UNAIDS

An Evaluation of the contribution of the UNAIDS Joint Programme to strengthening HIV and Primary Health Care outcomes

Country case studies

Pakistan

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Abbreviations and acronyms

AIDS	acquired immuno-deficiency syndrome
AJK	Azad Jammu and Kashmir
ART	antiretroviral therapy
ARV	antiretroviral
BHU	basic health unit
CBO	community-based organization
DHIS	District Health Information System
DSD	differentiated service delivery
EHG	Euro Health Group
EPHS	essential package of health services
FSW	female sex worker
GB	Gilgit Baltistan
Global Fund	the Global Fund to fight AIDS, TB, and malaria
GBV	gender-based violence
HIV	human immuno-deficiency virus
IBBS	integrated biological and behavioural surveillance
ICT	Islamabad Capital Territory
ILO	International Labour Organization
JUNTA	Joint UN Team on AIDS
KP	Khyber Pakhtunkhwa
MoNHSR & C	Ministry of National Health Services and Regulation
MSM	men who have sex with men
NACP	National AIDS Control Programme
NCDs	non-communicable diseases
NHSP	National Health Support Programme
OOP	out-of-pocket
PDHS	Pakistan demographic and health survey
PACPs	provincial aids control programmes
PforR	Programme for Results
ICT	Islamabad Capital Territory
PWID	people who inject drugs
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PHC	primary health care
PPHI	People's PHC Initiative
PLHIV	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
PMRC	Pakistan Medical Research Council
RMNCH	reproductive, maternal, newborn and child health
SCI	service coverage index
SDG	Sustainable Development Goals
SRHR	sexual and reproductive health and rights
TG	transgender
UBRAF	unified budget results and accountability framework
UHC	universal health coverage
UN	United Nations

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNCHR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNSDCF	United Nations Sustainable Development Cooperation Framework
WHO	World Health Organization

Glossary of key terms

Term	Definition
Communities	Groups of people that may or may not be spatially connected, but who share common interests, concerns or identities. These communities could be local, national or international, with specific or broad interest [a]
Community-led (AIDS) responses	Actions and strategies that seek to improve the health and human rights of their constituencies, specifically informed and implemented by and for communities themselves and the organizations, groups and networks that represent them [b]
Community engagement	A process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes [c]
Comprehensive HIV services	Services provided across a continuum that addresses the prevention, testing, treatment, and care needs for people living with and affected by HIV. This may include combination HIV prevention, HIV testing, antiretroviral therapy (ART), management of co-morbidities and coinfections (e.g., tuberculosis (TB), sexually transmitted infections (STIs), viral hepatitis, cervical cancer, non-communicable diseases (NCDs), mental health conditions, etc.), and specific services and interventions for key and other populations (e.g., pre-exposure prophylaxis, harm reduction, condoms, lubricant).
Comprehensiveness of care	The extent to which the spectrum of care and range of available resources responds to the full range of health needs of a given community. Comprehensive care encompasses health promotion and prevention interventions, as well as diagnosis and treatment or referral and palliation. It includes chronic or long-term home care and, in some models, social services [d]
Differentiated service delivery	An approach that simplifies and adapts HIV services to better serve the needs of people living with HIV/AIDS (PLHIV) and to optimize the available resources in health systems [e]
Empowerment	The process of supporting people and communities to take control of their own health needs resulting, for example, in the uptake of healthier behaviours or an increase in the ability to self-manage illnesses.[d]
Essential public health functions	The spectrum of competences and actions that are required to reach the central objective of public health — improving the health of populations. This document focuses on the core or vertical functions: health protection, health promotion, disease prevention, surveillance and response, and emergency preparedness.[d]
Health system	All organizations, people, and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, family caregivers; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; and occupational health and safety legislation. The WHO health system framework identifies six health system "building blocks": leadership and governance, health financing, health workforce, health services, health information systems, and medical products, vaccines, and technologies [f]
Health benefits packages	The type and scope of health services that a purchaser buys from providers on behalf of its beneficiaries.[d]
Integrated health services	The management and delivery of health services so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease

Term	Definition
	management, rehabilitation and palliative care services through the different functions, activities, and sites of care within the health system.[d]
Interlinkages	Joined or connected, with the parts that are joined often having an effect on each other
Key populations/ vulnerability	Key populations are groups that have a high risk and disproportionate burden of HIV in all epidemic settings. They frequently face legal and social challenges that increase their vulnerability to HIV, including barriers to accessing HIV prevention, treatment and other health and social services. Key populations include gay men and other men who have sex with men (MSM), sex workers, transgender people and people who inject drugs. Vulnerability refers to unequal opportunities, social exclusion, unemployment or precarious employment (and other social, cultural, political, legal and economic factors) that make a person more susceptible to HIV infection and developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk, and they may be outside of their control. These factors may include lack of the knowledge and skills required to protect oneself and others; limited accessibility, quality and coverage of services; and restrictive societal factors, such as human rights violations, punitive laws or harmful social and cultural norms (including practices, beliefs and laws that stigmatize and disempower certain populations). These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV. [g]
Multisectoral action on health	Policy design, policy implementation and other actions related to health and other sectors (for example, social protection, housing, education, agriculture, finance and industry) carried out collaboratively or alone, which address social, economic and environmental determinants of health and associated commercial factors or improve health and well-being.[d]
People-centred care	An approach to care that consciously adopts the perspectives of individuals, carers, families and communities as participants in and beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care also requires that people have the education and support they need to make decisions and participate in their own care.[d]
Person-centred care	Care approaches and practices in which the person is seen as a whole, with many levels of needs and goals, the needs being derived from their personal social determinants of health.[d]
Primary care	A key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care.[d]
Primary health care	A whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities.[d]
Primary health care-oriented systems	Health system organized and operated to guarantee the right to the highest attainable level of health as the main goal, while maximizing equity and solidarity. A primary health care-oriented health system is composed of a core set of structural and functional elements that support achieving universal coverage and access to services that are acceptable to the population and equity enhancing.[d]
Service package	A list of prioritized interventions and services across the continuum of care that should be made available to all individuals in a defined population. It may be endorsed by the government at national or subnational levels or agreed by actors where care is by a non-State actor [d]

Term	Definition
Synergy	The interaction of elements that when combined produce a total effect that is greater than the sum of the individual elements
Universal Health Coverage	Ensured access for all people to needed promotive, preventive, resuscitative, curative, rehabilitative, and palliative health services, of sufficient quality to be effective, while also ensuring that the use of these services does not expose any users to financial hardship.[d]
Vertical programmes	Health programmes focused on people and populations with specific (single) health conditions.[d]

Sources for glossary:

a) Community engagement: a health promotion guide for universal health coverage in the hands of the people. Geneva: World Health Organization; 2020
b) Community-led AIDS responses: final report based on the recommendations of the multistakeholder task team [Internet]. UNAIDS; 2022 [cited 2023 Apr 29]. Available from: https://www.unaids.org/en/resources/documents/2022/MTT-community-led-responses
c) WHO community engagement framework for quality, people-centred and resilient health services. Geneva: World Health Organization; 2017
d) Operational Framework for Primary Health Care. Geneva: World Health Organization and UNICEF; 2020
e) Updated recommendations on service delivery for the treatment and care of people living with HIV. Geneva: World Health Organization; 2019
f) Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. [Internet]. World Health Organization; 2007 [cited 2023 Apr 7]. Available from: https://www.who.int/publications/i/item/everybody-s-business----strengthening-health-systems-to-improve-health-outcomes
g) UNAIDS terminology guidelines, 2015. https://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf

Executive summary

Introduction

The purpose of this case study was to generate evidence and learnings from the different ways in which the UNAIDS Joint Programme has supported countries to leverage PHC and HIV linkages across various contexts. The case study used a mixed methods approach combining qualitative and quantitative methods for data collection and analysis. An initial document and data review was supplemented by primary data collection through key informant interviews and focus group discussions with key stakeholders from the national and provincial levels. Altogether, 99 key stakeholders shared their experiences through one-on-one interviews or focus group discussions.

Pakistan is witnessing an increasing trend of new HIV infections with a four-fold increase over 20 years and an epidemic concentrated among key populations. The HIV prevalence is highest among key populations (injection drug users, transgender, men who have sex with men and sex workers) and Pakistan is far from reaching the global 95-95-95 targets. The National Health Vision of Pakistan (2016-2025) envisage to improve the health of all Pakistanis, particularly women and children by providing universal access to affordable, quality essential health services, delivered through a resilient and responsive health system and includes key elements of the PHC approach.

Key findings

The evaluation found that the Joint UN Team on AIDS had not fully leveraged the recent PHC policy window to improve HIV outcomes as well as broader health outcomes. Despite the national health vision being largely a PHC informed strategy and the country undergoing major PHC reform, the HIV response in Pakistan is still to a large extent a siloed programme, with standalone ART and PMTCT clinics being prioritized and with separate financing, separate data and procurement systems and separate funding structures for HIV. There were however recent examples of more attention to applying all three pillars of the PHC approach by the Joint UN Team on AIDS or by individual UN agencies; examples included: WHO-supported PHC Model of Care; contribution of individual UN agencies to the development of the UHC Benefit Package; support to an update of the Pakistan's AIDS strategy with an increased attention to applying the PHC approach; and Cosponsors' contributions to community engagement, multisectoral initiatives and addressing stigma and human rights concerns.

The evaluation noted a lack of a unified understanding of HIV integration and interlinkages with PHC among Joint UN Team on AIDS members and with PHC related efforts mainly influenced by individual UN agency mandates globally and in-country. There was further no cohesive national Joint Plan aimed at strengthening linkages between HIV and PHC for improved HIV outcomes and broader health gains. The evaluation also found inadequate coordination between Joint UN Team on AIDS members at provincial level, which will be important aspects to address in Pakistan where the health sector is devolved to provinces, and inadequate coordination between different stakeholders to strengthen community engagement aspects.

The evaluation identified that integration of HIV and PHC in Pakistan faces barriers such as financial constraints due to low health care spending, limited political commitment, and absence of comprehensive health strategies in certain regions. Challenges such as HIV stigma, low awareness, health care workforce constraints, and fragmented data systems further hinder integration. However, successful integration can be promoted by leveraging existing PHC strategies, a substantial network of facilities and health workers, and sustainable inclusion of HIV interventions in the UHC benefit package. Overcoming these barriers and capitalizing on enablers is pivotal for advancing HIV integration with PHC in Pakistan.

The evaluation found missed opportunities in terms of using investments, infrastructure, innovations, and lessons learned from the HIV response to improve broader health outcomes in Pakistan. HIV has often been treated as a separate issue rather than being fully integrated into the

broader health care system. This separation has led to a lack of synergy between HIV programmes and other health interventions, limiting opportunities to learn from and adopt innovations and lessons from the HIV response. In response to the COVID-19 pandemic, efforts led by WHO, UNDP and UNAIDS promoted differentiated service delivery models for HIV services. These strategies, including multi-month dispensing and home-based delivery of ARVs. Such strategies have the potential to improve treatment and care of other chronic diseases and to enhance health care access and outcomes.

The Joint UN Team on AIDS' proactive efforts have led to significant strides in addressing the needs of key populations and promoting equity, gender and human rights. Important achievements over the last years have included multisectoral actions and efforts to combatting stigma and discrimination. These combined endeavours showcase the Joint UN Team on AIDS' commitment to fostering inclusivity and fighting stigma in the HIV response. Yet there are still apparent gaps and challenges and key populations need specific attention when designing appropriate service delivery models within a PHC context.

The evaluation noted that the Joint UN Team on AIDS in Pakistan has the potential to take the agenda of HIV integration and interlinkages with PHC forward. This will include a focus on enhanced alignment, strategic thinking, and coordination with government departments and the private sector. However, addressing the complex task of potentially integrating HIV services into primary care requires additional joint and strategic thinking and resources and skilled personnel, which are currently insufficient.

Conclusions and considerations on the way forward

Recent progress related to applying the PHC approach to HIV response in Pakistan was observed, however the HIV response in Pakistan is still largely siloed in practice. Despite substantial focus on multisectoral approaches and people/community empowerment and engagement in the UBRAF plan, this alignment has not yet translated into a comprehensive plan for integrating HIV with other services and/or in primary care settings - how, what, and where to integrate still remains unclear. This underscores the importance of enhancing strategic alignment and cooperation between Joint UN Team on AIDS members to ensure a cohesive approach. There is scope to develop a clear and comprehensive action plan building on the PHC approach of the National Health Vision, learning from the PHC model of care applied in two districts and assessing the potential for increased integrating service delivery and patient centred care for marginalized populations who are at risk of different infections and diseases (HIV, hepatitis, TB, STIs, mental health, drug use etc.).

The Joint Programme has a distinct added value through leveraging the specialized expertise of its member agencies. This collaborative approach, reinforced by effective leadership from UNAIDS and supported by UBRAF funding, has the potential for further advancements in the integration agenda. Addressing the complex task of integrating HIV with PHC requires additional resources and skilled personnel to ensure the Joint Programme's effectiveness in advancing HIV and PHC integration efforts.

The following bullets present opportunities for the Joint Team on AIDS on the way forward.

- Conduct a situation analysis and using learnings from WHOs pilot PHC model of care.
- Develop a national action plan for integration of HIV services within the broader health system including primary care/related disease programmes, including comprehensive actions and regular monitoring mechanism to address HIV stigma and discrimination.
- Build capacity of existing network of community health care workers and boost meaningful involvement of key populations and affected groups.
- Improve coordination, communication, multisectoral action and policy by the members of the Joint UN Team on AIDS.
- Enhance sustainable financing for HIV - plan for transition from Global Fund and UHC Benefit Package funded by domestic resources.

1. Introduction and context

1.1. Purpose and scope of the case study

The country case studies within the broader UNAIDS Joint Programme (the Joint Programme) evaluation aim to gather evidence and insights regarding the integration of HIV response into primary health care (PHC). This exploration is centred on how the Joint Programme has facilitated linkages between HIV and PHC services in diverse contexts. These studies assess the practical implementation of HIV responses within a PHC framework, documenting current status, achievements, challenges, risks, and opportunities. Furthermore, they also explore the broader impact of HIV investments on overall health outcomes in the country. The ultimate goal is to offer recommendations for advancing the Joint Programme strategies in relation to HIV-PHC services linkages and integration.

Four countries were chosen for these case studies: Angola, Botswana, Indonesia, and Pakistan. This selection was made based on factors like the evaluation's significance for UNAIDS country offices, the Joint Programme, and governments. Additionally, geographic diversity and variations in HIV epidemiology and health systems were considered in the selection process.

1.2. Approach/methods/limitations

Approach and methods – The case study undertaken employed a mixed methods approach, encompassing both qualitative and quantitative techniques, to comprehensively gather and analyse data. This involved an initial review of key documents and data, which was further complemented by primary data collection. The literature review encompassed pivotal national and provincial documents, such as the National Health Vision (2016-2025), Universal Health Coverage (UHC) Benefit Package for Pakistan, PHC vital signs for Pakistan in 2022, Pakistan UHC Monitoring Report in 2022, Pakistan AIDS Strategy Update for 2022-2026, Pakistan National HIV Programme Review in 2023, Joint Statement on PHC for UHC by health and development partners in 2021, Punjab Health Sector Strategy from 2019-2028, Khyber Pakhtunkhwa Health Policy spanning 2018-2025, WHO's PHC model of care, National Health Accounts for 2017-18, and the National Health Support Programme (NHSP). The primary data collection through key informant interviews and focus group discussions were conducted over the course of 4-30 July 2023, involving prominent stakeholders at the national and provincial levels (Sindh, Punjab and Khyber Pakhtunkhwa).

The selection of these key stakeholders was done through purposive sampling, aimed at soliciting pertinent information and substantiating evidence at both the national and provincial tiers. These stakeholders were drawn from a diverse array of backgrounds, including UN organizations, government bodies including health facility personnel from the public sectors, multi and bilateral organizations and civil society representatives. Notably, the fieldwork extended beyond national level, involving three provinces (Sindh, Punjab and Khyber Pakhtunkhwa) where UNDP operates within the framework of its role as the principal recipient for the Global Fund HIV grant in Pakistan. After the 18th Constitutional amendment, the provision of health services, including HIV response, is the responsibility of the respective provinces. The inclusion of the provinces in the case study is premised on the considerable variation in the governance and service delivery mechanisms across provinces, burden of HIV and consequent provincial response.

Key informant interviews were conducted using a semi-structured interview guide delineating predetermined questions aligned with the themes of the country case study. Similarly, focus group discussions engaged informants in reflective discussions based on the interviewer's queries. These discussions facilitated the exchange of comments, observations, and reactions among group members. The full interview guide/focus group discussion guide is available in Annex 1 of the report. The cumulative efforts resulted in the completion of 27 key informant interviews/group discussions with the participation of participants from national level and three provinces.

The country case study was conducted within a defined time frame and scope, resulting in a focused participation of select individuals. This approach facilitated interactive discussions and collaborative learning sessions. Key informants were thoughtfully chosen to represent diverse viewpoints on the designated themes, enabling the capture of valuable insights and lessons. Through their input, the study gained a comprehensive understanding of the intricate interplay between HIV and PHC.

The data gathered from these key informant interviews and focus group discussions was meticulously noted, subsequently subjected to analysis, and systematically categorized according to the central themes and content. To ensure the robustness of the evaluation, a triangulation strategy was adopted, both across and within different data sources categories. This encompassed use of all qualitative data and the population of the evaluation evidence matrix according to sub-questions and overarching evaluation inquiries, effectively bolstering the triangulation process.

1.3. Limitations

It is imperative to acknowledge certain limitations of the study. The country case study was restricted by time and scope to include only three provinces of Pakistan and results cannot be generalised to other provinces. The study used a purposive sampling strategy by which key informants were selected to bring forward perceptions from a variety of stakeholders on the selected themes and learnings to be documented. This approach however has an inherent risk of bias- particularly observer bias[1] and selection bias. The study applied standardised tools for data collection and triangulated evidence as an effort to limit bias, however bias might not have been eliminated. Furthermore, a holistic PHC response to HIV in Pakistan has not been in the forefront and there were limited data available to explore the three components of PHC systematically.

Consequently, a careful interpretation of the report's findings is advised, mindful of these constraints. Nonetheless, the report notably accentuates pertinent insights, opportunities, and areas necessitating attention, while contemplating potential avenues for future work.

