the treatment services and 3,511 are currently on ART (latest data Oct 2016). Prevalence rates in key populations is similar to national prevalence averages although there are substantial variations across districts.

Punjab's HIV Strategy specifically mentions PPTCT in the following outcomes and outputs:

- Outcome 1: HIV prevalence is reduced in key populations and maintained to less than 0.1% in the general population (Outputs 1.3: Develop pre-departure prevention education for intending migrants, and referral systems for HTC, ART and PPTCT for returning migrants and families, output 1.4: Improved uptake of PPTCT services by women who are vulnerable in selected districts)
- Outcome 2: HIV morbidity and mortality is reduced and quality of life is improved for PLHIV (Output 2.2 support for a continuum of care model, output 2.3 build linkages with social welfare programmes)
- Outcome 3: Policy environment and AIDS Programme response is enhanced and sustained for HIV prevention, treatment care and support (output 3.4: Increase sustainability and efficiency of the response, resource allocation and external resource mobilisation)

Punjab has developed a PKR 2.04 billion PC-1 (2016-2019) with 80% coverage plans for the key populations (exact numbers listed in Annex 7), expansion of PPTCT centres across the 36 districts DHQ facilities, extensive training of healthcare and mid-level non-physician providers, strengthening of linkages with RMNCH services at the first and second level health facilities, and fund allocations for advanced diagnostic testing and ART, other commodities.

Sindh

Sindh has a concentrated HIV epidemic among PWID and transgender people. In 2011, an extensive review of the country situation assessed the existing epidemiological evidence for Sindh, PWIDs 24%, HSWs 10%, and MSWs 3%[21].

21 Reza T et al. Patterns and trends in Pakistan's heterogeneous HIV epidemic. Sexually Transmitted Infections. 2013 Sept. 89 (Suppl) 2

Though PPTCT is not specifically mentioned in the HIV Strategy, it is covered by the broad nature of the 3 key outcomes and outputs listed below:

- Outcome 1: HIV prevalence is reduced in key populations and maintained at less than 0.1% in the general population (Outputs 1.1 – 1.3)
- Outcome 2: HIV morbidity and mortality is reduced and quality of life is improved for PLHIV (Output 2.2 - 2.3)
- Outcome 3: Policy environment and AIDS Programme response is enhanced and sustained for HIV prevention, treatment care and support (output 3.4: Increase resource, strategic information use and resource mobilisation)

Final approval of Sindh PC-1 for the amount of PKR 1.74 billion was pending in the beginning of December 2016. The focus of the PC-1 is mainly on key populations – PWID, sex workers, and bridging populations with 80% coverage through SDPs. The plans for PPTCT expansion are to 11 centres, with integrated PITC testing at TB first level facilities/BHUs, extensive media and awareness campaigns, small grants, and multi-tiered monitoring with inclusion of the district leadership in the HIV response.

NGOs in PPTCT Care and Support

At least 50-54 NGOs are involved in HIV prevention and treatment care service such as PPTCT support, public awareness, and service delivery with key populations, home based care, and including the Association of PLHIV. In fact a strong feature of the current PPTCT programme is the growing involvement of NGOs over the years. For example, NGOs are providing many of the essential and complementary services at the community level that HIV programme would otherwise not be able to provide due to access, efficiency of out-reach and capacity constraints. However, these are still fairly rudimentary and dependent on external aid with frequent stop and starts that affects NGO/CBO functioning and community level credibility.

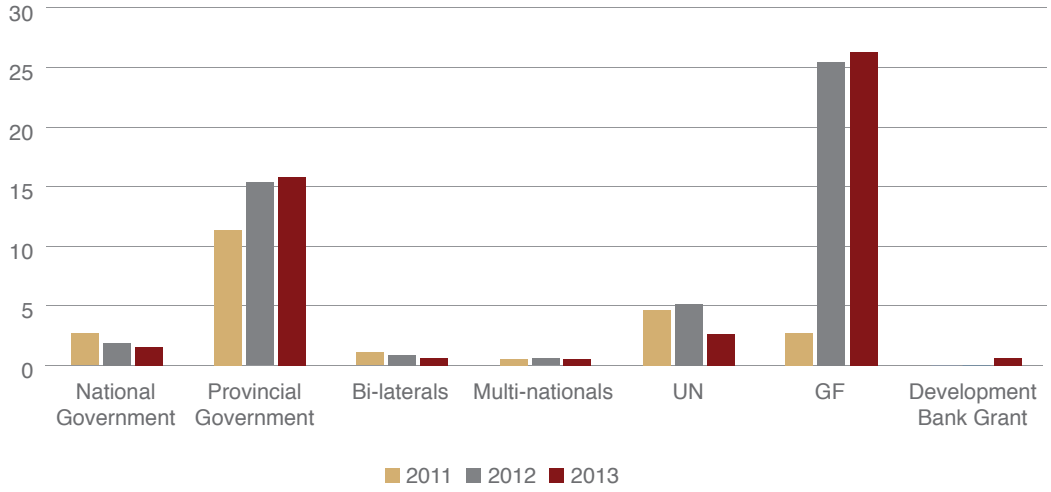
Good linkages between the NGOs and medical providers are critical in assisting PLHIV and their families and for achieving good health outcomes. In PPTCT programme these linkages are still developing with some centres having greater maturity (i.e. stronger linkages) than others.

Generally PPTCT centres do not have any regular meetings between partner NGOs to address the issues of low referrals. This role is expected to be undertaken by the PACPs and thus hinders development of PPTCT centre-NGO relationships and coordination. In addition, PPTCT centres and PACPs have rarely approached cross-sector NGOs working in social welfare, MCH and reproductive health to find possible synergies of interest.

Donor Engagement in HIV Programming and PPTCT

A large number of donors, funding agencies and UN partners are involved in different aspects of HIV/PPTCT programme. These mainly include GFATM, WHO, UNAIDS, UNICEF, UNODC, UNICEF, and UNFPA.

Figure 6: Government and Donor Wise Funding Support



According to GARPR report 2014[22] the funding landscape has changed over the last 5 years, from primarily World Bank soft loan and grant funding, to increased domestic allocations through PC-1s and strengthened GFATM support (Figure 6). In 2016 GFATM (including regional grants) accounted for over 50% of the total HIV response amounting to USD 9.023 million. Provincial Government account for 37%, UN 7% other external donors 3% and Federal Government 3% of the total HIV budget. From 2011 through 2013, expenditures by the National Government decreased given Devolution, while expenditures by Provincial governments and Global Fund increased, primarily due to the World Bank loan contribution to the Punjab Government for Health Systems Strengthening, which includes HIV.

There is also a Joint UN Team on AIDS (JUNTA) to coordinate the response of United Nations Agencies and to provide assistance to the government in the strategic development of activities. The JUNTA includes UNAIDS, WHO, UNICEF, UNDP, UNESCO, ILO, UN-Women and the World Bank. There is also a Country Coordinating Mechanism with membership from donors, UN partners, government, PLHIV and NGOs.

22 Pakistan Global AIDS Response Progress Report 2014

CHAPTER 2: STRATEGIC FRAMEWORK VISION, GOALS & STRATEGIC DIRECTIONS

2.1 The Guiding Principles

In June 2016 United Nations General Assembly adopted the **Political Declaration on HIV & AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030.**

The 2016 Political Declaration calls on the world to support the 2030 Agenda for Sustainable Development through reducing both new infections and AIDS related deaths to less than 500,000 globally, and eliminate HIV related stigma and discrimination by 2020.

The sustainable development goals (SDGs) set an ambitious agenda for 2030 for all countries to work towards. In the context of health and HIV under **SDG-3** the countries have committed to ***'ensure healthy lives and promote well-being for all at all ages' and SDG-5 for 'ensuring gender equality and access to opportunities, information and resources for all women and girls'.***

It is expected that the implementation of revised PPTCT strategic framework will play a critical role in reducing new HIV infections and preventing HIV related deaths in Pakistan as envisaged in the political declaration 2016 on HIV & AIDS, and contribute towards Agenda 2030 for sustainable development by accelerating progress towards **SDG-3 Target 3.2** (By 2030 end preventable deaths of newborns and under-five children), Target 3.3 (By 2030 end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis); and **Target 3.7** (By 2030 ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes).

Global evidence indicates that achieving national (and provincial) PPTCT goals and targets requires foremost an enabling political environment and sustained programmatic leadership to ensure availability and quality of services for the most marginalised and vulnerable women and their families. Pakistan's PPTCT Strategic Framework 2016 takes guidance from three main documents: (i) WHO's PMTCT Strategic Framework (2010-2015); (ii) Towards eMTCT-Conceptual Framework for the Middle East and North Africa Region (WHO-UNICEF-UNFPA-UNAIDS 2012); and (iii) UNAIDS HIV Strategy 2016-2021. The Strategic Framework identifies five Strategic Directions with specific strategies or action points proposed under each area. The five Strategic Directions are:

1. Leadership and Commitment,
2. Demand Generation and Access to Services,
3. Integration and Strengthening Health Systems and Services,
4. Expanding the Continuum of Care; and
5. Resource Mobilisation and Sustainability.

Monitoring, Evaluation and Research are cross-cutting across all priority areas and the four PPTCT prongs. However, the Framework deviates from the past approach in that the five strategic directions are considered cross-cutting and thus the specific activities are placed according to the interventions rather than prongs. In Chapter 3 detailed actions are proposed on how to implement and monitor the activities. In addition, the Framework strongly recommends the engagement and involvement of PLHIV throughout the process with the overall aim to increasing both coverage of PPTCT services and equity for the most marginalised.

