TARGETTED HIV PREVENTION INTERVENTIONS SERVICES DELIVERY GUIDELINES FOR KEY POPULATION SPECIFIC COMMUNITY-BASED ORGANIZATIONS

HIV AIDS (NACP)
Common Management Unit for Global Fund-AIDS, TB & Malaria
Ministry of National Health Services Regulation & Coordination

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PREFACE

NATIONAL COORDINATOR COMMON MANAGEMENT UNIT (GFATM)
MINISTRY OF NATIONAL HEALTH SERVICES REGULATION& COORDINATION

Pakistan faces an emergent public health threat in the form of HIV AIDS. With over 150,000 people living with HIV (PLHIV) in Pakistan, and about 20,000 people being added to the pool annually we are on the brink of catastrophic consequences as only 25,000 PLHIV are registered in the thirty-three (33) HIV treatment centers and about 15,000 PLHIV are on receiving antiretroviral therapy. This necessitates a vigorous and robust national response to curb and curtail the AIDS epidemic, scale-up HIV testing, expand HIV treatment coverage, intensify HIV prevention services to avert new HIV infections, eliminate mother-to-child transmission and cause an ultimate decline in HIV associated morbidity and mortality.

HIV Prevention holds the key to reducing HIV transmission and consequent decline in new HIV infections. The National HIV Response has been designed in light of latest available epidemiological evidence, informed decision making and innovative HIV prevention models to provide high impact targeted interventions to key populations in high HIV prevalence cities. The National-HIV-Prevention Model has been introduced in the country to scale up HIV prevention, testing and treatment services by engaging communities in whom the HIV epidemic is concentrated.

The ***"Focused Targeted Interventions: Service Delivery Guidelines for Key Population specific Community-based Organizations"*** have been developed to facilitate effective implementation of the National HIV Prevention Model. The document shall provide the implementers clear guidelines on service delivery and approaching the unreached populations through a community sensitive and acceptable approach.

NACP-CMU is committed to making Pakistan HIV free by implementing an effective, coordinated HIV/AIDS response based on innovative, yet focused targeted strategies to deliver community-led comprehensive HIV prevention, testing and treatment services for people most affected by and at risk of HIV. The Government is cognizant of the fact that every penny invested today in the fight against AIDS will pay great dividends in the future in terms of infections averted, lives saved, increased productivity and economic prosperity of the country.

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FOREWORD

Pakistan is faced with a concentrated HIV epidemic that although driven by people who inject drugs is fast expanding in other key populations including men who have sex with men, hijra/transgender, male and female sex workers. The country has witnessed isolated episodes of HIV out breaks predominantly in Punjab and Sindh provinces. The fifth National Integrated Biological and Behavioral Surveillance (IBBS), Round-5 (2016-17) has reported an estimated prevalence rate of less than 0.1% in the general population but an alarming well-established epidemic in the key populations especially in the sexual networks and transgenders that continues to escalate.

The alarming situation compelled the Ministry of National Health Services Regulation and Coordination (MoNHSR&C) and the National AIDS Control Programme (NACP) to revisit its HIV response and opt for a location for population approach. This new approach was contextually designed to provide high impact HIV prevention interventions to members of the key populations in which the HIV epidemic is concentrated for scale-up of HIV testing, prevention and treatment services to the vulnerable and affected population.

NACP, MoNHSR&C engaged in a series of extensive consultations with all stakeholders and launched an extensive technical process of use IBBS (2016-17) data to develop a high impact Intervention Scenario, target setting, and revision of national and provincial AIDS strategies. The efforts of Provincial AIDS Control Programmes (PACPs), APLHIV, CSOs, WHO and UN partners in the entire process is highly appreciated that included IBBS 2016-17, to redesigning of the National HIV Response namely ***"Accelerated response to HIV through effective prevention, treatment, care & support interventions for Key Populations in Pakistan"*** and technical support in developing guiding documents for efficient service delivery and effective programme implementation.

This document has been developed based on the vision of the National Programme which have been contextually tailored according to country specific best practices intervention and impact analysis scenarios, needs of the communities, and technical inputs received from members of the target communities. The role of the National Programme technical Team is highly commended in developing a crisp and easy to understand hands-on document for providing guidance to the service delivery providers and implementers in the field. The document covers various aspects including implementing the HIV prevention interventions, activities, services, data management, financial management, reporting, record keeping and coordination amongst the stakeholders.

The National Programme hopes that through effective role of the national response it will be able to meet the targets laid out in the National Strategic Plans, Sustainable Development Goals and other national and international commitments.

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ACKNOWLEDGEMENTS

These guidelines have been developed for use by Community-based Organizations involved in implementing the National HIV Prevention Model. Contributions of the following individuals/ organizations in the development of these guidelines, associated standardized operating procedures (SOPs), checklists and tools are acknowledged. The document is a living document that may be updated based on modifications in implementation design, introduction of new interventions (PEP, PReP etc.).

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ACRONYMS

AEM	AIDS Epidemic Modelling
AIDS	Acquired immune deficiency syndrome
ART	Anti-retroviral treatment
ARVs	Anti-retroviral medicines
BCC	Behavior change communication
CBO	Community-based organizations
CHBC	Community home-based care
CNIC	National identity card
DIC	Drop-in-center
EOBI	Employee old age benefits institution
FSW	Female sex workers
GF	Global fund
HIV	Human immunodeficiency virus
HTC	HIV testing and counselling
IBBS	Integrated Behaviourial and Biological Survey
IEC	Information, education and communication
KPs	Key populations
MARP	Most at risk population
M&E	Monitoring and evaluation
MSM	Men who have sex with men
MSW	Male sex workers
MIS	Management information system
ML	Management Letter
NACP	National AIDS Control Programme
NGOs	Non-government organizations
OIs	Opportunistic infections
ORWs	Out-reach worker
PEP	Post exposure prophylaxis
PLHIV	People living with HIV
PPTCT	Prevention of parent to child transmission
PR	Principal-Recipient
PReP	Pre-exposure prophylaxis
PPTCT	Prevention of parent to child transmission
PUDR	Progress update and disbursement request
PWID	People who inject drugs
SOPs	Standard operating procedures
SR	Sub-Recipient
SSR	Sub-Sub-Recipient
STIs	Sexually transmitted infections
TG-HSW	Transgender-Hijra sex workers
THQ	Tehsil headquarter hospital
VCCT	Voluntary Confidentiality Counseling and Testing

EXECUTIVE SUMMARY

Pakistan continues to have a concentrated HIV epidemic with an estimated prevalence among the general population at less than 0.1%[1]. The epidemic is concentrated among key populations (KPs) driven by people who inject drugs (PWIDs) followed by Hijra or Transgender sex workers (HSW/TGSW), men who have sex with men (MSM), male sex workers (MSW) and female sex workers (FSW). A major shift in the epidemic trend has been noted during the IBBS-2016 Round: the epidemic has reached a plateau in PWID but a surge in populations engaged in and with sexual networks has been reported with an impending risk of spillover into the general population through bridging populations. Furthermore, HIV infection in vulnerable groups namely: migrants, jail inmates, truckers as well as the nosocomial spread of infection due to poor infection control practices, transfusion of unscreened blood and (repeated) therapeutic use of infected syringes by quacks has been reported. Over the last decade isolated episodes of HIV outbreaks have been reported in various parts of the country. Geographic distribution of key populations has shown an expansion from major urban cities and provincial capitals to smaller cities and peripheries.

The growing HIV epidemic is a source of great concern for policy makers, program managers and all stakeholders involved in the HIV response as on one hand the infection is slowly crossing the line from key populations to the general population while on the other hand the uptake of HIV preventive and curative services is extremely low. A host of socio-economic factors including low literacy rates, poverty, lack of HIV awareness, stigma and discrimination, social marginalization, fear of punitive actions by the law enforcers and weak social support systems as well as limited span and coverage of HIV prevention programming have contributed to the silent rise in the number of HIV new infections.

Following the 5th National HIV Surveillance Round (IBBS 2016) the National AIDS Control Program (NACP) in collaboration with its partners including UN and development partners, private sector (non-government organizations, civil society and community-based organizations), members of key populations and association for people living with HIV (APLHIV), technical experts and academia held a series of consultations to review the available epidemiological evidence, revisit the national and provincial AIDS strategies and programmes, and define an effective roadmap to prevent the escalation of the epidemic from a concentrated to generalized epidemic. The fundamental principle of the high impact approach needed to address the growing HIV epidemic is that it has to be community inclusive therefore, KP-specific targeted interventions will be implemented by non-government actors/ community-based organizations who will have to foster close linkages with healthcare delivery systems in targeted districts. HIV programming shall be supported by a robust monitoring and evaluation system, as well as a centralized data repository for disease surveillance and programme review so that efficiencies in service delivery and resources may be ensured. Strong government commitment and ownership is needed at all levels for stewardship and sustainability.

For the purpose the National and Provincial AIDS strategies were revised (2017-2021) to incorporate the up-to-date data and set targets accordingly. Data from the IBBS-2016 was modelled using HIV soft-wares to generate HIV impact intervention scenarios for maximum impact. The national HIV AIDS technical working group developed and

[1] IBBS 2016

endorsed a standard package of key population specific HIV prevention targeted interventions. The entire exercise was costed to identify the total country needs that were matched with available resources (PC-1s and donor support). Due to resource constraints a location-for-population approach was adapted with for implementation of the high impact HIV programme both preventative and curative. City prioritization for each key population based on HIV prevalence was done for execution of the HIV Prevention Model. Similarly, based on PLHIV geographical mapping, decentralization of HIV treatment centres was planned to provide free of cost HIV diagnostic and treatment services to all PLHIV across the country.

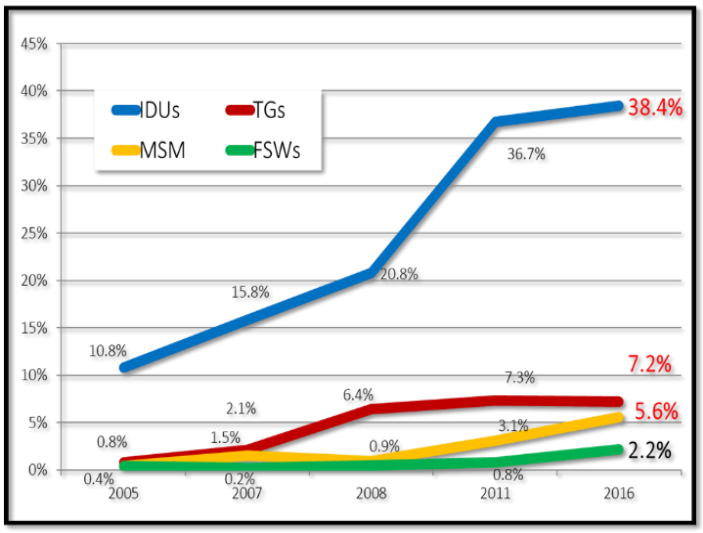
The HIV Community and members of the KPs are essential stakeholders for facilitating the implementation of the HIV programme due to their cognizance with the community needs, demands and sensitivities. Thus, community-based organizations (CBOs) have been tasked with delivering pre-defined comprehensive HIV prevention services packages to the target population groups. The roles and responsibilities of the community-based organizations were carefully articulated to promote and enhance the uptake of HIV preventive and curative services and ultimately achieve better health outcomes. A national guideline document has thus been developed drawing on the stakeholder discussions, up-to-date IBBS data and subsequent AEM workshops for implementing high impact targeted interventions (TI) for specific key populations. The document may also be used for future development of strategies as well as guide the program implementers in program activities.

The National HIV response aims to scale up case identification, HTC, treatment uptake and programme coverage while addressing overarching issues of stigma, discrimination, human rights and gender issues.

INTRODUCTION

Pakistan HIV Epidemic Overview

Pakistan is following a comparable HIV epidemic trend having moved from ***'low prevalence, high risk'*** to a ***'concentrated epidemic'*** in the early to mid-2000s. The epidemic is concentrated among key populations (KPs) namely People Who Inject Drugs (PWID), Men Who have Sex with Men (MSM), Transgenders (TGs) and sexual workers (male, female and transgender).



Data from the HIV surveillance[2] rounds have shown that the HIV epidemic continues to rise in all key populations: In PWID the HIV prevalence has increased from 10.8% in 2005 to 38.4% in 2016, in sexual networks the national HIV prevalence also showed a rise since the first surveillance round was conducted in the country (2005). In TGs the HIV prevalence rose from 0.8% in 2005 to 7.2% 2016, in MSM/MSW from 0.4% (2005) to 5.6% (2016) and in FSW from 0.2% in 2007 to 2.2% in 2016. Although HIV prevalence in the general population remains less than 0.1% but up to date epidemiological evidence suggests not only a shift in geographical trends of key populations from major urban cities and provincial capitals, to smaller cities and peripheries but also a shift in epidemic within the key populations with an impending spill over into the general population through bridging populations and vulnerable populations.

As of 2018 Pakistan has an estimated 150,000 people living with HIV with about 20,000 new infections added to the pool[3]. HIV modelling suggests that if the HIV epidemic continues to rise at the current pace the estimated number of PLHIV will rise from an estimated 177,000 in 2020 to 410,000 in 2030. The growing HIV epidemic indicates that the national HIV response is not effective enough to halt the spread of infection. It also suggests that the scope, coverage and uptake of HIV preventive and treatment services is also not satisfactory. This fact has been substantiated by data from IBBS-2016 that suggests low uptake of HIV preventive services by key populations (KPs), unprotected sexual practices and needle sharing among PWIDs.

Key Population	Condom Use	HIV Preventive Services Utilization
PWID	15.8%	24.6%
TG/TGSW	13.1%	15.1%
FSW	38%	8.3%
MSM/MSW	8.6%	13.3%

[2] IBBS Reports (2005 to 2016)
[3] AEM Pakistan 2017

National programmatic data also points out the glaring gap between estimated PLHIV and those on treatment with currently only 9% of the PLHIV taking antiretroviral therapy[4]. This low uptake of HIV preventive and treatment services in light of the escalating HIV epidemic poses a serious challenge for policy makers, public health specialists and program managers to effectively and timely make efforts for curbing and curtailing the spread of HIV in the country.