2. Introduction to the status of the national PHC and HIV response

2.1. Overview of health context

2.1.1. Key demographic, socio-economic and burden of disease/health data

With a population of approximately 241.1 million as of 2023[2], Pakistan stands as the world's fifth most populous nation. Furthermore, the country hosts over 1.4 million registered Afghan refugees for more than four decades[3]. The land covers 881 913 square kilometres, making Pakistan the 33 largest country globally.

Pakistan is administratively divided into provinces such as Punjab, Sindh, Khyber Pakhtunkhwa (KP), Baluchistan, and additional territories including Gilgit Baltistan (GB), Azad Jammu and Kashmir (AJK), and Islamabad Capital Territory (ICT). Notably, a constitutional amendment in 2018 incorporated the Federally Administered Tribal Area into Khyber Pakhtunkhwa.

These administrative divisions further branch out into smaller units, reflecting Pakistan's hierarchical governance structure. The distribution of the population is such that 63.5% inhabit rural regions,

[1] Observer bias: researcher's expectations, opinions, or prejudices influence what they perceive or record in a study;

[2] Pakistan Bureau of Statistics (PBS), 2023; Pakistan Population and Housing Census 2023

[3] https://data.unhcr.org/en/country/pak

while 36.5% of populations reside in urban centres. As of the 2017 census, the sex ratio in the country is 106 males for every 100 females (detailed results of census 2023 awaited).

Pakistan's human development index was 0.681 in 2015, categorizing it as a country with a medium level of development according to the national report's thresholds[4]. However, the global human development index for Pakistan was calculated as 0.557 in the Human Development Report Indices 2019[5], ranking the country 154th out of 189 countries and placing it in the medium human development category. The divergence in scores arises from variations in methodology, data, and estimation criteria between the national and international levels.

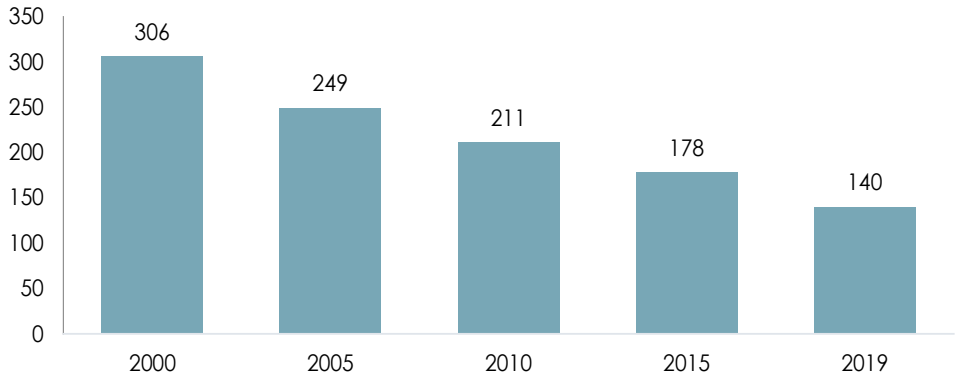
Health indicators within Pakistan are intricately intertwined with its economic landscape. Classified as a lower-middle income country, Pakistan consistently invests in the enhancement of its healthcare system. Based on the official 2019 report on multidimensional poverty, about 38.8% of Pakistan's population experiences multidimensional poverty. Disparities across regions are evident, with the lowest poverty rate (31.4%) in Punjab and the highest (71.2%) in Baluchistan. Khyber Pakhtunkhwa and Sindh also exhibit varying rates, underscoring the diverse socioeconomic scenario across provinces[6].

2.1.2. Progress on SDG3 targets

SDG Target 3.1 Reduce maternal mortality

The Pakistan Maternal Mortality Survey 2019 reflected a maternal mortality ratio of 186 per 100 000 live births (199 in rural areas and 158 in urban areas)[7] during three years preceding the survey. Though there is a declining trend of maternal mortality in Pakistan (Figure 1), reaching the target of reducing the maternal mortality by less than 70 per 100 000 live births by 2030 might not be feasible.

Figure 1. Maternal mortality rates per 100 000, Pakistan 2000-2019



Source: Universal Health Coverage Monitoring Report 2022, Pakistan

The maternal mortality ratio reflects wide variations across provinces, being highest in Baluchistan followed by Sindh, and Khyber Pakhtunkhwa (165/100 000 live births) (Figure 2).

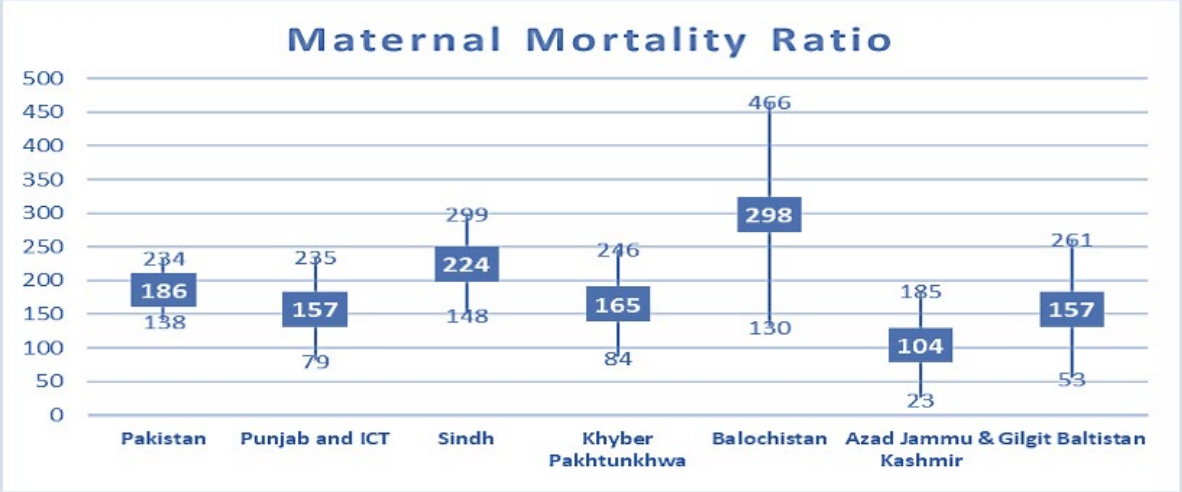
[4] UNDP, 2017; National Human Development Report

[5] UNDP, 2020; Human Development Indices and Indicators 2019 - Statistical Update

[6] Multidimensional poverty in Pakistan; https://www.ophi.org.uk/wp-content/uploads/Multidimensional-Poverty-in-Pakistan.pdf

[7] Pakistan Maternal Mortality Survey 2019: https://dhsprogram.com/pubs/pdf/SR267/SR267.pdf

Figure 2. Maternal mortality ratio, Pakistan provinces



Source: Pakistan Maternal Mortality Survey 2019

SDG target 3.2: End all preventable deaths under 5 years of age

In Pakistan, there has been a gradual decrease in the neonatal mortality rate from 52 deaths per 1 000 live births in 2006-07 to 42 deaths per 1000 live births as reported in the Pakistan Demographic and Health Survey (PDHS) of 2017-188. However, the current rate of progress suggests that Pakistan's projected neonatal mortality by the year 2030 would still be 32 deaths per 1 000 live births, which is considerably higher than the Sustainable Development Goals (SDG) target of less than 12 deaths per 1 000 live births.

According to the PDHS 2017-18, the under-five mortality rate in Pakistan has shown improvement, declining to 74 deaths per 1 000 live births from 89 deaths per 1 000 live births in the PDHS of 2006-07, both for the three-year period preceding the survey. However, the infant mortality rate remains high at 62 deaths per 1 000 live births, according to the PDHS 2017-18 findings8.

SDG target 3.3: Fight communicable diseases

HIV - The SDG Indicator for HIV is “the number of new HIV infections per year amongst uninfected adults per 1 000 people aged 15-49”. The target for 2030 is to end AIDS across all countries. UNAIDS has set a target of reducing to less than 200 000 new HIV infections globally among adults by 2030[9]. This would mean a reduction to 0.02 new cases per 1000 people globally in 2030.

For Pakistan, there is an increasing trend with less than 0.05 new infections among adults 15-49 years in 2 000 to 0.2 new infections in 2020 per 1 000 population - a four-fold increase over 20 years (Figure 3).The most recent integrated biological and behavioural surveillance (IBBS) survey (2017) findings reflect that the prevalence of HIV is highest among injection drug users (38.4%) followed by transgenders (7.1%), men who have sex with men (MSM) (5.4%) and female sex workers (FSW) (2.2%)[10]. The highest prevalence was among people who inject drugs (PWIDs) from Kasur (50.8%), Karachi (48.7%), Bahawalpur (25.1%) and Mir Pur Khas (23.2%). The highest prevalence for HIV for trans gender (TG) was reported from Larkana (18.2%) followed by Bannu (15%) and Karachi (12.9%). Among FSWs, highest prevalence of HIV was reported from Sukkur (8.8%), followed by Larkana and Mir Pur Khas (4.1% each), Nawabshah (3.8%) and Peshawar (3%). Among MSM, highest prevalence of HIV was reported from Kasur (9.7%) followed by Karachi (9.2%) and Nawabshah (7.5%). Currently,

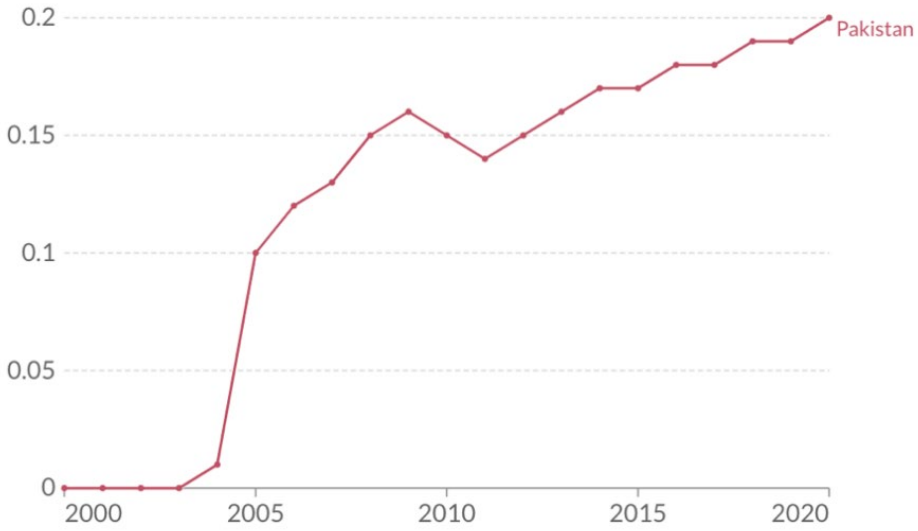
[8] Pakistan Demographic and Health Survey (2017-18): https://dhsprogram.com/pubs/pdf/FR354/FR354.pdf

[9] Understanding fast-track: Accelerating Action to end the AIDS Epidemic by 2030: https://www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_en.pdf

[10] NACP. Integrated Biological & Behavioral Surveillance in Pakistan (2017). Islamabad: National AIDS Control Program (NACP) 2017: https://www.aidsdatahub.org/sites/default/files/resource/ibbs-pakistan-round-5-2016-2017.pdf

the IBBS round 6 is underway and expected to provide epidemiological insight on HIV transmission in six key populations (PWID, TG, FSW, MSM, male sex workers, TG sex workers, and prisoners) as well as ascertain the prevalence of hepatitis B and C and syphilis among these populations.

Figure 3. HIV incidence, new HIV infections per year amongst uninfected adults per 1 000 people aged 15-49, Pakistan 2000-2020[11]



Source: SDG Tracker https://ourworldindata.org/sdgs/good-health-wellbeing

Tuberculosis - The SDG indicator for TB is the number of new cases of TB per 100 000 people. The 2030 target is to end the epidemic of TB in all countries. The World Health Organization's End TB strategy has set a target of reducing incidence of TB by 80% over 2015 levels (which imply a target of around 28 cases per 100 000 by 2030)[12].

According to the Global TB Report 2022, Pakistan ranks 4th among the high-burden countries in the world and accounted for 7.8% of the global cases in 2021. The number of new TB cases in a year has increased from 331 780 in 2015 to 339 129 in 2021. The TB treatment coverage was around 55% while the TB case fatality ratio (estimated mortality/estimated incidence) is 8% in 2021. HIV-positive TB incidence is 6.8 per 100 000 population[13].

Hepatitis - Pakistan is currently grappling with an epidemic of hepatitis B, C, and D. The country lacks a comprehensive national hepatitis surveillance system, resulting in limited epidemiological data. To date, only one national survey on hepatitis B and C seroprevalence has been conducted by the Pakistan Medical Research Council in 2008. The findings of this survey revealed a hepatitis B prevalence rate of 2.5% and a hepatitis C prevalence rate of 5%. Subsequently, the provinces of Punjab and Sindh carried out separate surveys.

In 2018, the Government of Punjab conducted a survey, which indicated a hepatitis B prevalence rate of 2.2% and a hepatitis C prevalence rate of 8.2%. Similarly, the Government of Sindh conducted a survey in 2019, revealing a hepatitis B prevalence rate of 1.05% and a hepatitis C prevalence rate of

[11] SDG Tracker https://ourworldindata.org/sdgs/good-health-wellbeing
[12] The End TB Strategy, World Health Organization: https://apps.who.int/iris/bitstream/handle/10665/331326/WHO-HTM-TB-2015.19-eng.pdf?sequence=1&isAllowed=y
[13] World Health Organization Application https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&entity_type=%22country%22&lan=%22EN%22&iso2=%22PK%22

6.2%. In an effort to combat the hepatitis epidemic, the federal government is providing free hepatitis medications on an outpatient basis at its hospitals.

SDG target 3.4: Reduce mortality from NCDs and promote mental health

Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease-NCDs in Pakistan pose a significant challenge in terms of equity and socio-economic development, with variations observed at the provincial and area levels. The burden of NCDs, which accounted for 29.9% of the total disease burden in 2000, has increased to 43.7% in 2019. This upward trend is also evident in mortality data, with NCD-related deaths estimated to make up 55.3% of the total 1.49 million deaths in the country in 2019[14].

Suicide mortality rate The proportion of deaths due to suicide has almost doubled from the year 2000 (0.61% of all deaths) to 2019 (1.18% of all deaths). It is important to mention that the suicide deaths are underreported due to social stigma and cultural or legal concerns[14].

SDG target 3.5: Prevent and treat substance abuse

According to the latest national level survey conducted in 2013, 6.7 million people of 15 to 64 years had used one or more illicit substance during the past 12 months[15]. Most of the drug users were between 25 to 39 years of age. Cannabis is the most commonly used substance and is used by four million people. The survey also estimated that there were 860 000 regular heroin users. Around 1.6 million people reported the use of non-medical use of opioids in the past 12 months. Nineteen thousand people reported the use of methamphetamine in the previous one year. In total, 4.25 million were dependent on drug substances requiring planned treatment for their drug use disorder. Men were the most frequent drug users as compared to women. Women who use drugs were found to be less likely to report undergoing treatment compared with men. The most common reason for not seeking treatment was an inability to pay the cost for treatment.

Consistent with, IBBS 2017 for HIV, Pakistan has a concentrated HIV epidemic amongst key populations including PWIDs[16]. HIV epidemic within the country follows the Asian Epidemic Model and is driven by high HIV prevalence among PWIDs, which is more than 40% in some cities of Pakistan[17] There were 430 000 people who inject drugs (PWIDs), out of which 73% shared the syringes[15]. [17] The government recently (2022) approved the implementation of Opioid Agonist Maintenance Therapy and preparations are underway at the federal and provincial levels to roll out services.

SDG target 3.7: Universal access to sexual and reproductive care, family planning and education

In Pakistan, the average number of births per woman was estimated to be 3.4 in 2020. Pakistan has made a commitment to achieving universal access to reproductive health and increasing the contraceptive prevalence rate to 50% by 2025. Yet, the contraceptive prevalence rate appears to be relatively stagnant as reflected by the PDHS 2017-18; only 25% of couples were currently using modern contraceptive methods, which is slightly lower than the 26% reported in 2012-13. There is variation in the contraceptive prevalence rate (modern methods) across provinces, highest in the Gilgit Baltistan (35%) followed by Azad Jammu and Kashmir and Islamabad Capital Territory (30%), Khyber Pakhtunkhwa (28%), Punjab (27%), Sindh (21%) while lowest in Baluchistan (18%)[18].

[14] Institute of Health Metrics and Evaluation (IHME), GBD compare: https://vizhub.healthdata.org/gbd-compare/

[15] UNODC. Drug Use in Pakistan 2013. Islamabad: United Nations Office on Drugs and Crime 2013. https://www.unodc.org/documents/pakistan/Survey_Report_Final_2013.pdf

[16] NACP. Integrated Biological & Behavioral Surveillance in Pakistan (2017). Islamabad: National AIDS Control Program (NACP) 2017: https://www.aidsdatahub.org/sites/default/files/resource/ibbs-pakistan-round-5-2016-2017.pdf

[17] Bergenstrom A, Achakzai, B., Furqan, S., ul Haq, M., Khan, R., & Saba, M. Drug-related HIV epidemic in Pakistan: a review of current situation and response and the way forward beyond 2015. Harm reduction journal. 2015; 12. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4608141/

[18] Pakistan Demographic and Health Survey 2017-18: https://dhsprogram.com/pubs/pdf/FR354/FR354.pdf

SDG target 3.8: Achieve UHC

UHC is the provision of quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all with financial risk protection. The UHC service coverage index (SCI) is a comprehensive measure that gauges the extent to which essential health services are accessible to individuals. It encompasses 16 proxy indicators, categorized into four groups: reproductive, maternal, newborn, and child health; infectious diseases; NCDs; and service capacity and access.

The goal of UHC is to prioritize integrated essential healthcare services within all levels of the healthcare delivery system, spanning from community-based care to PHC centres, first level hospitals, tertiary hospitals, and the population as a whole. Both the public and private sectors are involved in delivering these services to effectively and efficiently address the burden of diseases. Annual UHC SCI across provinces/regions is reflected in Table 1 below.

