

UNAIDS

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

Report



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The evaluation was designed to be forward-looking with the aim of identifying opportunities for the Joint Programme to strengthen HIV and Primary Health Care (PHC) integration and linkages. It was focused on, but not limited to, the activities and contributions of the UNAIDS Secretariat and five Cosponsors: WHO, UNICEF, UNFPA, UNDP and the World Bank. As the Joint Programme does not have a strategy or workplan with targets or milestones for its work on HIV and PHC intersections and lacks a fully developed set of indicators, it was difficult for the evaluation to assess measurable results that can be attributed to the Joint Programme.

The evaluation concluded that, while individual Cosponsors have supported integration of HIV with other services, there is limited evidence of an intentional or collective Joint Programme approach at country level. Going forward, more discussion and guidance are needed on the role the Joint Programme can play in strengthening and sustaining the HIV response in relation to and beyond PHC. Careful consideration will be required in each country to determine whether, where, how and the extent to which HIV should be integrated into PHC and broader health systems. It will be essential to ensure that achievements and gains in the response to HIV are not lost and that multisectoral responses with communities at the centre remain key elements of efforts to end AIDS.

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Table of Contents

Acronyms and abbreviations	5
Glossary of key terms	7
Executive Summary	9
1. Introduction	18
1.1 Background	18
1.2 Objectives and scope of the evaluation	21
2. Evaluation design, approaches and methodology	22
2.1 Theory based process evaluation.....	22
2.2 Utilization-focused and gender, equity and social inclusion responsive approach.....	22
2.3 Theory-driven evaluation.....	24
2.4 Evaluation questions.....	25
3. Evaluation methods.....	27
3.1 Data collection methods	27
3.2 Data analysis, synthesis, and development of recommendations	29
3.3 Limitations.....	29
4. Evaluation findings	31
4.1 Key findings EQ1.....	31
4.2 Key findings EQ2.....	41
4.3 Key findings EQ3.....	59
4.4 Key findings EQ4.....	66
4.5 Key findings EQ5.....	71
5. Conclusions	80
6. Recommendations.....	83
ANNEXES.....	87
Annex 1: Terms of Reference Independent Evaluation	87
Annex 2: Theory of Change	101
Annex 3: ToC assessment.....	103
Annex 4: Evaluation matrix	104
Annex 5: Key informant interview/group discussion guides	110
Annex 6: Online survey analysis.....	113
Annex 7: Stakeholder mapping	119
Annex 8: Overview of relevant indicators.....	121
Annex 9: Country selection criteria.....	131
Annex 10: Methodology for country case study.....	134
Annex 11: Key informants at global and regional level	138
Annex 12: List of key documents and Databases.....	141
Annex 13: Documents reviewed: Global and regional level	143

List of Figures

Figure 1. Evaluation framework	24
Figure 2: Global Fund: Integration needed at governance, systems, and service delivery levels.....	38
Figure 3: External/international resources for the HIV response over time.....	51
Figure 4: Resource availability for HIV in LMICs by source of funding, 2010–2022 and 2025 target ...	51

List of Tables

Table 1: Evaluation questions.....	25
Table 2: Number of informants interviewed or participating in focus group discussions	27
Table 3: Limitation and mitigating actions	29
Table 4: Services proposed for integration/linkages with HIV in global HIV strategies/guidelines	36
Table 5: HIV and PHC integration and interlinkages – progress against selected UBRAF 2022-2026 targets and output indicators.....	46
Table 6: Commonly cited enablers and barriers to applying the PHC approach to HIV responses	56
Table 7: Summary of relevant TSM assignments conducted since 2020	73
Table 8: Cosponsor FTE staff allocation to Global AIDS Strategy Results Areas	77
Table 9: Assumptions underpinning the ToC	103
Table 10: Survey results – gender, organisation and country (Q1-Q3)	113
Table 11: Summary analysis Q4-Q8.....	114
Table 12: Example of 1 week mission schedule	134