Evolution of the National HIV Response

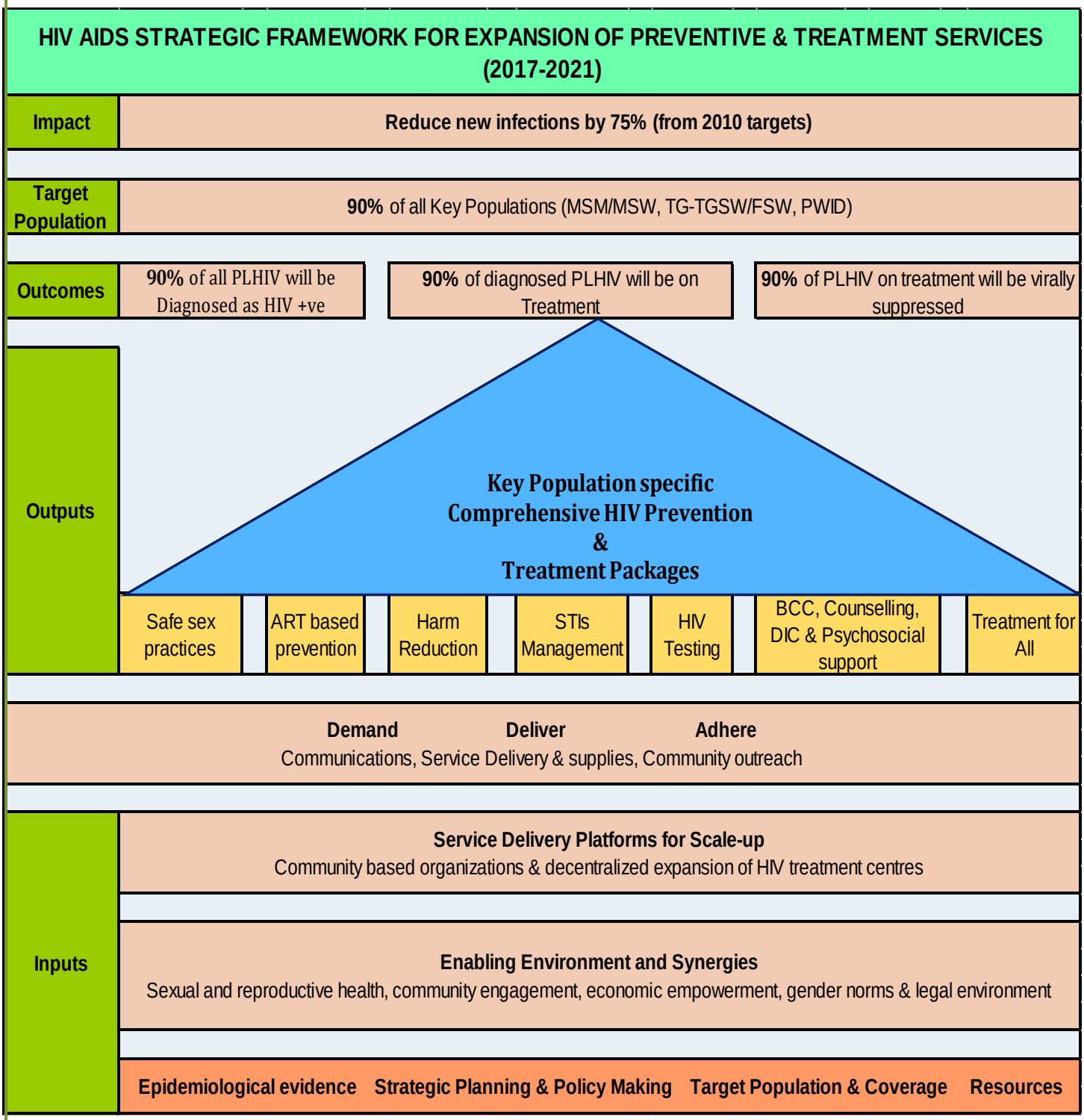
In response to the growing HIV epidemic in the country, the National AIDS Control Programme (NACP) with the support of development partners developed its first national strategy framework in 2001 that culminated in establishment of first response called Enhanced HIV and AIDS Control Project. The initial response focussed on lab-based HIV testing and ended in 2008. This was followed by the 2nd National Strategic Framework that was more focussed and included HIV prevention and testing interventions for Key Populations. The HIV response evolved according to the epidemiological evidence generated from the 05 surveillance rounds that were conducted in the country to provide up to date evidence for strategic guidance and programming. The country then developed the 3rd Strategic Framework 2015-20 that focussed on quality HIV treatment and care services. The 3rd Strategic Framework 2015-20 was revised to cover the period from 2017 to 2021 in light of the recent IBBS-2016 round and the AIDS Epidemic Modelling workshops.

Following the 5th national HIV surveillance round NACP redefined its approach to countering the HIV epidemic in the country by adopting a new strategy comprising of high impact interventions in the highest burden districts of the country while continuing to provide comprehensive HIV prevention, diagnostic and treatment services to most at risk populations and people living with HIV. After devolution in 2011, the Provinces mobilized their own resources for providing preventive and treatment services to the HIV infected and at risk populations. The National Programme at the federal level has been a central coordinating role and provides normative guidance and technical support to the provinces for service delivery including implementation of HIV prevention interventions, HIV diagnostic and treatment services. The National programme has also been supported by Global Fund, WHO and UN partners in implementing the HIV programme in the country. The entire HIV response in the country is community inclusive and enjoys the ownership and support of the PLHIV and KP communities.

During the development of the strategic framework (2017-2021) a thorough exercise of gap identification with appropriate mitigation measures was done through a review of all program interventions. In-depth consultations with provincial programmes, stakeholders, development partners, members of the key population communities, representations of civil society and Association of people living with HIV (APLHIV) were conducted. The national response was strategically designed making use of up to date epidemiological evidence and included review and revision of the National and Provincial AIDS Strategies, adoption of recommended key population specific HIV

[4] NACP-MIS

prevention packages, introduction of a community led HIV prevention model and implementation of WHO treatment for all guidelines. The strategic framework given below defines the salient features of the national response.



KNOWING THE KEY POPULATIONS

Key populations shortly known as "KPs" have been defined as groups who, due to specific higher-risk behaviours, are at increased risk of contracting HIV infection irrespective of the epidemic type or local context[5]. They often have underlying social and legal issues attributed to their risky behaviours that increase their susceptibility to getting infected with HIV. Pakistan currently has four key populations namely people who inject drugs (PWIDs), men who have sex with men (MSM), transgenders (TGs) and sex workers {male (MSW), female (FSW) and transgender (TGSW)}.

People who inject drugs (PWIDs)

"**People who inject drugs (PWIDs)** refers to a group of people who inject non-medically sanctioned psychotropic (or psychoactive) substances." These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes.

Among the key populations PWIDs are the most vulnerable to HIV infection and are at a 22 times higher risk of getting infected with HIV than the general population[6]. Globally there are approximately 11.8 million people who inject drugs of which 13.1% are estimated to be living with HIV. In Asia alone, there are 4.67 million people who inject drugs with a regional HIV prevalence of 12.5%[7]. In Pakistan the number of PWIDs have been estimated to be 113,500 people with a national HIV prevalence of 38.4%. In some cities/districts the HIV prevalence in PWIDs was significantly higher than the national HIV prevalence (Kasur = 50.8% and Karachi = 48.7%)[8]. The increased risk has been attributed to sharing of needles and close engagement with sexual networks. These factors are further buttressed by social exclusion, criminalization, marginalization and poverty.

Harm reduction programmes for PWIDs include needle and syringe programmes (NSP), opioid substitution therapy (OST), condom use complemented by supportive services like STIs management, abscess treatment, management of opportunistic infections in addition to psychosocial support and counselling have proven effectiveness in preventing HIV and controlling the spread of infection. Yet only 86 countries including Pakistan have NSPs and 44 countries have OST. Introduction of OST has remained a major challenge for Pakistan. Low coverage and limited uptake of these services have resulted in the continuous spread of HIV. These programmes need to be scaled up for maximum impact and to have the requisite preventative effect for people who inject drugs in particular and the wider population in general.

Men who have sex with men and male sex workers (MSM & MSW)

Men who have sex with men (MSM) is another important key population. "The term MSM is used to define sexual behaviors, regardless of gender identity, motivation for engaging in sex, or identification with any particular community[9]." In simple terms it refers to men who engage in sexual activity with members of the same sex regardless of how they identify themselves. Many of these men do not identify themselves as gay,

[5] http://www.who.int/hiv/pub/guidelines/arv2013/intro/keyterms/en/
[6] UNAIDS (2018) "Miles to go: closing gaps, breaking barriers, fighting injustices"
[7] World Drug Report 2016
[8] IBBS-2016
[9] Asia Pacific Coalition on Male Sexual Health

homosexual or bisexual. Thus, the term covers a large variety of settings and contexts in which male-to-male sex takes place. MSM generally have the following typical characteristics: (i)they are born biologically male and have sexual relations with another male and (ii) they must engage in consensual male to male sex including anal and oral sex. Male sex workers (MSW) are those men who engage in commercial or transactional sex with men.

Globally epidemiological evidence has suggested that MSM are 28 times more likely to acquire HIV than the general population. HIV prevalence in MSM in various countries across the globe has been reported to be significantly high with many cases still unreached. Socio-cultural rejection/ marginalization, religious backlash, legal barriers and punitive laws in addition to homophobic stigma, discrimination and violence have forced a greater proportion of this population to go underground, denying them access to vital HIV preventive and treatment services thus, elevating their risk of HIV. High HIV prevalence among men who have sex with men around the world is indicative of the fact that not only HIV prevention strategies are failing to reach this group but also service utilization by this group is very low.

The size of MSM in Pakistan has been estimated as 832,213. A major chunk of this MSM population is found in open space and streets 63%, followed by game clubs and net cafes (14%). Less than 10% of the MSMs are thought to operate through hotels, guest houses, hostels, brothels, cemeteries and abandoned buildings[10]. Thus, the risk of HIV within this key population varies according to sexual behaviours and overlapping of other risk factors such as injecting drug use and alcohol use. MSM who preferentially engage in penetrative anal sex are less at risk than those who engage in both penetrative and receptive anal sex and those who engage in only receptive sex. Male Sex Workers are also at a higher risk.

HIV prevention interventions in MSM include condom and lubes, community empowerment, community/home-based/self-HIV testing, pre-exposure prophylaxis (PrEP), post exposure prophylaxis (PEP) in addition to supportive services like STIs management, management of opportunistic infections, psychosocial support and counselling have proven effectiveness in preventing HIV and controlling the spread of infection in this high-risk group. In order to scale up HIV preventive services for this particular key population extensive programming with active engagement of the MSM community needs to be done to access this hidden population.

Transgenders and transgender sex workers

Transgender people have a gender identity or gender expression that differs from their assigned sex. It also refers to individuals whose gender identity is the opposite of their assigned sex (transman and transwoman). Transgender is independent of sexual orientation as transgender people may identify themselves as heterosexual, homosexual, bisexual, asexual, or may decline to label their sexual orientation[11].

The transgender community is the most at risk group of contracting and living with HIV. TGs across the world are victims of high levels of stigma and discrimination, gender-based violence and abuse, social exclusion and marginalization. This population group are forced to move out of their homes losing family and friends, provided with limited

[10] IBBS 2016

[11] Oxford Dictionary & Wikipedia

educational, economic and empowerment opportunities subjected to work place discrimination and violence[12]. They are also denied their due legal rights, and have limited access to various health and social services. This constellation of identity distinctness and overlapping socio-cultural, legal and economic factors the transgender community is pushed to the outskirts of society increasing their vulnerability to HIV. More than often sex work becomes the most viable source of income and survival for this population[13].

Globally, an estimated 25 million transgender people are living around the world and an estimated 19% transgender women are living with HIV[14]. HIV prevalence among transgender women (people who are assigned male at birth but identify as being women) is higher than transgender men (people who are assigned female at birth but identify as being men). Little data is available about transgender men and their vulnerability to HIV. Pakistan has an estimated 52,425 transgender people living in the country with an HIV prevalence of 7.1%.

Transgender people have diverse HIV prevention needs and community specific targeted prevention approaches that cater to the distinct needs of individuals so that HIV infections can be reduced. Global evidence has proven that HIV prevention initiatives that empower transgender people and enable them to take the lead in meeting the needs of their own community are the most effective.

Female Sex Workers

A **female sex worker (FSW)** is defined as a woman who engages in consensual sex in return for money or payment in kind. These women take part in consensual sexual acts that may be peno-vaginal, anal or oral sex and involves transactions of commercial value, either money or anything in kind.

Pakistan has an estimated 173,447 female sex workers and the HIV prevalence in this KP was found to be 2.2%[15]. Of the total FSW 36% are based in Kotee-Khannas, 29% are home based, 17% are available through cell phones and 14% are street based. Less than 5% are brothel and hotel based. The risk of HIV infection increases with an overlap of injection drug use, unprotected sex, sexual contacts with members of pother KP groups such as PWIDs, MSM/MSW, TGSW etc.

Sex workers are an economically vulnerable key population as their economic sustenance is derived from sex work. This vulnerability places them at a high risk of HIV, social discrimination, violence, criminalization and marginalization. At the same time, they have proven to be the most receptive key population to the uptake of HIV prevention services. The nature of sex work varies between communities, regions and type of clientele. However, one of the biggest challenges faced by female sex workers is the refusal/non-cooperation of the client to use condoms or have safe sex. Often clients use intimidation methods, violence or offer more cash for unprotected sex[16]. The clients of sex workers act

[12] Winter, S., et al (2016) 'Transgender people: health at the margins of society', The Lancet
[13] Avert (2018)
[14] Winter, S., et al (2016) 'Transgender people: health at the margins of society', The Lancet
[15] IBBS R-5 2016
[16] Ghimire, L. et al (2011) 'Reasons for non- use of condoms and self- efficacy among female sex workers: a qualitative study in Nepal' BMC Women's Health 1:42

as a 'bridging populations', transmitting HIV between sex workers and the general population. High HIV prevalence among the male clients of sex workers has been detected in studies globally [17].

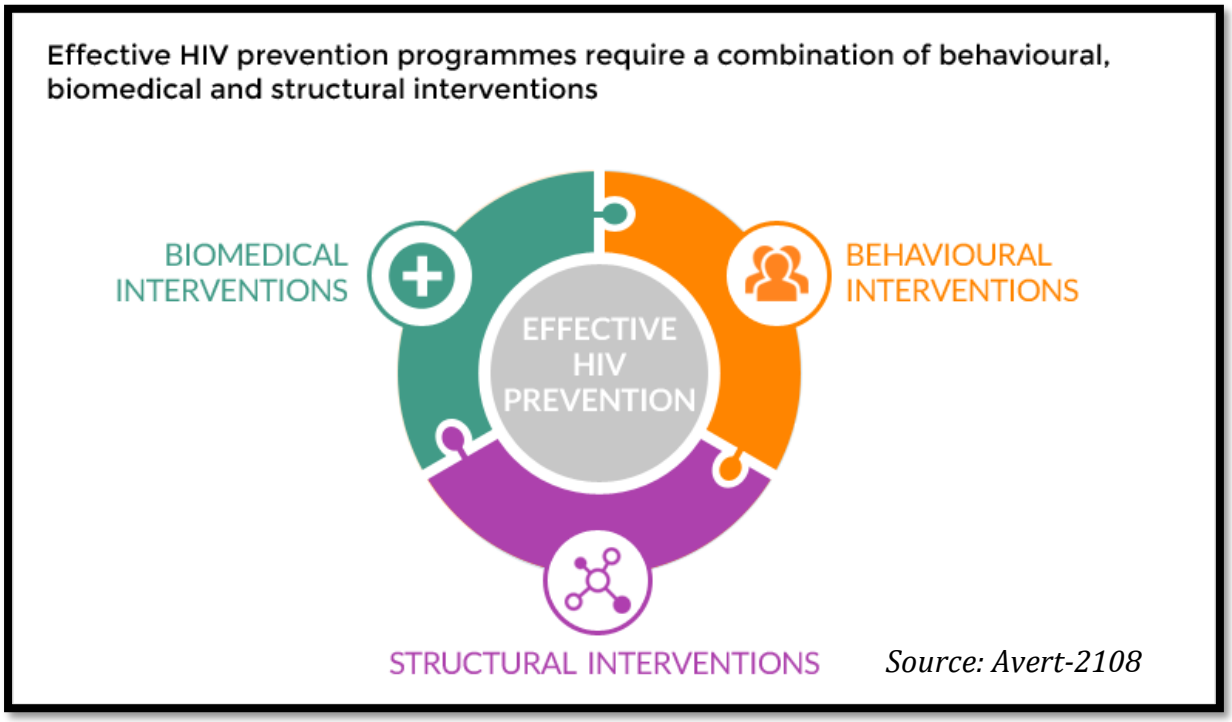
HIV experts emphasize the need to combine HIV prevention strategies for sex workers, including integrating condom distribution with other HIV services, fostering linkages between HIV services and other sexual and reproductive health services such as family planning services, gynecological services and maternal health for safe guarding the health of FSW and reducing HIV transmission.

Clients of sex workers are individuals (commonly male but can also be female) who have bought sex from a sex worker (male, female or transgender) for which he/she has paid in money or in kind.

[17] Jin, X. et al (2010) 'HIV prevalence and risk behaviors among male clients of female sex workers in Yunnan, China' JAIDS 53(1):131-135

INTRODUCTION TO HIV PREVENTION

HIV prevention programmes comprise of a set of interventions that aim to halt the HIV transmission. For a number of years, HIV prevention programmes focused primarily on preventing the sexual transmission of HIV through behaviour change using the "ABC approach - Abstinence, Be faithful, Use a Condom" of HIV. However, as advancements were made towards understanding HIV from a public health perspective different social determinant such socio-cultural, economic, political, legal and other contextual factors were taken into account. This led to the evolution of "combination prevention" for effective[18].



Types of HIV prevention

Primary HIV Prevention

Primary HIV prevention is aimed at reducing HIV incidence by reducing the incidence of HIV transmission. This can be accomplished by sustained engagement with individuals to reduce the risk factors (drug/substance use and sexual behaviours).

Secondary HIV Prevention

Secondary HIV prevention refers to reducing the HIV prevalence and retarding the progression of disease severity through early detection and prompt interventions. It also includes supporting the people living with HIV (PLHIV) to adhere to HIV treatment (ART) and maintain viral suppression.

Combination Prevention:

UNAIDS has defined combination prevention as *"rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural, and structural interventions, prioritised to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections"*.