Table 1. UHC SCI in Pakistan 2015-2021

Annual UHC SCI[19]							
Province/Area	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Islamabad	44.7	47.7	48.9	48.5	51.3	56.0	56.3
Punjab	40.6	42.8	45.6	47.3	48.2	52.0	53.8
Azad Jammu & Kashmir	39.0	40.7	43.6	46.2	47.9	49.8	50.2
Khyber Pakhtunkhwa	36.2	40.7	45.8	47.3	47.6	50.3	49.8
Gilgit Baltistan	35.8	39.3	41.0	42.6	43.5	45.2	48.5
Sindh	37.6	40.6	43.9	45.0	46.7	48.6	48.0
Baluchistan	27.1	29.3	32.3	33.5	35.0	35.2	35.7
Pakistan	**39.7**	**42.1**	**45.3**	**46.3**	**47.1**	**49.9**	**52.0**

Source: UHC Monitoring Report 2022, Pakistan

In Pakistan, the costs incurred through out-of-pocket (OOP) expenses in the healthcare sector are remarkably high, constituting 56.5% of the current health expenditures and 51.9% of the total health expenditures. OOP health expenses within the private sector are considerably greater than those within the public sector.

An examination of the National Health Accounts 2017-18 reveals that Punjab has the largest proportion (53%), whereas Islamabad has the smallest proportion (1%) of the overall OOP health spending. Additionally, urban areas exhibit a higher level of OOP health expenditure compared to rural areas[20]. In 2015, the percentage of population with household expenditures on health exceeding 10% and 25% was 4.47 and 0.50 respectively. The number of people incurring impoverishing health spending decreased from 1.27% in 2013 to 0.68% in 2015, based on the extreme poverty line[21].

[19] UHC Monitoring Report 2022, Pakistan

[20] National Health Accounts 2017-18, Pakistan. Pakistan Bureau of Statistics https://www.pbs.gov.pk/sites/default/files/national_accounts/national_health_accounts/national_health_accounts_2017_18.pdf

[21] World Bank Development Indicators

2.2. National PHC policy and programmatic response and challenges

2.2.1. Health sector strategic plans, reforms, and UHC Benefit Package

Health sector strategic plans and health reforms related to PHC

The governance structure in Pakistan underwent a major reform, when in 2010, 17 federal ministries including the health ministry was devolved to its four provinces (Punjab, Sindh, Khyber Pakhtunkhwa and Baluchistan) giving them legislative, operational and financial responsibilities. The functions of health planning, legislation, service regulation, financing service delivery, human resource production and service delivery programming were devolved to the provinces. In 2011, the federal health ministry was abolished which posed challenges in national coordination for global health commitments, drugs licensing, and regulation of medical and nursing professions.

Consequently, in 2013, Ministry of National Health Services Regulation and Coordination was constituted to undertake the federal functions. The federal health ministry is mandated to provide oversight on the international agreements and targets; licensing of the human resource production; licensing, registration and pricing of drugs, research and surveillance; setting up standards; and inter-provincial coordination. The provincial health departments are mandated to make policies, strategies, plans, legislations; financing of the health care; human resource planning, deployment, management; services menu, programming, implementation; market surveillance, supply systems for drugs; monitoring and evaluation; surveillance; strategic purchasing, regulation, and accountability.

The Political Declaration on UHC adopted by the United Nations General Assembly in 2019 reiterates that PHC forms the bedrock of a viable health care system. In September 2018, all countries in the Eastern Mediterranean Region including Pakistan signed the Salalah Declaration and the UHC2030 Global Compact, committing to joint efforts for UHC by establishing fair, resilient, and sustainable health care systems.

In order to provide an overarching national vision and agreed upon common direction, harmonizing provincial and federal efforts for achieving the desired SDG3 outcomes, the National Health Vision of Pakistan (2016-2025) was developed in 2016. The National Health Vision envisaged to improve the health of all Pakistanis, particularly women and children by providing universal access to affordable, quality essential health services, delivered through a resilient and responsive health system. The National Health Vision provides strategic guidance on how to improve the coverage and functionality of primary and promotive health services, while ensuring the widening of essential service packages. It also proposes ensuring the quality of services by implementing Minimal Standards for Delivery of Service at all levels. At the national level there no specific PHC policy/strategy.

Over the first two years of devolution, the provinces came up with province-specific health sector strategies laying out an eight-year strategic direction across public and private health sectors. The health sector strategy for Sindh and Punjab was from 2012-20 while for Khyber Pakhtunkhwa it was from 2010-2017. Punjab drafted its updated Health Sector Strategy for 2019 - 2028 while Khyber Pakhtunkhwa had its updated Health Policy for 2018-2025 period. It is noteworthy that Sindh has not updated its Health Sector Strategy since it expired in 2020.

A significant increase in legislative activities has been seen across all four provinces post-devolution in 2010. Legislation has for the first time been directed towards important health reform areas of public-private partnerships, health services regulation and autonomy of teaching hospitals. Certain level of restructuring of provincial health departments has also taken place to steer health stewardship. Khyber Pakhtunkhwa, Punjab and Sindh developed their following latest health sector policy documents aligned with the National Health Vision (2016-2025) to steer the health sector in their respective province. A summary is provided in Table 2 below.

Table 2. Provincial planning and governance initiatives in Punjab, Sindh and Khyber Pakhtunkhwa

Provincial planning and governance initiatives			
	Punjab	**Sindh**	**Khyber Pukhtunkhwa**
Policy/planning	Punjab Health Sector strategy (2019-2028) including roadmap for primary care in place	Sindh Health Sector Strategy 2012-2020	Khyber Pakhtunkhwa Health Policy – 2018-2025 with a roadmap for primary care in place
Regulatory authorities/ health care commissions	Established and functional	Established and functional (under expansion)	Established and functional (under expansion)
Essential Package of Health Services	Developed and costed	Developed and costed	Developed and costed
Service delivery integration	Functional integration of three different programmes (LHW programme, maternal and child health programme and nutrition programme) as integrated IRMNCH but run on PC 1/project mode. No vertical programme horizontally integrated into department of health under regular government budget.	Vertical programmes horizontally integrated into department of health under regular government budget	Functional integration of three different programs (LHW programme, maternal and child health programme and nutrition programme) as Integrated Health Project (IHP) but run on PC 1/project mode. No vertical programme horizontally integrated into department of health under regular government budget. Functional integration of HIV, hepatitis and thalassemia programme as integrated HIV, hepatitis and thalassemia control programme (IHHTCP) but run on PC 1/project mode. No vertical programme horizontally integrated into department of health under regular government budget.
Private sector harnessing	Punjab health care commission for regulation of health sector	Sindh health care commission for regulation of health sector	key populations health care commission for regulation of health sector
	Contracting out of equipment/technology maintenance	Contracting-out management of primary and secondary care facilities to People's PHC Initiative (PPHI)	Contracting out underperforming health facilities to private organizations for management through public sector Health Foundation
	Contracting out of medicine and supplies delivery	Contracting-out ambulance services, in selected districts	
	Contracting out of facilities maintenance		
	Sehat Sahulat Program (insurance programme for poor with only inpatient services engaging private health facilities – Government pays premium on behalf of people)	Sehat Sahulat Programme (insurance program for poor with only inpatient services engaging private health facilities – Government pays premium on behalf of people)	

Source: Author based on review; Punjab Health Sector strategy (2019-2028)[22], Khyber Pakhtunkhwa Health Policy – 2018-2025[23], Sindh Health Sector Strategy 2012-2020[24], Health systems changes after decentralisation: progress, challenges and dynamics in Pakistan[25].

Since 2013, federal and provincial governments in Pakistan started health protection/insurance programmes targeting eight NCDs with high catastrophic health expenditures and secondary care for the poorest segment of society targeting 14 million families.

At the same time, vertical national health programmes including LHW programme, TB control programme, malaria control programme, maternal, newborn and child health programme, expanded programme of immunization, hepatitis control programme, and HIV/AIDS control programme were devolved to the provincial governments, as a result of 18 constitutional amendment, with varying degree of challenges of ensuring coverage, efficiency and effectiveness.

UHC Benefit Package

Pakistan has made efforts to reform its health care system and improve access to essential services. In this regard, it has developed the UHC Benefit Package. The UHC Benefit Package developed at the national level has been localized by all provinces and each province now has an Essential Package of Health Services (EPHS) for the primary and secondary care level. The National UHC Benefit Package and provincial EPHSs include HIV services/programmes - at the community/primary care level (section 2.4 of this report).

The NHSP is a flagship programme for implementation of the UHC package in Pakistan and follows the "Programme for Results (PforR)" approach, which disburses funds based on achievement of results. The government and development partners plan to allocate more financial resources to UHC and initiatives such as the NHSP supported by the World Bank and other development partners, complement the implementation of the EPHS across provinces.

In June 2022, the World Bank's Board of Executive Directors approved US$ 258 million for the NHSP, and other donors have also pledged funding. The overall objective is to support Pakistan to improve UHC through Integrated PHC, with a focus on reproductive, maternal, newborn and adolescent health, infectious diseases, and NCDs and mental health. The World Bank support under NHSP will be provided till 2026. The funding details are reflected in Table 3 below.

[22] Punjab Health Sector strategy (2019-2028): https://phkh.nhsrc.pk/sites/default/files/2021-06/Health%20Sector%20Strategy%20Punjab%202019-2028.pdf

[23] Khyber Pakhtunkhwa Health Policy – 2018-2025: https://www.healthkp.gov.pk/public/uploads/downloads-41.pdf

[24] Sindh Health Sector Strategy 2012-2020: https://phkh.nhsrc.pk/sites/default/files/2019-06/Sindh%20Health%20Sector%20Strategy%202012-20.pdf

[25] Zaidi SA, Bigdeli M, Langlois EV, Riaz A, Orr DW, Idrees N, Bump JB. Health systems changes after decentralisation: progress, challenges and dynamics in Pakistan. BMJ Glob Health. 2019 Jan 30;4(1):e001013. doi: 10.1136/bmjgh-2018-001013. PMID: 30805206; PMCID: PMC6357909.

Table 3. NHSP allocation Pakistan[26]

NHSP allocation by PforR Window and IPF Component (US$ million)					
	IDA*	Global Financing Facility Country allocation committed	EHSG* being processed	Pakistan @100 MDTF* being processed	NHSP Total
PforR Window					
KP	**44.5**	**6.2**	**5.9**	**7.4**	**64.1**
Punjab	**110.0**	**15.4**	**14.7**	**18.3**	**158.3**
Sindh	**63.7**	**8.9**	**8.5**	**10.6**	**91.7**
Sub-total (KP, Punjab & Sindh)	**218.2**	**30.5**	**29.1**	**36.3**	**314.1**
Unallocated*	**0**	**5.2**	**4.9**	**6.2**	**16.3**
Total for PfR	**218.2**	**35.7**	**34.0**	**42.5**	**330.4**
IPF Component					
MoNHSR & C	**9.0**	**1.3**	**1.2**	**1.5**	**13.0**
KP	**6.3**	**0.9**	**0.8**	**1.0**	**9.0**
Punjab	**15.5**	**2.2**	**2.1**	**2.6**	**22.4**
Sindh	**9.0**	**1.3**	**1.2**	**1.5**	**13.0**
Sub-total (MoNHSR & C, KP, Punjab & Sindh)	**39.8**	**5.7**	**5.3**	**6.6**	**57.4**
Unallocated*	**0**	**0.6**	**0.7**	**0.9**	**2.2**
Total for IPF Component	**39.8**	**6.3**	**6.0**	**7.5**	**59.6**
Total	**258.0**	**42.0**	**40.0**	**50.0**	**390.0**

* Refers to a grant which will co-finance IDA if and when Baluchistan joins the NHSP. If Baluchistan does not join later, this amount will be reallocated to other implementers, considering the implementation progress and results achieved**.**

IDA = International Development Association

EHSG = Essential Health Services Grant

MDTF = Multi Donor Trust Fund

IPF = Investment Project Financing

Source: Pakistan - National Health Support Program (English). Washington, D.C. : World Bank

2.2.2. Leadership and responsibilities for delivering PHC at all levels

After the 18th constitutional amendment in 2010, the responsibility of delivering primary care lies with the provincial health departments. The federal health ministry is only responsible for provision of primary care in Islamabad Capital Territory. The primary care service provision modalities vary across provinces as noted below:

- Khyber Pakhtunkhwa – The provincial health department has district health officers across each district of province who are responsible for provision of primary care services within the district. The vertical programmes (LHW programme, maternal and child health programme, expanded programme on immunization programme, malaria control programme, TB control programme, HIV/AIDS control programmes, district health information system) are vertically run by their respective provincial programme offices on project mode through PC 1 (the Planning Commission's form for the planning and budgeting of the public sector development projects). However, there is a focal person for each vertical programme at the district health office for coordination and liaison with the provincial programme offices. The primary care facilities are spread across the district and include the basic health units (BHUs) and rural health centres (RHCs). The community-based component of PHC is run through the LHWs (frontline community-based workers) who are responsible for providing education/awareness and treatment of minor

[26] Pakistan - National Health Support Program (English). Washington, D.C. : World Bank Group. http://documents.worldbank.org/curated/en/438401654609799746/Pakistan-National-Health-Support-Program

ailments. The LHWs is one of the largest health related workforce in the country though their number is still sub-optimal as they cover around 58% of the population.

- Sindh – The provision of primary care services in Sindh is through People's PHC Initiative (PPHI) Sindh. PPHI is a public-private partnership programme which is autonomous (not under provincial health department) while the government provides finances for provision of services. The initiative was launched in 2007 to improve healthcare access, especially for those living in remote and rural areas. It is worthwhile to mention that the PPHI programmes were launched in other provinces as well, however, the programme was closed, and the health facilities were returned back to provincial health departments in Punjab and Khyber Pakhtunkhwa owing to a number of reasons. A recent reform took place in Sindh and all vertical programmes were brought under the department of health and made part of the regular budget (a shift from project mode to regular budget/horizontal integration).
- Punjab – The structure of the health care provision in Punjab is similar to the Khyber Pakhtunkhwa except that in the health sector there are two departments; one is Primary and Secondary Healthcare Department and the other is Specialized Healthcare and Medical Education Department.

2.2.3. Community structures and engagement

Pakistan has a mixed health and community system, which includes government health facilities, health facilities managed by the private sector, community workers and contributions from civil society and philanthropy. The government's strong suit in health care is its focus on bringing PHC services directly to communities. Apart from this, many people in Pakistan also prefer traditional and alternative healing methods alongside conventional healthcare.

The community health structure primarily includes the frontline health workers including LHWs, the community midwives, lady health visitors, and the outreach staff of community-based organizations (CBOs). LHWs are governed as a public sector vertical programme with a large workforce (around 89 000) spread across the country with around 58% population coverage. LHWs work in the community, are assigned 150-200 households, are required to visit 4-6 households daily and provide education, awareness regarding key health issues and treat basic medical ailments.

The community midwifes are under the maternal, newborn, child, and adolescent Health programme and are mandated to provide the safe deliveries in community settings (at their birth stations). Lady health visitors are staff of the BHUs (a primary care facility) and provide family planning and maternal, newborn, child, and adolescent health services at the BHUs and conduct field visits when needed.

The administrative structure for provision of health services goes down to the level of the district, where the district health office is established across all districts of Pakistan. The district health office is mandated to provide services in the district including the supervision of community level activities. The lowest administrative unit within a district is Union Council where the BHUs are situated. With each BHUs, are linked the LHWs who work in the catchment community of BHUs and have a monthly meeting at the BHUs where they prepare and present their monthly report.

2.2.4. Role of private sector

The private sector has a mix of hospitals, general practitioners, pharmacies, traditional health workers and hakeems offering health services. The private sector in Pakistan has seen growth during the last two decades and currently two thirds (66%) of the health care services are accessed from the private sector[27] with efforts by the government to engage private sector in provision of health services. This is reflected in the engagement of the private sector in the Sehat Sahulat Programme (a social health protection/insurance programme) at national and provincial levels and the public-

[27] Pakistan Standard of Living Measurement Survey 2019-20, Pakistan Bureau of Statistics, Govt. of Pakistan; https://www.pbs.gov.pk/sites/default/files/pslm/publications/pslm_district_2019-20/tables/4.2.pdf

private partnership employed by government of Sindh to manage its primary care facilities across the province.

One important issue is the regulation of the private sector for ensuring quality and safety of the health service provision. Health care commissions have been established in three provinces (Sindh, Punjab, and Khyber Pakhtunkhwa) and Islamabad Health Regulatory Authority, however, the attempt to control quackery and malpractices have not succeeded. Quackery, unsafe blood transfusions and unsafe use of injections have been identified as the areas which need special attention with regards to preventing spread of HIV in the recently conducted HIV response review 2023 for Pakistan[28].

2.2.5. Government Health systems and service delivery challenges and social inequities affecting access to health services

The health sector in Pakistan confronts several challenges that hinder equitable access to health care services, particularly affecting marginalized groups and women. Although there have been improvements in health awareness and service access, the country lags behind neighbouring nations in South Asia and the Eastern Mediterranean region. Critical health indicators such as maternal, newborn, and child health have been adversely impacted by the COVID-19 pandemic. Despite a well-established health infrastructure, the operationalization of the district health system is hindered by a shortage of qualified health personnel, especially nurses and midwives. The skewed deployment of the existing workforce in urban settings leaves rural populations underserved. Shortages in qualified healthcare professionals, including nurses and midwives, pose challenges to delivering effective health services, particularly in rural areas. The existing workforce is skewed towards doctors who often prioritize private practice, leading to an inadequate provision of essential health services. The private sector dominates healthcare provision with perceptions of low-quality health services provided at the public health facilities. While private services may be of higher quality, high out-of-pocket spending contributes to financial strain and limits access to essential health services. This exacerbates poverty and health-related financial shocks[29].