The PPTCT Strategic Framework takes into account the needs assessments from the national and all four provincial HIV Strategies including the HIV PC-1 documents[23] along with MNCH Strategies that reflect provincial priorities, target setting, and available resources. In Chapter 3 National PPTCT Strategic Framework has five main areas for strategic guidance and planning activities along with a detailed section (Chapter 3) on how to implement and monitor activities.

2.2 Vision, Goals and Programmatic Objectives

Vision

The vision of the PPTCT Strategic Framework is that women and children, particularly those most at risk of HIV infection, in all provinces and areas of Pakistan, are alive and free of HIV.

Goal

The goal is to eliminate by 2030 new infant and paediatric HIV infections and improve maternal, new-born and child health and survival in the context of HIV.

Objectives and Targets

Scale up national and provincial PPTCT programme services, coverage and access, to particularly reach and provide services to key populations, the most marginalised groups and those affected by HIV/AIDS:

1. To increase PPTCT coverage and uptake to at least 60% in the estimated population of HIV+ pregnant women in Pakistan by 2021.
2. To reduce new HIV infections in children, wives and partners of key populations and HIV+ men by 50% by 2021
3. To reduce the unmet need for family planning for all estimated HIV+ women of reproductive age to less than 50% by 2021 (this target is connected to target 1 above) To increase the number of estimated HIV+ women who are tested and know their status to > 90% by 2021.
4. To increase the number of estimated HIV+ women who are tested and know their status to > 90% by 2021.
5. To reduce HIV attributable deaths in infants, children and mothers by 90% by 2021.

23 Balochistan, Khyber Pakhtunkhwa, Punjab and Sindh

Strategic Directions

This section describes the 5 Strategic Directions for action and incorporates the PPPTCT prongs 1-4 across the strategic areas and the overall goals of reducing HIV transmission in infants and women/girls. The strategic directions are consistent with the international commitments to Fast Track the AIDS Response and achieve the 90-90-90 treatment targets[24].

1. Strengthen Leadership and Commitment to PPTCT and the HIV Response

The success of HIV-PPTCT programme, services and overall response mainly depends on how committed, informed and resourceful the leadership is about controlling HIV in Pakistan. Leadership refers to both political and programmatic decision makers (i.e., particularly participation of Health, Planning and Development, and Finance departments/ ministries). Good leadership is particularly crucial in creating the supportive environment for implementing effective PPTCT programme, policies, and ensuring accountability for results. Some key strategies for strengthening leadership are:

1.1 Targeted Advocacy - To promote a sense of priority for HIV, targeted advocacy is needed with decision makers in parliament across different party lines, with government officials in Health, Planning & Development, Education and Finance for necessary financial, human resources, commodities, logistical supports, and longer term behavioural awareness. The advocacy whether in the form of provincial campaigns (not recommended in low prevalence, concentrated epidemics) or via evidence-informed small group "sensitisation and knowledge building sessions" should be anchored within the national and provincial governance structures and include district level leadership right down to sub-districts (based on mapping or recently conducted 2015-16 IBBS data).

Advocacy should focus on building leadership vision and understanding of HIV responses, putting in place strong accountability monitoring mechanisms (i.e., ensuring that resources invested are delivering results), targeted to reaching the key populations (KP), building champions at all levels for uninterrupted HIV programming, expanding role of PLHIV in monitoring of services and feedback, and need-based programming.

The National/Provincial AIDS Control Programmes should function as the "central hub"" for leveraging and/or expanding partnerships to promote prevention of new HIV infections in women and children (i.e., PPTCT) as a priority agenda. Understandably this will be in the context of Pakistan being a high fertility, high maternal and child mortality country with low numbers of HIV-positive women and their subsequent deliveries, thus HIV being one among many competing public health priorities but one in which prevention-of-mother-to-child-transmission can be easily achieved with fairly low cost efforts.

24 UNAIDS HIV Strategy 2016-2021. 90% of people know their HIV status, 90% of those that are HIV+ are on ART, and 90% of those on ART are HIV viral load suppressed.

1.2 Expand PPTCT Alliances/Partnerships and District Leadership - Targeted efforts should be made through district leadership in higher risk districts to provide preventive service programmes to KP and bridging populations (e.g., clients of sex workers, truckers etc.) and spouses of KP. Effective targeting would require engagement of media, youth, local PLHIV-organisations with leadership, and other opinion leaders that drive the political processes in Pakistan to create the enabling environment for PPTCT services.

Learning from past PPTCT programming the advocacy and sensitisation will need to be locally relevant and gender appropriate – the same approach across provinces or districts may not be feasible or effective. Similarly approaches will need to be tailored for advocacy for interventions for KP with the decision makers. For example, decision makers may not be willing to invest resources in PWID programming, and therefore PACPs may need to make an economic case for addressing HIV epidemic in PWID and public health implications for the general public in failing to do so. For example, strategic information generated through PACP progress reports can be packaged to influence political responsiveness and accountability in districts or at the provincial levels within the PPTCT services.

Budgetary allocations should be need-based and rationalised on: (i) evidence of HIV risks and impacts of interventions in given localities and provinces, and (ii) efficiency of unit costs and programme interventions. UNICEF and other technical agencies can assist in the capacity building efforts for PACPs and government decision makers to become efficient planners and implementers thus saving scarce resources.

1.3 Building Community Leadership of Local CBOs – The socio-cultural norms that prevent women including HIV-positive women from accessing and uptake of PPTCT services will require community engagement and mobilisation to change the societal narrative. Issues of stigma, male dominance, discrimination, gender based violence, and low empowerment of women for education, access to reproductive health and rights, and mobility will need to be addressed through community groups, social mobilisation, gender transformative approaches particularly in counselling, engagement of men, and through other formal/informal platforms in order to increase coverage of PPTCT services for those in need.

2. Demand Generation and Enabling Access to Quality Services

Low PPTCT coverage and uptake remains a challenging arena in Pakistan particularly within the larger landscape of 3-5 million deliveries per year[25] i.e., timely identification and access to 2,000 HIV-positive pregnant women. While the provincial governments are somewhat committed[26] to continuation of PPTCT services there are gaps in the level of understanding in terms of quality of services, unnecessary expansion of infrastructure versus cost efficiency, and targeted service delivery programmes.

25 UNICEF Pakistan 2013

26 Issues remain about Balochistan PC 1 commitments, and firm commitments to resource allocations in Khyber Pakhtunkhwa

2.1 Address Socio-Structural Barriers to Accessing Services – Finding means to understand and reduce the socio-structural barriers that limit women's access to PPTCT services including costs, discrimination, and lack of information will be addressed through pilot initiatives, collaborations with local CBOs/PLHIV networks, and sensitization of men to become active partners in referring spouses/partners.

Access to services (through removing barriers of cost and distance travel) will also likely increase since three out of four provinces are expanding wide geographic coverage of PPTCT-HIV-Paediatric care and treatment services through variable models of Family-Centred Health Centres with well-defined package of PPTCT services – testing, counselling, antenatal care, ART, deliveries, infant prophylaxis, and EID. Specialized services such as CD4, HIV viral load PCR, and other advanced diagnostics will be decentralised to tertiary care and in some cases DHQs through transfer of skills; improvement of infrastructure and equipment; operationalisation of task shifting; use of point of care diagnostics and/or networking of laboratories.

Standardisation of clinical and care algorithms are already partially being used in certain settings and can be strengthened to improve the quality and standards of care. PACPs will need to put in place "institutional" systems for quality improvement mechanisms i.e., Health Quality Recognition to ensure high standards of service delivery across various levels of facilities and providers.

2.2 Support Community Initiatives for Demand Generation - For increasing access the most important requisite is targeted "demand generation" in the key populations such as PWID and their spouses (first priority), sexual partners of MSWs/HSWs, FSWs, bridging groups such as clients of sex workers, truckers, jail inmates, and spouses of male migrants etc. Common strategies of setting targets for service delivery programmes to provide HTC for key populations and their partners, increasing spousal disclosure in ART centres, utilising CHBC for community level identification and referrals into PPTCT services, and peer-peer referrals need to be implemented.

2.3 Find Innovative Public - Private Partnership - Exploring new public private partnerships across MNCH and other social welfare programmes (i.e. Benazir Income Support Programme, Rural Support Programme Network, Pakistan Poverty Alleviation Fund etc.) and organisations will need to be undertaken to better leverage scarce resources, reduce duplications, maximise opportunities and results towards the common goal of keeping Pakistan's women and children safe from HIV and promoting universal access to PPTCT services. Special attention should be paid that partnerships do not dilute the efficacy of PPTCT services in reaching those most in need.

3. Integration and Strengthening of Health Systems, Services and Linkages

PPTCT programming in Pakistan has generally been offered "parallel" to MNCH services in an effort to jumpstart services and to effectively manage HIV-related stigma and discrimination. However, nearly a decade into programming, it is now recognised, that to maximise resources and efficiencies, integration of services and strengthening linkages are extremely important. By integration costs can be saved and services expanded to reach a greater number of women/families in need of services.

3.1 Optimizing Functional Integration MNCH-PPTCT Services - According to review of various provincial PC-1 documents - integration may take several forms: provision of a continuum of services at one service delivery point (Family Health Centres in DHQs), or within a facility but at different service delivery points; or requiring referrals to a different facility for different services. The latter two require effective referral mechanisms and linkages across referral points. In addition strong linkages between the facility and the community/PLHIV Associations/CHBCs are essential to ensure uptake, retention and continuum of care.

This PPTCT Strategic Framework recognises that majority of the births do not occur in health facilities[27] and engagement (and curriculum changes/learning/practical trainings) of frontline providers such as CMWs, LHWs, LHVs, and private sector providers have to be put in place via the MNCH broader programming if maternal mortality and mother to child prevention coverage is to be increased in communities. In addition, collaboration with FP programme (Population Welfare Departments) for availability of supplies and needed referrals for IUCDs or permanent contraceptive choices has to be available.