Acronyms and abbreviations

ANC	ante natal care
AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral drugs
CBO	community-based organisation
CCM	country coordinating mechanism
CDC	centre for disease control and prevention
CHW	community health workers
CSE	comprehensive sexuality education
CSO	civil society organization
DFAT	Department of Foreign Affairs (UK)
DSD	differentiated service delivery
EHG	Euro Health Group
EHSP	Essential Health Services Package
EMTCT	elimination of mother-to-child transmission (of HIV)
EQ	evaluation question
ERG	evaluation reference group
ESA	Eastern and southern Africa
FSW	female sex worker
GAM	Global AIDS Monitoring
GAS	Global AIDS Strategy
GBV	gender-based violence
GDP	gross domestic product
GESI	gender, equity, and social inclusion
Global Fund	the Global Fund to Fight AIDS, Tuberculosis and Malaria
HCV	Hepatitis C virus
HIV	human immuno-deficiency virus
HMIS	health management information system
HQ	headquarters
HRH	human resources for health
IBBS	integrated bio-behavioural survey
ILO	International Labour Organization
IOM	International Organization for Migration
Joint Programme	UNAIDS Joint Programme
JPMS	Joint Programme Planning, Monitoring and Reporting System
KII	key informant interview
LMIC	low- and middle-income countries
M&E	monitoring and evaluation
MCH	mother and child health
MMD	multi month dispensing
MNCH	maternal newborn and child health
MSM	men who have sex with men
MOH	ministry of health
NAC	national AIDS council
NAPHA	National AIDS and Health Promotion Agency
NASA	national AIDS spending assessment
NCD	non-communicable diseases
NCPI	National Commitments and Policy Instrument

NHA	national health accounts
NSP	national strategic plan
OECD DAC	Organisation for Economic Co-operation and Development's Development Assistance Committee
PCB	Programme Coordinating Board
PEP	post-exposure prophylaxis
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PHC	primary health care
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission (of HIV)
PNC	post-natal care
PrEP	pre-exposure prophylaxis
PWID	people who inject drugs
RMNCAH	reproductive maternal newborn child and adolescent health
RSSH	Resilient and Sustainable Systems for Health
SDG	sustainable development goals
SDG3 GAP	Sustainable Development Goals 3 Global Action Plan
SIDA	Swedish International Development Cooperation Agency
SRA	strategic results area
SRH	sexual and reproductive health
SP-PHC	WHO Special Programme on PHC
STI	sexually transmitted infections
TB	tuberculosis
ToC	theory of change
TOR	terms of reference
TRP	technical review panel
TSM	Technical Support Mechanism
UBRAF	Unified Budget Results and Accountability Framework
UHC	universal health coverage
UHC BP	UHC benefits package
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNSDCF	United Nations Sustainable Development Cooperation Frameworks
VMMC	voluntary medical male circumcision
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization
WHO GHSS	World Health Organization Global Health Sector Strategies on HIV, viral hepatitis and sexually transmitted infections

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, ART, management of co-morbidities and co-infections (e.g. TB, STIs, viral hepatitis, cervical cancer), NCDs, mental health conditions, etc.), and specific services and interventions for key and other populations (e.g. PrEP, 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 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. ^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 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
Joint Programme	UNAIDS Joint Programme (consisting of UNAIDS Secretariat and UNAIDS Cosponsors)
Key populations	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, people who inject drugs, prisoners and other incarcerated people, sex workers and transgender people. ^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
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
Vulnerable populations	Vulnerable populations are groups of people that are vulnerable to HIV infection in certain situations or contexts, such as infants, children and adolescents (including adolescent girls and young men in sub-Saharan Africa), orphans, people with disabilities and migrant and mobile workers. They may also face social and legal barriers to accessing HIV prevention and treatment. These populations are not affected by HIV uniformly in all countries and epidemics and may include key populations. Each country should define the specific populations that are vulnerable and key to their epidemic and response, based on the epidemiological and social context. ^e

Sources:

- 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: WHO; 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: WHO; 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.

Executive Summary

Evaluation purpose and scope

The evaluation was primarily designed for learning and planning purposes. The main objective was to conduct a forward-looking process evaluation that identified opportunities for the UNAIDS Joint Programme to strengthen HIV and primary health care (PHC) integration and linkages, at the same time as assessing, as far as possible, what the Joint Programme has achieved.

The evaluation covers the period January 2020-August 2023. The geographical scope included global, regional and country levels (the latter primarily through four case study countries). The technical scope considers the PHC approach with three main components: primary care and essential public health functions as a core of integrated health services; multisectoral policy and action; and empowered people and communities. The evaluation did not include a scoping review or a systematic review of peer-reviewed articles. Furthermore, at country level, the evaluation was not able to assess the current state of PHC and systems for health in respective countries to make a specific case for what to integrate HIV into/with as this requires substantive assessments which were not feasible within the resource and timeframe for the evaluation. Finally, the evaluation was not intended to include a detailed assessment of UNAIDS Secretariat and Cosponsor capacity.