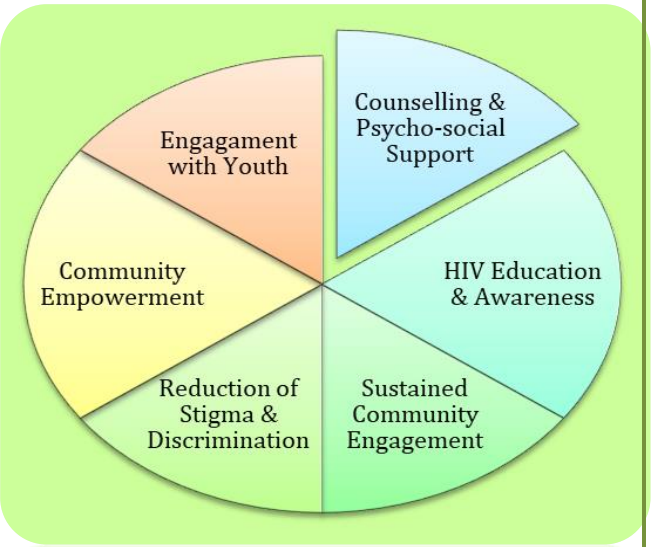
[18] https://www.avert.org/professionals/hiv-programming/prevention/overview

Combination prevention refers to holistic prevention programming that seeks strong and active community engagement, community empowerment, providing a conducive environment to strengthen the health and social systems, address legal and policy barriers, gender and equity issues, as well as disease and behaviour associated stigma and discrimination.

Types of HIV Prevention Interventions

Behaviour Interventions:

These interventions constitute a basic part of combination prevention and are aimed at mitigating risky behaviours to reduce HIV transmission. They comprise of culturally appropriate and community acceptable ways to promote HIV education and awareness, creating demand for uptake of HIV preventive services, increase the consistent use of condoms and clean needles, and enhance treatment adherence.



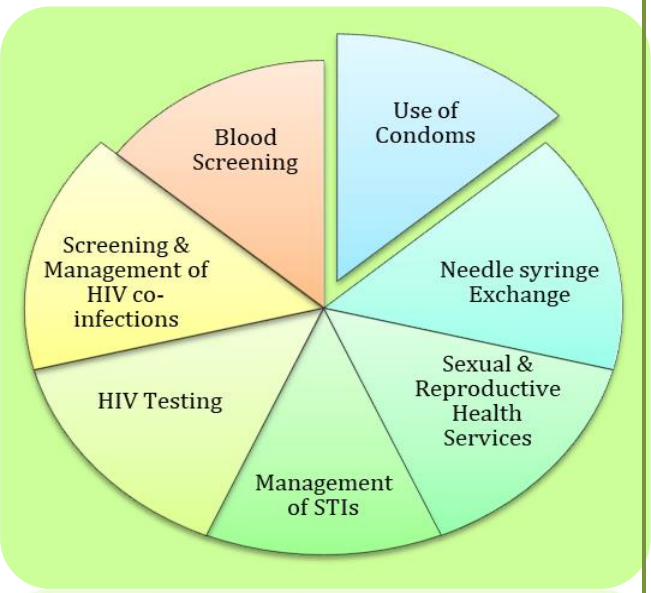
Behaviour change interventions may include

- Counselling and psycho-social support
- HIV education and awareness
- Sustained community engagement
- Reduction of stigma and discrimination
- Community empowerment
- Engagement with youth

Behaviour interventions tend to positively influence attitudes, behaviours and social norms and result in increased coverage of HIV preventive services, increased HIV testing rates and increased linkages to HIV service providers with an ultimate reduction in HIV transmission.

Biomedical Interventions:

Biomedical interventions complement behaviour interventions and consist of medical and clinical approaches with the ultimate aim of reducing HIV transmission.



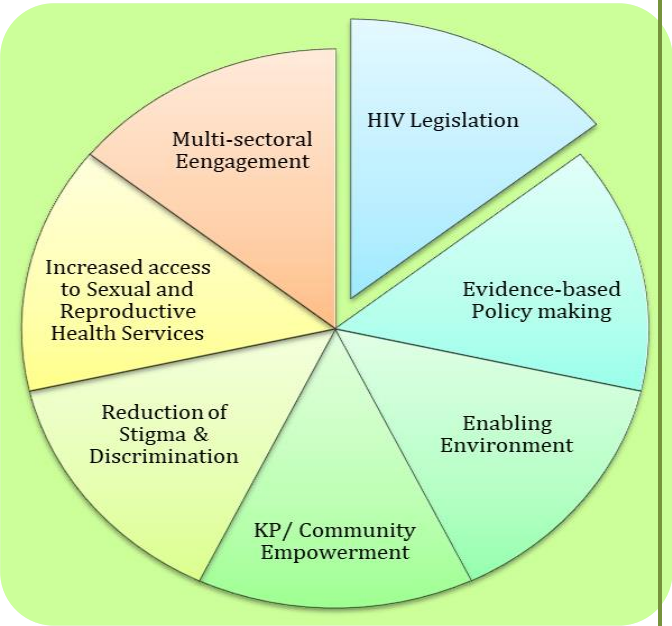
As Pakistan is a Muslim country, male circumcision is religious ritual. Biomedical interventions such as opiod substitution therapy (OST), pre-exposure prophylaxis (PrEP) and treatment as prevention (TasP) have been heralded as potential game changers in the HIV response. These interventions however are marred by political entanglements, weak to poor treatment adherence and consistency in taking ARVs. Other biomedical interventions include

- Use of condoms
- Needle-syringe exchange programmes
- Sexual & Reproductive Health Services
- Management of sexually transmitted infections (STIs)
- HIV testing
- Screening and management of HIV co-infections such as tuberculosis (TB) and Hepatitis-C (Hep-C)
- Blood screening

Strong reinforcement of behaviourial interventions coupled with sustained HIV education, advocacy and engagement is needed to promote the uptake of biomedical interventions and ensure consistency utilisation of harm reduction services.

Structural Interventions

Structural interventions address the larger picture that increase the susceptibility to HIV infection. These interventions address the HIV pre-disposing vulnerabilities that may social, economic, political, cultural, legal and/or environmental. These interventions also cover the prejudices and judgements embedded within societies that overarchingly influence the HIV response as well as uptake of HIV prevention, treatment and support services. These interventions are difficult to implement as they require advocacy at the higher levels, engagement of multi-stakeholders for an integrated response as well as mass scale sensitization to address key barriers (gender inequalities, stigma & discrimination, poverty and social marginalization) to HIV services uptake. The following key structural interventions have been identified



- Strengthen HIV legislation, law enforcement and programmes to safeguard the rights of key populations and end KP targeted violence.
- Evidence based policy making for focused high impact programming
- Enabling environment
- KP/Community empowerment to enable them to make healthy choices.
- Reduction of stigma and discrimination
- Increased access to sexual and reproductive health services.
- Multi-sectoral engagement for a holist and robust programming

RATIONALE

The HIV surveillance rounds conducted periodically in the country showed a steady increase in the HIV prevalence amongst the key populations. HIV prevalence in the sexual networks remained low as compared to people who inject drugs however, data from IBBS R-5 (2016) suggest a rapid surge in HIV prevalence in all the other key populations namely men who have sex with men, transgenders, male, female and transgender sex workers.

KP	2005	2007	2009	2011	2016
PWIDs	10.80%	15.80%	20.80%	36.7%	38.40%
HSWs	0.80%	2.10%	6.40%	7.30%	7.20%
MSWs	0.40%	1.50%	0.90%	3.10%	5.20%
FSWs	-	0.20%	0.02%	0.80%	2.20%

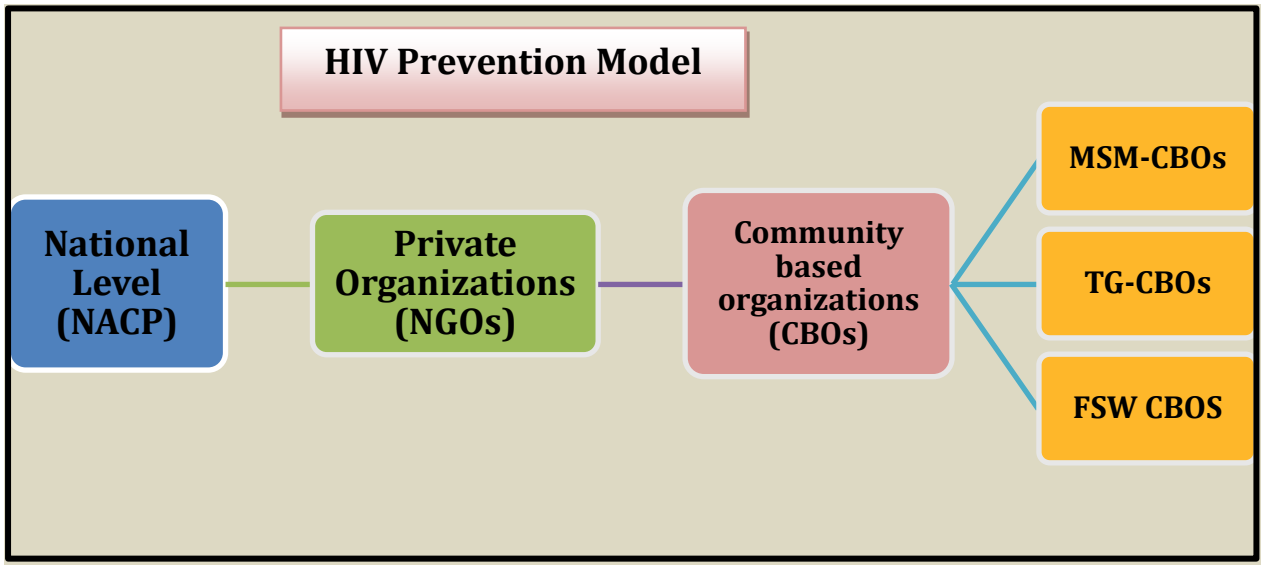
The increasing HIV prevalence trends in key populations suggest that HIV preventive services need to be scaled up and coverage improved to curtail the spread of infection and reduce HIV transmission. Review of data has shown that uptake of HIV services such as condom use, HIV testing, PrEP and PEP, STIs management and HIV treatment is extremely low. The major challenge for HIV programme managers and policy makers is reaching the unreached or hidden members of the KPs. Scientific evidence suggests that in order to contain the epidemic where the prevalence has still not reached alarming levels it is important to attain a 'saturated coverage (regular contact & STI care) of KPs to at least 80%.

Therefore, key population specific community-based organizations have been engaged to provide a basic set of comprehensive HIV prevention services to the target populations in high HIV prevalence settings, develop the necessary linkages with treatment facilities to ensure that the positive cases are initiated on ART and through rigorous outreach ensure regular follow-up of uptake of HIV preventive and treatment services.

HIV PREVENTION SERVICE DELIVERY MODEL OUTLINE

Community specific target interventions delivered by members of the respective communities hold the key for effective service delivery.

The HIV Prevention Model was designed by the National Programme keeping in view the up-to-date epidemiological evidence, aspirations and needs of the KP communities, international recommended best practices and targets set in the Pakistan AIDS Strategy (2017 to 20121). The NACP with the support a non-government organization will be implementing the community-based HIV Prevention Model to provide high impact comprehensive HIV preventive services to the target key population groups.



A national or international non-government organization will be hired for rolling out the HIV prevention in target districts of the country. Identification of target districts will be done on the basis on up-to-date epidemiological evidence. The NGO will contract local key population specific community-based organizations for implementing the prevention model.

COMMUNITY BASED ORGANIZATIONS AND HIV SERVICE DELIVERY

Community based organizations (CBOs) have emerged globally as strong contenders in the HIV response to provide essential HIV prevention, care and treatment services to the most at risk, vulnerable, infected and affected communities. These CBOs work closely with public sector facilities through a wide range of contextually appropriate, community acceptable flexible arrangements to facilitate access to HIV prevention and treatment through advocacy, education, community mobilization, voluntary counselling and testing (VCT), sexually transmitted (STIs) and opportunistic infections (OIs) management, psycho-social support, palliative and home-based care, and mutual support.

CBOs predominantly comprise of members of key populations, KP-networks and consortia, support groups, people living with HIV, and/or faith-based organizations[19]. The CBOs are driven by the needs of their respective communities and believe in ***"services for the community by the community"***. These organizations provide the much-needed inroads in reaching out to the marginalized and castaway sections of the population that are ignored by mainstream health services and fill the crucial gaps along the HIV continuum of care.

CBOs derive their strength from the diversity of services provided through community compliant arrangements that penetrate access barriers with a better understanding of the community dynamics, behaviours, and community cultures. Services are provided to the clients within their communities in a congenial environment by peers, friends, members of their community whom they can trust and interact with without fear.

Services provided by CBOs are not a replacement of hospital-based care or services provided by public sector health facilities rather they serve to improve the coverage of HIV prevention, care and treatment services, and enhance the impact of the HIV response to control the number of new HIV infections, reduce HIV transmission and improve the quality of life of people living with HIV (PLHIV) with a holistic reach, test, treat and retain approach.

KEY POPULATION SPECIFIC COMPREHENSIVE HIV PREVENTION SERVICES PACKAGES

Active involvement of members of the key populations and PLHIV community has been the hallmark of the national HIV response and the HIV programme in the country has been designed to meet the needs of the target communities.

A comprehensive literature review followed by an extensive consultative process was carried out to formulate evidence supported, internationally recommended best practices-based HIV prevention intervention for each of the specific key populations[20]. These interventions were contextually analysed for appropriateness and acceptability and endorsed by the respective communities for incorporation into the national and provincial strategies for implementation. The HIV prevention packages for each KP are as follows:

[19] Expanding access to HIV treatment through community-based organizations (Sidaction, UNAIDS, WHO Joint Publication)
[20] AEM Pakistan (2017) -Technical Note

Intervention Package for PWID

- NSEP Services: Provision of new syringes, needles, band-aids and alcohol swabs; collection of used syringes and needles; provision of condoms; provision of hygiene services; behaviour change communication messages on HIV, safe sexual practices, safe injecting practices and STIs.
- HIV Testing & Counselling for PWID and spouses.
- Spouse Prevention Program: Provision of condoms, counselling on HIV and safer sexual practices, provision of living support package, referral to PPTCT centres.
- Referral to ART and adherence support.
- STI diagnosis and treatment.
- Paramedic and Basic Medical Care: Antiseptic dressing for wounds and abscesses,
- Referral to private medical practitioners for basic medical care.
- ART Adherence Unit: residential care for 8 weeks for detoxification, initiation and maintenance on ART and adherence support.

Intervention Package for MSM/MSW

- Behavioural change communication through outreach (includes Condom & Lubes, IEC material)
- Drop in Centre facility (for repeat BCC /Psycho social support & Counselling)
- VCCT with pre-& post counselling & psychological counselling (community-based HIV testing)
- STI diagnosis & Treatment
- Referral support to PLHIV clients with strong follow-up
- Condoms & lubes distribution
- Career counselling and family counselling in DIC.

Intervention Package for HSW

- BCC - Behavioural change communication through outreach (includes Condom & Lubes, IEC material)
- Drop in Centre facility (for repeat BCC /Psycho social support & Counselling)
- VCCT with pre-& post counselling & psychological counselling (community-based HIV testing)
- STI diagnosis & Treatment
- Referral support to PLHIV clients with strong follow-up
- Condoms & lubes distribution
- Career counselling and family counselling in DIC

Intervention Package for FSW

- Establishment of Drop-In Centres (DIC) to deliver services to FSWs;
    - Screening/testing of HIV, Hep-B, Hep-C, Syphilis and PAP Smear
    - Vaccination of Hep-B in case of non-reactive;
    - Syndromic Management of STIs;
    - Ensuring confidentiality, collection of client data and issuance of vaccination cards to clients for access to services
- Community-based outreach through peer educators for behaviour change;
- Establish condom distribution network to enhance safe sex practices;
- Promotion of an enabling environment in the project area;
- Registration of FSWs through bio-metric registration system developed by PACP.

PLANNING & OPERATIONAL DETAILS OF HIV PREVENTION SERVICE DELIVERY

i) Epidemiological and Literature Review

The 5th National IBBS Round was conducted in 2016 that provided up-to-date data to policy makers and programme managers for future programming. Following the IBBS R-5 AIDS Epidemic Modelling (Pakistan-AEM-2017) workshops and consultative meetings were held with a broad stakeholder involvement including members of the civil society, key population communities and PLHIV community to review the newly generated epidemiological evidence, study the international recommended best practices for adaptation, evaluate the existing baseline data available and deliberate on a future high impact model. The HIV AIDS Technical Working Group (TWG) reviewed and endorsed the IBBS R-5 findings, outputs of the AEM workshops and recommendations for implementation of high impact focused targeted interventions for key populations.