Responsive health systems support that integration of PPTCT services and MNCH-FP are necessary in keeping mothers alive. Several opportunities exist to integrate services including increasing access to FP services within HIV services (i.e., Family Care Centres); HIV testing at STI clinics; providing point of care diagnostics for HIV, CD4 and PCR testing and preventing missed opportunities to provide continuum of care, such as postpartum and early infant diagnosis (EID) services during immunisation or home visits by community workers.

3.2 Ensuring Quality of Care through Capacity of Health Care Providers – Achieving effective PPTCT coverage and scale as envisioned in this Framework is heavily dependent on capacity of the national/provincial health systems to deliver PPTCT services. Weakness in human resource capacity, (number, skill mix, distribution), lab infrastructure, supply chain, health information systems, financing and programme management have hampered the attainment of health goals, including maternal and child health targets. To achieve the targets in this Framework, the NACP/ PACPs will promote and support ongoing health systems interventions to improve the delivery of HIV prevention, care and treatment services for women and children. Special focus will be given to task shifting from a doctor centred model to more mid-level non-doctor providers, and to task sharing particularly in districts/areas where doctors are less likely to be available.

3.3 Ensuring Essential Medicines, ART and Laboratory Support – The provincial PC-1s (except Balochistan) have allocated funds for HIV commodities (ART and other essential medicines) including testing kits in their budgets. Currently GFATM and donors (USAID and UNICEF) are providing ART and commodity, safe birthing supplies. Specific efforts will be made to strengthen commodity security through improving, forecasting and quantification (push-pull system), strengthening logistics information systems and improving efficiency in commodity procurement and distribution.

27 Pakistan Demographic Health Survey 2012-13 – 52% of births happen at home

Delivery of efficacious HIV Treatment and Care services requires the availability of labs for diagnostics and patient monitoring. The existing basic labs, CD4, HIV viral load and additional biochemistry/haematology capacities will be reviewed to develop strategies for improving the lab services. Where feasible, new lab service delivery points will be opened or linked within existing DHQ or BHU set-ups, and better and efficient diagnostics technologies (i.e., DBS, private sector lab linkages etc.) and networking introduced.

3.4 Building Robust Information Systems - The PPTCT infection elimination strategy requires a robust health information system to track progress and to provide data for decision making and future advocacy at all levels. Data requirements for monitoring progress in implementation of this Framework will be captured directly through standardised formats including future Electronic Medical Records, disaggregated for gender specific information and decision making including some key indicators in the District Health Management Information Systems (DHMIS). To support these efforts, a comprehensive Monitoring and Evaluation Framework and tools will be developed, and shared at different levels of health facilities and centres.

3.5 Strengthening Linkages - Linkages have been a weak component of previous PPTCT programming. In this phase three levels of linkages will be developed: (i) linkages between other Health programmes such as family planning, maternal-child health, immunisation, Hepatitis, TB; (ii) between health facilities and community based services and referrals; and (iii) between cross-sector programmes such as education, in GBV and women's empowerment social justice initiatives, law enforcement, and livelihood skills development.

4. Expanding the Continuum of Care Model

Past PPTCT and HIV experience has shown that public sector and specifically NACP/ PACPs cannot provide all the key services along the continuum of care. This PPTCT Strategic Framework strongly focuses on ways of engaging NGOs/PLHIV CBOs and greater involvement of PLHIV as extremely important in service delivery implementation, enhancements of services, ownership, sustainability, and most importantly making the services more responsive to the needs of the end beneficiaries and their families. The assumption is that services closer to home and delivered through local partnerships will be more cost-effective and acceptable to PLHIV.

4.1 Improving Retention in Care - Retention of mothers and their infants throughout the continuum of care will be ensured by strengthening psychosocial support systems such as linkages with existing CHBC sites (GFATM supported), and other local CBOs and seed funding for expansion of roles for the PLHIV Association. Community support systems will be strengthened through rolling out "Community Strategy" in high risk districts with identified number of cases or risk factors. Functional BHUs and frontline workers will be equipped with recognition, basic management and referral links to ensure that communities work with their local facilities and providers to identify and follow up mothers and babies in need of intervention and care. Small grants (in three provinces) will support low cost, innovative methods of providing HIV care support to generate, motivate and maintain this community involvement.

4.2 Supporting Initiatives that Economically Empower Women and HIV Affected Households - As the epidemic matures and the PLHIV live longer, the risks of drug resistance, and other terminal illnesses requiring end of life care goes up. This often ignored care-work done in the household, mainly by women and girls, is referred to in economics literature as the "care economy"[28] This work sustains families, allows children to go to school, and frees the time of other household members to generate income. In Pakistan, in the absence of home based social safety nets other than very limited CHBC sites, there is the potential to generate a "care gap" that women will end up subsidizing with their own time, energy and limited household productive resources.

The Framework recognises that the current care agenda will need to include some level of understanding and assisting the care economy with a particular focus on the caregiver, and that in so doing, national/provincial level policy planners of health systems should work with other social development or welfare sectors to support household livelihoods and well-being. In addition, national governments must define specific public sector roles and responsibilities for the provision of care and provide guidance in shaping private and NGO sector inputs.

5. Resource Mobilisation and Sustainability of Programming

Resource mobilisation is essential for long term HIV-PPTCT programming. To facilitate country ownership, NACP/PACPs have and will continue to additionally undertake various advocacy strategies to ensure the mobilisation of adequate resources for implementation of the PPTCT Strategic Framework.

5.1 Expand Strategies for Resource Mobilisation – Resource mobilisation will aim to engage multi-sectoral partners in the HIV-PPTCT response and to facilitate their participation, at least two meetings per year to be organized with all relevant stakeholders and service providers, (including DoH, community-based and PLHIV organizations and multi-sectoral partners such as TB, Hepatitis, Social Welfare, Prisons, Home Department, Law Enforcement Agencies, Education, NCSW etc.).

Reports on progress of the response will be made available to the partners, and address re-occurring or new coordination challenges. Provincial AIDS Control Programmes to facilitate smaller meetings as needed on specific issues related to prevention, treatment and care access. These strategies will include timely development and renewal of PC-1s (already developed), new costed HIV Strategies with costing of services keeping in mind efficiency, increasing internal and external funding commitments, seeking innovative financing mechanisms, and leveraging existing resources. Harmonisation of donor funding including expansion of funds under GFATM to be also part of the provincial plans for continuing PPTCT-HIV programming.

5.2 Develop Sustainable and Efficient Programmes - Sustainability will be guided at the provincial levels by development of implementation plans, a resource mobilisation strategy, M&E plans, coordination mechanisms, communication strategy, and sector specific involvement at each level of the governance system.

28 Elson D et al. "Macroeconomics and Macroeconomic Policy from a Gender Perspective." Paper delivered at the Public Hearing of Study Commission on Globalization of the World Economy—Challenges and Responses. Berlin 2002. www.icrw.org.

CHAPTER 3: IMPLEMENTATION PROCESS AND ACTIVITIES

The PPTCT Strategic Framework recommends following a phased implementation plan by the Federal/provinces based on available resources, provincial HIV epidemiology and the prevalence/dispersion of risk population, and existing human resource capacities. The PACPs will develop their own implementation plans giving priority to interventions that increase the access to and coverage of PPTCT services by: (i) reaching key populations with Service Delivery Programmes (SDPs), (ii) support voluntary spousal disclosure and testing through ART centres and SDPs, and (iii) expansion of the geographic coverage (particularly in high burden districts/localities) of new Family Centred ART-PPTCT-Paediatric treatment and care centres with linkages to community-based organisations. On an annual basis, PACPs will periodically review this Strategic Framework and proposed actions to document lessons, progress made and corrective adjustments for the next phase of implementation.

This chapter summarises key lessons and actions based on stakeholder discussions; review of provincial PC-1 documents and HIV Strategies; and findings of the PPTCT Programme Evaluation for improving effectiveness and coverage. The implementation activities are shown under their respective strategic directions with some activities having an overlap across multiple areas.

3.1 Planning and Implementing Effective Service Delivery Programmes

Strategic Direction: 2 (Demand Generation & Access) and 3 (Integration & Strengthening of Health Systems and Services)

Provincial Contexts and Rationale – the Framework clearly recognises that provinces understand their respective HIV contexts, health system constraints, resource availabilities, and priorities the best. Both HIV preventive and treatment, including PPTCT services and linkages will operate within the paradigm of: (i) provincial autonomy, (ii) urgency to increase prevention services for KP to at least 80% and above, (iii) ensure quality of services at health facilities, (iv) access for the most marginalised and vulnerable without discrimination to socio-economic status, and (v) emphasis on measuring results and performance.

During provincial consultations some challenges were observed that will need to be addressed in order to ensure increased effectiveness of this phase of PPTCT programming:

Area	Balochistan	Khyber Pakhtunkhwa	Punjab	Sindh	AJK
Committed PACP leadership with support of DoH	Lacking. Funds from PC 1 were transferred to other programme	✓	✓	✓	Lacking
Approved PC 1 with committing of adequate resources	No	PC 1 approved but low resources	✓	PC 1 not approved	No
Need based planning of the HIV-PPTCT response by the PACP (i.e. planning is based on credible data, costed for efficiency and feasibility, and prioritized)	No	Not sufficient evidence informed planning	No. May need revisions based on IBBS 2016	No. May need revisions based on IBBS 2016	No planning done yet
Technical expertise present (i.e. availability of PACP staff positions)	No	Somewhat, PACP has vacancies	Yes	Yes	No
Availability of human resource to implement programming	No	Yes	Yes	Yes	No
Review of lessons from past programming with mitigation strategies identified	No	No. Weak	No. Weak	No. Weak	N/A
Overall Rating	Weak with need for substantial guidance on the PPTCT-HIV response management	Fair. Will need to ensure continuity and adequate coverage of services and monitoring of progress.	Good. Will need to be cautious in over-expansion of services and low numbers and utilization. Will need to closely monitor progress	Good. Will need to ensure effective implementation and monitoring of progress.	Weak.