2.3. Overview of the national HIV epidemic and response

2.3.1. Key epidemiological HIV data, trends, and data on key population groups vulnerable or affected by HIV, key geographies

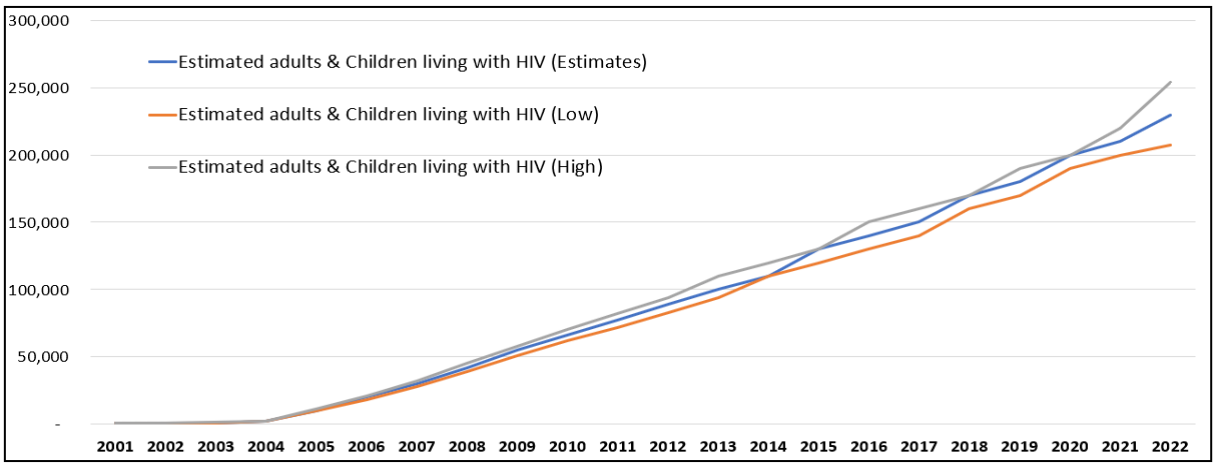
Based on the latest (2022) estimates from Asian Epidemic Model and Spectrum modelling, approximately 229 522 PLHIV in Pakistan. Figure 4 below shows the modelled estimate of numbers of PLHIV, suggesting a 3.5-fold increase in 2022 since 2010[30]

[28] Pakistan National HIV Programme/Response Review 2023, The Common Management Unit, Ministry of National Health Services, Regulations & Coordination

[29] Shaikh, B.T., Ali, N. Universal health coverage in Pakistan: is the health system geared up to take on the challenge?. Global Health 19, 4 (2023). https://doi.org/10.1186/s12992-023-00904-1

[30] Pakistan National HIV Programme/Response Review 2023, The Common Management Unit, Ministry of National Health Services, Regulations & Coordination

Figure 4. Estimated number of PLHIV - Pakistan 2001-2022



Source: Pakistan National HIV Programme/Response Review 2023 (NACP)

The provincial distribution of PLHIV indicates that Punjab has the highest estimated PLHIV burden of 50% (114 761), followed by Sindh 40% (91 808), Khyber Pakhtunkhwa 6% (13 771) and Baluchistan 4% (9182)[31]. Among 229 522 PLHIV, 57% are from key populations (43% MSM, 10% PWIDs, 2% sex workers and 1% transgender people/sex workers)[32]. The adult HIV prevalence rate is estimated to be around 0.1%, considering assumptions related to the progression of the pandemic. HIV is primarily concentrated in these populations, although there is transmission between key and general populations[30].

The most recent Integrated Biological and Behavioural Surveillance (IBBS) study 2017, reveals the following HIV prevalence rates: 38.4% among PWIDs, 7.1% among transgender people, 5.6% among male sex workers, 5.4% among MSM, and 2.2% among FSWs[33].

The main drivers of the HIV epidemic in Pakistan are the sharing of contaminated injecting needles and syringes and unprotected sex, particularly among PWIDs, MSM, transgender individuals, and sex workers. Nosocomial infections also contribute to the spread of HIV in Pakistan.

HIV prevention and treatment coverage in Pakistan remains one of the lowest in Asia and the Pacific. The number of ART centres in Pakistan has increased in recent years.[34] Yet, the testing coverage among the key populations is low with only 6% among MSMs, 15% among male sex workers, 30% among TG sex worker, 6% among FSWs and 17% among PWIDs[32]. ART centres across Pakistan have been established in public sector hospitals (secondary and tertiary level) which allow for partial integration of services as the host hospital laboratory is used for baseline tests of PLHIV visiting ART centres and PLHIV can also receive treatment for other health conditions at the same hospital. The increasing trend of estimated PLHIV in Pakistan indicates that the programmatic HIV prevention and treatment services implemented over the years have been unable to curb the epidemic. While the coverage rates of key populations in Pakistan have somewhat improved according to programmatic data, there are concerns about the quality and reliability of the outreach services in effectively controlling the rising trend of the epidemic.

[31] Asian Epidemic Model and Spectrum Modelling Estimates

[32] Pakistan AIDS Strategy IV 2022-2026

[33] NACP. Integrated Biological & Behavioral Surveillance in Pakistan (2017). Islamabad: National AIDS Control Programme (NACP) 2017: https://www.aidsdatahub.org/sites/default/files/resource/ibbs-pakistan-round-5-2016-2017.pdf

[34] In total 70 across the country and currently the province of Punjab has scaled up from 11 ART centres in 8 districts to in 2016 to 45 ARTs centres in all 36 districts in 2022. The province of Sindh, under the leadership of the health minister, has taken the decision to establish ART centres in each district of Sindh. In Khyber Pakhtunkhwa, ART centres are in process of being established at the divisional level (administrative level above the district) while previously the ART centres were only in the provincial capital Peshawar.

2.3.2. The aims and strategic orientation of the current national AIDS strategy (2022-2026), and progress against 95-95-95 targets

The Pakistan AIDS Strategy (PAS IV) revised in 2023[35] focuses on enhancing HIV prevention, expanding testing among key populations, establishing resilient health systems, and creating an enabling environment for a comprehensive response to the AIDS epidemic. The strategy employs the PHC approach of community-led programming and fostering partnerships between communities and health systems to ensure that HIV programmes are effectively integrated into the broader health system. In order to scale up the HIV treatment services and improve adherence, the PAS IV strategy envisages community-based outreach testing programmes in all priority cities not yet covered, provider-initiated testing and counselling for pregnant women in collaboration with the maternal and child health programmes and introducing differentiated service delivery (DSD)/one stop shop model (inclusive of PMTCT and paediatric services) with:

- initiation of ART at the main/established ART centre
- shifting of stable patients to a satellite clinic near his/her home, where the patient will receive refills of ARVs
- the patient will check-in at the main clinic every six months.

In this regard, the strategy suggests having either a private clinic/hospital, or a BHU (rural areas) as the satellite clinic OR engage the private practitioners or hospitals already engaged in the provision of TB services to provide ART refills to PLHIV facilitating better management and increasing access to treatment at the decentralized level. The strategy also suggests integrating HIV into the regular surveillance system in the country managed by National Institute of Health (NIH). The strategy proposes to foster partnerships between communities and health systems by establishing referral systems between community-based organizations and health facilities, as well as ensuring that health systems are responsive to the needs of local communities. The strategy stresses the importance of inclusion of HIV interventions in the UHC Benefit Package for sustainability and integration in regular health systems. In terms of a multi-sectoral approach, the strategy proposes to include marginalised key populations in social welfare programmes such as the Ehsaas programme.

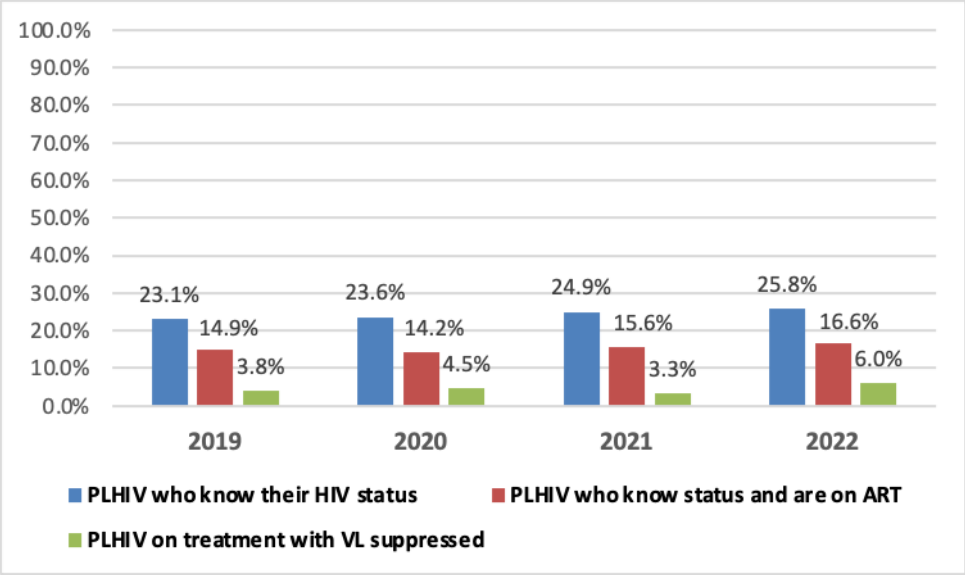
Figure 5 illustrates the progress of Pakistan in relation to the three 95 targets over a span of four years, from 2019 to 2022, revealing a combination of upward and downward trends during this timeframe. The percentage of individuals aware of their HIV status witnessed a slight rise, increasing from 23.6% in 2020 to 24.9% in 2021, and 25.8% in 2022. A substantial gap still exists between the current situation and the target of 95%.

Between 2020 and 2022, there was a 2.4% increase in the number of individuals identified as HIV-positive and accessing ART, but the proportion was still only 16.6%.

The proportion of PLHIV who receive ART and achieve viral load suppression remains alarmingly low at 6% (against the target of 95%). Although there was a modest increase of 0.7% between 2019 and 2020, there was a subsequent decline of 1.2% between 2020 and 2021. (Figure 5)

[35] Pakistan AIDS Strategy IV 2022-2026

Figure 5. Progress towards 95-95-95 targets, Pakistan 2019-2022



Source: Author based on data from Pakistan National HIV Programme/Response Review 2023, The Common Management Unit, Ministry of National Health Services, Regulations & Coordination

2.3.3. Equity, human rights and gender equality aspects of the HIV response

In Pakistan, a range of cultural challenges profoundly impacts vulnerability and access to crucial health services, intersecting with human rights and gender equality concerns. These issues are deeply rooted in societal norms, economic disparities, and systemic obstacles that hinder equitable healthcare access.

From a human rights perspective, marginalized groups (including ethnic minorities, refugees, TG, MSM, and sex workers) encounter discrimination and exclusion, stripping them of their fundamental right to health[36]. These disparities stem from unequal resource distribution, low literacy rates, limited access to information, and inadequate legal safeguards. Moreover, gender inequality poses a significant hurdle for women and girls. Cultural norms restrict women's mobility, financial independence, limiting their ability to access health care. Additionally, women often face unequal treatment in health care settings, compromising the quality of care they receive.[36]

Economic inequities further exacerbate the problem. Widespread poverty prevents many vulnerable individuals from affording essential services. High health care costs, including consultation fees, tests, medications and transport costs to the health facilities, create barriers that hinder their ability to seek necessary medical attention. Geographical disparities compound these issues, with remote and underserved areas lacking sufficient healthcare infrastructure, making it challenging, especially vulnerable groups, to access timely and quality services.

Stigma surrounding HIV in Pakistan is so pronounced that people living with HIV are hesitant to reveal their status even to family and healthcare providers treating them for other conditions. Health care professionals also exhibit unwelcoming attitudes, stigmatizing and discriminating against PLHIVs, sometimes leading to treatment refusal. Stigma also discourages individuals from seeking care due to the fear of discrimination and social isolation. The latest stigma index study for Pakistan was conducted in 2009-10[37] and reportedly the current one is under progress. The IBBS 2017

[36] Country Reports on Human Rights Practices: Pakistan 2022: https://www.state.gov/wp-content/uploads/2023/02/415610_PAKISTAN-2022-HUMAN-RIGHTS-REPORT.pdf

[37] An Index to measure the Stigma and Discrimination experienced by People Living with HIV in Pakistan, 2009-10: https://www.stigmaindex.org/wp-content/uploads/2022/04/Pakistan-SI-Report-2010.pdf

survey[38] also reflected on the status of stigma and discrimination for PLHIVs. The IBBS 2017 findings reflect that 63.8% PWIDs, 52% TGs, 35.6% FSWs and 31.3% MSMs were "ever discriminated". With regards to access to care, 30.5% of the PWIDs, 16.6% of the TGs, 6.6% of the FSWs and 6.3% of the MSMs were denied health care (IBBS 2017).

Inadequate education and health literacy also play a role. Limited awareness about health rights and available services reduces the ability of vulnerable populations to navigate the health system.

2.4. HIV financing and UHC Benefit Package

2.4.1. Current financing for HIV and extent to which HIV services are included in any UHC/health insurance system or health services packages.

The Government of Pakistan and the Global Fund to Fight AIDS, TB, and Malaria (the Global Fund) are the main sources of financing for the HIV response. Pakistan does not receive any support under the US President's Emergency Plan for AIDS Relief (PEPFAR). Analysing the budget allocations for January 2021 to December 2022 reveals that the Government of Pakistan contributed US$ 22.9 million (35.8%), while the Global Fund allocation amounted to US$ 41.1 million (64.2%). Total expenditure over the same period amounted to US$ 37 million. Out of this, 51% of the expenses were covered by the Government of Pakistan, while the remaining 49% was financed through the Global Fund grant. See also Table 4.

It is important to mention here that though the Out of Pocket (OOP) expenditure on health is high in Pakistan, the provision of HIV treatment is free including laboratory testing and ARVs. ARVs are provided by the Global Fund across all ART centres in Pakistan. ART centres also treat opportunistic infections with drugs that are financed both by the Global Fund and government funds. In order to have a more comprehensive account of the HIV spending in Pakistan, national AIDS spending assessment is currently underway in the country.

Table 4. Financing for HIV in Pakistan, January 2021- December 2022

	Government of Pakistan	Global Fund
Budget US$	22 896 715	41 048 165
Share of allocation	35.8%	64.2%
Expenditure US$	19 226 861	18 759 794
Share of expenditure	51%	49%
Budget utilisation	84%	46%*

Source: Reproduced from Pakistan National HIV Programme/Response Review 2023, The Common Management Unit, Ministry of National Health Services, Regulations & Coordination

*Note: The low budget utilization rate is potentially due to operational preparedness of the new principal recipient during the first year of implementation

HIV interventions at the community and primary care level have been made part of the UHC Benefit Package as a special initiative (see services listed in Box 1). The status of this special initiative is based on the premise that HIV interventions are already being funded through the Global Fund and government, so the HIV interventions costs need not to be included in the package. The potential implications of this will be discussed under the findings section.

[38] NACP. Integrated Biological & Behavioral Surveillance in Pakistan (2017). Islamabad: National AIDS Control Programme (NACP) 2017: https://www.aidsdatahub.org/sites/default/files/resource/ibbs-pakistan-round-5-2016-2017.pdf

Box 1. HIV services as part of the UHC Benefit Package

Community Level

- Community-based HIV testing and counselling (for example, mobile units and venue-based testing), with appropriate referral or linkage to care and immediate initiation of ART in high-risk districts
- Provision of condoms to key populations, including sex workers, MSM, people who inject drugs, TG, and prisoners
- Provision of disposable needles and syringes to PWID
- Routine contact tracing to identify individuals exposed to TB and link them to treatment and care
- Screening for HIV in all individuals with a diagnosis of active TB; if HIV infection is present, start (or refer for) ARV treatment and HIV care.

Primary care facility level

- Provider-initiated testing and counselling for HIV, STIs and hepatitis, for all in contact with the health system in high-prevalence settings, including prenatal care with appropriate referral or linkage to care including immediate ART initiation for those testing positive for HIV
- Partner notification and expedited treatment for common STIs, including HIV.

3. Introduction to the Joint Programme strategic orientation and approaches

3.1. Joint Programme and Joint UNAIDS Plan on HIV/AIDS overview of the strategic direction and priorities and how they are responding to country needs and gaps

The recently conducted national HIV response review in 2023 highlighted a myriad of gaps in HIV programming in Pakistan. A summary of the key findings is provided below.[39]

- **Governance** The national HIV response faces governance challenges, with high turnover of senior officials hindering effectiveness. Sub-optimal mechanisms disrupt coordination between Provincial AIDS Control Programmes (PACP) and the National AIDS Control Programme (NACP).
- **Data inadequacy** - Incomplete data integration at the national and sub-national level hampers comprehensive analysis for informed decision-making. Lack of accurate Population Size Estimates and reliance on outdated HIV prevalence data (IBBS survey 2017) compromise planning and execution of the response.
- Poor data systems - Data quality, management, and systems require improvement. Comprehensive data sharing and timely availability are crucial for guiding the response effectively.
- **Limited effectiveness of interventions** - Current efforts to prevent, test, and treat HIV have limited effectiveness as reflected by the 95-95-95 indicator status. Limited access to ART services, low rates of viral load suppression, and dropout from ART contribute to the problem.

[39] Pakistan National HIV Programme/Response Review 2023

- **Limited civil society capacity** – non-governmental organizations and CBOs have limited capacity to deliver HIV services at scale, hindering the continuum of care for key populations.
- **Limited key populations outreach** - Overlapping risks of HIV, hepatitis C, STIs, and TB among key populations are not adequately addressed through integrated outreach programmes.
- **Inadequate awareness and sensitization - leading to stigma and discrimination** - Stigma and discrimination persist, impacting both community engagement and health care worker attitudes. Awareness initiatives and stigma reduction efforts are insufficient.
- **Fragmented HIV and health service integration-** Integration of services, such as opioid substitution therapy and pre-exposure prophylaxis (PrEP), remains fragmented and lacks proper decentralized access.
- **Limited political will** - Political commitment and ownership are inconsistent, and transition issues following changes in the Global Fund Principal Recipient have raised concerns about the programme's continuity.
- **Limited meaningful engagement** of community - Meaningful involvement of people living with HIV and key populations in the design and monitoring of services is limited, undermining the effectiveness of interventions.

The JUNTA plans are developed under the Joint Programme division of labour guidance[40]. Each JUNTA member based on their assigned area of expertise, UBRAF priority area and the local country needs, drafts its activities for the year along with the costing. The JUNTA members then discuss and finalise activities based on consensus. The JUNTA meets on a quarterly basis to share progress on the agreed upon activities in the joint work plan. The JUNTA's workplan for 2020-2021 and the Secretariat focused on the following UBRAF strategic result areas for 2020-2021 (see section 3.2)

- Strategic Result Area 1 - Children, adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment
- Strategic Result Area 3: Young people, especially young women and adolescent girls, access combination prevention services and are empowered to protect themselves from HIV
- Strategic Result Area 4: Tailored HIV combination prevention services are accessible to key populations
- Strategic Result Area 6: Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed
- Strategic Result Area 7: AIDS response is fully funded and efficiently implemented based on reliable strategic information.