Data from IBBS (2016) was used to map key population specific high HIV prevalence cities. Based on the city specific population size estimates (PSE) and HIV prevalence; cities/districts across the country were identified for programme implementation. Target setting was done using baseline coverage, KP specific HIV prevalence and intervention packages. Unit cost for each KP was calculated on the basis of intensity, scale and component of HIV prevention interventions. All the available data was analyzed to determine programme effectiveness using appropriate statistical adjustment parameters and assumptions. Based on consensus of all stakeholders, the TWG adopted the high impact exclusive of opiod substitution therapy (OST) scenario for implementation from 2018 to 2021.

Pakistan AIDS Strategy (2017-2021) was revised in light of up to date epidemiological evidence and supportive data from the formative research and literature review. A review of the gaps with plausible mitigative measures was done taking into account past experiences of service delivery projects for key populations, findings of the cost-benefit analysis of the previously implemented community home-based care model (CHBC) and successes of internationally recommended community-based model managed by non-government organizations. All evidence was thoroughly deliberated during a series of relevant multi-stakeholder national consultations to define future modalities for effective programme implementation and efficient service delivery.

ii) Planning Phase

During the planning the it was decided that preferably an international or national non-government organization (i-NGO/NGO) would be contracted as the implementing partner for implementing the HIV Prevention Model. The i-NGO/NGO shall have geographical presence across the country especially in the programme target districts, shall have sufficient HIV specific work experience preferably with key populations and shall also process robust management, financial, procurement, audit and, monitoring and evaluation (M&E) systems.

The HIV Prevention Model is based on high impact focused targeted interventions that need to be delivered to members of the key populations who are largely unreachable and unapproachable through KP-specific CBOs. Successful implementation requires meticulous planning, engagement of key-population specific community-based organizations and selection of competent staff that is preferably a member of the target

KP or enjoys strong linkages with the target KP at all levels and is fully cognizant of the community needs, aspirations and dynamics. The model implementation modalities, job descriptions, distinct roles and responsibilities of all staff engaged in programme implementation were clearly worked out. Furthermore, key performance indicators were defined for measuring the outcome of interventions, data collection and reporting tools were developed for homogenous and accurate reporting. A web-based management information system (CBO-MIS) was also put in place for real-time case-based reporting.

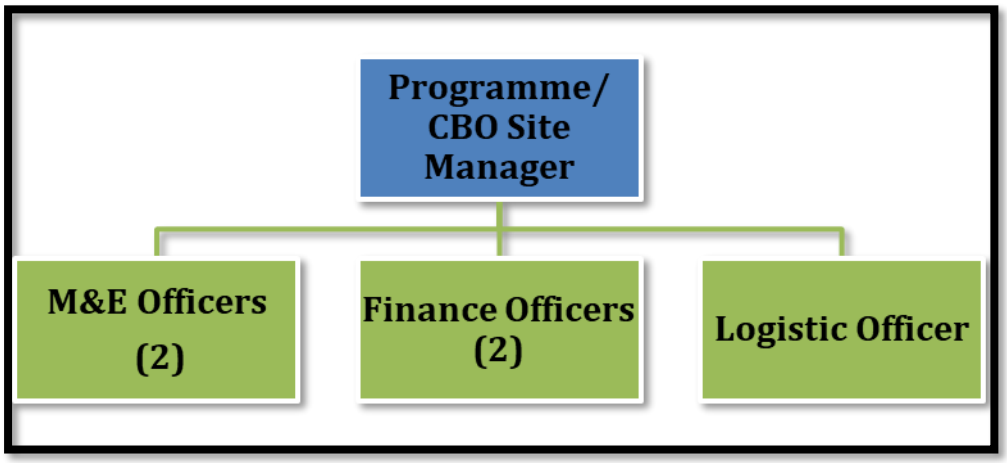
iii) Infrastructure & logistic support:

The NGO contracted for overseeing the implementation of the HIV Prevention Model shall have regional presence in areas of programme implementation for improved management and efficient utilization of resources. Appropriate systems at the organizational level must be in place to standardize understanding of processes and procedures, ensure quality service delivery and management of the interventions. These systems include programme management systems, stock keeping, procurement and supply chain management systems, financial management systems, human resource management systems, systems for monitoring and evaluation, and management information systems.

The staff structure at the NGO level for implementing the HIV Prevention Model comprises of

(a) Project Manager centrally based
(b) Two monitoring and evaluation officers regionally based
(c) Two finance officers regionally based
(d) Logistic officer centrally based
(e) The NGO core technical staff will provide technical support and guidance to the project staff, take part in occasional monitoring visits to the district-based CBOs, conduct data verification and validation, and facilitate the project staff in efficient service delivery.

NGO-Staff Structure for Implementing the HIV Prevention Model



The staff shall be recruited as per policy of the NGO based on a transparent and highly competitive process according to the model TORs for the positions mentioned above. After recruitment the capacity of the hired staff shall be strengthened through professional development initiatives for improved programme performance and

outcomes. Sustained mentoring on various programme processes and functions needs to be ensured for addressing gaps and improving efficiencies.

The NGO-HIV Prevention will use a location-for-population approach to contract the services of local community-based organizations (CBOs) to deliver high impact comprehensive HIV prevention services packages to the specific target key populations. The CBOs will provide services only to its target key population group. In KP target cities or districts where CBOs do not exist, the NGO using KP-community linkages will establish a CBO for program implementation in the subject districts comprising of eligible and apolitical community members enjoying strong community support and repute within the target KP-communities. The NGO shall provide infrastructure, logistic and technical support to the newly developed CBO.

Each CBO shall have the following basic infrastructure:

(a) Sufficiently equipped office space within the locality of programme implementation for management of programme activities.

(b) Drop-in centre holds a central place in HIV prevention projects as it serves as a "safe haven/ abode" for community members to freely and safely interact with members of their own communities, as an information seeking and sharing point, access point for uptake of HIV preventive services, knowledge about treatment, advice and as an advocacy point for their rights, needs and dignity. It also enables the intended beneficiaries to socialize, entertain, educate and provide each other support through support group meetings. DICs should cater to the needs of the intended target KP group/community and be responsive to their changing needs. Ideally a DIC is located within the target community however, the CBO may select a contextually appropriate, easily accessible and safe locality to establish the DIC. DIC may be located within the vicinity of the CBO office or at a community acceptable and accessible location. One DIC shall ideally cater to 500-1000 clients but the number may vary based on availability of resources. The DIC maybe managed by DIC coordinator who may have additional roles of a counsellor or psychologist as the DIC also provides a safe haven to the community members to seek emotional and psychosocial solace and support.

(c) An important element of CBO-Model is sustained engagement/ contact with KP community members to promote HIV awareness and create demand for uptake of KP-specific HIV Prevention services packages with the ultimate aim of decreasing HIV transmission and reducing new HIV infections.

(d) Provision for flexi-hours shall be made available to CBO staff as the work-timings of target KPs vary. They may divide their work schedule to time spent in office and time spent in the field. Appropriate records and documentation shall be maintained to capture the same while allowing room for greater efficiencies.

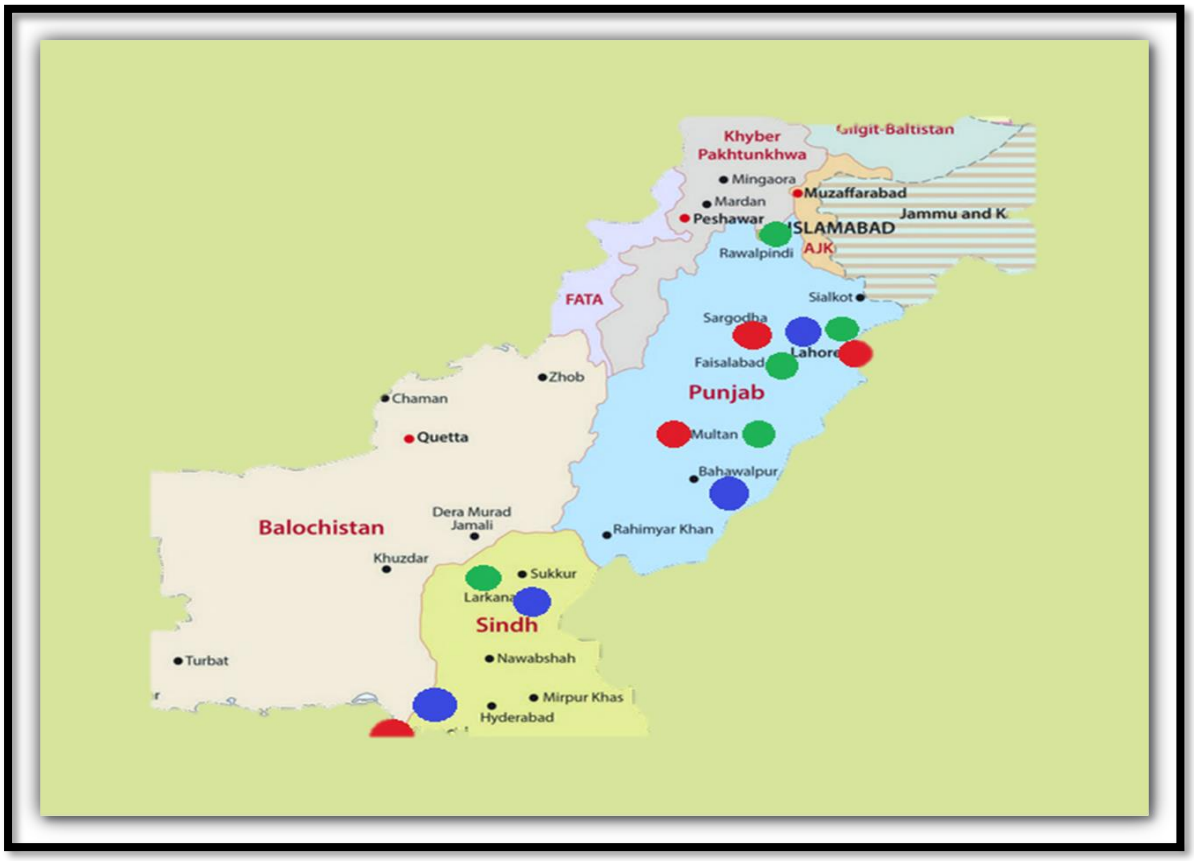
(e) While implementing the community-based Model the following basic principles with regard to HIV service delivery shall be respected:
- Informed consent
- Client Confidentiality
- Provision of Quality HIV prevention, care and support services

- Needs based Services provision
- Voluntary utilization of comprehensive HIV prevention services (KP-specific)

iv) CBO Cities and catchment areas:

Based on the country's up-to-date surveillance data and AIDS epidemic modelling exercise, city prioritization was done based on key population size estimates and HIV prevalence. The target cities/ districts are further divided into zones by the CBOs on the basis of presence of target key population groups/identification of hotspots, most at risk groups within the target population groups and vulnerable groups within the target community. The boundaries of the catchment areas within the prioritized cities can be further worked out by the CBOs as part of their out-reach and field work plans and the same maybe communicated to potential clients. In the map given below CBOs have been plotted in the target cities where programme implementation has been started in 2018.

In the initial phase, the programme has been launched in two high HIV burden provinces namely Sindh and Punjab covering eight (08) cities/districts. **(Annex-1)**



v) CBO Design & Objectives for implementation of the National HIV Prevention Model

The National Programme had envisioned a cost-effective CBO design for implementation of the National HIV Prevention Model based on the catalytic potential of community-based organizations to promote HIV awareness, enhance uptake of HIV prevention and treatment services, address ethnic and socio-economic barriers within and among KP communities.

The CBO will comprise of a site office with a basic management infrastructure that will serve as an administrative base/ key programme implementation unit. All staff will meet in the office to discuss programme implementation modalities, review progress, exchange notes, discuss issues and challenges, complete office work, documentation and record keeping, develop and review out-reach plans, financial management, stock keeping and maintenance of diagnostics, STIs medicines and other logistics, as well as perform other relevant official work.

Each CBO shall be provided with a refurbished mobile van and motor bikes for undertaking outreach activities. The mobile van has seating arrangements for staff, space for housing HIV rapid test kits and medicines for syndromic management of STIs, supporting kits (gloves, sterile pads, dressings, swabs etc.) for conducting HIV tests, performing physical examination of symptomatic clients as well as condoms and lubricants for distribution. The van will also serve as onsite counselling and HIV testing centre for a limited number of clients if required. The windows of the mobile van will have curtains for maintaining privacy and confidentiality of the clients. The van will also serve as a repository for reporting tools and documents required during outreach visits. Outreach workers (ORWs) may also accompany the van on motorbikes to perform outreach activities in areas where the van may not go. In such cases the van shall be parked at a suitable distance to provide back up to the ORWs for provision of HIV prevention services. The ORWs may carry a suitable quantity of HIV testing and prevention supplies in their backpacks/satchels for HIV community/field testing, and may test up to 5 individuals in the field (community & mobile van). If the number exceeds 10 the clients may be requested to get themselves tested in the DIC or CBO office. The paramedic accompanying the outreach team will be responsible for syndromic diagnosis of STIs.

Once a client is tested positive, the ORW will appropriately counsel the individual to initiate HIV treatment. After obtaining informed consent from the client the ORW will get the individual registered at the nearest ART centre or ART centre of client's choice for further management. After registration at the ART centre and initiation of ART the client will remain a recipient of the HIV prevention services offered by the CBO. If allowed by the client the CBO staff may offer HIV Prevention services to spouse/ partner of PLHIV.

The key objectives of this design are

- Promote HIV awareness and education to address disease associated stigma and discrimination within the communities, to mitigate disease associated myths and misperceptions, and to promote behavior change communication (BCC).
- Increase coverage and uptake of HIV prevention, testing and treatment services through a focused targeted approach led by KP-community members and/or peers.
- To manage conditions and co-morbidities such as sexually transmitted infections (STIs) that increase the risk of HIV transmission
- To provide psycho-social support HIV infected to accept and cope with the concept of being HIV positive and to empower such individuals to lead healthy and productive lives.

vi) CBO staff structure (HIV prevention model)

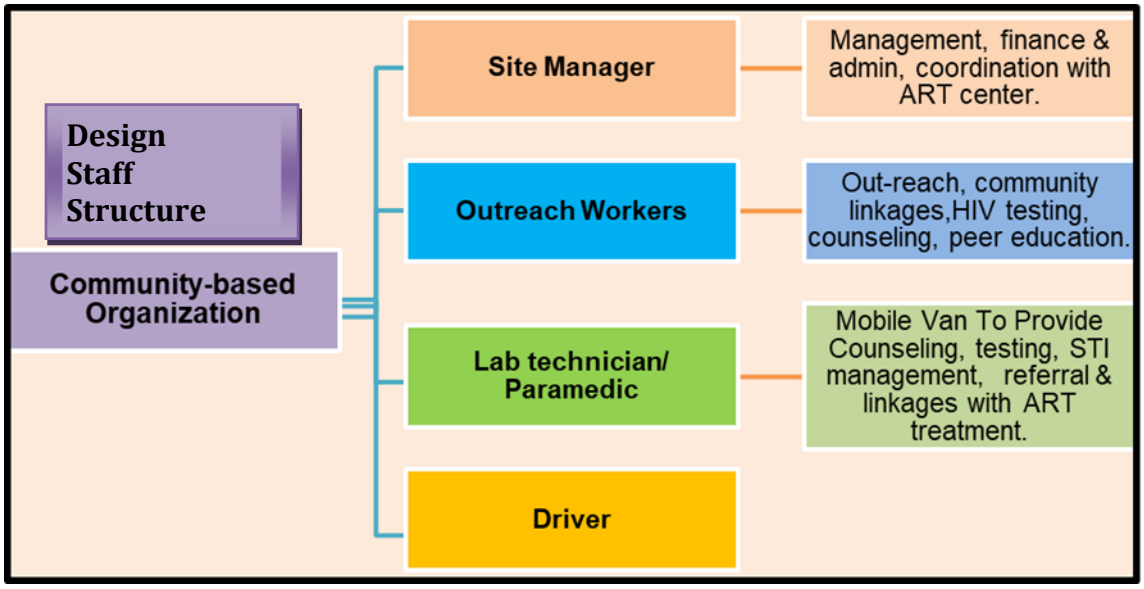
The National Programme has identified a basic team structure for implementing the HIV prevention model based on the objectives of the programme. Each CBO will be providing services to its own target community. No CBO can provide services to members of other key population groups.