Key Action Points - Access to and uptake of PPTCT services is determined foremost by good case identification (i.e., awareness and knowledge of HIV status and availability of HIV testing and counselling services to key populations and especially their spouses. In

Pakistan, according to the AEM Analysis Report (2015) the key gaps are low coverage of SDPs and lack of referral between SDPs and PPTCT programme. Key responsibility rests with the PACPs and DoH with inclusion of cross-sector partners, NGOs, PLHIV and civil society for effective implementation and oversight. Some key areas are:

3.1.1 Operationalizing Service Delivery Programmes for Key Populations – The new SDPs should be designed on the basic principles of: (i) credible evidence, such as the IBBS data (2015-16) along with other independent (and credible) research should guide the placement of SDPs in districts/high risk localities; (ii) categories where the services are most likely to have the highest impact (PWID, sex workers, bridging populations, and at risk adolescents) and what numbers to be reached as per PC-1 targets and need; (iii) with at least 80% coverage; and iv) ensuring close monitoring of the targets and performance by the PACPs. For ensuring success, PACPs should make the necessary programmatic adjustments based on evidence and desired impact (estimations or scenario based), and not political expediency or interests. This will require the following:

- **Efficiency Based Contracting -** PACP will ensure that SDP contracts are based on performance, with clear specifications of minimum targets to reach per quarter, and leaving the flexibility of programmatic improvements to the implementing NGOs/ partners. Cost-efficiency is a high priority for provincial governments and the PACPs. Contracts should be standardised to meet the fundamental criteria of accountability, transparency, and good governance and be awarded on competitive merit-based selection of implementing partners as a must for effective programmatic results.

- **Integration of PPTCT in SDPs -** Promoting PPTCT messages within SDPs in terms of partner disclosure, systematic testing, 100% condom use, needle exchange and harm reduction interventions including the push for Oral Substitution Therapy, referrals and access to PPTCT services, and ART initiation and compliance is absolutely critical.

- **Culturally Appropriate PPTCT Messages -** Like context specific programming, PPTCT messages will need to vary by provinces/localities, be gender appropriate and be best delivered as “one-on-one counselling sessions” or interactions rather than impersonal media campaigns (shown to be less effective with KP), IEC materials (low literacy), and social media (not enough access). Monitoring mechanisms will track whether or not messages influence behaviour change.

Key questions to address are: (i) are 80% of key populations being targeted with prevention services, (ii) are SDPs able to access (i.e., coverage) and test >90% of the eligible target audience, (iii) what percentage increase in referrals of women and men to ART or PPTCT services is being documented.

3.1.2 Strengthening Provider Initiated HIV Testing and Counselling (HTC and PITC) for Spouses within ART centres and SDPs – The Framework recognizes the urgency of reaching 100% testing of all spouses (particularly wives) among male patients registered at ART centres nationwide, and at least 80% coverage of eligible spouses or sexual partners through SDPs of PWID, MSWs and HSWs. The advantages of universal testing

whether initiated by the provider (PITC) or by the client particularly in spouses are: (i) early initiation of ART for women/partners found to be HIV-positive, (ii) using ART as a prevention intervention in sero-discordant couples and thus preventing new infections in uninfected women (i.e., Treatment as a Prevention strategy), and (iii) increasing the potential referral base for PPTCT services. Spousal HIV testing uptake will be used as a key performance indicator at ART centres and in SDP monitoring.

Other elements include:

- Review and revision of IEC materials and one-on- one counselling strategies to convince clients to increase spousal disclosure, improve spousal communication, permit testing, condom use, and negotiate safe sex and needle use practices.
- Identify clear linkages and referrals between HTC points of services (whether community CHBC or SDP based), VCT centres or other health facilities and ART-PPTCT centres so that clients can receive a complete continuum of services with lower loss to follow up.

Key questions to address are: (i) are interventions increasing the numbers/percentage of spousal testing in SDP – if not what are additional strategies to increase testing rates, (ii) what barriers are affecting uptake (i.e. which sub-populations or groups are resistant to testing or disclosure, and (iii) are ART centres covering 100% spousal testing.

3.1.3 Capacity Building of Care Providers at all Levels – Effective delivery of PPTCT services are dependent on a cadre of well-trained and competent care providers. This will be made possible through a three prong approach: (i) establishing clear National PPTCT Guidelines and Protocols on ART management (i.e. Option B+), counselling on HIV prevention, safe sex, family planning, infant feeding, and safe delivery,)ii) combined with didactic trainings for doctors and mid-level providers, nurses and paramedical staff, counsellors, NGO providers, and other cadre of government outreach such as LHWs, CMWs, and Family Welfare Workers (FWWs), and (iii) post-training on-site mentorship and learning for an initial period of 3-6 months.

- Develop clear Standard Operating Procedures (SOPs) for health facilities/providers at the DHQ, BHU, and tertiary care teaching hospitals. The SOPs will describe processes and provide instructions to maximize PPTCT and child care service delivery at health facilities in accordance with National Guidelines. The SOPs will guide clinicians in providing interventions, treatment and care in maternal and child health care settings, and in evaluating performance, thereby serving as a quality assurance tool for management. The SOPs will also focus on scenarios for initiating PITC such as risk behaviours, prolonged unexplained weight loss and illness in relatively younger people, sexual intercourse with sex workers, unscreened blood transfusions are some of the criteria that can be highlighted.
- Ensure that there are adequate numbers of women staff in the work force to meet the needs of female patients.

3.1.4 Develop Provincial Training Plans – For the categories of providers to be trained, prioritized by district risks and training need assessments. Resource allocations should be jointly shared by the PACPs along with contributions from DoH, MNCH, LHW, Hepatitis and TB programmes in-order to integrate HIV within mainstream DoH programmes, and to have ownership and synergy.

- Since a considerably vast majority of births occur at home it is important to include CMWs, LHWs/LHVs, TBAs and private sector providers in basic level of trainings about HIV and good infection control practices. The "Training Plans" should have detailed strategies on how best to access and implement phased trainings.

- Appraisals and quality assurance of providers should be a routine feature of the implementation plan.

3.1.5 Integration of PPTCT-RMNCH Services - – Integrating PPTCT within RMNCAH services has been recognized as a cost-effective way of achieving universal health coverage, improving efficiency, and quality of services. Rationale behind integration of HIV-PPTCT and RMNCAH is that more women/children will learn of their HIV status, make smarter reproductive health choices, start ART early, and thus reduce risks of transmission and lead longer and healthier lives. The concerns are that in low prevalence epidemics HIV efforts would be stigmatized and outcomes would get diluted with integration.

- In low prevalence HIV epidemics the three most preferred ways of integration[29] are: (i) Different health services are integrated in the so called "one-stop shop," by offering multiple services at the same facility. This is a model that Sindh and Khyber Pakhtunkhwa are following; (ii) Integrating services might consist of coordinating services across different service delivery sites; for example, implementing a referral service so that those identified as HIV positive at an MNCH site can receive HIV care at an HIV site, resulting in increased coverage of ART; and (iii) Integration at the management or health facility level at either the district, provincial or national level, could result in more efficient uses of personnel. This is closer to what Punjab is following.

- Evidence supporting the cost-effectiveness of PPTCT-RMNCAH integration is well presented in an analytical paper[30] using three countries Malawi, Mozambique and Uganda. The paper found that significant cost savings and better outcomes are present for different scenarios of integration and that integrating family planning into HIV care facilities results in even greater benefits.

- Additional focus will need to be given to at risk adolescents and how early prevention efforts through SDPs or through integrated RMNCAH programmes can be applied.

29 Duffy, M et al. Practical Information and Guidance for Integration of MNCH and HIV Programs within a Continuum of Health and Social Services. 2013. USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One

30 Cost-Effectiveness of Integrating PMTCT and MNCH Services: An Application of the LiST Model for Malawi, Mozambique, and Uganda. 2013 USAID DHS Occasional Paper 7.

3.2 PLHIV at the Centre of Care and Services

Strategic Direction: 1 (Leadership Empowerment at the Community level), 2 (Demand Generation and Access), and 4 (Expanding the Continuum of Care).

Rationale – Learning from past experiences, in this PPTCT Strategic Framework, PLHIV and organisations working with them particularly the PLHIV Association are critical stakeholders and are envisioned to play a greater strategic role in expanding coverage, demand creation, implementing the Continuum of Care model (CoC) and improving their skills to support service delivery.

Key Action Points – Over the course of HIV infection, PLHIV have different levels of needs – medical/physical and mental health issues, social and legal consequences (stigma, discrimination, human rights violations), and economic challenges (inability to work, costs of care, death of primary earners) that require a wide range of services. Developing this comprehensive continuum of care requires substantial planning and partnerships between PLHIV, government and NGOs particularly during the process of entry into and retention along the CoC. Under the leadership of PACPs/NACP, in this Framework the focus is building on PLHIV capacities and engagement throughout:

3.2.1 Involvement of PLHIV throughout the Assessment, Design, Implementation and M&E PLHIV will be involved in all stages of the programme cycle, from assessment through to monitoring and evaluation.