Evaluation approach and methodology

The evaluation was a process evaluation based on a theoretical framework. The evaluation developed a theory of change, which has served as the overall analytical framework for the evaluation. The theory of change has informed the evaluation protocol and the development of five evaluation questions (EQs) and 13 sub-questions.

The evaluation used a mixed method approach combining qualitative and quantitative methods for data collection, review, triangulation, and analysis. The evaluation data collection methods included a document and data review, four country case studies (Angola, Botswana, Indonesia and Pakistan) and key informant interviews and group discussions at global, regional, and country levels, by which 491 people had an opportunity to share their experiences and opinions through the evaluation. Primary data was further generated through an online survey for country and regional levels responded to by 174 stakeholders.

All data were collected and coded in evidence matrices based on the assumptions and evaluation questions. This ensured the analysis considered and triangulated all relevant secondary and primary data collected, thereby reducing the risk of evaluation bias, and improving robustness. The evaluation team also undertook analysis of evidence and findings within and across country case studies and synthesis of global findings against the theory of change.

Limitations

The evaluation's limitations include the small number and choice of case-study countries, a short time frame to conduct interviews and field work, terminology challenges related to PHC and primary care which affected discussions and a need to align and probe conversations around the topic. Quantitative data scope and data gaps with no specific strategy or workplan with dedicated targets or milestones for its work on HIV and PHC integration making it difficult to follow progress and assess results. Despite these limitations, the implemented mitigation measures allowed the evaluation to be confident in its key findings.

The following table provides a summary of key findings. Further detail and more findings are found in the relevant sections of the main report.

Key findings

Workstreams	Summary of key findings
<p>Coherence and conceptual clarity <i>(Key findings from EQ 1.1-1.3)</i></p>	<ul style="list-style-type: none"> ■ There is agreement within the Joint Programme on the importance of applying a PHC approach to achieve HIV goals, but less clarity about what the Joint Programme aims to achieve. A lack of conceptual clarity and a common understanding of definitions of “PHC”, “primary care” and “integration” among Joint Programme stakeholders has further contributed to limited progress in taking forward the HIV and PHC integration agenda. ■ Joint Programme guidance on HIV and PHC integration largely focuses on integration of specific health services and, while there are similarities across strategies and guidelines there are also some differences and there is limited guidance with respect to integration of HIV with broader health systems or other aspects of PHC. ■ The Joint Programme’s global strategies are broadly harmonised with those of key HIV funding agencies with respect to integration and linkages, and efforts have been stepped up recently, including through global consultations, however there is scope for further strengthening alignment. Country case studies identified missed opportunities for closer alignment and harmonization of Joint UN Team AIDS and government efforts as well as of efforts within the Joint Programme.
<p>Leveraging the PHC approach for strengthening HIV outcomes and improving health outcomes for PLHIV and those at risk of HIV <i>(Key findings from EQ 2.1-2.3)</i></p>	<ul style="list-style-type: none"> ■ The Joint Programme has applied the principles of two out of three pillars of the PHC approach (multisectoral policy and action and empowering people and communities) to improve HIV outcomes, and this happened prior to the recent increased global focus on PHC. However, the Joint Programme has had less focus on HIV integration within primary care - the first pillar of the PHC approach. There are examples of integrated delivery of other health services with HIV services (for example, sexual and reproductive health, tuberculosis, hepatitis, family planning and cervical cancer) and of integrating HIV services into primary care (for example, HIV testing, prevention of mother to child transmission, ART), but the extent to which the Joint Programme has taken an intentional or collective approach to this is difficult to determine. ■ Available data suggest that there has been progress on specific integration related indicators, but there is no overarching framework or agreed core set of indicators for monitoring Joint Programme action or results on HIV and PHC integration efforts. ■ There is a role and mandate for the Joint Programme to build political commitment for sustainable HIV financing and sustainable financing for PHC and universal health coverage (UHC) that drives HIV impact, but how to operationalise this is not well defined and its potential role is not fully leveraged. The available evidence on the extent to which HIV services are being included in health benefits packages is mostly based on country self-reporting and sometimes contradictory, and progress appears to be highly variable across countries. The Joint UN Teams on AIDS are assisting governments to establish legal frameworks around social contracting as a critical first step in sustainability of community-led HIV service delivery - efforts which need to be scaled.
<p>Leveraging HIV investments and learnings to strengthen broader health</p>	<ul style="list-style-type: none"> ■ HIV resources could and should be applied to strengthen the wider health system and broader health outcomes. However, the extent to which this has happened is mixed and in many cases HIV investments remain siloed. At country level, despite examples of Joint Programme and individual Cosponsor actions contributing to broader health outcomes, there is little evidence of a strategic and proactive approach by the Joint Programme to leverage the HIV response to achieve this.