The CBO team should be community-centred and preferably comprise of members of the target/ specific-KP community. The individuals to be employed by the CBO should meet the basic minimal prerequisite qualifications, well-versed with the CBO model and the distinct community characteristics of the target community (MSM/MSW, TG/TG-SW, FSW) to effectively and efficiently provide comprehensive HIV prevention services to the clients/members of the target key communities/populations while respecting the basic codes, principles and values of CBO based service delivery. The CBO team should preferably comprise of members of the target/specific-KP community.

The key members of the CBO team include

- CBO Program/Site Manager
- Outreach workers (minimum 02 per site with an additional 01 ORW for 500 clients)
- Paramedic or Lab technician
- Driver

*(Roles and responsibilities of CBO Team attached as **Annex-2)***



vii) Functions of CBOs

The CBO managed sites will perform the following functions:

Guiding principles for CBO functions

- After identification of potential clients obtain consent from the individual.
- Maintain and ensure confidentiality
- Provide HIV education and promote the ***"ABCDs"*** (abstinence, being faithful, using condoms, and do not share needles) of HIV prevention
- Respect social, cultural, religious norms, values and worth of clients/PLHIV
- Always act in the best interest of the target population, community and PLHIV

- Make every effort to provide access to HIV prevention and treatment services
- Recognise and respect diversity among people and counter discrimination and oppressive behaviour
- Abide by the laws of the society
- Respect all human rights
- Do not counsel when ORW's functioning capacity is significantly impaired
- Develop and maintain professional competence
- Use supervision for appropriate personal and professional support and development
- ***HIV testing and counselling should always be voluntary.***

Key functions to be performed by CBOs
Each CBO shall perform the following main services

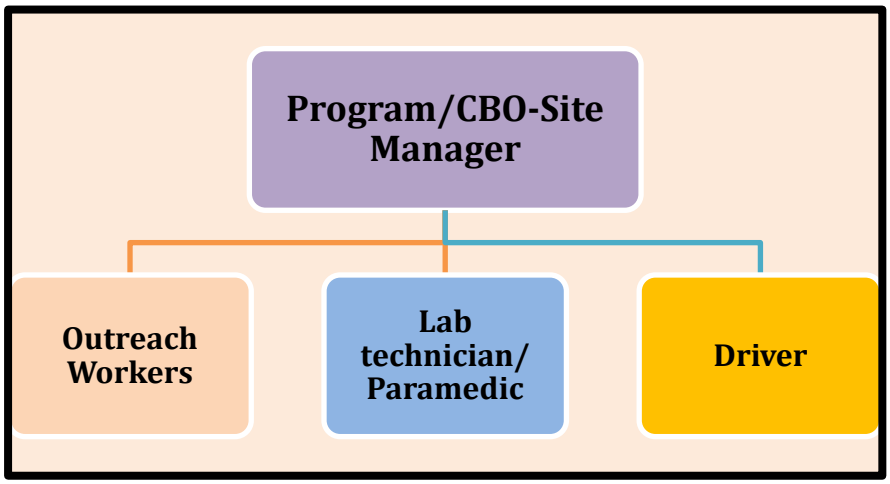
- ✓ Community Outreach
- ✓ Community Linkages
- ✓ Program Orientation
- ✓ Behaviour change communication
- ✓ Counselling
- ✓ HIV Prevention Services including condoms & lubes distribution
- ✓ HIV Testing
- ✓ PLHIV Referral support
- ✓ Drop-in centre
- ✓ Sustained community engagement
- ✓ Community Empowerment & Developing Community Peers
- ✓ Management of STIs
- ✓ Management of HIV co-infections (TB, HCV & Hep B)
- ✓ Management of Opportunistic Infections & associated co-morbidities

viii) Initiation of CBO Model and Service Delivery

The CBO Model shall be formally launched in the target community by establishing strong linkages and connections with both the primary and secondary stakeholders. Primary stakeholders are the members of the target key population group whereas secondary stakeholders include Provincial AIDS Control Programmes (PACPs), key social influencers (healthcare providers, police, local leaders, community heads etc.), concerned government departments (law enforcement, human rights, justice, social welfare etc.), non-government organization operating in the same areas that may be providing identical services, PLHIV communities, and other relevant bodies. Programme orientation shall be provided to both types of stakeholders to create a conducive environment for programme implementation. Sustained communication and coordination between all stakeholders involved in the HIV response shall be maintained for creating an enabling environment for service delivery and program implementation.

KEY SERVICES TO BE PROVIDED BY CBOs

After establishment of the CBO in the respective target districts and fulfilling the preliminaries of programme implementation the phase of service delivery to the respective target populations will be initiated. The organogram below outlines the staff structure of the CBO that will be the service delivery implementers of the high impact comprehensive HIV prevention services packages to the respective target key populations.



The CBO Program Manager prior to implementation shall be fully oriented with the basic concept of the CBO-based HIV Prevention Model. He/she shall be well versed with the key objectives, processes and tools of programme implementation. He/she shall outline the project activities to be performed, develop work plans and track progress accordingly. The following functions shall be carried out by the CBOs:

a. Community Outreach

CBO Team shall conduct ***outreach visits*** to KP specific hotspots as per the monthly/quarterly outreach plan to ensure provision of quality comprehensive HIV prevention services and optimize coverage of HIV prevention services for maximum impact. (***Frequency of Field Visits attached as Annex-3)***

Community outreach plays in important role in reaching the unreached and hidden communities. It serves as an important HIV prevention tool to reduce stigma and discrimination surrounding HIV and through specifically tailored messages educate and reduce the risk of HIV transmission. Community outreach activities also empower the target population groups to be actively involved in HIV service delivery and provide peer support to the affected and infected members of their communities.

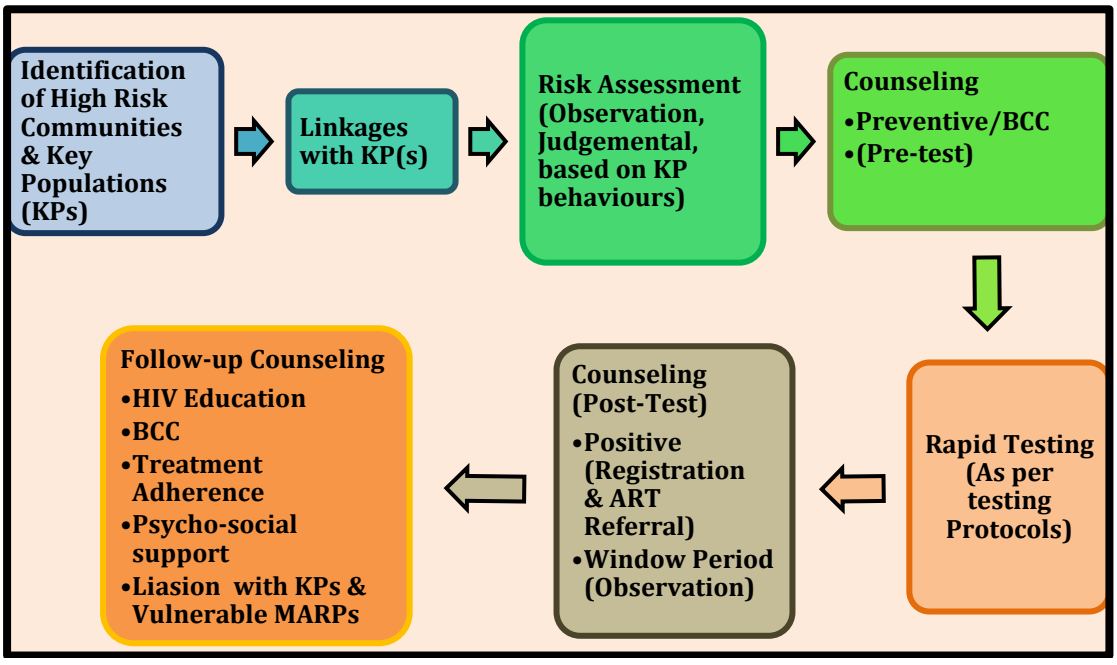
Active Case-finding and identification of most at risk sub-groups within the target communities/population by focused out-reach activities, developing and strengthening strong linkages with the target key populations (KPs)/ communities and their influencers for easy access, approach and service delivery is an important element of HIV community service delivery.

Outreach Visits	• Out-reach Workers
Active Case Finding	• Out-reach Workers
Counseling	• Out-reach Workers • Lab Technician/ Paramedic
HIV Testing & Registration of HIV positive clients	• Lab Technician/ Paramedic • Outreach Workers
Condoms & Lubes Distribution	• Lab Technician/ Paramedic • Outreach Workers
STIs Management	• Lab Technician/ Paramedic
Behaviour Change Communication/ HIV awareness	• Out-reach Workers

In resource constraint settings that are challenged by a concentrated HIV epidemic a calculated and prioritized approach needs to be adopted when providing tangible services to members of the target communities. The outreach workers using their understanding and linkages with the target community will thus have to conduct a risk assessment of the clients to prioritize them for HIV testing. All clients reached through outreach activities shall be provided HIV awareness and HIV prevention knowledge, behavior change communication (BCC) and peer support to encourage the uptake of HIV preventive services and shall be registered with the CBO for sustained contact.

Standardized tools have been developed to record and document the various aspects of outreach.

Steps for conducting Outreach Activities (Active Case-finding & Management)



This pathway identifies the steps to be taken when performing outreach activities to deliver the pre-defined comprehensive HIV prevention Services package to the target communities.

b. Community HIV Testing and Counseling

1. **Counseling** (individual/community-based, pre and post-test, family, career, ART adherence and psycho-social) depending on the needs of the clients. The 5 Cs that form the cornerstone of HIV testing and counseling services must be respected and are as follows:

   i. Informed Consent: The client shall be informed of the purpose/intent of testing, process, services to be available depending on the HIV test result and the right to refuse a HIV test. Under no circumstances shall a coerced or mandatory HIV test be conducted.

   ii. Confidentiality: The communication between the client and service provider (ORW, paramedic, counsellor etc.) must remain confidential and not be shared with anyone including family, partner or spouse of the client without the consent of the client. between the

   iii. Counseling: HIV testing shall be supported by appropriate and informative pre- and post- test counseling as well as psycho-social counseling to enable the client to cope with the HIV result.

   iv. Correct test result: HIV testing is performed in accordance with WHO recommended HIV testing protocols making use of appropriate aseptic measures and quality controls. The client shall be informed of the test result although the client reserves the right to refuse the result.

   v. Connection/linkage to prevention, care and treatment: the CBO shall link the PLHIV to a nearby ART centre or ART centre of the client's choice for uptake of HIV treatment services while at the same ensure provision of appropriate HIV prevention services to the both the HIV positive and negative clients. Sustained contact will serve to enhance the uptake of HIV prevention services as well as provide treatment adherence support to the positive clients that will ultimately result in reduced HIV transmission.

Guiding notes: Informed Consent

- *The purpose of programme/ intervention shall be clearly explained to the client.*
- *A description of procedures/ services with a clear explanation of foreseeable risks or discomforts to the client maybe discussed with the client.*
- *Benefits of the procedures/ services may also be highlighted to the client and the client through tactful and effective counselling maybe encourage to utilize HIV prevention services.*
- *A description of any compensation that maybe given or not given shall be clearly explained.*

- *Client must be assured of the confidentiality of discussion, services and records*
- *It must also be made clear that participation/ enrollment/registration is voluntary and that it may be discontinued at any time.*
- *The process shall not be coercive or forcefully persuasive under any circumstances.*

Guiding notes: Counselling in HIV

- *Establishing rapport and a trusting relationship with clients both through verbal communication and supportive body language.*
- *Assure the client of privacy and confidentiality by ensuring respect for person and information.*
- *The Out-reach worker/Counsellor/person providing counselling services shall show respect for the views, beliefs and lifestyle/behaviour of the client and have a non-judgemental, empathic and supportive attitude towards the client*
- *The Out-reach worker/Counsellor/person providing counselling services should be attentive, be a good listener, receptive and accepting of the clients' experiences, feelings and thoughts. Impersonal statements may be used to acknowledge the clients' perceptions or hidden fears. The Out-reach worker/Counsellor/person providing counselling services should abstain from issuing sarcastic or incriminatory remarks.*
- *The Out-reach worker/Counsellor/person providing counselling services shall at each step guide and facilitate the client in making appropriate choices regarding his/her health, while discussing the advantages, disadvantages and implications of their choices.*
- *The Out-reach worker/Counsellor/person providing counselling services must at all times remember that he/she is there to listen, guide and support clients in making appropriate lifestyle and treatment choices to improve their quality of life NOT to judge and preach.*
- *The Out-reach worker/Counsellor/person providing counselling services must have a clear understanding of the HIV Prevention Model and the KP-specific comprehensive prevention services packages to guide the clients about necessary HIV prevention and risk reduction measures as well as uptake of HIV prevention services.*
- *Detailed notes of counselling sessions should be taken and reviewed.*
- *During counselling sessions, the counsellor shall discuss the following issues:*
    - *basic information about HIV*
    - *information about HIV transmission and HIV risk reduction*
    - *demonstration and discussion of condom use*
    - *benefits of HIV testing and potential issues*
    - *HIV testing and results*
    - *general information and concerns/queries of the clients*
    - *availability of free of cost HIV treatment services at the HIV treatment centres and the importance of HIV treatment adherence.*

2. **HIV testing** that is both community-based as well as at the CBO site/ DIC/ Dera/ Hotspots followed by registration of PLHIV and referral to geographically contiguous ART centers for further management. The site of HIV testing shall be decided by the clients based on their level of comfort and safety. Clients shall not be compelled for testing in the field or mobile van. The outreach staff in consultation with potential clients shall decide on the site of testing based on onsite assessment and judgement.

   WHO three test protocol for HIV testing shall be followed:

   i. Test Kits: Rapid HIV testing is using Determine HIV-1/2 Ag/Ab Combo and Uni-Gold HIV Test. These kits are based on antigen-antibody detection mechanism.

   ii. Process: A drop of blood obtained by finger prick is placed on the designated end of the testing stick/ strip. A small amount of buffer is added to the sample to facilitate the testing process. The test result is obtained within 10-30 minutes on the same day and is interpreted as
      1. No stripe: test not performed correctly
      2. Single stripe: test negative/not reactive
      3. Two stripes: positive/ reactive test result

   iii. After positive test-I and test-II the client undergoes a third confirmatory test at the ART centre. In case of positive test-III the PLHIV is initiated on anti-retroviral therapy (ARVs).

   iv. Window period: This is the time between potential exposure to HIV infection and the point when the test will give an accurate result. During the window period a person can be infected with HIV and be very infectious but still test HIV negative. The window period usually varies from 3 weeks to 3 months.

(Each step during HIV testing shall be accompanied by empathetic, informed and supportive counselling and sustained contact with the client to encourage and promote uptake of comprehensive HIV prevention services. The principles of informed consent and confidentiality must be upheld at all cost).