- Using PLHIV (both women and men) for 'assessments' in the process of gathering and analysing information, experience and evidence in order to identify needs for developing programmes. Effective assessments ensure that programmes are relevant and address a gap or need. For example, understanding the scope of and key trends in the HIV epidemic in the district/locality will help to target efforts and resources more strategically. PLHIV may be better positioned to: (i) focus on issues that are most important/relevant, (ii) ask questions in ways that the target audience understands, and (iii) involvement at the assessment stage increases the likelihood that the target audience will have a sense of ownership over the results and will buy into the solutions. This will increase the sustainability of programme and the involvement of people living with HIV in it.

- Involvement during the Planning and design means identifying key goals and objectives, the populations to reach, the strategies you will use to achieve your goals and objectives, and developing your work plan and monitoring and evaluation framework. Advantages of involvement at this stage are: (i) more need responsive, (ii) be seen as credible and accessible by your target audience, and (iii) potentially helps to find local solutions.

- During the Implementation phase common strategies are: (i) inclusion of PLHIV (both women and men representation) on advisory groups and steering committees, (ii) involvement of peer outreach educators in the implementation of programmes, and (iii) working collaboratively with PLHIV organisations on programme implementation.

- Monitoring and Evaluation – Involving PLHIV in monitoring and evaluation makes sure that the programme is delivering things that are important to the end beneficiaries. Having PLHIV develop data collection tools, conduct evaluations, review and analyse data can result in more relevant and nuanced understandings because of their lived experience. This helps to make sure that programmes are continually informed by a strong and relevant evidence base that is grounded to the needs of the end beneficiaries

3.2.2 Capacity Building of PLHIV towards Self-Sufficiency – PLHIV often belong to marginalised groups, and may not have the formal education or capacities to undertake the responsibility of service delivery or NGO/CBO organizational management. In addition, PLHIV are often asked to take on a lot of work as volunteers with no financial compensation, even though other representatives hold paid positions. This limits the amount of time and resources people are able to devote to their role, for they must do other work to support themselves.

- Capacity Building refers to helping PLHIV, particularly women affected and living with HIV to develop requisite skills and knowledge towards self-sufficiency in terms of availing opportunities, finding gainful employment in HIV service delivery or empowerment to represent themselves and their networks.[31] Capacity-building can be hard work and takes time and investment. Developing learning activities will require a needs assessment and trainings should always be followed by ongoing monitoring, support and supervision. Some common areas identified by the PLHIV Association and PLHIV organisations are: (i) knowledge about how NGOs work, such as aspects of funding, programme design, planning, implementation, monitoring and evaluation, (ii) information about health, HIV and antiretroviral treatment, (iii) understanding of government recruitment systems, (iv) advocacy and campaigning, and v) legal rights and access.

3.3 Policies for an Enabling Rights Based Environment

Strategic Direction: 1 (Leadership and Advocacy for Commitment)

Rationale – Despite considerable improvements in the last decade, levels of stigma and discrimination of PLHIV and KP remain high in Pakistan leading to increased vulnerability and barriers to access HIV care services.

Specific factors that result in barriers to access include ambiguities in legislation and criminalisation of certain risk behaviours, attitudes of healthcare and service providers, socio-cultural taboos on the sexual mode of transmission, and costs of services (testing, transport, and admissions). Targeted advocacy and building the capacity of leadership at all levels will help reduce socio-cultural barriers and create a non-discriminatory environment where the rights of all citizens are guaranteed.

31 Leadership Through Accountability Programme www.gnpplus.net/programmes/empowerment/hiv-leadrship

Key Action Points - Policy formulation and enactment with good implementation are fundamental to ensuring a favourable policy environment that responds to the needs and rights of the affected population. Key responsibility for advocacy for policy formulation and enactment will lie with NACP/PACPs and DoH under the guidance of Technical Steering Committees. Some key areas of focus in policy and laws are:[32]

3.3.1 HIV Prevention and Treatment Legislation - Any HIV legislation should take into account and determine that who can conduct an HIV test, confidentiality of testing, sharing of results, situations in which disclosure is mandated , rights of the patient, and recourse for negligence etc.

3.3.2 Review and Finalize HIV/AIDS Policy – Currently there is no HIV/AIDS Policy in Pakistan, however, there is a draft policy from 2007 that can be reviewed and revised as feasible in the light of provincial autonomy and devolution.

- Some particular considerations for the HIV/AIDS policy are - If a PLHIV is a citizen of Pakistan then he/she is entitled to the same rights as any other citizen of Pakistan and by law cannot be discriminated against, on the basis of health status, gender, and socio-economic status or HIV risk factor(s). In the event that discrimination does exist, then the policy must provide measures for the elimination of such discrimination, whether by legislation, policy or programmes.

3.3.3 Inclusion of HIV in District Health Committees - – to strengthen local accountability and leadership HIV should be one of the health components in DHCs.

- Some particular considerations for the HIV/AIDS policy are - If a PLHIV is a citizen of Pakistan than such a PLHIV does indeed should have the same rights as all other citizens of Pakistan and by law cannot be discriminated against, on the basis of health status, gender, and socio-economic status or HIV risk factor. In the event discrimination does exist, then the policy must provide measures for the elimination of such discrimination, whether by legislation, policy or programmes.

3.3.6 Review of Laws of Pakistan and Contradictions with the Rights of PLHIV and KP – The detailed report[33] highlights that the majority of PLHIV and KP are engaged in activities that are considered to be in violation of various laws of Pakistan. A concerted effort is needed by the NACP and PACPs along with the law department to review many of these ambiguities and find practical solutions to address them.

3.3.7 Addressing Absent Laws through Review and Advocacy – KP engaged in sex work are unable to report any abuse that they may encounter due to their professions. This situation requires rationalization and appropriate amendments in law, in order to ensure that

32 Scan of Law and Policies Affecting Human Rights, Discrimination and Access to HIV and Health Services by Key Populations in Pakistan. UNDP-NACP 2015

despite their professions, all aggrieved citizens are entitled or have a right to seek relief and should not be judged by their social origin.

- Similarly there should be laws to penalize "transmission of HIV", i.e., women infected by husbands who deliberately continue unprotected sexual contact despite knowing of their HIV-positive status, should have avenues for recourse and criminal punishment of violators.
- Spousal Disclosure of Status law – should have a defined duration after which disclosure between infected spouses, i.e., men and women becomes mandatory, and this should be rigorously implemented

3.3.8 Feasibility Review of Policy for Universal Testing - Although universal HIV testing is being recommended as a long-term, cost effective, approach by WHO particularly in generalised epidemics. The evidence is less clear in low prevalence settings, and requires considerable financial and technical commitment for training counsellors, provision of adequate physical facilities, and laboratory support. The Framework based on discussions with stakeholders recommends provincial piloting of universal-testing to determine feasibility of universal testing in terms of yield, logistics, and outcomes before large scale implementation across all districts.

3.4 Coordination and Sustainability

Strategic Direction: 5 (Resource Mobilisation and Sustainability)

Rationale – Coordination for implementing the Framework will happen at the national and provincial levels. It will require the PACPs and NACP to take the leadership and bring together coordination and decision making from different government and non-government partners. At the district level, decentralised health management committees will help to actualise the PPTCT Strategic Framework through the incorporation of explicit targets and interventions in Annual Work Plans. At the national level, NACP will compile the results of the implementation of the Framework.

For long term sustainability it is well recognised now that external/donor investments in HIV are likely to continue to decrease in Pakistan as other higher HIV burden countries take greater priority in resource distribution. Current and future HIV programming, including PPTCT, needs to become more cost-efficient and effective in getting the maximum value for money.

In collaboration with Ministry/Departments of Finance and Planning & Development, PACPs will need to use advocacy and opportunities to mobilise internal (i.e. government's own resources) including domestic sources such as private philanthropy, corporate and private sector.

Action Points – Finding win-win relationships for complementarity of services will be the key responsibility of NACP/PACPs to mainstream HIV services in other health and cross-sector partnerships. Priority strategies are:

3.4.1 Coordination through the Technical Working Group (TWG) for Treatment and Car - It is recommended to use the existing structure of the Technical Working Group for

Treatment and Care to also oversee PPTCT programme. The TWG will be particularly instrumental in monitoring progress, providing suggestions, and helping in resource mobilisation. If feasible to the provinces, the TWG should have a wide membership from PACPs, technical personnel from Planning and Development and Finance, provincial parliamentarians (2-3), civil society experts on HIV-MNCH, PLHIV representative, 1-2 NGOs working in SDPs, and development partner (1-2). There should be particular attention paid to the gender representation on the TWG and clear targets defined (i.e., the number of women on the TWG from the total membership number).

- The TWG's specific objectives will be: (1) to monitor performance and effective accountability through an independent representation of diverse people, (2) to strengthen coordination and harmonisation across provinces and the national level for one unified reporting of PPTCT goals and results, (3) to assist in resource mobilisation, and 4) to provide technical and practical facilitation for the implementation of the Framework and processes.

3.4.2 Resource Mobilisation and Financial Efficiency – PACPs will aim to reduce costs of PPTCT programming through mainstreaming and efficiency improvements. Simple exercises looking at: (i) Allocative Equity - is the Programme directing funds and services to the most marginalised or poorest groups as per risk mapping or evidence, (ii) Allocative and Productive Efficiency – are the optimal mix of inputs/resources in place for providing the necessary and demanded programmatic interventions, (iii) Economies and Efficiency - what are the actual costs of delivering interventions (including advocacy interventions), and what is the productivity and results achieved, and (iv) Economies – what are the compared unit costs local, national, and regional levels. Some considerations for example are: Can additional collaborations between provinces reduce costs, across sectors (welfare, overseas employment, drug and law enforcement, education) reduce costs?