3.2. Overview of Joint UN Plan on HIV/AIDS and funding (2020-2023) with main activities of UNAIDS Secretariat and its Cosponsors

The table below provides an overview of eight UNAIDS Cosponsors (WHO, UNICEF, UNDP, UNFPA, UNHCR, UNODC, UNESCO, UN WOMEN) and the UNAIDS Secretariat engaged in the Joint Programme in Pakistan since 2020. It highlights their main activities and funding levels. The data is sourced from the JPMS and reflects planned activities and funding. Consequently, there might be some variations, particularly in financing. The bolded activities in Table 5 are activities directly linked to furthering the PHC approach of HIV responses. As reported by the World Bank respondent, World Bank in Pakistan is not involved in any kind of activity related to HIV.

[40] UNAIDS Joint Programme division of Labour Guidance 2018: https://www.unaids.org/sites/default/files/media_asset/UNAIDS-Division-of-Labour_en.pdf

Table 5: UBRAF financing in Pakistan by agency, activity, and year (2020-2023)[41]

Cosponsor	Activities	2020 US$	2021 US$	2022 US$	2023 US$	Total
UNAIDS[42]	Scaling up PrEP programming including monitoring system aimed at appropriate PrEP implementation and documentation of lessons learnt to help inform the roll-out of PrEP; Strengthened and harmonized national and provincial information systems for proper monitoring of the response and surveillance on the epidemic to inform strategic and operation planning and financing; **Evidence-informed advocacy and policy dialogues with key decision makers (including Provincial Home Departments and CSOs) to effectively implement OST**; s**trengthening capacities of CSOs/CBOs for scaling up community led and community based service delivery;** capacity strengthening of government and health care providers to scale up HIV testing particularly in Punjab and Sindh which have most of HIV cases; s**trengthening the linkages between testing and treatment, and mechanisms for retention support through engagement with civil society and communities in priority Cities of all four provinces**; strengthening linkages and monitoring systems for Viral Load suppression; **Rights-based and evidence informed comprehensive HIV legislation and policies in the country to facilitate access to HIV prevention and treatment**; contribute to UNSDF/OPIII implementation; periodic review of the Joint UN Programme and its contribution to UNSDF/OPIII by the JUNTA; strengthening skills, competencies and diversities of UNAIDS country office Pakistan to deliver UNAIDS mandate; harmonization of monitoring and evaluation systems provincial coordinator for Sindh support revision of National and provincial AIDS strategies	243 000	243 000	198 951	198 951	883 902
WHO	Review and expand **decentralized/DSD for HIV testing, treatment, and support,** along with providing technical aid for the testing and treatment expansion plans in Punjab and Sindh; Establish an HIV Drug Resistance system, create communication strategies for PrEP in Punjab and Sindh, and enhance PrEP client management; facilitate **equitable access to the National Policy for HIV Self Testing** and partners notification; **pilot a PHC Model for HIV, hepatitis, and STIs in two districts**; assessment of safe injection practices, technical support for advanced disease management, and the **development of a surveillance system for STIs.**	100 001	49 999	140 000	140 000	430 000
UNICEF	Expand HIV testing, treatment, and adherence services for children, women, and partners, while emphasizing **comprehensive PMTCT** and paediatric HIV care; **promote community engagement and empowerment to mobilize support for HIV initiatives**; strengthen **institutional and community-based interventions in areas like Larkana and Rathodero, focusing on services, awareness, and addressing stigma**; continuation of **community-based HIV services** to prioritize awareness, social mobilization, and	-	180 000	302 000	71 400	553 400

[41] Joint Program Monitoring System (JPMS) 2020-2023

[42] The activities and budget for UNAIDS secretariat was provided for the year 2020-21 & 2022-23; the biennial budgets have been distributed equally to have year-wise figures

Cosponsor	Activities	2020 US$	2021 US$	2022 US$	2023 US$	Total
	strengthening referral systems, including family tracing and testing; evaluation of paediatric HIV care and prevention services to strengthen their effectiveness.					
UNFPA	Raise awareness among communities, particularly women, men, and adolescents, about g**ender-based violence (GBV), women's protection issues, and mental health support; e**nsure the **availability of services like clinical management of rape for survivors,** offering medical and psychosocial support along with referral assistance for GBV cases and mental health concerns. provide **mobile and static GBV case management services in affected communities**, and train protection staff and organizations on GBV, clinical management of rape referral pathways, and interagency protocols; **integrate sexual and reproductive health (SRH) services into emergency policies, including lifesaving SRH and family planning services in affected areas**. Build capacity of health service managers and providers in various areas of SRH through training; Strengthen Coordination mechanisms at national and provincial levels for effective RH and GBV services in emergencies. **Integrate SRH and GBV into resilience-building and emergency preparedness plans to** support the most vulnerable populations.	-	-	1 695 000	1 695 000	3 390 000
UNDP	**Provide technical assistance to provincial AIDS control programmes for strategy development on combating transphobic stigma and discrimination** in Punjab and Sindh, including consultative dialogues with key populations and stakeholders for communication and advocacy strategies on PrEP stigma; design media campaigns and **community-led workshops to address stigma and discrimination** related to PrEP and sensitize communities for demand generation; provide technical assistance for the **digitization of sustainable data systems, and target youth of key populations against stigma and discrimination through a digital campaign;** build capacity of l**egal aid staff on inclusive approaches to tackle HIV stigma, and engage religious leaders for sensitization and capacity building against stigma**; empower at-risk youth for testing and treatment services through sensitization and capacity building.	31 015	49 999	100 000	76 000	257 014
UNHCR	**Focus on awareness and education dissemination through seminars and capacity-building workshops for community elders, media, students, and society catalysts, aiming to reduce HIV-related stigma**; Intensify **Harm reduction activities,** encompassing syringe provision, condom distribution, HIV testing, referral of positive cases to treatment services, and treatment compliance follow-up; **collaborate with key community members and families of HIV-positive individuals to decrease stigma**; test 300 PWID and other key populations for HIV and ensure linkage to treatment services for positive cases.	30 839	-	-	-	30 839
UNODC	**HIV screening for approximately 2 500 prisoners** in Sindh's prisons and facilitate coordination meetings between the prison and the provincial AIDS Control Programme; ensure the availability of **HIV prevention interventions and STIs treatment services for inmates**; **Build Capacity of prison health staff on HIV prevention and treatment** within prison settings, alongside training on HIV testing and counselling standard operating procedures; conduct feasibility study on opioid substitution treatment and an external evaluation of an existing harm reduction program for PWIDs, followed by national and provincial dialogues to adopt evaluation recommendations; **PWIDs and their spouses gain access to HIV prevention and treatment services;** conduct advocacy meetings and organize coordination efforts between prison and health programmes, accompanied by **capacity-building training for staff and peer educators**, as well as the establishment of HIV testing and counselling centre services; provision of personal protection equipment items for COVID to selected prisons in Punjab and Khyber Pakhtunkhwa.	100 000	107 000	95 077	95 087	397 164

Cosponsor	Activities	2020 US$	2021 US$	2022 US$	2023 US$	Total
UNESCO	**Revise "Health Education Guidebook for Teachers and Health Staff" for health and hygiene education in schools and increase HIV/AIDS awareness**; enhance the capacity of teachers and educational institutions in high HIV priority areas of Sindh and Punjab by **integrating HIV/AIDS and related health topics into the learning process**. Collaborate with the South Punjab Education department's "TRANSEDUCATION" initiative, focusing on **providing education and skills training to TG individuals** through evening classes within the framework of the Accelerated Learning Programme.	25 000	-	55 000	38 500	118 500
UNWOMEN	Conduct awareness trainings on **Ending Violence Against Women and Girls** for women beneficiaries, partners, and men/boys, along with providing information on referral mechanisms; conduct sensitization and capacity-building sessions on essential services specifically for women and girls who have survived Gender-Based Violence (GBV). Carry **legislative advocacy efforts in Khyber Pakhtunkhwa and Baluchistan to address the issue of child marriage and mitigate the inequalities in social, economic, and educational opportunities faced by girls.**	-	-	-	42 500	42 500
TOTAL		**529 855**	**629 998**	**2 786 028**	**2 357 438**	**6 303 319**

3.3. Main partnerships engaged in implementing the Joint UNAIDS plans on HIV/AIDS, and activities targeting integration of HIV and PHC

The JUNTA has been working closely with the Ministry of National Health Services and Regulation (MoNHSR & C), NACP, Global Fund common management unit, PACPs, provincial departments of health, Association for People Living with HIV, CSOs, and Global Fund Principal Recipients (UNDP and Nai Zindagee Trust).

As health care is devolved, the JUNTA also coordinates and collaborates closely with provincial level counterparts. The AIDS control programmes across the provinces work independently with oversight provided by the MoNHSR & C. The influence of the NACP on PACPs has reduced over time; support is mainly sought from NACP during the introduction of new interventions or updated guidelines etc.

The JUNTA has been actively assisting governmental entities through a combination of technical expertise and financial support. The focus has been on providing technical assistance, frequently involving specialized professionals to undertake specific tasks such as policy formulation, strategy development, and capacity building.

Notably, there are some activities with explicit support for a PHC approach and UHC. These include: PHC model of care and decentralized/DSD for HIV testing, treatment and support; PMTCT and community mobilization and engagement; addressing stigma and discrimination and intersectoral activities (see Section 4 of this report).

4. Findings

4.1. EQ1: To what extent is there conceptual clarity and internal coherence within the Joint Programme and external coherence with other actors in relation to leveraging HIV and PHC integration and linkages?

SUMMARY OF FINDINGS – EQ 1

- **No unified understanding.** The understanding of HIV integration and interlinkages with PHC varies among JUNTA members and the differences between PHC and primary care are not clear.
- **No dedicated focus on HIV integration within primary care.** As a JUNTA, there is no dedicated focus on HIV integration within primary care in Pakistan, given it has recently become part of the discourse and not explicitly on their agenda. PHC related efforts are mainly influenced by individual UN agency mandates globally and in-country. There is no cohesive national joint plan aimed at strengthening linkages between HIV and PHC.
- **Inadequate coordination between JUNTA members at provincial level.** Coordination between the JUNTA members at national level is good, but coordination at the provincial level needs considerable improvement; this will be important for HIV and integration aspects in Pakistan where the health sector is devolved to provinces.
- **Gaps in integration between HIV and PHC services still exists.** Despite the national health vision being largely a PHC informed strategy and the country undergoing major PHC reform, the HIV response in Pakistan is still to a large extent a siloed programme, however with recent examples of attention to applying PHC-approaches:
  - The JUNTA supported the update of Pakistan's 2023 AIDS strategy, which incorporates a community-led PHC approach and aims to integrate HIV programmes effectively within the broader health system through community-health system partnerships.
  - WHO, UNICEF and UNAIDS supported Pakistan's significant healthcare reform, the UHC Benefit Package, including HIV interventions at primary care and community levels (2020-2022), however fully funded by Global Fund.
  - WHO supported the development of the LHW Strategic Plan 2022-2028 for LHWs and, subsequently, WHO and UNAIDS advocated for HIV inclusion in the revised LHW curriculum and dedicated two pages to HIV in the LHW flipchart.
- **Inadequate coordination between different stakeholders to strengthen community engagement.** Development partners, donors, and the government recognize the importance of integrating HIV prevention into primary care, across all three provinces, the programmes have scaled up services, taking services closer to communities (already scaled up to all districts in Punjab and in Sindh the scale up to districts is under progress, while in KP the scale up to division level is under progress). As a possible way forward, JUNTA and other stakeholders widely agreed that it would be important to including HIV testing/screening in primary care settings in high-risk districts but believe that the disease burden is insufficient to extend HIV testing and treatment services widely at primary care level.

4.1.1. What does the Joint Programme aim to achieve through strengthening HIV and PHC alignment, integration, and interlinkages? To what extent is there conceptual clarity?

Conceptual clarity regarding strengthening HIV and PHC alignment, integration and interlinkages varied between the JUNTA members, and most were unclear about the difference between PHC and primary care or saw the two as the same thing.

Those working in the health sector (both UNAIDS co-sponsors and other external stakeholders) had a clearer understanding of HIV and PHC integration and linkages and of how this might be applied in the country context, although there are different opinions about the "what and how" of HIV integration into PHC in Pakistan. JUNTA members at the provincial level were aware of the importance of integration of HIV services at primary care level and reflected on the approaches that could potentially be employed for integration. Although the JUNTA has discussed HIV and PHC integration recently (2023), it is not specifically on their agenda and there is no stated objective nor cohesive joint plan aimed at strengthening linkages between HIV and PHC.

Some JUNTA members and other external stakeholders suggested that the burden of HIV in Pakistan is not high enough to warrant integration of all components of the HIV response at the primary care level. More specifically, most stakeholders were of the view that only the prevention component of HIV response (including advocacy, awareness, provision of condoms etc.) should be delivered at primary care level including through community structures and that HIV screening/testing, should only be offered at this level in districts where the burden of disease is very high.

4.1.2. To what extent are relevant HIV/PHC goals, plans, strategies, and activities harmonised and aligned internally within the Joint Programme at country levels?

Coordination between the JUNTA members at national level is overall well but, Joint UN team on AIDS's annual plans largely reflect individual agency mandates and workplans rather than a Joint UN Programme strategy for the HIV response in Pakistan. This is also the case for PHC related aspects, yet some good efforts of the JUNTA to address multisectoral action and policies and community engagement in UBRAF workplans in 2020 – 2022 were noted.

Based on findings from the three provinces visited, coordination at the provincial level needs considerable improvement among JUNTA members; this will be important for HIV and PHC integration as responsibility for the health sector is devolved to provinces in Pakistan.

4.1.3. How does the Joint Programme's work on HIV and PHC integration and linkages complement and harmonise with the efforts of national governments and external actors?

In 2021, major health partners, including the Global Fund, GAVI, the Global Financing Facility, WHO, UNICEF, UNAIDS, UNFPA, the World Bank, and several bilateral development partners jointly pledged support for Pakistan's UHC efforts, focusing on community-based PHC reforms. These reforms are guided by the Astana Declaration, which underscores that PHC serves as the cornerstone for accessible, affordable, impartial, comprehensive, and high-quality primary care and public health services, accessible to all through a multi-sectoral health approach.

Despite the National Health Vision being largely a PHC informed strategy and the country is undergoing major PHC reform, the HIV response in Pakistan is still to a large extent a siloed programme, however with recent initiatives (2022/2023) to move towards a more integrated approach. Examples include: Cosponsor involvement in developing the UHC Benefit Package, updating the Pakistan AIDS strategy, and shaping the LHWs strategic plan which highlight their commitment to integrating HIV interventions and community-led health care into the broader health system. However, it is important to note that some of these activities, for example, the formulation of the UHC Benefit Package, have not been implemented as activities with UBRAF funding.

There are some specific agency activities in the Joint UN plan on HIV/AIDS that relate to support for the PHC approach and UHC. These include the PHC model of care and decentralized/DSD for HIV testing, treatment and support (WHO), PMTCT and community mobilization and engagement (UNICEF), self-testing and addressing stigma and discrimination (UNDP). These activities, which are described in more detail below, are aligned with UHC reforms in Pakistan, which are centred on a resilient and well-functioning PHC system, and with other national government's plans, many of which are developed with the financial and technical support from JUNTA members.

4.2. EQ2: To what extent is the Joint Programme applying the PHC approach to HIV responses and what are the achievements and lessons learned?

SUMMARY OF FINDINGS - EQ 2

- **Some progress in applying the PHC approach to HIV responses.** Since 2020, Pakistan has made progress in adopting a PHC approach to tackle HIV, highlighted by initiatives such as the WHO-supported PHC Model of Care. Collaborative efforts among UN agencies, including WHO, UNICEF, and UNAIDS, have further supported the integration of HIV interventions into the broader health care system, aligning with UHC and updates to the Pakistan's AIDS strategy. UNDP, UNFPA, UNESCO and UNODC have contributed with multisectoral initiatives such as: addressing stigma and promoted human rights, improved services in prison settings and reaching key populations with prevention services. These combined actions underscore Pakistan’s commitment to enhancing health care accessibility and comprehensiveness through a PHC lens, fostering holistic and sustainable HIV responses.
- **Nurturing political commitment in the HIV response with focus on sustainability.** The JUNTA effectively collaborates with Pakistan's government, notably during events like World AIDS Day, to boost political commitment. However, the 2023 HIV response review emphasizes the need for consistent public awareness efforts due to limited sustained commitment. While Sindh province shows stronger dedication due to the Larkana outbreak, overall political support for HIV integration into health care is still emerging. Structured discussions, integration into work plans, and proactive measures for sustainable financing are recommended.
- **Barriers and Pathways.** Integration of HIV with PHC in Pakistan faces barriers such as financial constraints due to low health care spending, limited political commitment, and absence of comprehensive health strategies in certain regions. Challenges such as HIV stigma, low awareness, health care workforce issues, and fragmented data systems further hinder integration. However, successful integration can be promoted by leveraging existing PHC strategies, a substantial network of facilities and health workers, and sustainable inclusion of HIV interventions in the UHC Benefit Package. Overcoming these barriers and capitalizing on enablers is pivotal for advancing HIV integration into PHC in Pakistan.

4.2.1. What has been achieved since 2020 in terms of applying a PHC approach to HIV responses?

The following achievements provide a snapshot of JUNTA activities to enhance HIV integration and interlinkages with PHC since 2020.

PHC model of care initiative

As part of the JUNTA plan under UBRAF funding, WHO has supported the piloting of the “PHC model of care initiative” in two districts, in order to generate learning on providing HIV responses with a

PHC approach convergent actions[43] The PHC model of care initiative started in early 2023 and will be implemented in a phased manner over a four-year period. Its approach to health combines multisectoral action, community empowerment, and primary care, with the aim of providing equitable and sustainable health care for all, backed by evidence-based practices and continuous monitoring. The initiative was launched after a high level SDG3 Global Action Plan mission for the PHC accelerator and the PHC model of care is structured around the following six objectives.

1) Integrate prioritized essential health services aligned with UHC Benefit Package including communicable diseases
2) Improve patient safety standards in selected hospitals and primary care facilities in Islamabad Capital Territory and Charsadda
3) Ensure access to integrated essential outpatient health services by enrolling 1 000 families in the Sehat Sahulat Programme (a social health insurance programme) in Islamabad Capital Territory
4) Provision of health education and improved water and sanitation services
5) Improve community engagement in the catchment of PHC facilities
6) Implement family practice approach in the catchment of PHC facilities.