Guiding notes: HIV Testing

- *Informed consent shall be obtained from the client after explaining the testing protocols, procedure, results and interpretation, benefits of testing, information about treatment and appropriate lifestyle modifications and adoption of protective and preventive measures. Aseptic testing techniques and universal precautions should be exercised while conducting HIV tests both in the field and at the CBO site/ DIC/ Dera/ Hotspots.*
- *Outreach workers will identify most at-risk individuals for HIV testing, provide pre-test counselling and perform tests in the field if number of clients is 05 or less.*
- *In case of 05 or more clients the outreach worker(s) will call the mobile van for providing HIV testing, syndromic management of STIs, counselling and HIV prevention services.*

- *If the number exceeds 10 the clients may be requested to get themselves tested in the DIC or CBO office.*
- *High risk clients (previous test non-reactive) maybe encouraged to take a repeat test after at least every six months[21]. However, depending on the type of HIV test and extent of risky behavior (exposure to risk factors) repeat testing may be performed at 6 weeks, three months and six months after exposure.*

HIV Rapid Testing Algorithm (Annex-4)

A negative or indeterminate test result maybe suggestive of the fact that the HIV test may have been conducted during the "window period" when post HIV exposure antibodies have not yet been formed, or the inconclusive result may be a consequence of a non-specific reaction. Sustained engagement with clients/ individuals yielding an inconclusive result may be maintained with adequate post-test counseling. Furthermore, they shall be offered and encouraged to go for retesting after an interval of six weeks in order to allow the window period to have elapsed. In resource constraint settings or any other special circumstances where a repeat test may be delayed >6weeks the clients with shall be encouraged to take the repeat HIV at least once every six months (in case of indeterminate HIV test results).

c. Distribution of Condoms & Lubes

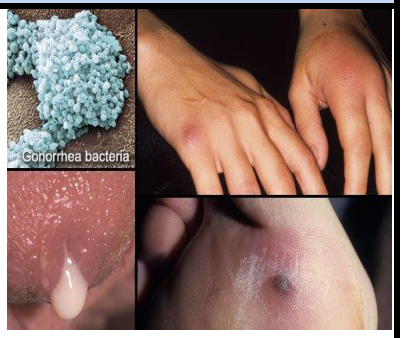
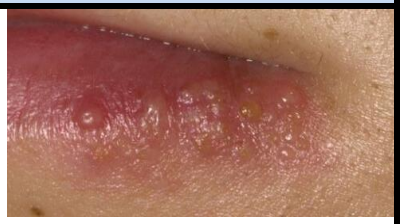
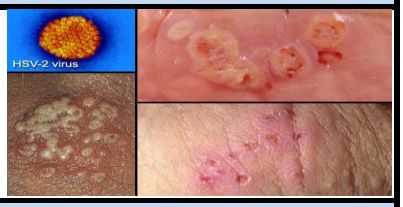
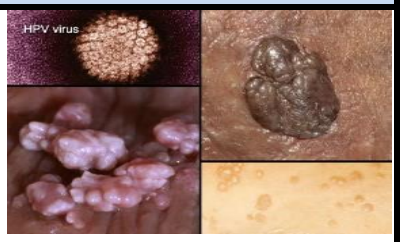
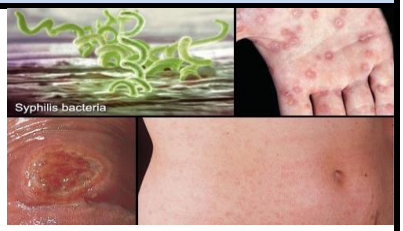
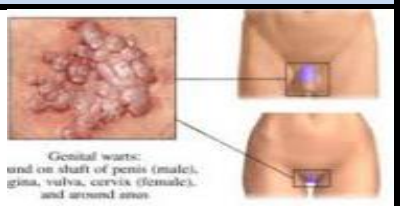
Distribution of condoms and lubes to members of the target communities. Condoms and lubes are considered essential for HIV prevention in sexual networks. The ORW/Counsellor shall explain the correct use of condoms and lubes and give dummy presentations when required as well as inform the clients about the benefits of safe sex and use of preventive measures both for the client as well as his/her partner.

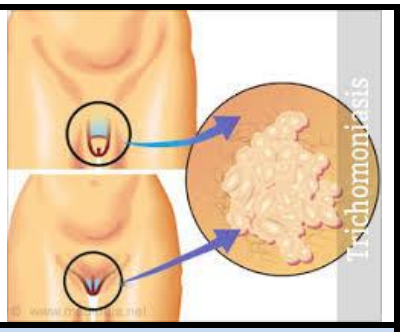
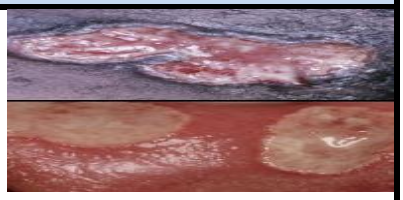
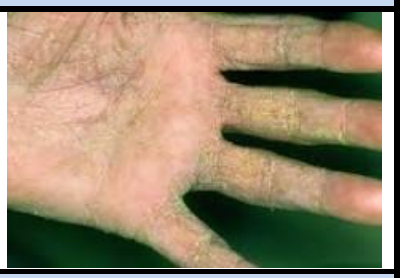
d. Management of Sexually transmitted Infections (STIs)

Syndromic management of STIs (sexually transmitted infections) plays an important role in reducing the risk of HIV transmission. Sexually transmitted infections (previously known as venereal diseases) are infections that are transmitted from one individual to another through sexual contact (that includes sexual intercourse, kissing/oral sex, use of sex toys etc.). STIs commonly include chlamydia, genital herpes and warts, gonorrhea and syphilis.

A paramedic working with the CBO shall be trained on the identification of symptoms and appropriate medication dispensing in line with WHO guidelines for syndromic management of STIs. A table of common STIs was prepared with description of common STI presentations and images has been prepared for use in the field.

[21] CDC Repeat HIV testing guidelines

STI	Common Presentations	Picture
Gonorrhea	- Discharge from the urethra/vagina/penis (pus like/watery/creamy/green, yellow or beige coloured - Pain or burning during urination with increased frequency - Sore throat ± Fever - Painful intercourse (females) - Testicular, penile inflammation and swelling - Pain in lower abdomen/ pelvic region	
Oral Herpes	- Cold sores or fever blisters - Itching of the lips or skin around the mouth - Burning or tingling near the lips or mouth area - Fever, sore throat, painful swallowing - Swollen glands - Rash on gums, lips, mouth and/or throat	
Genital Herpes	- Painful, fluid filled blisters and crusted sores on the genital areas, buttocks, thighs or anus - Mild tingling or shooting pain in legs, hips and buttocks - May spread to the lips through oral contact	
Genital Warts	- Small bump or group of bumps in the genital or anal region with a cauliflower like appearance. - May be flesh or grey colour outgrowths - Bumps that may be painless - Itching - Discharge	
Syphilis	- Round, firm, painless ulcer on the genitals or anal region - Rash on the soles of hands, feet and/or other parts of the body - Fever with enlarged lymph nodes, fatigue ± hair loss	
Chlamydia	- Burning or itching genitals - Discharge - Painful urination - Rectum and throat involvement may also occur	

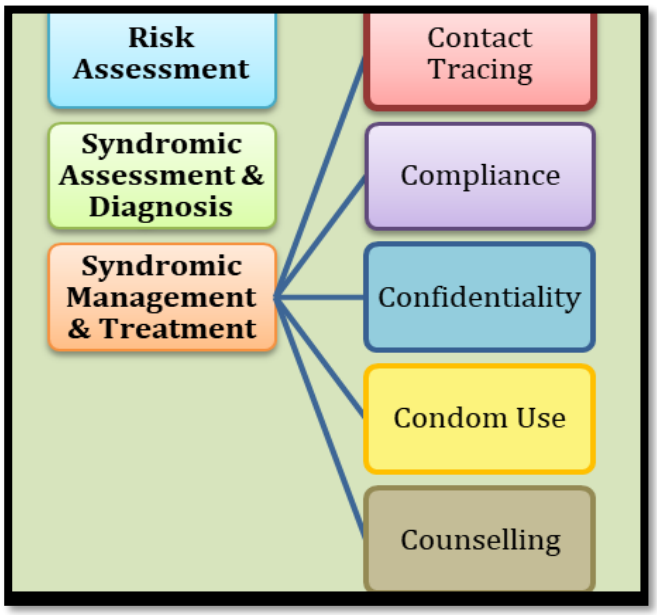
Trichomoniases	- Burning, painful micturition - Penile/ urethral discharge (men) - Pus like discharge with a strong odor, itching of the vaginal area and painful intercourse	
Chancroid	- Painful lumps in the genital area that progress to pus filled sores that eventually rupture/open and are surrounded by a narrow red line. - Can cause painful swelling of the groin lymph nodes and glands if untreated.	
Scabies	- Skin rash composed of small red bumps and blisters - Itchy skin and secondary infection may occur due to continuous scratching	

Steps in STIs management

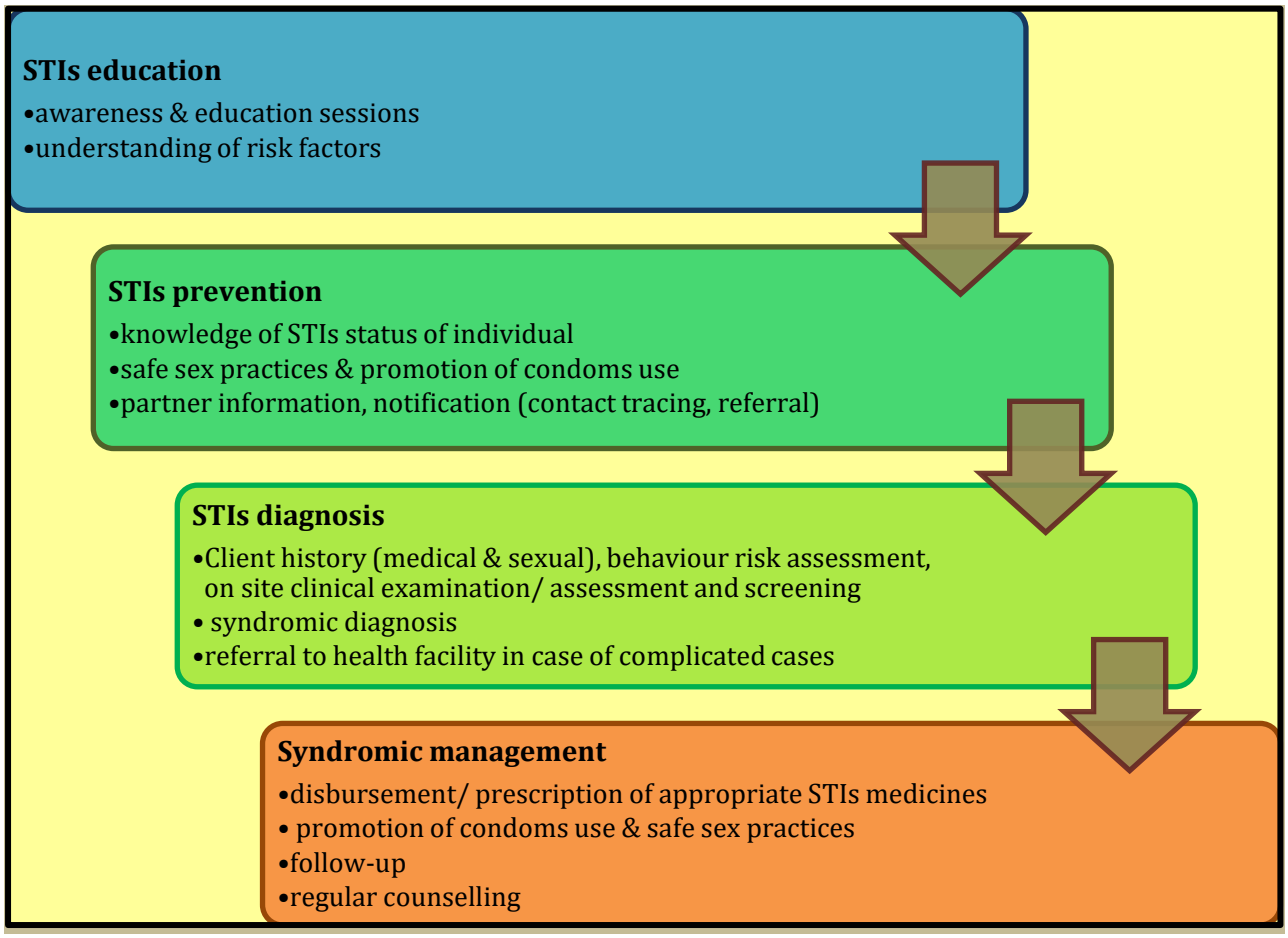
The basic steps in STIs management include knowledge of STIs and the risk factors associated with contracting STIs. Individuals and communities engaged in sexual networks and polygamous relationships are at an increased risk of getting infected themselves and transmitting STIs to their partners.

Key populations engaging in and with sexual networks need to adequately educated about the ways and means to reduce the risk of contracting and transmitting STIs as STIs not only result in complications to the affected individuals but also increase their risk to acquiring HIV.

A detailed medical and sexual history followed by thorough clinical examination can guide the lab technician/paramedic to identify the type of lesions, appropriately classify and treat them.



The figure below demonstrates a stepwise approach to syndromic management of STIs at the community level.



e. *Coordination and linkages with ART Centers*

Linkages with the HIV treatment centres have to be strengthened to ensure linkage of positive clients to the treatment centres for initiation and uptake of HIV treatment and diagnostic services. This mechanism needs to reinforced for effective tracking of PLHIV along the care, support and treatment cascade and curtailing the loss of clients along the cascade, address and resolve medical/health/treatment issues of PLHIV, smooth functioning of the PLHIV referral and follow-up mechanisms. Case managers have been appointed in heavy burden ART centres to facilitate the HIV clients. The CBO site manager shall develop close liaison with the case manager to track patients and link the positive clients to HIV therapeutic care.

f. Community Peers

Engagement of/with volunteer Peer Educators to create HIV/AIDS awareness and education about appropriate HIV protection measures, HIV testing and treatment is an effective element of HIV prevention programmes. Community peers are considered credible communicators for reaching out to the communities as they are considered ***"one of them".*** As they enjoy the trust and confidence of the communities, they can effectively convey various HIV prevention and behaviours change strategies, motivate the target communities for the uptake of HIV prevention and treatment services, and provide the much-needed sense of belonging, love and support to the communities who are otherwise

ostracized from the society and are the subject of social violence, discrimination and abuse.

DATA COLLECTION & REPORTING

Standard services at and by the CBO site

All the services provided at and by the CBO site should be displayed on the wall of the premises and every client should be informed of the services available at that particular site. In case some essential services are unavailable the CBO should establish linkages with other partner community organizations or NGOS working in that area to deliver those services. In our current grant NACP has selected a high impact intervention model with the following best practices-based HIV prevention services packages for each key population.

Registration

- Client registration starts from the field. When an ORW identifies approaches a client in the community and after obtaining informed consent provides the client any service (outlined in the KP-specific comprehensive HIV prevention services package) the client is registered in the field and is given a unique identification code (UIC). This code becomes the identification key of the client is used to mark the uptake of any service provided to the client. His/her relevant particulars (name, age, gender, address, contact details etc.) in addition to relevant supporting documents (CNIC) should be recorded in the registration file. Complete bio-data of the client shall be recorded and it will be a one-time activity. The UIC shall be used in all subsequent tools to record the client's uptake of services.
- When a client has been tested and declared positive (as per 3-test protocol) he/she is registered by the CBO site as PLHIV.
- The positive client after informed consent and post-test counselling will be registered to the HIV treatment center and his UIC will be used to track and retain him/her within the HIV treatment, care and support cascade.
- CBO sites shall be provided biometric devices for client registration and they will be linked to the HIV Prevention MIS and ART MIS for registration and tracking of clients.

Data recording:

Data collection and reporting tools have been developed for homogeneous and standardized data collection and according to the reporting requirements at the programmatic level, as well as in line with national and international commitments. A centralized data reserve will be maintained at the National level with access and user rights given to the implementers as per their needs. The Provincial AIDS Control Programmes and other stakeholders shall enjoy visitor rights for access to information. A battery of tools has been developed based on the programme design, reporting requirements and objectives to reliably collect data, monitor and track the disease response (Annex-5).

a) Reporting Tools

The following registers/tools have been provided to the CBO sites for record keeping.

i. Client Registration Files
ii. Out-Reach Services Register
iii. HIV Testing and Counseling Register

These tools are for manual use and are to be filled by the appropriate designated staff and the information should be regularly uploaded into relevant registers/sheets/books of the CBO-MIS.