3.4.3 Development of a Resource Mobilisation Strategy – tto meet the existing gaps in the PC-1s support, PACPs with the approval of DoH may choose to seek additional support in the form of technical assistance, capacity building, or financial resources from donors, GFATM grants, UN agencies, or other corporate sources. This will be done through a documented and detailed resource mobilisation strategy to avoid the previous pitfalls of seeking "ad hoc" funding and "one off" activities.

3.4.4 Transparency and Reporting - The reporting frameworks and results culture within the PACPs will be strengthened to improve the administrative efficiency, savings and improve the overall transparency of PPTCT programme results and contribution to results.

3.4.5 Sustainability through Strengthening Local Small NGOs – PACPs will help nurture and support (direct through small grants, and indirect through donor linkages) the capacity of PLHIV organisations/NGOs/CBOs to seek external funding, proposal writing, competitive bidding, and overall institutional strengthening.

3.4.6 Revive Multi-Sectoral Engagement – PACPs will take the lead in reviving the previously (2010) held provincial Steering Committee and Coordination meetings. The

provincial meetings will have: (i) clear agenda, (ii) participation of broad stakeholders from civil society, PLHIV, government departments, donors, and NGOs, and (iii) transparency of progress and findings of these meetings will be shared and those mechanisms will be clearly defined by the PACP.

- Schedule regular quarterly engagement with cross-sector partners in Education, Law Enforcement, Justice, Overseas Employment, Social Welfare, Population Welfare, and Provincial Commission on the Status of Women – to address mainstreaming, challenges and barriers to implementing programming, and reducing stigma for PLHIV.

3.5 Measuring Progress and Monitoring Evaluation

Rationale - Successful implementation of the PPTCT Strategic Framework will require continuous monitoring and adjustment of the implementation process. Monitoring and tracking of progress was a weak component of the last PPTCT Strategic Framework. Key indicators and targets have been developed (Annex 5) and can be used for tracking performance and implementation of this framework. These indicators will also feed into the global PPTCT indicators of progress. It is recommended that districts and facilities set their own targets in line with overall provincial and national targets. Data collection and reporting on the PPTCT indicators will in part be through routine monitoring, operations research, programme reviews and if possible some population level surveys.

Key Action Points – The PACPs and NACP will be responsible for the monitoring and data collection on outcome, process and input levels for the PPTCT services and coverage. Adaptations will be needed for: (i) different facilities (BHU, DHQ or Tertiary Hospital), (ii) levels of indicators and frequency of data collection, and (iii) human resource availability by provincial funds and/or PC 1 plans.

3.5.1 Routine Monitoring – Consideration will be given to innovative measures to improve programme data management such as through electronic medical recording and using patient smart card system between SDPs-ART-PPTCT-Paediatric centres.

- Inclusion of HIV-PPTCT indicators in District Health Management Information systems (DHMIS) can be piloted in the most at risk districts using web-based DHIS portals and validation by the PACPs or District Health Teams through routine spot checks.
- HIV-PPTCT Commodity tracking and matching can be piloted within the Logistics Management Information System (LMIS) to streamline HIV commodities ordering, reduce wastage, track supply and utilisation, from different categories of health facilities. This also can be piloted in selected districts.
- Linkage of HIV-PPTCT with the CHBC, and community level frontline workers (LHWs and CMWs) that are providing services or referrals to PLHIV or screening clients for risk identification interventions (i.e. HTC)
- Linkage of Early Infant Diagnosis results with the PPTCT centres so that providers can check results relatively quickly and inform the beneficiaries.

3.5.2 Outcome Monitoring - Deciphering the transmission rates and overall programmatic outcomes will require a more detailed level of cohort monitoring such as 1) **Risks of HIV by Birth Exposure and by Feeding Practices** - which is a cohort register to determine children outcomes based on their 6 week PCR test results, infant feeding practise and ART coverage during breastfeeding. Ultimately the transmission rates at 6 weeks, one year and 18 months can be determined, 2) **Comparing HIV risks in mother-baby pairs to national non-HIV mother-baby pairs** using selected sentinel DHQ sites (according to provincial prioritisation) following up mother baby pair will be approached to share data sets on mother- infant pairs that will then be compiled nationally to determine maternal and childhood outcomes at set time points. Efforts shall be made to increase these sites so that more data on mother-baby pair is available.

- Routinely scheduled Programme Reviews (6-12 monthly) should thoroughly examine what the available data is showing from routine and other independent sources, and make the necessary data quality audits, and programmatic adjustments. *These reviews should include PLHIV satisfaction, increase in uptake of services, referrals from SDPs, and quality of care outcomes.*

3.6 Research Questions

Rationale – Research is instrumental in helping formulate policy, design programmes, analyse socio-cultural and behavioural barriers, propose solutions for these barriers, and evaluate changes through policies and programme interventions to overall improve programme results (particularly coverage, access, quality, logistics, and impact).

Action Points – The purpose of research within the *PPTCT Strategic Framework* is to develop and test programme strategies that will optimise performance. By embedding implementation research as well as social-behavioural and anthropological research, the PPTCT programme can help generate lessons learned, optimise program performance, and inform the knowledge base for other regional countries faced with similar challenges. Some priority areas within research are:

Table 3. Priority Areas for Research

Area	Questions
Risk Reduction and Prevention of HIV in girls and women	**Policy Level** 1. How are existing policies and laws consistent or incompatible with HIV i) prevention efforts in at risk groups , and with ii) marginalised and poor women by provincial contexts? 2. Mapping of policy gaps and advocacy or legislative efforts needed for various HIV laws and policies? 3. Feasibility of universal HIV testing and costs in low prevalence epidemic and in the context of Pakistan's public health resource constraints **Incidence and Prevalence** 4. Incidence studies – what are innovative ways to estimate incidence in this group? 5. What interventions can improve male participation in HIV testing and counselling? Male disclosure? 6. What strategies work best with different KPs? Adolescents at risk of HIV? What are retention strategies and why do they fail/sustain over time? **Socio-Behavioural Aspects** 7. Impact of HIV on societal discrimination and gender violence among women and men? How does it differ and its implications 8. What messages resonate with different groups? Efficacy and uptake of various media platforms – how does it work? Evidence
Addressing Family Planning and Reproductive Health Rights in PPTCT programming	1. What are the common myths about FP, ART and HIV by provincial contexts? 2. Are health care providers trained and ready to provide FP and RH counselling to HIV and non-HIV women? Comparison of biases and practices 3. Estimations of post- partum FP in HIV-positive women and economic modelling to advocate to decision makers 4. Expanding the FP options – long term methods and right to choose 5. What are the optimal methods for integrating FP-PPTCT services and increasing voluntary uptake as well as provider productivity in public sector, private and NGO based services? 6. Role of men and how can it be increased in HIV positive families and beyond?

Area	Questions
Access to and Quality of Care Services	1. Barriers that limit access to care services – at what stage, costs, stigma, or others? What can alleviate the barriers and what methods have successfully worked and failed – case studies of reasons 2. Quality mapping of different centres and comparisons to utilisation. What are the quality of care indicators compliance? 3. Retention in care strategies? What works or not? 4. What is the loss to follow up by centres and what strategies can be incorporated 5. What are the long terms impacts and costs of Option B+ in terms of adherence/compliance, human resource, and infrastructure 6. How does PPTCT affect outcomes in children at 1, 2 and 5 years – does HIV free translate into increased child survival compared to non-HIV positive households? 7. Impact of EID on infant ART initiation duration and delays
Management and Planning for Sustainability	1. How is HIV Programme leadership (at national/provincial level) engaged in needs based and effective planning? Is HIV-PPTCT programming efficient compared to regional and global interventions? What are the best practices from Pakistan? 2. Are principles of rights and equity being followed in programming and implementation by partners 3. Engagement and role of PLHIV – is it increasing, stagnant or reducing? How are strategies to build PLHIV capacity performing – case studies 4. Expansion of new CBOs led by PLHIV? 5. What new cross-sector alliances and partnerships have been developed? What are the intended and unintended consequences for PPTCT services? How has it affected PPTCT coverage? 6. Is there a Participatory process of planning and monitoring including sharing of the results to inform enhancements in programming?
Dissemination of Research and Programmatic information	1. Are there regular stakeholders and information sharing meetings at the provincial and national level 2. Is Pakistan consistent with its global PPTCT reporting indicators 3. Inclusion HIV-PPTCT indicators in population level surveys such as PDHS, PSLM, HIES etc. to follow trends and detect changes 4. Are there formal mechanisms to ensure Capacity building for data generation and evidence use in different levels of programme implementers and decision makers?

Annex 1: Revision Process of PPTCT Strategic Framework 2007 in Pakistan

Objectives of the PPTCT Strategy Review

In 2015, UNICEF Pakistan in collaboration with the National/Provincial AIDS Control Programme (NACP/PACP) commissioned an independent Evaluation of the PPTCT Programme (2007-2015) in Pakistan[34]. Based on one of the recommendations of the PPTCT programme evaluation, UNICEF Pakistan in response to a request from NACP and the PACPs has now commissioned the review and revision of the PPTCT Strategic Framework (2007). The specific objectives of the review are:

1. To provide UNICEF and Government of Pakistan via the National and Provincial AIDS Control Programme a detailed review and revision of the existing PPTCT Strategic Framework in terms of i) making PPTCT services more efficient, ii) better placed to scale up HIV testing and counselling, iii) to diagnose and treat more HIV+ women and iv) to bring the PPTCT programme in line with the latest international recommendations.
2. 2. The review will help UNICEF and Government partners particularly provinces on how best to position PPTCT prevention and treatment services within community-based settings, and integration within Maternal-Child Health programmes and health facilities to reduce and eliminate new HIV infections in infants in Pakistan in the most cost-effective manner.
3. The revised strategy will also address how to improve PPTCT programme equity and uptake of services by the most marginalised, vulnerable and key risk populations.