A 'Package of Services' for HIV, viral hepatitis and STIs is being implemented as part of the piloting of the PHC Model of Care at the identified facilities. The package for HIV is focused on HIV prevention, including advocacy and awareness raising, screening at primary care facilities and referral to ART centres. The package also includes stigma and discrimination reduction in health care settings. The package of services is provided in an integrated people centred manner at the piloted PHC facilities (as reported and observed at one of the BHU in Charsadda). However, findings of the piloted PHC model of care are awaited.

Increased attention to the PHC approach in the Pakistan AIDS Strategy

As noted earlier in this report, the JUNTA has supported the updating of the Pakistan AIDS Strategy (2022-2026). The updated strategy employs the PHC approach of community-led/run programming and fostering partnerships between communities and health systems.

Contribution to the development of the UHC Benefit Package

As noted earlier in this report, while not part of the activities of the JUNTA under UBRAF funding, WHO and UNICEF supported the development of the UHC Benefit Package for Pakistan and its provincial localisation during 2020-2022. HIV interventions at the community and primary care level (Box 1) have been included in the UHC Benefit Package as a special initiative. However, the HIV interventions in the UHC Benefit Package is dependent on the Global Fund grant and it depends on public sector development budget (run on project mode) in Khyber Pakhtunkhwa and Punjab where it is not part of the regular budget. In Sindh, the sustainability aspect is addressed to some extent as the provincial AIDS control programme has transitioned from public sector development budget i.e., project mode to regular budget (horizontal integration), however, the programme is still dependent on the Global Fund grant

Community health workers and empowerment of communities

WHO, in helping to shape the "LHW Strategic Plan 2022-2028", advocated for the inclusion of HIV-related content in the revised LHW curriculum of LHWs. UNDP has provided significant support for the empowerment of communities through CBOs**.**

Human rights-based approaches and tackling stigma and discrimination

UNDP has supported strategy development on combating transphobic stigma and discrimination in Punjab and Sindh, and a digital campaign against stigma and discrimination targeting young key populations. In addition, UNDP has built the capacity of legal aid staff in all four provinces on approaches to tackle HIV stigma and discrimination using rights-based and inclusive strategies. The

43 i.e. Islamabad Capital Territory by Federal Health Ministry through District Health Office ICT and Charsadda by Department of Health Khyber Pakhtunkhwa through District Health Office Charsadda

establishment of legal aid desks through a competitive process in 2022 laid the foundation for this training in collaboration with UNAIDS. A programme involving religious leaders from various faiths has also been initiated to combat stigma and discrimination against key or at-risk populations. Initial consultations and planning meetings with the Ministry of Religious Affairs were conducted to identify religious leaders in Punjab and Sindh. UNDP is also designing a sensitization and capacity-building programme to empower and enable at-risk youth and key populations to establish sustainable connections with testing and treatment services.

UNFPA has worked in partnership with UNAIDS on capacity development of key influencers including the media and religious leaders, with a focus on addressing stigma and discrimination among key populations in Pakistan and in Sindh and Islamabad Capital Territory in particular. UNFPA has also conducted capacity building for health care providers in Sindh to address stigma and discrimination in health care settings, and sensitization for the police on key populations.

Education

Taking a multisectoral approach, UNESCO has used UBRAF fund to support activities around TG education. In collaboration with the South Punjab Education Department's "TRANSEDUCATION" initiative, UNESCO is providing education and skills trainings to transgender individuals through evening classes within the framework of the Accelerated Learning Programme. This initiative aims to improve the employability of transgender people. UNESCO also revised the “Health Education Guidebook for Teachers and Health Staff” and information about HIV/AIDS has been included in the guidebook.

Prisons

UNODC implemented a project in Sindh Province to strengthen HIV prevention, treatment, and care services for prison inmates. This involved capacity building for health and prison staff, enhancing coordination between prisons and the health department, and organizing coordination meetings. Screening tools were developed, and an HIV testing and counselling centre was established. Training for prison health staff and the inclusion of HIV, hepatitis, and TB components in the prison management information system were conducted.

Following success in Sindh, UNODC extended similar interventions to Punjab prisons, an HIV testing centre was established, and staff were trained. Based on the prison health services in Sindh and Punjab, the provincial prison departments from the provinces have requested UNODC for the continuation of prison interventions in Sindh and Punjab provinces and also the establishment of similar interventions in Khyber Pakhtunkhwa and Balochistan prisons.

Integrated service delivery/ decentralization efforts

Despite the recent efforts described above, HIV services in Pakistan are still largely verticalized in practice with standalone ART clinics being prioritized and with separate HIV data and procurement systems and largely separate funding structures for HIV.

The province of Sindh under the leadership of the health minister took the following very important policy decisions pertaining to improving accessibility of HIV services (a week before evaluation teams visit). Once implemented, these policy decisions have the potential to facilitate the integration of HIV services into regular service delivery systems. The role of the JUNTA in these efforts are however not clear.

- Decentralisation of ART provision by the HIV Control Programme ensuring availability of drugs to all cases through department of health and PPHI run health facilities, designated centres, mobile health units, LHWs, social mobilisers, volunteers, riders. Mobile units are also to be deployed at districts and will carry medicines of HIV, hepatitis and TB.
- HIV Control Programme to increase HIV screening/testing in collaboration with district health officers, PPHI and reproductive maternal, newborn, child and adolescent health, hepatitis, TB control wings. A dedicated team will oversee the endeavour at HIV provincial headquarters releasing daily updates. Offering testing to all pregnant women, siblings and partners of index

cases, vulnerable groups among general population. In addition to improved contract tracing and lost to follow-up measures.

In Punjab, it was informed by the provincial AIDS control programme that in the high burden districts, HIV screening is done at the BHUs and RHCs for all pregnant women and prior to dental procedures. The LHWs in the high burden districts also conduct HIV screening, and pre and post-test counselling service. Punjab has established ART centres at the district level (at the hospital) across all districts of Punjab.

Prevention of PPTCT of HIV services

PMTCT services are provided at the outpatient department of gynaecology and obstetrics of selected hospitals through PPTCT centres. The gynaecologist and paediatrician are trained on PMTCT while there is a dedicated PPTCT coordinator who establish coordination between the ART centre and the gynaecology and obstetrics department. The ART centre refers the PLHIV mother to the PPTCT coordinator for registration, ensured ARV compliance, viral suppression, planning of the delivery at the gynaecology/obstetrics department and coordination with paediatrician for the management of newborn.

However, antenatal care screening for HIV was not universal and reportedly constrained by fiscal pressures. The number of PPTCT centres was referred to as inadequate with 12 PMTCT centres across the three provinces. In Punjab, PMTCT services are being provided through eight PMTCT centres in eight districts. Senior gynaecologist and paediatrician from the host hospital where PMTCT is situated are trained on PMTCT. More than 700 cases have been provided PMTCT services and 99% is the success rate for prevention of vertical transmission. PACP is planning to increase PMTCT services to divisional and high burden districts in revised PC1. In the Khyber Pakhtunkwa, there is only one PMTCT centre in a tertiary hospital of provincial capital where so far 285 deliveries have been performed and vertical transmission of HIV has been prevented in all cases. In Sindh, there are three PMTCT centres.

4.2.2. What is the Joint Programme doing to build political commitment for sustainable HIV financing in the context of PHC?

The JUNTA works closely and advocates with the Government of Pakistan to enhance the HIV response and is well placed to build political commitment. At the programmatic level, UNAIDS collaborates with the government, CSOs, key populations, and other stakeholders to ensure that HIV is on the national health and development agenda. The UNAIDS Secretariat regularly meets with the NACP and PACPs, the federal health ministry and the provincial departments of health to facilitate the HIV response in Pakistan.

There is no plan for transitioning from Global Fund support to domestic funding after the current Global Fund grant ends in 2030. However, there is no specific Joint Programme advocacy around sustainable HIV financing and the consultation with the JUNTA highlighted the increasing need for collective advocacy efforts.

The 2023 HIV response review highlights limited political commitment in Pakistan and the lack of consistent evidence-based high-level advocacy. In Sindh province, there is greater political commitment to the HIV response than in other provinces, possibly because of the Larkana outbreak and the fact that the health minister is a medical doctor. The JUNTA as a whole has not engaged in building high level commitment for HIV integration into PHC. One reason for this is that the integration of HIV into PHC has become part of the discourse only very recently.

The notable achievement of the JUNTA to have HIV services included in the national UHC Benefit Package is undermined by its status as a “Special initiative”, which means that these services are funded entirely by external resources (the Global Fund) and public sector development budget (run on project mode), with inherent sustainability risks. Sindh has transitioned recently from the project mode to regular government budget but still largely dependent on the Global Fund grant.

4.2.3. What are the main enablers and barriers to strengthen HIV and PHC integration and linkages? How is the Joint Programme addressing these at country level?

Strengthening HIV and PHC integration and linkages in Pakistan faces barriers – the main barriers include a lack of political commitment, limited health funding, lack of comprehensive strategies, stigma and discrimination. Enablers include existing policy and infrastructure for PHC and integration of HIV with the UHC Benefit Package.

Identified barriers to strengthen HIV and PHC integration and linkages

Health financing

Pakistan's spending on health has been historically low. The government only spends 1.2% of the gross domestic product on health and only 38% of government health spending is spent on PHC.[44] Per capita spending on PHC (for both public and private sector) in Pakistan is around US$ 15.4[44].The likelihood of increased funding allocations for health or PHC by the government seems remote given competing priorities and the current economic context in Pakistan. The country is grappling with severe inflation, a declining currency and critically low foreign reserves, further aggravated by the floods in 2022/2023 posing significant concerns for its financial stability.

Limited political will

Lack of political commitment to HIV and its integration into PHC reflects both limited financing and fiscal space, donor dependency and limited collective advocacy. There is also political reluctance to engage with HIV-related issues due to stigma and cultural sensitivities.

Lack of a health sector strategy/PHC strategy in Sindh

In the province of Sindh, the health sector strategy expired in 2020. There has been no update of the health sector strategy or a PHC strategy since. The health department has used the UHC Benefit Package/EPHS as a guide for the recent developments in the health sector but lacks a clear strategy and objectives for the health sector.

Stigma and discrimination in health care settings

As noted earlier, HIV is highly stigmatized disease in Pakistan to the extent that PLHIV fear disclosing their HIV status to their families and even health professionals providing care for other illnesses. Fear of stigma and discrimination associated with HIV and key populations may deter people from seeking care at primary care facilities, thereby hampering integration efforts.

Lack of awareness among general population

Awareness about HIV as a disease, its mode of spread, and treatment is very low among general public. Many people still believe that HIV is not treatable and is a "death sentence". This is the legacy of a media campaign during the 1990s that focused on the message that HIV is associated with unsafe sex/immoral sexual behaviour and is not treatable.

Limited skills of health care professionals

According to most key informants consulted, health care professionals working at the primary care facilities do not have the knowledge and skills to manage HIV patients. During the course of their medical studies and clinical training they have few opportunities to manage PLHIV. Limited knowledge was reported as a factor that contributes to stigmatizing and discriminatory attitudes and behaviour towards PLHIV by health workers.

Shortages/high turnover of primary care doctors

There is a very high turnover rate of doctors and medical officers at primary care facilities (medical officers only go to primary care facilities for 6-12 months, where they get additional marks for

[44] PHC Vital signs for Pakistan 2022, Ministry of National Health Services and Regulation, Pakistan

specialization or prepare for their specialty care entrance exam and then mostly move to urban centres). Many models have been tried to keep medical officers at primary care facilities including clustering of primary care facilities where 2-3 facilities were assigned to one medical officer, who would visit the assigned primary care facilities on a rotational basis and who was paid three times the salary, but nothing has resolved the issue.

Fragmented HIV data management systems

The 2023 HIV response review identified challenges with data and the health information management system in Pakistan, most notably with the systematic and complete sharing of data between the NACP, the Punjab AIDS Control Programme and the Global Fund Principal Recipient Nai Zindagi. Significant issues need to be addressed including lack of integration and consolidation of provincial case-based data at the national level, disagreement on population size estimates, and lack of up-to-date IBBS data on HIV prevalence among key populations. Integration of HIV with PHC would require building capacity for data management at the primary care level and integrating data systems across the three health care levels.

Identified enables to strengthen HIV and PHC integration and linkages

National Health Vision of Pakistan (2016-2025)

The National Health Vision of Pakistan (2016-2025)[45] recognizes the importance of primary and promotive health care, propose to increase investments in PHC and institute pro-poor social protection initiatives to facilitate access to essential primary and secondary care services. The National Health Vision also envisage to improve the coverage and functionality of primary and promotive health services, while ensuring the widening of essential service packages by introducing family medicine, newborn survival, birth spacing and contraceptives supply, NCDs, mental health, under-nutrition, disabilities, problems of ageing population and other issues. It also recognizes the potential of the outreach PHC, delivered at the community level by LHWs and an increasing number of community midwives, and other community-based workers who have earned success and trust in the communities. The National Health Vision focus on the PHC and social protection gives an overarching impetus to integrated people centred PHC.

PHC approaches of the revised Pakistan AIDS Strategy

HIV's integration into the mainstream health landscape in Pakistan remains limited, impacting its potential to substantially contribute to the overall health systems strengthening and broader health goals. This situation stems from various factors that have constrained the integration and alignment of HIV investments, infrastructure, tools, knowledge, and innovative programme approaches with the broader health care system. In one of the provinces (Khyber Pakhtunkhwa), the HIV programme is integrated with Hepatitis and Thalassemia programme, but HIV still remains segregated within the integrated programme. Realising this, the Pakistan AIDS Strategy IV (2022-2026) propose to establish intersectoral/interdepartmental coordination mechanisms at the provincial level led by the Department of Health (or Planning & Development department) with involvement of AIDS, TB and malaria programmes, and membership from key stakeholders, including civil society, PLHIV, key populations representatives, SRHR, maternal and child health, nutrition, blood safety, hepatitis programmes, law enforcement and prison departments. The current AIDS strategy is thus an enabler of integration, but with scope to have integrated approaches more deliberately formulated and identified.

PHC as part of Punjab health sector strategy and health policy Khyber Pakhtunkhwa

In light of the National Health Vision of Pakistan (2016-2025), Punjab developed its Health Sector Strategy 2019-2029 and Khyber Pakhtunkhwa its Health Policy 2018-2025 with a roadmap for

[45] National Health Vision for Pakistan (2016-2025)
https://phkh.nhsrc.pk/sites/default/files/2020-12/National%20Health%20Vision%20Pakistan%202016-2025.pdf

primary care. The Punjab Health Sector Strategy explicitly recognizes the growing concern with regards to hepatitis and HIV and the need to scale up services. The Health Policy Khyber Pakhtunkhwa 2018-2025 highlights the need to address the growing burden and spread of infectious diseases including HIV and hepatitis B and C, and the health department plans to focus on primary prevention through awareness raising, expanding immunization for hepatitis B in children, vaccination of high-risk groups, screening and ensuring provision of safe blood.

The UN Sustainable Development Cooperation Framework

The latest UN Sustainable Development Cooperation Framework for Pakistan (2023-2027) guide UN organizations' work and collaboration in Pakistan to achieve SDGs. The framework has explicitly identified strengthening of the HIV response in Pakistan under the health domain. Under the outcome 1, the framework envisages to focus on UHC through implementation of an essential package of health services, while under the outcome 2, the framework gives special attention to societal enablers, including to reduce/eliminate HIV-related stigma and discrimination, engaging in advocacy to promote enabling legal environment and to reduce/eliminate gender-based violence, to be delivered by community-led organizations[46]. The UNSDCF can be leveraged to make HIV become more visible on the UN development landscape of Pakistan.

A large infrastructure of primary care facilities across the country

Primary care services are offered by a network of BHU, rural health centres, dispensaries and health centres (mainly in urban areas) and first aid posts mainly in Azad Jammu and Kashmir and Gilgit Baltistan. In total, there are around 16 000 public sector primary care facilities (Table 6)[44].

Table 6. PHC facilities, Pakistan

Province/Area	BHU	BHU plus	Dispensary	MCH	OTHER	RHC	TB Centre	Urban HC	FAP	Total
Punjab	1 182	1318	492	240	38	314	15	84	-	5 682
Sindh	776	-	915	125	30	128	-	41	4	3 040
KP	940	1	972	141	260	121	2	-	-	3 589
Balochistan	697	-	535	91	4	107	8	-	-	2 033
Islamabad	12	5	48	2	4	3	-	14	-	151
Gilbit B	23	-	285	71	4	3	9	-	136	857
AJK	223	-	63	6	2	46	1	4	304	732
Total	**3853**	**1324**	**3310**	**676**	**342**	**722**	**35**	**143**	**444**	**16 084**

Source: PHC Vital signs for Pakistan 2022, Ministry of National Health Services and Regulation, Pakistan.

BHU = basic health unit, MCH = maternal and child health centre; RHC = rural health centre; TB = tuberculosis centre; HC = health centre; FAP = first AID posts

A large frontline health workforce

At community level, health services are provided by cadres including LHWs, community midwives, and vaccinators and others. There are around 89 000 LHWs across the country (Table 7) who cover around 58% of the population.[47]

[46] UN Sustainable Development Cooperation Framework 2023-2027 Pakistan: https://pakistan.un.org/sites/default/files/2022-11/Pakistan_UNSDCF_Final.pdf

[47] LHW strategic Plan 2022-2028, Ministry of National Health Services Regulation & Coordination

Table 7. Community LHWs distribution, Pakistan provinces

Province/Area	Number of LHWs	
	Allocated	Deployed
Punjab	44 770	42 648
Sindh	22 576	20 466
Khyber Pakhtunkhwa	16 100	15 334
Baluchistan	6720	6 147
Islamabad	330	285
Gilgit Baltistan	1 385	1 360
Azad Jammu & Kashmir	3 068	3 020
Total	**94 949**	**89 282**

Source: LHW strategic Plan 2022-2028, Ministry of National Health Services Regulation & Coordination

An approved UHC Benefit Package with HIV interventions at community and primary care levels

The inclusion of HIV interventions in the UHC Benefit Package should facilitate further efforts to integrate HIV within PHC.

4.3. EQ3 To what extent is the Joint Programme using investments, infrastructure, innovations, and lessons learned from the HIV response, including adaptations during the COVID-19 pandemic, to improve broader health outcomes?