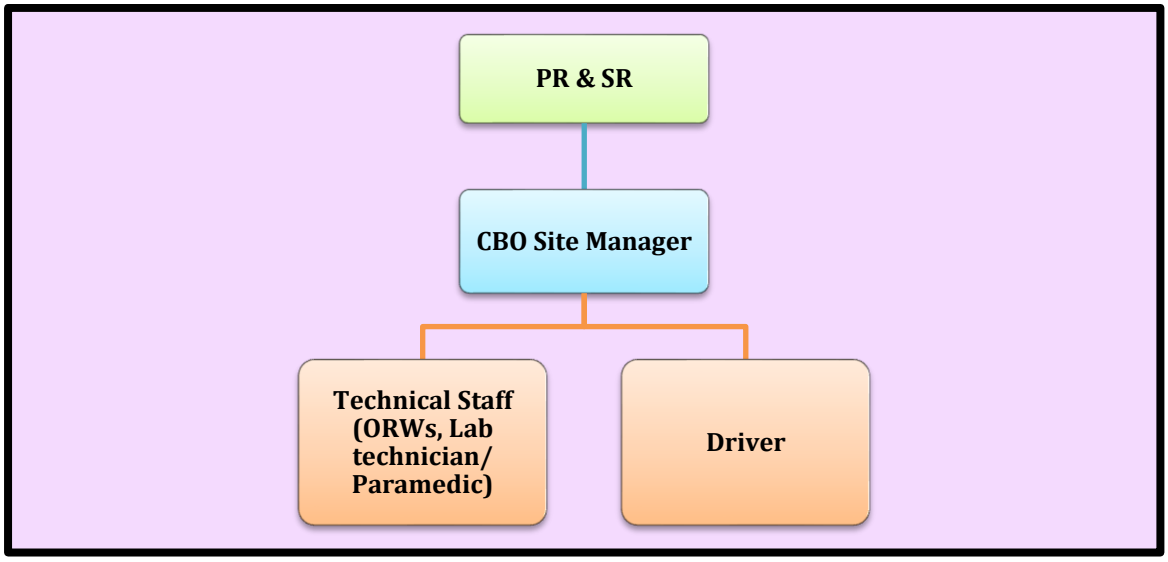
b) Reporting Indicators/Requirements

Detailed KP specific indicators recording and reporting sheets have been developed for recording the different services provided by the CBO **(Annex-6)** for capturing data on a monthly and quarterly basis. Performance of the CBO site will be measured using the following grading codes with reference to Global Fund grant in particular but can be contextualized as per the programme needs and management requirements. *(Reporting Protocols attached as **Annex-7)***

Grade (1) = 90% and above = Good Grade (2) = 85-90% = Satisfactory Grade (3) = 80-85% = Low performing Grade (4) = Below 80% = Poor performance
✓ ***If one indicator is low performing and another is poor performing (ML) will be issued and 20% of funds will be deducted from HR budget*** ✓ ***If two or more indicators are poor performing (ML) will be issued and 30% of funds will be deducted from the HR budget.*** ✓ ***If the site continues to show low to poor performance for two consecutive quarters then the SR has the right to take appropriate action either to deduct upto 50% of the HR budget or consider annulling the contract with the SSR (these decisions have to be taken in consultation with the PR).***

c) Reporting Lines

All staff shall comply with the following reporting lines and any or all documents shall be channeled accordingly.



CBO IMPLEMENTATION SOPs

Standard operating procedures for CBOs have been developed and deduced from the parent Service Delivery Guidelines for CBOs document to provide a cursory and crisp **"How to Implement Guide"** to Community Based Organizations regarding the implementation of the HIV prevention interventions, activities, services, data management, financial management, reporting, record keeping and coordination amongst the stakeholders. (Annex-8)

In addition to the distinct roles and responsibilities of the CBO staff, the following should also be observed:

- CBO sites should be adequately equipped with an efficient, working communication system for information sharing, maintaining manual records and electronic database, transport for referral and out-reach activities.
- Client files and records should be securely kept, regularly up-dated with all supporting documents (CNIC, certificates etc.), coded and with limited access (ONLY Relevant staff). Client information shall not be shared, photocopied or pictured under any condition.
- If a patient has died or has been lost to follow up his file should be considered "closed" after 5 years to protect the client/family. For record purposes it should be locked away.
- Health products and diagnostics kept at CBO sites as per guidelines shall be well stocked and maintained at appropriate storage and temperature conditions at all times. Expiry dates and quantity in stock should be regularly checked and updated on monthly basis to avoid expiries and stockouts.
- Linkages with the local NGOs, community-based organizations, ART centers and health care facilities should be strengthened to facilitate the target population, community and PLHIV in the management of opportunistic infections, HIV-TB and HIV-Hep-C co-infections.
- The CBO staff should strive to promote HIV literacy (prevention, treatment and spread of disease), promote and create awareness regarding CBO services (being provided), build and develop linkages with the community (infected/affected, at-risk-population groups and vulnerable populations) to reduce stigma, promote healthy lifestyle practices via effective self-protection and prevention strategies, increase access and utilization of HIV services (care and treatment).

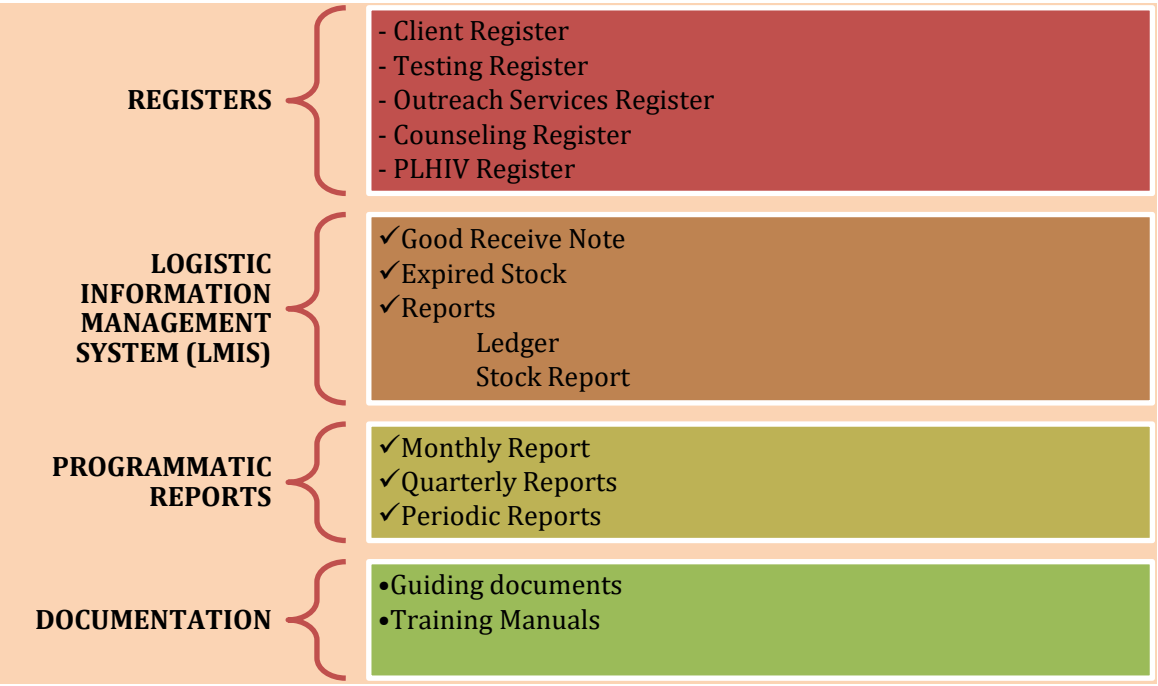
The CBO staff should foster a close working relationship with the target population and PLHIV to provide holistic care, support and guidance to the clients and PLHIV to effectively achieve CBO objectives, improve the quality of life of the target population and PLHIV through treatment adherence, better healthy lifestyle practices and enable them to become active citizens contributing to socio-economic development of the country.

HIV PREVENTION-MANAGEMENT INFORMATION SYSTEM

Introduction

Community Based Organizations (CBOs) MIS has been developed for CBOs implementing the HIV Prevention Model in the country with the aim to automate the manual process of key population/ HIV prevention management, PLHIV management, LIMS management and PLHIV's treatment.

Main Modules of the HIV Prevention-MIS



Dashboard

The HIV Prevention MIS dashboard is a user interface that has been created to provide the users with easy to read information of importance and as required. Data maybe analyzed as per requirements of the user to displayed in the form of graphs, tables or charts. Detailed SOPs attached at ***(Annex-9)***

MONITORING AND EVALUATION (M&E)

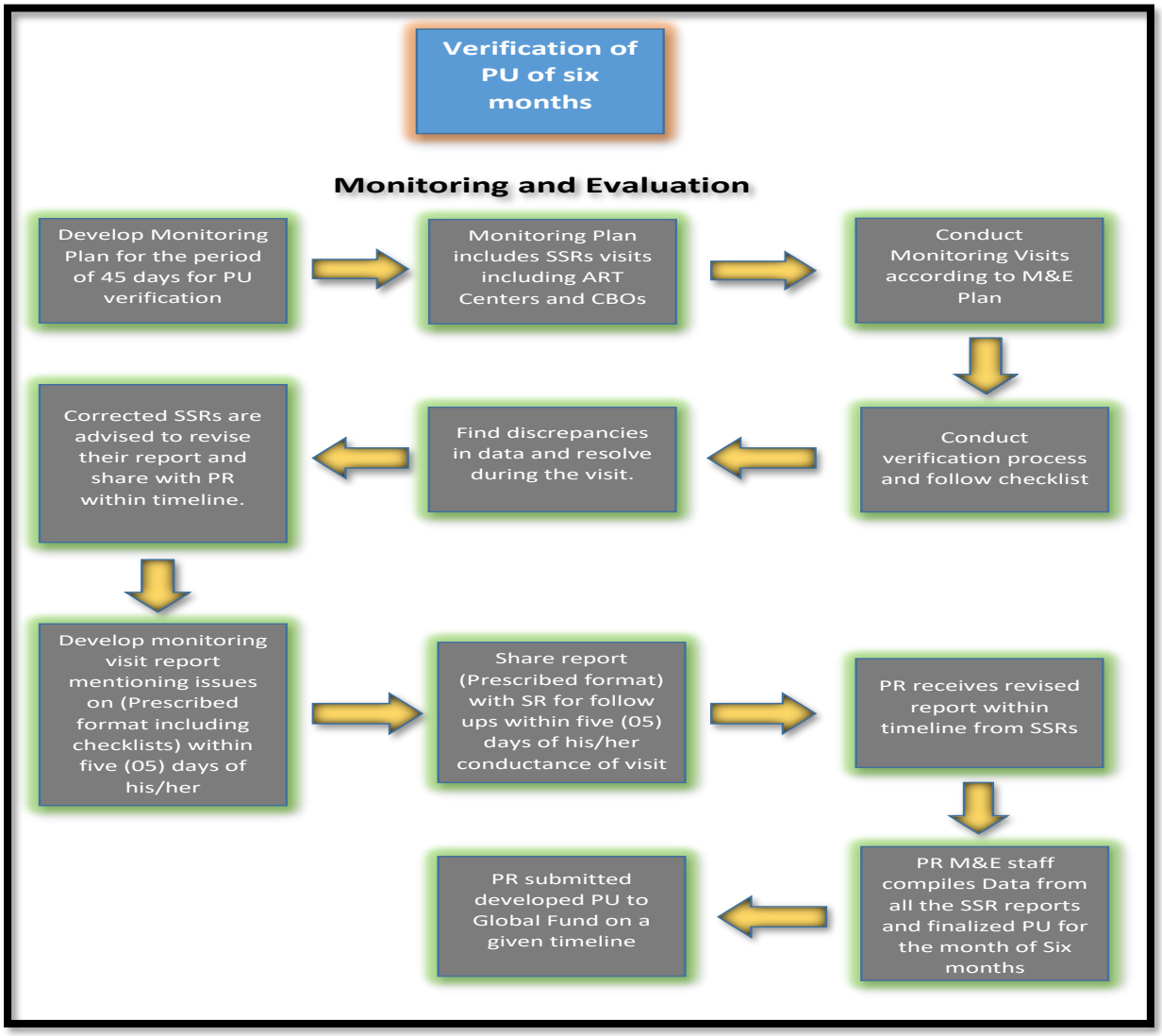
Monitoring refers to the systematic process of collecting, analyzing and using information to track the programme progress towards reaching its objectives in terms of set program indicators. Monitoring is an ongoing process that services to study the activities, way the activities are conducted, number of services delivered and people reached. Evaluation is the systematic assessment of the activity, project, programme, strategy, policy, operational area and the performance. Evaluation is based on analysis of a chain of events (inputs, activities, outputs, outcomes and impacts), processes and contextual factors influencing the achievements or progress made and lack of. M&E aims to determine relevance, impact, effectiveness, efficiency and sustainability of interventions. It also provides an opportunity to identify gaps and weaknesses for mitigation[22].

Based on the key functions to be performed by CBOs programme specific indicators have been developed to record performance and achievements. Quarterly (minimum requirement) visits shall be conducted to review performance. The process shall include data review and be supported by key informant interviews with the beneficiaries to elicit the beneficiaries perception about the quality and acknowledgement of services. Six monthly programmatic updates shall be shared with policy makers for progress review and informed decision making. Performance Indicators to be used for measuring programme performance are as follows:

Key Population	Performance Indicators
Transgenders including transgender sex workers (TG& TGSW)	Percentage of transgender people reached with HIV prevention programs-defined package
	Percentage of transgender people that have received an HIV test during the reporting period and know their results
	Percentage of transgender people that have received treatment for STIs
	Percentage of condoms consumed by transgender people
Female Sex Workers	Percentage of Female sex workers reached with HIV prevention programs-defined package
	Percentage of Female sex workers that have received an HIV test during the reporting period and know their results
	Percentage of Female sex workers that have received treatment for STIs
	Percentage of condoms consumed by Female sex workers
Men who have sex with men (male sex workers are also included in this category due to overlap that occur within the communities (KP-groups)	Percentage of men who have sex with men reached with HIV prevention programs-defined package
	Percentage of men who have sex with men that have received an HIV test during the reporting period and know their results
	Percentage of men who have sex with men that have received treatment for STIs
	Percentage of condoms consumed by men who have sex with men

[22] Adapted from Gage and Dunn 2009, Frankel and Gage 2007

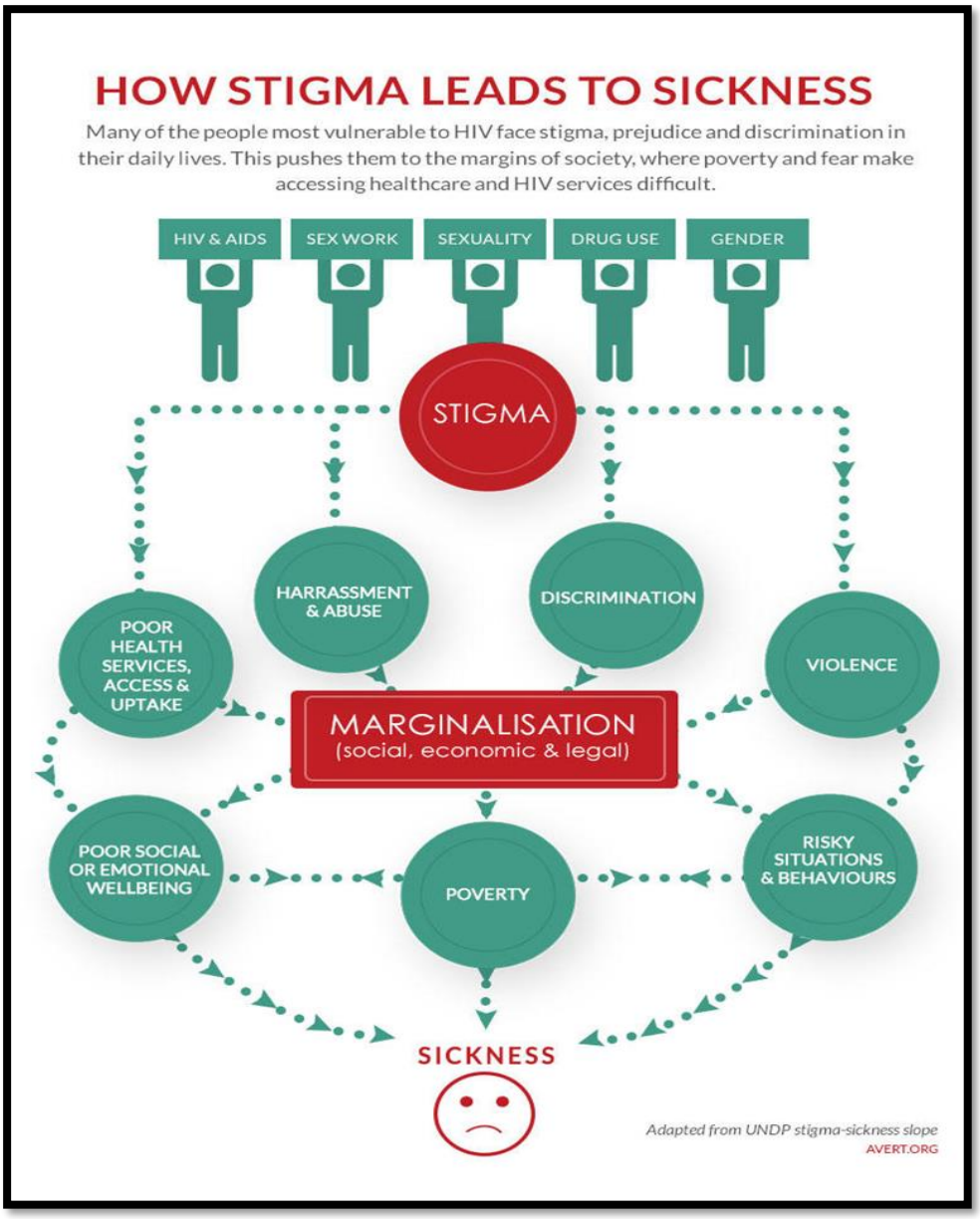
The following mechanism has been conceptualized periodic monitoring of field activities and service delivery at the regional level.