Purpose of the Strategic Framework Review

The purpose of the current review is to revise the National PPTCT Strategic Framework through a participatory process with the NACP/PACPs, and in line with the provincial PC 1's and HIV/AIDS Strategies (2012).

The Process

The review process covered the PPTCT Strategic Framework (2007) and included consultations in Federal and all 4 provinces including AJK during August – November 2016. The main consultation objectives were to identify how 1) coverage of PPTCT services can be enhanced, 2) integration within MNCH services, 3) enhance access to and quality of services, and 4) ensure sustainability.

34 Evaluation of the PPTCT Programme in Pakistan (2007-2015). UNICEF 2015 by Consultant Dr Ayesha Khan. www.unicef.org

The key consultations were with government planners (programme managers of national/ provincial AIDS Control Programmes), focal persons for PPTCT-Paediatric centres, Planning and Development officials, plus a desk review of HIV Strategies and PC 1 documents and FGDs with PLHIV. The review process relied heavily on the findings of the PPTCT Evaluation Report (2015).

Preliminary provincial; findings were shared via presentations to respective PACPs, and the UNICEF RG. A draft of the PPTCT Strategic Framework was shared with UNICEF team in early November and a larger stakeholder validation meeting was held in late November to reach consensus on the Framework and proposed recommendations.

Audience of the Evaluation

The main audience of the PPTCT Strategic Framework are PACPs/NACP and UNICEF Pakistan along with other government planners, NGOs, civil society experts, GFATM, UN Agencies, and donors. The main end beneficiaries are PLHIV.

Limitations of the Review Process

The review process was limited by i) lack of updated HIV epidemiology and surveillance data on MARPs (current round of IBBS is still ongoing), ii) lack of functional SDP data to guide where service gaps exist, and iii) limited number of FGDs in provincial capitals missing out on PLHIV from smaller districts/localities.

Ethical Considerations

The review process adhered to UNEG's ethical guidelines[35] and ensured that participation (i.e. selection of stakeholders, primary data collection and stakeholder interviews/FGDs/ questionnaires) were via informed consent and voluntary.

To safeguard rights, dignity, and privacy particularly of PLHIV beneficiaries or recipients of PPTCT services all unique individual identifiers were removed from the data collected and responses to protect the confidentiality of individuals and institutions unless permission was explicitly obtained to list names with responses.

The review itself was independent, impartial, and rigorous and conducted with professional integrity and no conflict of interest was present between the consultant and the objectives of the assignment.

35 UNEGs Ethical Guidelines March 2008

Annex 2: List of Resources and Documents Reviewed

1. National PPTCT Strategic Framework 2007
2. National PPTCT Guidelines 2008 and WHO 2010 ART and PPTCT Guidelines
3. UNAIDS Pakistan Report 2014.
4. UNICEF website www.unicef.org
5. Pakistan Global Progress and Response Report 2015
6. WHO PMTCT Strategic Vision 2010-2015
7. Websites of Punjab, Sindh, KP and Balochistan AIDS Control Programmes.
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Annex 3: PPTCT List of Potential Key Indicators (Proposed Draft)

Indicators	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
Output Indicators												
No. (%) of mother-child transmission of HIV in women on ART prophylaxis												
No. (%) of mother-child transmission of HIV in women on ART treatment (full)												
% (number) new clients (women spouses) tested in MARPs												
No (%) of FSWs tested												
No (%) of women referred into ART-PPTCT care services from SDPs – list which SDP categories												
No (%) of women spouses tested at the ART centre												
No (%) of pregnant women referred into PPTCT from ART centres												
No (%) of pregnant women referred into PPTCT from community based sources – list source?												
No (%) of HIV+ women delivered by C-section – list whether on ART and since when												
% (number) of infants receiving OI prophylaxis from the total number of infants exposed to HIV												
% (number) of infants receiving ART prophylaxis from the total number of infants exposed to HIV												
No (%) of HIV+ mothers that are breast feeding												
No (%) of HIV+ mothers that are formula feeding												
No (%) of infants tested with PCR at 6 weeks – document the infant feeding practices												
No (%) of infants tested at 12months – document the infant feeding practices												
No (%) of infants tested at 18 months or at cessation of breast feeding – document the infant feeding practices												
No. (%) of PLHIV in HIV care by women and men												
% of PLHIV on ART by women and men												
% of PLHIV on ART with suppressed VL by women and men												

Indicators	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
Prevalence and Incidence Indicators												
No (%) of maternal deaths in HIV+ women												
No (%) of infant deaths in HIV+ mothers												
No (%) of women with HIV (15-49 years)												
Prevalence of HIV in adolescent girls 10-19 years												
Estimated incidence rates in women (15-49 years of age) in the last 1 year												
Estimated incidence rates in adolescent girls (10-19 years) in the last 1 year												
Process Indicators												
No (%) of HIV+ or HIV-affected women that are employed in paid work												
No (%) of PLHIV (women and men separately) that have received capacity building trainings in the last 1 year												
No (%) of new PLHIV led CBOs that are registered in the last 1 year												
No (%) of new cross-sectoral partnerships formed in the last 1 year												
No (%) of doctors that have received HIV-PPTCT training in the last 1 year												
No (%) of mid-level providers that have received HIV-PPTCT training in the last 1 year – list the category												
No (%) of counsellors that have received HIV-PPTCT training in the last 1 year												
No (%) of HIV-PPTCT related papers published from research in the last 1 year – commissioned by the PACP or other donors												
% of condom use among MARPs or needles per person in PWID												
%of people who know their HIV status												
Management Indicators												
No (%) of staff vacancies in the PACP – technical staff												
% of budget for prevention vs. treatment												
% budget utilisation per year												
Duration of SDP contract awarding process from advertisement to hiring of implementing partner												
% of HIV response financed domestically												

- Indicators marked in red are the 10 global indicators for monitoring the HIV response outcomes.

Annex 5: Monitoring Dashboard from PPTCT Centres

PPTCT Centre

Center Name	Total Denom-inator	Counseling Access	Uptake of HIV Test	Case Identifi-cation Ratio	Uptake of PPTCT service	PPTCT Component	PPTCT Component	PPTCT Component	PPTCT Component	Delivery Type (C-section)	Delivery Outcomes	Delivery Outcomes	PCR Test Compliance	Quality of Care	Quality of Care	MTCT Rate	MTCT Rate	Referral Category		
	Number of women in ANC clinics	Number of women coun-seled	Number of women screened for HIV	Number of women HIV+ (con-firmed)	Number of women regis-tered into PPTCT	Date of Last HIV VL	HIV VL Result	Number of PPTCT clients on ART	Number of PPTCT clients not on ART	Number of women with C-sec-tion	Number of Live-births	Num-ber of Non-Fa-cility De-liveries	Number of Infant PCR (4 weeks)	Number of Infant pARV	Number of Infant Clotri-moxazole	Number of Infants HIV+ by PCR (4 weeks)	Number of Infants HIV + (>18 months)	Number from ART center	Number from DHDs	Number from NGOs
Jan																				
Feb																				
Mar																				
Apr																				
May																				
Jun																				
July																				
Aug																				
Sep																				
Oct																				
Nov																				
Dec																				

PACP Master Sheet for NGOs

NGO A (Service Delivery)	Denominator	Total Denominator	HTC (men)	Counseling Access	Uptake of HIV Test	Case Identification Ratio	Uptake of ART services	Uptake of PPTCT service	PPTCT Component	PPTCT Component	Delivery Outcomes	Delivery Outcomes	PCR Test Compliance	Quality of Care	Quality of Care	MTCT Rate	MTCT Rate	Referral Category		
	Number of risk group (category) enrolled in services	Number of women (spouses of risk groups) enrolled in Services	Number of men counseled and tested	Number of women counseled	Number of women screened for HIV	Number of women HIV+ (confirmed)	Number of women HIV+ referred into ART center	Number of HIV+ pregnant women registered into PPTCT	Number of PPTCT clients on ART	Number of PPTCT clients not on ART	Number of Live-births	Number of Non-Facility Deliveries	Number of Infant PCR (4 weeks)	Number of Infant pARV	Number of Infant Clotrimoxazole	Number of Infants HIV+ by PCR (4 weeks)	Number of Infants HIV + (>18 months)	Number from ART center	Number from DHDs	Number from NGOs
Jan																				
Feb																				
Mar																				
Apr																				
May																				
Jun																				
July																				
Aug																				
Sep																				
Oct																				
Nov																				
Dec																				

PACP Master Sheet for DHD

	Total population of union council or local area	Number of men and women in DHD	Number of men counseled	Number of men tested	Number of women counseled	Number of women screened for HIV	Number of men HIV+ (confirmed)	Number of women HIV+ (confirmed)	Number of men HIV+referred into ART center	Number of women HIV+referred into ART center	Number of HIV+ pregnant women registered into PPTCT	Number of men LTFU	Number of women LTFU
Jan													
Feb													
Mar													
Apr													
May													
Jun													
July													
Aug													
Sep													
Oct													
Nov													
Dec													

Annex 5: Strategic Directions and Activities

Strategic Direction 1: To Strengthen Leadership and Commitment to HIV Prevention and Response