SUMMARY OF FINDINGS – EQ 3

- **Silos and missed opportunities.** To date, HIV has often been treated as a separate issue rather than being fully integrated into the broader health care system. This separation has led to a lack of synergy between HIV programmes and other health interventions, limiting opportunities to learn from and adopt innovations and lessons from the HIV response.
- **Leveraging COVID-19 responses to enhance to chronic disease care.** In response to the COVID-19 pandemic, efforts led by WHO, UNDP and UNAIDS promoted DSD strategies for HIV services. These strategies, including multi-month dispensing and home-based delivery of ARVs. Such strategies have the potential to improve treatment and care of other chronic diseases and to enhance health care access and outcomes.

4.3.1. To what extent is the Joint Programme leveraging HIV investments, knowledge, infrastructure, approaches, and innovative models developed by the HIV response to strengthen broader health outcomes? Are there any untapped opportunities?

In Pakistan, the healthcare system faces a myriad of challenges, including inadequate funding, a shortage of skilled healthcare professionals, unequal distribution of healthcare resources between urban and rural areas, and limited access to essential health services for marginalized and vulnerable populations as described earlier. Within this context, HIV has often been treated as a distinct health issue, rather than being holistically embedded within the healthcare framework. The separation of

HIV from mainstream health services has led to a lack of synergy between HIV programmes and other health interventions. This isolation prevents the leveraging of HIV-related investments, infrastructure, and knowledge to benefit the broader health system. For instance, the innovations and best practices developed through the HIV response, such as community-based approaches, could potentially enhance the delivery of other health services. However, this potential synergy remains largely untapped.

Moreover, the stigmatization and discrimination associated with HIV contribute to its marginalization within the healthcare system. This stigma creates barriers for PLHIV to access healthcare services, further reinforcing the perceived need for separation between HIV programmes and the broader health system.

4.3.2. To what extent is the Joint Programme using and promoting wider adoption of adaptations in service delivery developed in response to COVID-19 to improve broader health outcomes?

During COVID-19, WHO, UNDP and UNAIDS collaborated to promote DSD strategies for HIV services. These strategies, including tailored HIV testing for vulnerable populations, multi-month dispensing and home-based delivery of ARVs, improved HIV care and treatment during the pandemic, although the strategies employed have the potential to improve treatment and care of other chronic diseases, this was not specifically addressed.

Adaptation of approaches to dispensing ARV drugs was essential due to the temporary closure of health facilities and challenges related to travel. For clients living at a distance from ART centres, the provision of ARV drugs extended beyond the three-month interval. In cases where PLHIV faced difficulties in traveling to ART centres, the medications were dispatched directly to their home through courier services. An encouraging outcome was observed during consultations with key populations for this evaluation. It was reported that treatment adherence improved during the pandemic, and this was attributed to the adoption of the multi-month dispensing model, the convenience of home medication delivery, and heightened health concerns stemming from COVID-19.

Leveraging insights gained from COVID-19 could potentially help to improve management and outcomes for other chronic conditions, although the evaluation did not have sufficient evidence to assess to what extent this has taken place.

4.4. EQ4: To what extent does the Joint Programme ensure that equity, gender, and human rights issues, including the needs of key populations, are sufficiently addressed when leveraging HIV and PHC interlinkages and integration?

SUMMARY OF FINDINGS – EQ 4

- **Fostering equity and inclusivity.** The JUNTA's proactive efforts have led to significant strides in addressing the needs of key populations and promoting equity, gender and human rights. Important achievements over the last years have included multisectoral actions (education, prison and legal sector), enforcing community engagement and empowerment (LHWs) and efforts to combatting stigma and discrimination. These combined endeavours showcase the JUNTA's commitment to fostering inclusivity and fighting stigma in the HIV response. Yet there are still apparent gaps and challenges.
- **Impact of HIV integration on stigma.** There were different opinions about the potential effect on stigma in relation to integrating HIV services in primary care. Some believed integration

could normalize HIV and HIV care, while others feared it may exacerbate stigma for key populations and deter them from using services.

- **Nurturing community-led efforts.** Tackling HIV-related stigma in Pakistan's Revised AIDS Strategy, the JUNTA has been heavily involved in revising the Pakistan AIDS Strategy IV 2022-2026 to emphasize community-led efforts – a key component of the PHC approach which also related to combatting HIV-related stigma and discrimination. UNDP's UBRAF-funded initiatives focus on transphobic stigma, including advocacy, digital campaigns, and capacity-building. UNDP's multifaceted approach, such as legal aid training and engaging religious leaders, reflects its commitment to addressing stigma. UNHCR's efforts under UBRAF funding include seminars, workshops, and collaborations to reduce HIV-related stigma.

4.4.1. Which locations and population groups are potentially benefitting or being left behind?

Integration of HIV services in primary care facilities is a recent consideration. Opinions differ on its impact on stigma. The respondents' views were sought for potential benefits or risks associated with HIV service integration in primary care facilities. During the course of consultations, two divergent opinions emerged with regards to the effect of integration on stigma and discrimination. One opinion was that integration would reduce stigma associated with HIV. By treating HIV alongside other health issues, the normalization of care occurs, encouraging individuals to seek assistance without fear of discrimination.

The other opinion was that integration would make access difficult as key populations (TG, MSM, male sex workers, FSWs, PWIDs) are discriminated against based on their identity. A PLHIV from a key population group would not be comfortable accessing care from a primary care facility and would face the "double" stigma and discrimination (key population and HIV positive). Widespread stigma and discrimination associated with HIV could intensify if integration is not managed with sensitivity, which could deter individuals from seeking care. Health care provider preparedness is vital; health care professionals need to adopt sensitivity and inclusiveness towards key populations and PLHIV. Ensuring patient privacy and confidentiality becomes crucial in integrated settings. A lack of awareness about HIV or inadequate training among primary care staff could breach confidentiality, leading to reluctance to seek care. These were aspects mentioned by key informants consulted during the evaluation.

Several key informants were of the view that applying a PHC approach to the HIV response can potentially nurture community engagement, empowering local populations to actively participate in health care decisions and to reach those furthest behind. The LHWs and other community-based workers from health departments can dramatically improve the community outreach of HIV related services, this is an opportunity still to be fully leveraged.

With regards to integration of HIV screening/testing, it was informed that in KP, Punjab and Sindh it is mandatory to have HIV screening prior to any dental procedure, surgery and during antenatal care. Mandatory testing is a concern from a human rights perspective – and an area that needs to attention the JUNTA.

Low literacy can contribute to misconceptions and lack of awareness of health issues, including HIV, affecting uptake of health services and potentially hindering efforts to integrate services effectively[48].Literacy affects economic well-being, access to social and health services, awareness of health issues and other indicators of social development. In Pakistan there are significant disparities in the literacy rate between men and women and urban and rural areas. Around 71% of men were literate compared to 49% of women in 2018-19. The literacy rate in urban areas was 74% compared to 51% in rural areas in 2018-19. On the other hand, more women than men usually visit primary

[48] UHC Monitoring Report 2022, Pakistan

care facilities for antenatal care, postnatal care, child immunization services etc., and attention to these gender- related aspects would be important.

4.4.2. How is the Joint Programme supporting countries to ensuring stigma and discrimination free services for people living with HIV and vulnerable and key populations in all service delivery settings, including primacy care?

The JUNTA has contributed considerably to promoting stigma and discrimination free services for PLHIVs and key populations. The Pakistan AIDS Strategy IV 2022-2026, with JUNTA support, focuses on community-led anti-stigma efforts. UNDP's UBRAF initiatives combat transphobic stigma through advocacy and capacity building. UNHCR's UBRAF efforts involve seminars and workshops to fight HIV-related stigma, demonstrating the JUNTA's commitment to inclusivity.

However, Pakistan has not yet formally joined the "Global Partnership for Action to Eliminate all Forms of HIV-Related Stigma and Discrimination" which was established in 2018 following a call to action by the nongovernmental organization delegation to the UNAIDS Programme Coordinating Board.[49] Furthermore, there is no formal mechanism within the JUNTA to monitor the stigma and discrimination situation. The PLHIV stigma index is a standardized tool to gather evidence on how stigma and discrimination impacts the lives of people living with HIV.[50] The stigma index was developed to provide much-needed data and evidence that could be used to advocate for the rights of PLHIV. The latest stigma index study for Pakistan was conducted in 2009-10[51] and reportedly the current one is under progress. The IBBS 2017 survey[52] also reflected on the status of stigma and discrimination for PLHIV. The Association for PLHIV has established a complaint redressal mechanism for stigma and discrimination and they work closely with the PACP in this regard. The PACPs have their own complaint redressal mechanisms as well for addressing stigma and discrimination in their respective provinces.

The Pakistan AIDS strategy IV 2022-2026 developed with the support of the UNDPA and JUNTA partners acknowledges the need to address stigma and discrimination through community-led advocacy and education programmes. Sindh government in 2013 passed the Sindh HIV/AIDS Control Treatment and Protection Act, 2013 (later became law) which criminalized the stigmatization and discrimination of PLHIV with financial penalties. UNDP, UNAIDS and partner organizations advocated for the promulgation of this law. Apart from this law, there are no HIV specific laws, although Pakistan's constitution articulates equality and non-discrimination as fundamental rights. Articles 3 and 25 obligate the state to eliminate all kinds of exploitation and to guarantee that all citizens of the country shall be equal before the law and shall be entitled to equal protection of the law. An HIV bill has been drafted and is under review in the parliament to provide safeguards and protect the basic human rights of PLHIV[53].

UNDPs activities under the UBRAF funding as part of the Joint UN plan have played a significant role in shaping strategies to combat transphobic stigma and discrimination, particularly through consultative dialogues with key populations and stakeholders. These engagements have focused on effective communication and advocacy strategies, particularly addressing PrEP stigma. Moreover, UNDP's technical assistance has been instrumental in digitizing sustainable data systems. In addition, UNDP has leveraged its efforts to target youth within key populations aiming to diminish stigma and discrimination through a digital campaign. UNDP has also demonstrated commitment to capacity building. It has equipped legal aid staff across four provinces with inclusive approaches to address

[49] https://www.unaids.org/en/topic/global-partnership-discrimination

[50] https://www.stigmaindex.org/

[51] An Index to measure the Stigma and Discrimination experienced by People Living with HIV in Pakistan, 2009-10: https://www.stigmaindex.org/wp-content/uploads/2022/04/Pakistan-SI-Report-2010.pdf

[52] NACP. Integrated Biological & Behavioral Surveillance in Pakistan (2017). Islamabad: National AIDS Control Program (NACP) 2017: https://www.aidsdatahub.org/sites/default/files/resource/ibbs-pakistan-round-5-2016-2017.pdf

[53] Country Progress Report, Pakistan - Global AIDS Monitoring 2020: https://www.unaids.org/sites/default/files/country/documents/PAK_2020_countryreport.pdf

HIV-related stigma and discrimination. These strategies are rooted in human rights principles, emphasizing inclusivity. The establishment of legal aid desks through a competitive process, in collaboration with UNAIDS, set the stage for this training initiative in 2022. A noteworthy initiative involves religious leaders from diverse faiths, brought together to combat stigma and discrimination against key populations or those at risk. The preliminary stages saw consultations and planning meetings with the Ministry of Religious Affairs, serving to identify religious leaders in Punjab and Sindh. As part of this endeavour, a sensitization and capacity-building programme is being meticulously designed to empower at-risk youth and key populations, fostering durable connections with testing and treatment services. UNDP's multifaceted efforts underscore its role in driving holistic change and promoting inclusivity in the fight against HIV-related stigma and discrimination.

However, there is a need to have a comprehensive action plan with identified milestones for addressing stigma and discrimination. This action plan should include system wide interventions like enforcing relevant laws, workplace integration, and job market equity, alongside efforts to promote behavioural change, cultural sensitivity, and health care worker ethics. Sensitizing political leaders and religious scholars is also crucial. A formal monitoring system of stigma and discrimination is necessary to track progress, with evidence guiding continuous improvement of these interventions.

4.5. EQ5: What is the added value of the Joint Programme in terms of leveraging HIV and PHC interlinkages and to what extent is the Joint Programme sufficiently resourced to pursue this?

SUMMARY OF FINDINGS – EQ 5

- **Leveraging the expertise of JUNTA.** The Joint Programme's distinctive value lies in its potential to capitalize on the expertise of its member agencies, particularly in the pursuit of strengthening the PHC approach in the HIV response and as well for leveraging investments and learnings from the HIV response to apply to improve broader health outcomes and SDGs.
- **Advancing HIV Integration and PHC Interlinkages through effective leadership** - Leveraging the respective strengths of the JUNTA members and bolstered by the effective leadership of UNAIDS, the JUNTA has the potential to take the agenda of HIV integration and interlinkages with PHC forward. This will include a focus on enhanced alignment, strategic thinking, and coordination with government departments and the private sector.
- **Nurturing accountability and resource sufficiency.** Transparency, accountability, and tangible support to governmental programmes have been the pillars of the JUNTA's work. Their engagement in broader health reforms, curriculum integration, and multisectoral approaches highlight their effective efforts. However, addressing the complex task of potentially integrating HIV services into primary care requires additional joint and strategic thinking and resources and skilled personnel, which are currently insufficient. Adequate resourcing (fiscal and human resources) is crucial for successful implementation, and staffing patterns must be reconsidered to ensure the effectiveness of the Joint Programme in advancing HIV and PHC integration efforts.

4.5.1. What is the added value of the Joint Programme in terms of leveraging HIV and PHC interlinkages? (the Joint Programme ways of working, collaboration, synergies, and comparative advantages)?

The Joint Programme's special strength is its potential to use each agency's expertise to foster joint actions and expertise of UNAIDS and its Cosponsors to further integration of HIV services in primary care and the full application of the PHC approach to the HIV response in Pakistan– for the latter particularly UNAIDS, UNICEF, UNFPA and WHO.

The Joint Programme's unique value, as identified during the course of this evaluation, lies in its ability to leverage the specialized expertise of each agency involved. This potential extends to engaging various sectors in the agenda of fostering HIV and PHC linkages. Leveraging the respective strengths of the JUNTA members, as delineated earlier, and bolstered by the effective leadership of UNAIDS, the Joint Programme has the potential to take the agenda of HIV integration into PHC forward.

Leadership and UBRAF funding helped achieve some good and relevant results, with room to improve have further focus on PHC and HIV interlinkages in UBRAF and well as provincial coordination and collaboration for evidence-based integration.

The level of coordination and collaboration within the JUNTA for their overall work has been considerably good at the national level while a great deal of improvement needed at the provincial levels. The JUNTA has ensured transparency in their work and demonstrated accountability. Furthermore, with regards to HIV response in Pakistan, the overall support provided to the MoNHSR & C, national and PACPs, both financially and technically, has been met with appreciation from the government and other stakeholders. Notably, the efforts to be part of the broader health reforms such as UHC Benefit Package, integration of HIV in the curriculum of frontline health workers and employing multisectoral approach in HIV response are some of the hallmarks of the work Joint UN team has done during the evaluation period.

However in terms of how to break down the siloed HIV response, with more focus on integrated service delivery approaches and integrated health system functions (financing, data management, health workforce etc.), there is a need for situational assessments, enhanced alignment of activities, strategic thinking, and prioritization as well as a close coordination and collaboration with the national and provincial government departments and the private sector which would elevate efforts to integrate HIV into PHC in a comprehensive way.

4.5.2. To what extent does the Joint Programme have the necessary skills and resources to contribute to strengthening HIV and PHC integration and linkages?

The JUNTA comprises of members who bring a diverse set of skills that encompass all essential elements to contribute to strengthening HIV and PHC interlinkages. Availability of necessary resources is essential to ensure that UN country offices can effectively implement the efforts to strengthen HIV and PHC linkages through the Joint work plan and funds available including through country envelopes.

Currently, the staffing levels for working on HIV in the UN agencies is perceived as inadequate, potentially undermining the effective working of the Joint Programme at country level and there is a need for increased capacity building on the PHC approach and how this can be applied strategically in the various contexts of the country.

Looking at staffing patterns as reported in the Joint Programme Capacity Assessment, 2020, only UNAIDS, UNICEF, UNODC and WHO have at least one fully funded full-time staff to work on HIV (Table 8). According to the UNAIDS Secretariat configuration exercise (2022), Pakistan (alongside India and Indonesia) had gaps in all three strategic priority areas and the report specifically mentioned that these countries may require high intensity support[54].

[54] UNAIDS Joint Programme Capacity Assessment, 2022: https://open.unaids.org/sites/default/files/documents/UNAIDS%20Joint%20Programme%20Capacity%20Assessment_Final%20Report_29Aug2022%20updated.pdf

Table 8: Joint Programme staff at country level per agency in 2020[55]

Agency	Total number of staff – capacity assessment	Equivalent of full-time positions capacity assessment
WHO	1	1
UNICEF	2	1.2
UNFPA	1	0.3
UNESCO	1	0.1
UNHCR	1	0
UNODC	2	1.5
World Bank	3	0.6
UNAIDS	3	3
Total Positions	**14**	**7.7**

Note: Since 2020, UNDP staff have been added, positions are not reflected here

5. Conclusions and considerations going forward

5.1. Conclusions

The understanding of integrating HIV into PHC among members of the JUNTA varied, with those directly engaged in health and HIV responses exhibiting a better grasp of the concept. Although coordination within the JUNTA has been generally satisfactory, and with substantial focus on multisectoral approaches and people/community empowerment and engagement in the UBRAF plan, this alignment has not yet translated into a comprehensive plan for integrating HIV with other services and/or in primary care settings - how, what, and where to integrate still remains unclear. This underscores the importance of enhancing strategic alignment and cooperation between JUNTA members to ensure a cohesive approach. The recent joint statement in 2021 by health and development partners emphasizes the significance of PHC and UHC in Pakistan, highlighting a convergence with global declarations and emphasizing the potential of integrating HIV into PHC within the broader health landscape.

Recent progress related to applying the PHC approach to HIV response in Pakistan, however the HIV response in Pakistan is still largely verticalized in practice with standalone ART and PMTCT clinics being prioritized and with separate financing, separate data and procurement systems and separate funding structures for HIV. There is scope to develop a clear and comprehensive strategy building on the PHC approach of the National Health Vision, learning from the PHC model of care applied in two districts and assessing the potential for increased integrating service delivery and patient centred care for marginalized populations who are at risk of different infections and diseases (HIV, hepatitis, TB, STIs, mental health, drug use etc.).