Workstreams	Summary of key findings
<p>outcomes (<i>Key findings from EQ 3.1-3.2</i>)</p>	<ul style="list-style-type: none"> ■ The COVID-19 response presents a good example of leveraging HIV investments for broader health gains. However, limited evidence was found of the Joint Programme promoting adoption of adaptations in HIV service delivery developed in response to COVID-19 to improve broader health outcomes (beyond HIV and COVID-19). ■ Lessons from HIV programming, for example, related to community-led interventions, strategies for reaching marginalised and vulnerable populations, including virtual interventions, and activism and accountability, could be adapted and applied more widely.
<p>Equity, gender, and human rights considerations (<i>Key findings from EQ 4.1-4.2</i>)</p>	<ul style="list-style-type: none"> ■ The Joint Programme has made significant efforts to generate strategic information related to key populations but has done less to identify which populations might potentially benefit from service delivery in primary care settings and which might be left behind. The Joint Programme has supported country efforts to improve monitoring of stigma and discrimination in health care settings and to deliver stigma and discrimination-free services, but progress towards the global target of reducing the percentage of key populations who experience stigma and discrimination to less than 10% is off track. The support for the PLHIV Stigma Index surveys, in particular from the UNAIDS Secretariat, has been critical and the results of these surveys serve as a key resource for shaping integrated service delivery models. ■ Integration of HIV services within primary care can potentially improve person-centred care over a life course if managed carefully. Yet, key populations are at risk of being left behind if HIV services are only provided through primary care facilities in public health systems therefore a contextualised approach to integration, together with HIV and key population literacy in primary care contexts, are needed.
<p>Added value and ways of working (<i>Key findings from EQ 5.1-5.2</i>)</p>	<ul style="list-style-type: none"> ■ The Joint Programme has added value to the overall HIV response through its ways of working, comparative advantage, collaboration and synergies, but there is less consensus about whether the Joint Programme brings the same added value to HIV and PHC integration and interlinkages or to a PHC approach that addresses HIV effectively, and most informants are of the view that it has yet to make a significant contribution. ■ The Joint Programme has not been sufficiently strategic about its role in strengthening HIV and PHC integration and linkages, both globally and in specific country contexts, based on where its comparative advantages lie in part due to an unclear Division of Labour (DoL) on the PHC approach and limited leadership of the UNAIDS secretariat. Increasingly constrained financial and human resources have limited the capacity of the Joint Programme to contribute to strengthening HIV and PHC integration and linkages. ■ The Joint Programme could potentially add value to the HIV and PHC agenda through its experience of multisectoral policy and action and community empowerment and participation, and through bringing a human rights, gender and equity lens to bear on primary care and within a UHC context.

Conclusions

Conclusion 1: The Joint Programme has the potential to add value but has not worked optimally to leverage HIV and PHC integration and linkages due to limited leadership coupled with a lack of conceptual clarity, joint strategic frameworks, tracking and accountability mechanisms, and compounded by resource constraints.

There is a consensus that the Joint Programme has the potential to add value to the HIV and PHC integration agenda through its areas of comparative advantage, including leveraging the respective expertise of different UN agencies, convening multiple sectors and partners, generating strategic information, highlighting human rights, gender and equity perspectives, and championing community leadership and voice. However, the evaluation findings show that the Joint Programme has not worked optimally to leverage HIV and PHC integration and linkages, both to improve HIV outcomes and to improve wider health outcomes. This is for a number of interrelated reasons:

- *Lack of leadership and unclear roles:* The Joint Programme is viewed as having had little engagement on HIV and PHC integration and linkages. The issue has not been on the agenda of the PCB and is not seen as a priority for the leadership of the UNAIDS Secretariat at global, regional or country levels. The current DoL is not clear on the roles of the Joint Programme agencies with respect to the three pillars of the PHC approach.
- *Lack of mutual agreement on objectives and definitions:* Although the Global AIDS Strategy sets out broad goals, there is a lack of clear and agreed objectives for the Joint Programme's work on HIV and PHC integration and linkages. There is no common understanding or agreed definitions of PHC or of HIV and PHC "integration" within the Joint Programme and this lack of conceptual clarity has hindered progress.
- *Absence of a joint framework, workplan and accountability mechanism:* Although HIV and PHC integration and linkages is a priority in the Global AIDS Strategy, there is no joint plan to take this agenda forward and it is not mainstreamed within existing Joint Programme mechanisms, for example, the Unified Budget Results and Accountability Framework (UBRAF), regional and country plans, country envelope funding, and the technical support mechanism. There is also no overarching framework or agreed core set of indicators for monitoring Joint Programme action and progress on HIV and PHC integration. There are multiple targets and indicators in different global strategies and monitoring and reporting mechanisms, but also significant gaps in available data. Existing indicators relate to the three pillars of PHC, but there are few indicators that relate to systems integration.
- *Capacity and resource constraints:* UBRAF is not fully funded and Secretariat and Cosponsor UBRAF funding has decreased in recent years. At country level the Joint Programme lacks the financial resources to support joint action on HIV and PHC integration and linkages. The UNAIDS Secretariat has resource constraints at global, regional and country levels. As a result of reduced funding, Cosponsors have fewer staff working on HIV at all levels – reducing their capacity to engage in the Joint Programme and provide support to countries, as well as to engage on issues such as HIV and PHC integration.

Conclusion 2: There has been limited intentional or collective Joint Programme action to promote HIV and PHC integration and linkages. Existing Joint Programme guidance largely focuses on integration of specific health services and there is limited guidance on HIV and PHC integration and linkages with respect to health systems.

There is little evidence of a coordinated Joint Programme or Joint Team approach to HIV and PHC integration efforts supported by UBRAF funding or planning. The Joint Programme has had a longstanding focus on multisectoral policy and action and empowering people and communities in HIV responses, but action on integration of HIV within primary care has mostly been driven by individual Cosponsors, based on their specific mandates and using their own funding. The evaluation identified a range of political, policy, institutional, financing, health system, legal and other enablers

and barriers to HIV and PHC integration and linkages, but little evidence of Joint Programme action to systematically identify or address such enablers and barriers.

Many examples of integration efforts promoted in Joint Programme global guidance documents involve 'clustering' where one or two services or programmes are added to HIV service delivery or vice-versa. This makes sense for HIV co-morbidities and may be pragmatic as part of a phased approach, but it does not necessarily build links with broader PHC services, integrate HIV systematically with essential health service packages, or support health system level integration. Furthermore, there is a lack of knowledge and consensus on what works, for whom, and in what contexts and the evaluation found few examples of Joint Programme support to countries to assess the implications of service integration or to operationalize integration in a way that meets the needs of populations and is appropriate to the country epidemiological and health system context.

Conclusion 3: There is limited documented evidence that the HIV response has strengthened wider health systems. Many lessons from the HIV response, including adaptations in response to COVID-19, have potential applicability to a successful PHC approach, but these have not been systematically promoted or adopted for the achievement of broader health outcomes.

The extent to which HIV investments, infrastructure, capacity, and systems established for the HIV response – for example, community and other health workers, laboratories, supply systems, and infrastructure – have strengthened wider health systems is unclear. Although there is a widely held perception that the HIV response has strengthened national health systems, there is limited robust and well-documented evidence to support this thinking. However, there are documented examples of this related to COVID-19. The actions of the Joint Programme and individual Cosponsors in supporting the COVID-19 response demonstrate how HIV platforms and lessons can be leveraged for other disease programmes and in response to a public health emergency.

The evaluation identified areas where lessons from the HIV response could be adapted and applied more widely to benefit other health areas and further the PHC approach. These included: differentiated service delivery; person-centred strategic information; use of digital technology and virtual approaches; multisectoral action; community-based and community-led interventions; strategies for reaching marginalised and vulnerable populations; and activism and accountability.

Conclusion 4: The Joint Programme has had a strong focus on the financial sustainability of the HIV response, including promoting HIV services in health benefit packages for UHC and supporting countries to establish frameworks for social contracting.

Successive global AIDS strategies have recognised that the current financing agenda is not about HIV alone but situated within the context of UHC. However, there is a lack of clarity about what this means in practice apart from HIV services being included in health benefit packages.