Based on programme requirements, monitoring plans shall be developed and implemented. Monitoring checklists and validation sheets have been developed by the programme for the purpose of supporting the monitoring mechanisms, to provide an overview of performance achieved and contribute to the overall informed decision making for future programming ***(Annex-10).***

HIV-RELATED STIGMA AND DISCRIMINATION

Stigma is synonymous with disgrace or dishonor. HIV related stigma refers to prejudice, disgrace and discrediting associated with HIV AIDS, people living with and perceived to be living with HIV as they are considered to be bearers of poor morals or of low character. This is mainly due to false myths and social taboos associated with HIV as till a couple of decades back it was always associated with death, socially disapproved behaviours (homosexuality, drug use, sex work and infidelity), only sexual transmission was thought to be the cause of HIV which was considered a sign of moral fault. Lack of HIV awareness also gave rise to misperceptions about the cause, transmission, prevention and treatment of HIV.



Discrimination leads to intentional or circumstantial denial of basic human rights. It results in marginalization of the PLHIV and they may be subject to physical, emotional and social violence.

The diagram[23] explains the vicious relationship between stigma, marginalization and disease that ultimately lead to reduce uptake of HIV prevention and treatment services resulting in increased HIV transmission, and disease associated morbidity and mortality. that co bole aLINS THE

HIV associated stigma and discrimination is one of the main reasons responsible for the wide gap in estimated number of PLHIV and those accessing HIV prevention, treatment, care and support services. The most at risk and vulnerable communities continue to face continue to face stigma and discrimination based on their actual or perceived health

[23] UNDP stigma-sickness slope

status, race, socioeconomic status, age, sex, sexual orientation or gender identity or other grounds[24].

Stigma and discrimination have been reported in health care settings, in educational and work settings, result in barring these individuals from accessing HIV services, erosion of their rights, and causing irreparable psychological damage.

Stigma and discrimination can be addressed by ensuring sustained engagement and contact with all sections of the society including but not limited to healthcare providers, law enforcers, community elders and influencers, religious leaders, academia and youth, politicians and even the general public. During this communication and interaction continued HIV awareness, education and advocacy sessions may be held to dissipate the falsifications attached with HIV and deliver HIV prevention messages for reducing HIV transmission and also timely approaching the HIV service delivery sites for linking the suspected clients to HIV treatment centres for management.

[24] https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(13)70311-6/fulltext

ANNEXURES

Annex-1: HIV Prevention Model: Cities/ Districts of Implementation

KP	City
MSM	Karachi
	Lahore
	Sargodha
	Multan
TG	Karachi
	Larkana
	Multan
	Faisalabad
	Lahore
	Rawalpindi
FSW	Karachi
	Lahore
	Larkana
	Bahawalpur

Annex-2: Roles and Responsibilities of CBO Staff

Staff Member	Roles and Responsibilities
CBO SITE MANAGER (Administration, financial management, data entry)	**<u>Site Management & Administration:</u>** • **Overall in-charge of Managing the CBO site as per PR-GF guidelines** • **Conducts orientation and refresher trainings/sessions of the recruited staff at least once in quarter** • **Ensures availability of appropriate and relevant documents, manuals, policies, guidelines, SOPs, IEC materials etc. at the CBO site.** • **Maintains the staff attendance register, reviews and approves the staff field activity work-plan, monitors field activities, develops and strengthens linkages with ART Centres, PPTCT sites, PLHIV networks, NGOs, community organizations, medical practitioners and district healthcare facilities in the area.** • **Ensure that services are offered regularly and as per protocols** • **Examines and ensures the timeliness, completeness and accuracy of target population, community, PLHIV records, financial and other administrative records with relevant supportive documentation** • **Reviews the client records for appropriate action (referrals, follow-ups, treatment, compliance etc.)** • **Ensures appropriate storage of STIs medicines, test kits and other consumables, their expiry dates, appropriate waste disposal methods and compliance to Universal Precaution principles (hygiene/cleanliness/safety practices)** • **Monthly progress review meeting with all the staff (minutes or report of the meeting shall be documented and shared with the SR and PR).** • **An internal monitoring system shall be developed by the site manager (checklist/tools) for monitoring the site performance on a monthly basis, recording findings and sharing the reports with the SR and PR on a quarterly basis.** • **Data quality checks to ensure accuracy of data generated (both manual and electronic)** • **Ensure that complete, accurate and verified monthly/ quarterly reports are sent in a timely manner**

	• **In addition to the assigned roles and responsibilities the Site Manager can assign any other relevant task/assignment to the staff** **<u>Financial Management</u>** • **Use GF/standard formats for effective tracking of project budgets/funds by program staff, ensuring completeness of documentation and record keeping** • **Prepares all vouchers and financial templates including preparation of Bank Receipts/Payments, Journal Vouchers, posting in financial ledgers** • **Preparation of payrolls and payroll reconciliation.** • **EOBI preparation and submission.** • **Acknowledgement of fund receipts.** • **Preparation and submission of PUDR, Quarterly expenses reporting, Cash balance and any other reports as per given timelines.** • **Liaison with the program team to provide the reasons for variances in the budget utilization** • **Closely liaison with the SR & PR financial teams for monitoring and liquidation of the data.** • **Management of Petty Cash and record keeping.** • **Management of bank books and transaction including posting and filing.** • **Managing personal file and record keeping.** • **Transport and fuel management.** • **Responsible for the Preparation of Ledger, Trial Balance, Reconciliation Statements.** • **Prepares accounts/ documents for final Audit of the organization.** • **Procurement management and record keeping.** • **Preparation and submission of Withholding tax on staff salary, suppliers' payments on monthly basis** • **Update inventory of assets on regular basis** • **Provide administrative support to program staff for effective project implementation** **<u>Data Entry:</u>** • **Responsible for operating and managing the CBO MIS by daily uploading the data entries (patient data as well as beneficiary data where necessary)** • **Converts hard copies of all the documents, forms and records into soft copies**

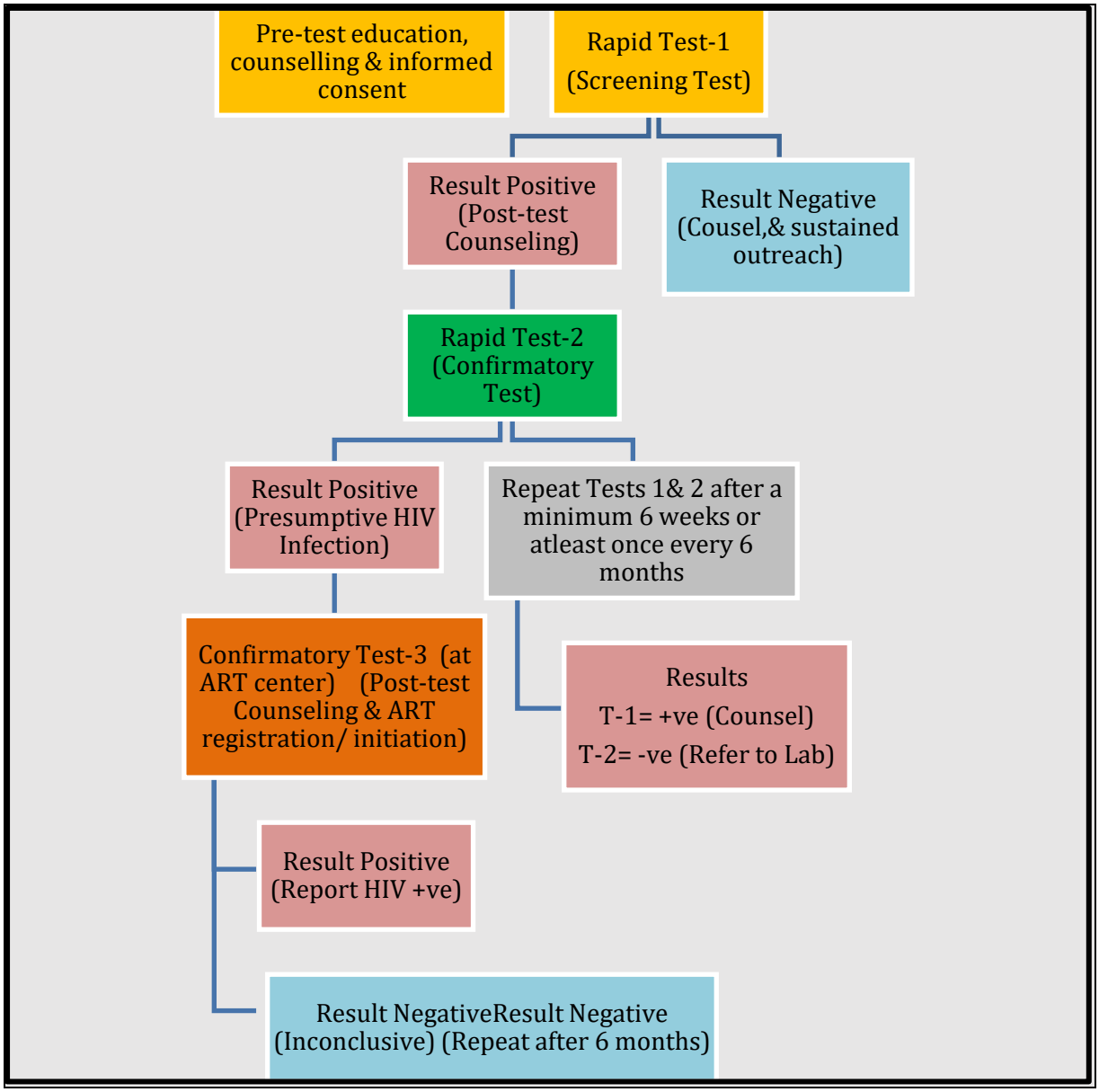
	• **Ensures up-to-date electronic record keeping and verification of manual data** • **Maintain and ensure completeness of PLHIV and beneficiary data both in the CBO MIS and manual registers** • **Prepare and share daily, weekly and monthly reports on patient data (Monthly report should be signed by the CBO site manager after verification of data.**
LAB TECHNICIAN/ PARAMEDIC	• **HIV/AIDS education and awareness** • **Use of universal precautions while dealing with clients and/or PLHIV (supportive nursing care/treatment) and conducting community-based testing** • **Providing basic nursing and palliative care to clients and PLHIV** • **Provide Counseling that is effective, ethically appropriate, in-line with HIV confidentiality principles and with respect for human rights and values of target population, community and PLHIV** • **Types of Counseling to be provided include** a. **HIV prevention/ transmission risk reduction** b. **Pre-& post-test Counseling** c. **Treatment adherence** d. **Couple counseling/ Family planning/ Reproductive Health** e. **Infant feeding and child care (FSW)** f. **Nutritional counseling** g. **Psychological Counselling)** • **Ensure timely completion, accuracy and documentation of HTC/VCCT Register and ensure that is entered in the required formats (for monitoring and review purposes)** • **Overall physical assessment of clients, target population, community and PLHIV, taking and recording vitals (temperature, BP, weight, height). In case of any change in client or patient condition/complaints inform CBO site manager for follow-up with ART/Treating Physician or medical referral** • **Ensure proper storage and report on the status STIs medicines, testing kits and other consumables** • **Function as case managers for overview of the referrals and linkages integrated care of the client's and/or PLHIV's case Coordinate referrals from and to other medical facilities, follow-up and overview of progress**

	• **Coordinate with the ORWs in following the work-plans for out-reach and follow-up activities** • **Practice Universal precaution principles** • **Participate in the staff meetings and provide feedback**
OUT-REACH WORKERS (ORWs)	• **Active case finding within the target community** • **Use of universal precautions while dealing with clients and/or PLHIV (supportive nursing care/treatment) and conducting community-based testing (<5 clients)** • **Types of Counseling to be provided during field visits to hotspots, DIC, community centers, and gatherings include** **a. HIV prevention/ transmission risk reduction** **b. Pre-& post-test Counseling** **c. Treatment adherence** **d. Couple counseling/ Family planning/Reproductive Health** **e. Infant feeding and child care (FSW)** **f. Nutritional counseling** **g. Psychological Support (about coming to terms with the disease)** • **Providing basic nursing and palliative care to the clients** • **Ensure PLHIV is adhering to treatment** • **Provide needs-based care and support services** • **Facilitate referrals to CBO sites, ART centres, external services and entities** • **Attend staff meetings when required** • **Ensure timely completion, accuracy and documentation of Outreach Register and ensure that is entered in the required formats (for monitoring and review purposes)** • **General physical assessment of clients, target population, community and PLHIV. In case of any change in client or patient condition/complaints inform CBO site manager for follow-up with ART/Treating Physician or medical referral.**

Annex-3: Frequency of Field Visits by CBO Team

A detailed weekly and monthly workplan should be developed by the ORWs to the different hotspots/ community centers/ gathering or meeting spots/ Dera/ DICs etc. CBO Site Manager should sign the workplan. Out-reach log should be maintained and signed by the CBO Site Manager after verification.		
S. No	**Clients/PLHIV Condition**	**Frequency**
1.	Clients who are low risk/ asymptomatic (HIV reactive) and don't need too much support from the team	One visit per month
2.	Clients who are at moderate risk/ stable but symptomatic (HIV reactive may include those in the window period)	One visit per week
3.	Clients in high risk /more serious condition (HIV reactive)	Daily visits depending upon the need of the clients, target population and community
4.	Clients starting ART treatment	2-3 visits per week to ensure treatment adherence, help in teaching the right way to take medicines
5.	Clients recently discharged from the hospital	May require more visits therefore should be dealt with appropriately

Annex-4: HIV Testing Algorithm



Annex-5: Data Collection Tools for Service Delivery

CBOs Services Recording_Final.xlsx

Annex-6: Reporting Formats

Reporting Formats

Annex-7: Record Keeping Protocols

- All the CBO staff will have to ensure ***ACCURACY, TIMELINESS, COMPLETENESS*** of records, data, client/patient files, financial records etc.
- Staff (as per job description) shall be made responsible for ensuring ***ACCURACY, TIMELINESS, COMPLETENESS*** of assigned registers/records/supporting documents that are to be counter checked and counter signed by the CBO Site Manager.
  (Site Manager shall be held responsible for incompleteness of record if reported by SR/PR M&E officers or LFA)
- Respective staff (as per job description) shall collect and put in place any pending documents/copies of CNICs etc. upon receipt of documents. Incomplete files should be reviewed and followed up till completion. Clients shall be reminded for furnishing the incomplete documents.
- Staff shall have complete understanding of respective reporting formats, reporting indicators and reporting timelines and shall display compliance.
- In Global Fund grants, funds disbursement is performance based. CBO Site Manager shall also keep track of the overall performance of the CBO site. Quarterly review of performance will be done both by the respective SR and PR.
- The CBO Site Manager shall hold weekly staff meetings to review progress, get feedback from staff regarding different aspects of program implementation and take appropraite actions. These meetings will be followed by a "Monthly Progress Review Meeting" *(minutes or report of the meeting shall be documented and shared with the SR and PR)*.
- ***Definitions***
  - **ACCURACY:** It refers to correctness of entries (freedom from error) in confromance with standard criteria (Global Fund formats and requirements).
  - **TIMELINESS:** Data is representative of the specified data reporting time period and is available, analyzed and shared with reporting competent authorty within the specified due dates/deadlines. (1 week after completion of the reporting month)
  - **COMPLETENESS:** It is defined as the degree to which the set of data characteristics fulifill the pre-defined requirements (Global Fund formats and requirement).

Annex-8 SOPs for CBOs

CBO SOPs.docx

CBOs SOPS

Annex-9 SOPs for HIV Prevention MIS

CBOs MIS SOPs.docx

Annex-10 Monitoring Checklists & Data Validation Sheets

CBO Checklist (Programme, M&E, PSM).docx