While some progress has been made, several challenges hinder the integration of HIV into PHC in Pakistan. Factors such as financial constraints, stigma, discrimination, limited awareness, and fragmented data management systems are some of the barriers. On a positive note, a well-established network of primary care facilities and community health workers, and the integration of

[55] UNAIDS Joint Programme Capacity Assessment, 2022: https://open.unaids.org/sites/default/files/documents/UNAIDS%20Joint%20Programme%20Capacity%20Assessment_Final%20Report_29Aug2022%20updated.pdf

HIV interventions into the UHC Benefit Package provide enablers for a more PHC-aligned HIV response. Overcoming these barriers and leveraging the identified enablers are pivotal to advancing the integration of HIV into PHC, ensuring comprehensive and accessible health care for all.

The Joint Programme has a distinct added value through leveraging the specialized expertise of its member agencies. This collaborative approach, reinforced by effective leadership from UNAIDS and supported by UBRAF funding, has the potential for further advancements in the integration agenda. Addressing the complex task of integrating HIV with PHC requires additional resources and skilled personnel, as the current staffing patterns need reconsideration to ensure the Joint Programme's effectiveness in advancing HIV and PHC integration efforts.

Maintaining political commitment and long-term sustainability also remains a challenge. Proactive measures are necessary to secure sustainable HIV financing beyond the Global Fund's conclusion in 2030, ensuring the continued success of offering HIV services in health benefit packages.

5.2. Considerations for strengthening Joint Programme contributions to alignment and integration of PHC and HIV services

The following presents a summary of considerations moving forward.

Situation analysis and using learnings from WHO's pilot PHC model of care

As a first step, a situational analysis for each province is imperative for the JUNTA to determine various crucial aspects of HIV integration within primary care. This analysis should be started with an assessment of HIV inequalities in Pakistan[56] succeeded by an analysis identifying the specific components of the HIV response that are suitable for integration, assessing the readiness of primary care facilities and community structures for such integration, evaluating the potential implications of the integration process, and gauging the existing political will to support these endeavours. Moreover, it is recommended that the JUNTA leverage the insights (when available) garnered from WHO's pilot PHC model of care which has an HIV prevention component integrated at primary care level. These findings could serve as valuable reference points to inform and guide future integration efforts effectively.

National action plan for integration of HIV services within the broader health system including primary care/related disease programmes

Based on the situational analysis mentioned above, the JUNTA in collaboration with Government of Pakistan, should develop a comprehensive and phased national action plan for transitioning from a disease specific approach with siloed funding, structures and systems to integrating HIV more with the broader health system and within primary care whenever this is feasible and integration of services with related disease programmes such as STIs, hepatitis, TB programmes, prison health programmes, drug addiction programmes etc.

The plan should be developed through an equity lens with a focus on key populations, people-centredness, and self-care approaches. The plan would stipulate which HIV services should be integrated in Pakistan based on HIV epidemiology and shared risk factors for other diseases and infections, responding to patient preferences, and taking stigma and discrimination aspects into consideration (including sensitizing health care professionals at primary care level to promote stigma-free care) The plan should outline clear objectives, timelines, and responsibilities for government and the relevant agencies within the JUNTA.

[56] UNAIDS has published a" framework for understanding and addressing HIV-related inequalities, UNAIDS; 2022; (https://www.unaids.org/sites/default/files/media_asset/framework-understanding-addressing-hiv-related-inequalities_en.pdf)

Building capacity of existing network of community health care workers and boost meaningful involvement of key populations and affected groups

The abovementioned action plan should clearly identify what could be the future role and involvement of community health care workers in HIV awareness raising and service delivery, this includes potentially expanding the scope of LHWs and other community health care workers for HIV prevention, messaging and HIV screening.

Key population organizations and affected groups should be central to the HIV response and organizations empowered to be at the table in decision making processes and planning processes - such as for the abovementioned situational analysis and action plan. Furthermore, the funding of PLHIV and key population organizations is reliant on external funds with substantial risk of losing gains and these structures when withdrawal of major donors.

Comprehensive actions and regular monitoring mechanism to address HIV stigma and discrimination

The action plans should also put specific emphasis on addressing stigma and discrimination which is considered of utmost importance for the successful and meaningful integration of HIV with primary care and through the existing community health care workers. It is crucial to sensitize the LHWs and the society at large about HIV, its modes of transmission, and available treatment options, dispelling misconceptions. To achieve this, comprehensive awareness campaigns must be initiated, emphasizing accurate information dissemination on a wider scale. Collaborating with community/religious leaders, influencers, and media platforms will amplify messages that foster understanding, acceptance, and the inclusion of individuals living with HIV. The actions should encompass interventions at the systems level such as enforcement of relevant laws, having integration in workplace policies, equitable share in job market as well as interventions that foster behavioural change, cultural adaptations, health care workers ethics and sensitization of the political leadership and religious scholars.

Finally, the Action plan should include regular monitoring mechanism needed to combat stigma and discrimination effectively and a formal mechanism to monitor progress on stigma and discrimination on regular basis. Pakistan should consider formally signing up to the Global Partnership to eliminate all forms of stigma and discrimination and regular reporting to the PLHIV stigma index.

Improving coordination, communication, multisectoral action and policy by the members of the JUNTA

The JUNTA at national level should bring the agenda of HIV integration with primary care/other disease programmes explicitly on their agenda. The annual plans should include the activities identified in the comprehensive plan for HIV integration with primary care and related diseases.

Members of the JUNTA at the national level should further strengthen coordination and collaboration between their provincial offices, mirroring the successful national-level efforts. The provincial offices should develop mechanisms for information sharing, joint planning, and synchronized implementation.

The JUNTA could explore the possibility of establishing “Mutual Trust Fund” with the funds pooled by members using the UBRAF funding as seed money to advance on the agenda. The premise of this proposition is to enhance the funding pool, raise individual JUNTA member’s contributions in order to have adequate fiscal space for a comprehensive response.

Effective communication channels should be established to ensure that alignment translates into actionable strategies at both national and provincial levels. The JUNTA should also do collective advocacy with the UN Resident Coordinator and use the UNSDCF as a strategic document to

prioritize HIV and elevate its prominence on their agenda. This approach seeks to synergize resources and efforts for a comprehensive multisectoral and impactful response to HIV. Examples include scaling up HIV in comprehensive sexuality education programmes for out-of-school young people, vocational training of PLHIV, covering the PLHIV in the government social protection programmes, and scaling up of accelerated education programme for PLHIV/ key populations are some of the low hanging fruits. It is important that the deliberation on HIV integration with primary care is structured and the JUNTA should make it part of their workplans.

The JUNTA should conduct multi-stakeholder dialogues more frequently involving government representatives, civil society, community leaders, and international partners to foster commitment, share progress, and address challenges.

Enhance sustainable financing for HIV

It will be important to advocate for proactive measures that are necessary to secure sustainable HIV financing beyond the Global Fund's expected conclusion in 2030, ensuring continued access to HIV services. A critical example is the financing for the HIV package in the UHC Benefit Package which is currently funded by external grants. There is a need to develop a sustained high-level advocacy strategy that goes beyond specific events, leveraging evidence-based data and success stories to build political commitment for sustainable financing of HIV and inclusion of HIV services in UHC Benefit Package – domestically funded and beyond prevention services. Sustainable funding for CBOs to be involved in delivering HIV prevention services would also be an important aspect - potentially exploring options of social contracting or other mechanisms. The JUNTA should work with the national and PACPs and provincial health departments to support them develop a plan for transition from Global Fund dependent HIV response to a more sustainable financing model with HIV services under the UHC Benefit Package funded by domestic resources. The JUNTA should advocate for allocations based on the needs of the respective province.

Annexes

Annex 1 – KII Guide

Note: the following guide is tailored to the Joint Team, we also developed tailored guides targeting the following categories of key informants:

- Global Fund, PEPFAR, BMGF, USAID, international non-governmental organizations etc.
- Government Ministry/central staff
- Facility staff/Service providers (government and or private/NGO)
- Community led/based organizations, key populations groups
- Academic/research organizations.

Country case studies - Key Informants Interview Guides

The UNAIDS Joint Programme contribution to strengthening HIV and Primary Health Care outcomes: interlinkages and integration

Interview guide for Joint Programme Cosponsors in country

Introduce the consultants and key informants. Note names and positions.

Introduce the assignment: Euro Health Group has been contracted to conduct an evaluation of the Joint Programme's work on leveraging the HIV and PHC interlinkages in order to strengthen these and identify opportunities for the Joint Programme work on PHC in the future.

The evaluation will identify how efforts to address HIV have been – conceptually and operationally – linked to the PHC approach and whether or how this can be further strengthened. The evaluation should capture the HIV-PHC interface, drawing on where things stand based on current experience and the way forward. The timeframe of the evaluation is from 2020 to date. At country level the Joint Programme on HIV includes the UNAIDS Secretariat Country Office and up to 11 Cosponsors. In this evaluation we are focusing on the work of WHO, UNICEF, UNFPA and the World Bank in addition to UNAIDS Country Office.

The evaluation will not only assess how the Joint Programme has supported integration of HIV into PHC and how HIV integration has improved HIV prevention, testing and treatment outcomes but also how this has strengthened PHC outcomes more broadly, e.g., improving the ability of PHC to care for people with chronic illnesses.

All information provided to the evaluation team will be kept confidential, and potential citations will not be traceable to any person or their details.

Thank you for your willingness to talk to us.

List of questions

- Can you describe any recent examples from your country where the Joint Programme has contributed to strengthen:
  - integrated service delivery (including in primary care)
  - multisectoral action and policy
  - empowerment of communities

  Any notable achievements since 2020?
  How is progress tracked?

  Probing Qs

  - Can you mention any recent examples of Joint Programme activities at country level to build political commitment for sustainable financing and delivery of integrated HIV services (e.g., comprehensive HIV services in health benefit packages)?
  - Any recent examples of Joint Programme multisectoral actions and policy?
  - To what extent is the Joint Programme promoting community-led approaches for demand generation and service delivery when appropriate? (and how can this potentially be this be improved?)

- Where does the Joint Programme add value through its joint ways of working on HIV and PHC integration and linkages? (e.g., convening power, collaboration, synergies etc) Probe: How is the Joint Programme using its comparative advantage, resources and ways of working to support HIV and PHC integration and linkages at country level? (Joint Programme leadership, advocacy, policy dialogue, convening, funding, guidance, technical support, strategic information at global, regional and country levels)
- To what extent do you think the Joint Programme has appropriate and adequate skills and resources to leverage the HIV and PHC interlinkages? What, if any, are the main gaps, and where should the Joint Programme strengthen its capacity?)
- What are the *main barriers* to integrating HIV into PHC and how is the Joint Programme addressing these, at country level? (Probing: are Joint Programme partners at the UHC table when discussing UHC/PHC etc?
- What are the *key enablers* to advance HIV and PHC integration? (Probing: How is the Joint programme tapping into these?)
- How is the Joint Programme identifying and assessing the main barriers and challenges to, and risks of, HIV integration in PHC?
- To what extent do you think that the Joint Programme has leveraged on HIV assets (investment, learnings, approaches, innovations) for broader health gains? Specific examples Any specific examples? (Probe: are there any missed opportunities?)
- What is the Joint Programme doing to ensure equitable access to HIV services delivered through a PHC approach? Which locations and population groups are potentially benefiting/or being left behind?
- Where should the Joint Programme focus its efforts in the future on HIV and PHC integration and linkages to maximize HIV and broader health outcomes? What should it do better or differently going forward (probing: Missed opportunities for the Joint Programme on the HIV-PHC interfaces) How can the Joint Programme best contribute to ensuring the equity, quality and sustainability of HIV services that are integrated with, or linked to, PHC?)
- Is there an imperative to integrate HIV more in PHC? How can this support HIV outcomes? How can it support broader health outcomes?
  - To what extent are relevant plans, strategies and activities related to HIV and PHC harmonized and aligned internally within the Joint Programme (UNAIDS, WHO, UNICEF, UNFPA, WB) at the country level? And externally? (Global fund, PEPFAR etc?)
- What can and should the Joint Programme do in the future to maximize on the interlinkages between HIV and PHC?

Annex 2 – Individuals met and group discussion participants

S.no	Organization	Participants	Level	Type
1.	Joint UN Team	1. Dr Muhammad Safdar Kamal Pasha (HIV focal person WHO) 2. Dr Inam Ullah Khan (Health Team Lead UNICEF KP) 3. Ms Sabrina (Programme Analyst Adolescents & Youth SRHR UNFPA) 4. Dr Pervez Shaukat (UNHCR) 5. Mr. Sameer Luqman (programme officer UNESCO) 6. Ms. Heather Doyle (Project Manager GF grant UNDP) 7. Dr Omar Riaz (Program Specialist UNDP) 8. Dr Manzoor (Adviser Drug Demand Reduction and HIV/AID UNODC 9. Ms. Yuki Takemoto (Country Representative, UNAIDS) 10. Dr Rajwal Khan (Strategic Information Advisor, UNAIDS) 11. Ms. Fahmida Khan (Advisor-Community Led Responses UNAIDS Country Office)	National	Group Discussion
2.	Nai Zindagee Trust (Global Fund PR)	1. Ms. Malika Zafar (Executive Director NZT) 2. Mr. Salman (Program Specialist)	National	KII
3.	Ministry of National Health Services Regulation & Coordination	1. Mr. Mirza Nasir-ud-Din Mashhood (Special Secretary Health M/o NHSR&C) 2. Mr Mustafa Jamal Kazi (National Coordinator Common Management Unit for AIDS, TB, Malaria)	National	KII
4.	UNDP	1. Ms. Heather Doyle (Project Manager, PMU, GF HIV grant) 2. Dr Omar Riaz (Program Specialist)	National	KII
5.	UNFPA	1. Dr Luay Shabaneh (Country Representative UNFPA) 2. Ms. Sabrina Khan (Programme Analyst Adolescents & Youth SRHR) 3. Ms. Rubina Ali (Assistant Representative UNFPA)	National	KII
6.	World Bank	1. Dr Ali Mirza (World Bank)	National	KII
7.	Director General Health Services, Provincial Department of Health Khyber Pakhtunkhwa	1. Dr Shaukat (Director General Health Services) 2. Dr Shahid (Additional Director General Health Services)	Provincial - Khyber Pakhtunkhwa	KII
8.	Integrated HIV, Hepatitis and Thalassemia Control Program (IHHTCP), Khyber Pakhtunkhwa	1. Dr Tariq (Deputy Program Manager Integrated HIV, Health and Thalassemia Control Program) 2. Dr Yasir (Health Officer HIV)	Provincial - Khyber Pakhtunkhwa	KII

S.no	Organization	Participants	Level	Type
9.	Provincial Team UNICEF Khyber Pakhtunkhwa	1. UNICEF Team Lead, Khyber Pakhtunkhwa 2. Dr Inam Ullah Khan (UNICEF Health Lead) 3. Mr. Aien Khan (Nutrition officer	Provincial - Khyber Pakhtunkhwa	Group Discussion
10.	Provincial Team WHO, Khyber Pakhtunkhwa	1. Dr Babar (Head of the WHO office KP) 2. Dr Haroon Bacha (HIV focal point WHO)	Provincial - Khyber Pakhtunkhwa	Group Discussion
11.	Staff at ART centre Hayatabad Medical Complex Peshawar, Khyber Pakhtunkhwa	1. Dr Sadia (Facility Head ART Centre HMC Peshawar- KP) and ART centre team 2. Dr Yasir (Health Officer HIV)	Provincial - Khyber Pakhtunkhwa	Group Discussion
12.	Visit to the ART centre Hayatabad Medical Complex Peshawar, Khyber Pakhtunkhwa	Health Staff at the ART centre	Provincial - Khyber Pakhtunkhwa	Observation
13.	Focus group discussion with the Transgender at Iqbal Plaza Peshawar, Khyber Pakhtunkhwa	Transgender community representatives	Provincial - Khyber Pakhtunkhwa	Group Discussion
14.	District Health Office Charsadda, Khyber Pakhtunkhwa	District Health Officer	Provincial - Khyber Pakhtunkhwa	
15.	Visit to BHU in Charsadda, Khyber Pakhtunkhwa and meeting with staff	1. Dr Farhad Khan (District Health Officer Charsadda, Khyber Pakhtunkhwa) 2. Dr Khizar Hayat (TB & HIV focal person district health office Charsadda) 3. Dr Haroon Bacha (WHO HIV focal point)	Provincial - Khyber Pakhtunkhwa	Observation
16.	Sindh AIDS control Program	1. Dr Naeem (Program Manager Sindh AIDS Control Programme)	Provincial - Sindh	
17.	Provincial office UNICEF Sindh	1. Dr Kamal (UNICEF Health Team Lead)	Provincial - Sindh	KII
18.	Provincial office WHO Sindh	1. Dr Sara (WHO Health Team Lead)	Provincial - Sindh	KII
19.	Peoples Primary Healthcare Initiative Sindh	1. Mr. Javed Ali Jagirani (CEO PPHI) 2. Dr Zakir Punar (Deputy Director Health Services, PPHI)	Provincial - Sindh	KII
20.	Focus group discussion with Humraaz (MSM CBO) Sindh	1. Project Manager Humraaz and team	Provincial - Sindh	Group discussion
21.	Focus group discussion with MDG (FSW CBO) Sindh	1. Project Manager MDG and Team	Provincial - Sindh	Group discussion
22.	Focus group discussion with the GIA (TG CBO) Sindh	1. Member GIA and team 2. Member TG community and public health professional	Provincial - Sindh	Group discussion

S.no	Organization	Participants	Level	Type
23.	Provincial AIDS Control Program, Punjab	1. Mr. Azhar (Provincial Manager Operations PACP)	Provincial - Punjab	KII
24.	Provincial Department of Health Punjab	1. Dr Riaz (Director Headquarter, Provincial Health Department Punjab)	Provincial - Punjab	KII
25.	Provincial Team UNICEF Punjab	1. Dr Qurat ul Ain (UNICEF Health Team Lead) 2. Dr Sara (HIV focal person UNICEF)	Provincial - Punjab	Group Discussion
26.	Provincial Team WHO Punjab	1. Dr Jamshed (WHO Health Team Lead) 2. Dr Irfan (Technical Focal Person HIV/AIDS) 3. Dr Amir Safdar (Technical Focal Person TB)	Provincial - Punjab	Group Discussion
27.	DOSTANA (MSM CBO) Punjab	1. Project Manager DOSTANA Male Health Society and team	Provincial - Punjab	Group discussion
28.	Khwajasira Society (TG CBO) Punjab	1. Project Manager Khwaja Sira Society and her team	Provincial - Punjab	Group discussion

Annex 3 – Documents reviewed and/or referenced

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