Element	Activities
Objective 1: Use advocacy to make PPTCT a priority agenda for political and programmatic leadership	• Development of an ***Advocacy and Communication Plan*** for reaching the goals of the elimination of mother to child HIV transmission and infection among women/girls from infected husbands/partners – by different target audience such as Parliamentarians, civil society, government planners, and other key influencers • Mapping of decision makers in political leadership (across party lines) who can be instrumental in enabling HIV policies and legislation, and support a conducive environment for PPTCT interventions – what role can they play, what advocacy messages would resonate with them? • Identify a selected group across different provinces of *"champions"* for ongoing advocacy and support • Targeted advocacy using evidence on health and economic data for ART expansion and ensuing savings, human rights commitments, SDG goals, and support for building inter-linkages and integration – how does it save the government money and is the right thing to do? • Inclusion of youth parliamentarians for informing them on what role they can play in awareness, legislation, and engagement • Review of existing laws and legislation for corrective changes • Review of budget allocations by needs and efficiency planning – which districts, what programmes should be undertaken first "prioritization", and what are the cost efficiencies being achieved. • Annual review of all campaigns and advocacy efforts – report to be published in the Annual PPTCT Progress Report
Objective 2: Expand PPTCT alliances and partnerships across sectors	• Formation of national and provincial HIV/AIDS Commissions to impartially guide and monitor the response. • Conduct Government/Public Sector Mapping of cross-sectoral departments and ministries such as Planning & Development, Social Welfare, Finance, Women's Commission, Human Rights, Law and Justice – what are the opportunities for facilitation, partnerships, resource support and coordination • Identify what are non-government and private sector opportunities and limitations – that can be addressed • Measure the annual partnerships and outcomes – as part of M&E • Identify means of alignment with the SDG commitments at the provincial level and with national overall picture

Element	Activities
Objective 3: Build community leadership of PLHIV and local CBOs/ PLHIV NGOs	• Identify community leaders in high prevalence districts as *"community activists"* and create mentorship linkages with PLHIV • Interactive Platforms - In higher prevalence localities and districts connect local leadership with community to understand the challenges and solutions for effective HIV-PPTCT services • Sensitize and eliminate HIV related social taboos into a medical illness • Trainings - Build capacity of PLHIV to lead CBOs, be part of design and service delivery, and monitoring

Strategic Direction 2: Focus on Demand Generation and Enabling Access to Quality Services

Element	Activities
Objective 1: Address socio-structural barriers to accessing PPTCT-HIV services for general population and particularly the Key Populations	• Using Small Grants and other means - Conduct operational research disaggregating low PPTCT coverage into actionable issues. For example, i) what are the social barriers, are they limiting care, ii) is it unknown status, what strategies would work there, iii) are costs of services responsible, iv) low linkages, or v) what sort and where would KPs be best able to access services? • Employ PLHIV to assist in needs assessment and suggesting local solutions • Strategies to increase the engagement of men in the whole Continuum of Care (CoC) process
Objective 2: Support community initiatives that create demand for PPTCT	• Establish peer-support groups through CBOs/local NGOs to assist in people/ groups at risk, HTC, defaulter tracking and referrals • Link with CHBC sites for community awareness and sensitization of where services are available • Low cost information dissemination by providing out-reach workers with IEC materials where PPTCT services are available for distribution/availability in community meeting places (mosques, BHUs, private providers, local bus stands, bazars, DHQs) • Create community awareness on good infection control practices – embed HIV, Hepatitis as part of the sessions
Objective 3: Find innovative ways to engage local private markets and providers competencies for PPTCT services	• Identify key area *"busy providers"* both male and female providers. • Disseminate PPTCT services information to them • Involve key providers from higher prevalence localities or districts in basic HIV recognition, testing centre and referral trainings, and infection control practices. *Every provider should be able to identify or have available a directory of nearby PPTCT-HIV ART centres.* • Pilot models of case identification and referrals through private sector sentinel sites

Strategic Direction 3: Working towards Integration and Strengthening of Health Systems, Services and Linkages

Element	Activities
Objective 1: Optimizing functional integration between MNCH-PPTCT services	• Defining what is the provincial application of how PPTCT-MNCH-FP services can be functionally integrated. *The approaches will vary according to resource availability, trained HR, infrastructure capacity, and programmatic commitment to integration.* • Piloting models of integration and reviewing outcomes on PPTCT service uptake and quality • ***Reaching Policy Consensus On Universal Testing*** – how will this be done, is it feasible in the limited resources, and where is the maximum yield likely to be. The Framework proposes a phased approach of 1) targeting 100% spousal testing in ART centres, 80% coverage in SDPs, 2) piloting universal testing in higher risk districts, and then 3) depending on the evidence scaling up to universal testing across all districts. • Reach a consensus ***Policy on Task Shifting*** and support for implementation to other cadres as per the provincial policies.
Objective 2: Ensuring quality of care services through standard protocols and provider competencies	• Making detailed ***Training Plan*** of the provincial needs and deficiencies in categories of doctors, mid-level providers nurses, counsellors, paramedics, LHWs, CMWs, FWWs, private providers and NGO staff • Costing of the training needs and feasibility • Updates of PPTCT Guidelines, SOPs, Counselling Guidelines, and Referrals between SDPs-ART-PPTCT-Paediatric centres – Family Centres etc. • Trainings on FP counselling as part of PPTCT service delivery • Technical quality assurance tools and review of the developed guidelines and SOPs to be done by PACPs in collaboration with UNICEF and other TA • Measuring provider competencies every 1-2 years and giving refreshers. *There should be a basic level of provider selection and competency.* • Publishing of the quality index ratings by centres as incentives for improved quality • Annual reviews

Element	Activities
Objective 3: Ensuring ART/laboratory diagnostics/ commodities security and distribution systems	• PACPs will provide updated list of ART, essential medicines, HIV diagnostics, and laboratory to be published yearly • Discussions on options for combined procurement between national/ provinces for economies of scale. *Would provincial rules of business allow that? Can a consensus be reached that builds national capacity and allows cost savings for the provinces?* • PACPs will facilitate and/or provide point of care testing equipment and supplies to established PPTCT service centres. • Putting in place Electronic record keeping and distribution systems in a phased manner – with district inputs on stock positions as part of the overall health commodities systems – integration with LMIS? • Annual review and costing exercise looking at matching of patient numbers, testing, ART distribution and commodities. *Discrepancy should not be <15%.*
Objective 4: Building rigorous information system	• Develop Electronic Record keeping - at PPTCT centres to be electronic and slowly phasing out of paper-based systems over 2 years • Inclusion of PPTCT indicators in DHIS • Inclusion of PPTCT in population level surveys particularly the upcoming PDHS – discussions with NIPS, PBS etc. • Linking PACP-GFATM supported information systems into a compatible and one compiled database that is regularly reviewed. • Ensure compatibility with global PPTCT indicators across the provinces
Objective 5: Strengthening linkages	• Develop specific MoUs/agreements between Population Welfare Department to have availability of FP supplies and trainings for longer term methods to PPTCT providers • Develop common interventions and cross-sector programmes such as education, in GBV and women's empowerment social justice initiatives, law enforcement, and livelihood skills development. • Annual review of the outcomes of these linkages, and what needs to be adjusted – this should be undertaken by the PACPs and documented in the shape of an ***Annual PPTCT Progress Report***

Strategic Direction 4: Expanding the Continuum of Care Model

Element	Activities
Objective 1: Improving retention in care	• Formalize the provincial CoC vision and strategy. How will DHQ or Family centres be linked from the home-community-heath facility and vice versa. • Map the PPTCT loss to follow up along the PPTCT cascade • Disaggregate the causes for loss to follow up • Districts should identify their CoC plans – mapping of providers and facilities and CHBCs or other NGO supported sites • Formal relationship with network of laboratories for EID and HTC referrals • Train and engage PLHIV as peer counsellors • Peer-peer mentorship • Conduct a Six monthly review exercise of PPTCT centres and retention in care targets matched to coverage expansion – address barriers identified during the review. • Strategies to address and mitigate healthcare provider stigma and biases
Objective 2: Supporting initiatives that empower and enable women from HIV-affected households to skills and economic resources	• Support and collaborate with external donors/UN agencies for interventions that enable "economic independence" through skill building, micro-credit, and job placements for HIV-positive women including those women who are negative but from HIV affected households. *Linkages to broader national programmes such as BISP, PTST, PPAF, Micro-credit Banks, etc, should be explored* • Embed economic and skills development programmes within SDPs (in some pilots) • Minimize the *"HIV dependency culture"* that promotes PLHIV as dependent and constantly in need of charity and disenfranchises them of longer term initiatives and self-sufficiency • Trainings for capacity building of PLHIV in financial management, low literacy maths, communication, negotiation, and CBO formations • Trainings for Grant writing and accessing internal and external funding support for PLHIV/women led CBOs

Strategic Direction 5: Effective Resource Mobilisation and Sustainable Programmes

Element	Activities
Objective 1: To expand resource mobilisation through internal and external funds	• Develop ***"Resource Mobilisation Strategy"*** based on PC 1, costing exercise, available resources, and efficiency. Define percentage of internal vs. external funding ratio (i.e. 70% vs. 30%) • Tap into private sector and corporate markets • Oversight on programming and resource utilization by the HIV/AIDS Commissions. – include broad range of partners for transparency and accountability • Develop resource mobilisation protocols – who does what and at what level? How are district leaderships going to be involved in resource mobilisation, and accountability? • Create a ***Database for Tracking Resources Going into PPTCT*** – this database should be placed in the PACP with oversight of DoH and Planning and Development.
Objective 2: Develop sustainable programmes that have an impact	• Programmatic decision to design and implement programmes that are i) value for money, and ii) work towards the goals of eliminating mother to child HIV transmission and new infections in women/girls. *PPTCT programmes that are based on political expediency and lack of an evidence based will be avoided.* • Annual programmatic reviews will focus on sustainability in terms of results achieved, costs incurred and the long term impacts • Decentralized approach to programming • Expansion in inclusion of local CBOs with lower cost local solutions, and cross-sectoral programming initiatives will be piloted and scaled as feasible.


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