The extent to which HIV services are included in country health benefits packages is highly variable and, in some cases this has yet to happen because HIV programmes continue to be well funded by external donors. While many countries report that ART services, for both treatment and prevention, are financed as part of overall health systems, other HIV services – especially HIV prevention – are not consistently included in health benefits packages in countries scaling or introducing UHC and the Joint Programme could do more to advocate for this. The Joint Programme has been active in supporting countries to establish frameworks for social contracting to enable governments to fund civil society organizations to deliver HIV services, but such approaches need to be stepped up to ensure the sustainability of services for key populations, in particular HIV prevention services.

Conclusion 5: The Joint Programme has a critical role to play in promoting and protecting the delivery of HIV services for key populations and ensuring that human rights, gender and equity issues are addressed within PHC oriented health systems.

Integration of HIV services within primary care facilities has the potential to increase the availability and accessibility of these services, in addition to improving person-centred care, addressing multiple health needs and improving HIV outcomes. However, key populations are at risk of being left behind. The evaluation highlighted significant concerns about the potential adverse effects of integrating HIV services into primary care facilities and identified a need for a context-specific approach to integration and linkages, including sustaining specialised service delivery and community-led services for key populations in parallel with primary care setting integration efforts.

The Joint Programme has a strong track record in supporting key populations, in highlighting equity, gender and human rights issues that influence HIV vulnerability and access to services, and in supporting efforts to monitor and address stigma and discrimination in health care settings. The evaluation found that the Joint Programme also has a critical role to play in promoting and protecting the delivery of HIV services for key populations in the context of HIV and PHC integration and convergence efforts. Yet, there were few examples of proactive efforts to date by the Joint Programme to ensure that the needs of key populations and equity, gender, and human rights issues are addressed in the context of integrating HIV within primary care settings.

Recommendations

The evaluation recommends the following steps between now and 2026 to strengthen HIV and PHC outcomes through leveraging convergence points and the comparative advantage of the Joint Programme.

Recommendation 1: As an urgent priority, ensure conceptual clarity, shared understanding, and consistent application of relevant established definitions (PHC, primary care, integration, and convergence), and develop a shared vision on HIV and PHC integration and convergence. (Action: UNAIDS Secretariat and Cosponsors - Global level, by end June 2024)

The Joint Programme (Secretariat and relevant Cosponsors) should first ensure that they have a common understanding of established definitions of PHC, primary care, integration and linkages, and convergence. These definitions should be clearly aligned in key guidance documents and strategies developed by the Secretariat and Cosponsors going forward.

The Joint Programme (Secretariat and relevant Cosponsors) should further articulate its vision and overall objectives in relation to HIV and PHC integration and linkages and sustainability in the context of the current Global AIDS Strategy and UBRAF – both for HIV outcomes and wider health outcomes. This should reflect the ToC and underlying assumptions developed for this evaluation.

Recommendation 2: As an urgent priority, revisit the Division of Labour (DoL) in relation to the three pillars of the PHC approach and ensure buy-in of leadership. (Action: UNAIDS Secretariat to lead ensuring all Cosponsors involvement - Global level, by end June 2024).

A precondition for successful work on the HIV and PHC integration agenda will be to ensure buy-in from the UNAIDS Secretariat and Cosponsor leadership at global, regional, and country levels and agreement on the DoL. Building on global level discussions in relation to recommendation 1, the Joint Programme should review the DoL in relation to the three pillars of the PHC approach, and agree on roles and responsibilities.

Recommendation 3: As an urgent priority, review and update UBRAF PHC related 2025 milestones and 2026 targets as part of the implementation of the 2024–2025 Biennial Workplan and Budget. (Action: UNAIDS Secretariat to lead, involving all relevant Cosponsors - Global level, by end June 2024)

Most 2025 milestones and 2026 targets for UBRAF indicators related to the PHC approach have already been reached. To meet Global AIDS strategy targets, the Joint Programme should set more ambitious milestones and targets for such indicators for 2025 and 2026.

Recommendation 4: As a high priority, develop global guidance on HIV integration with broader health systems, engage people living with HIV (PLHIV) and key population organisations in the HIV and PHC integration agenda and support countries with situational assessments, sustainability planning and country roadmaps for integration based on equity considerations. (Action: UNAIDS Secretariat and WHO leading in collaboration with relevant Cosponsors - Global and regional levels, by end December 2024)

The evaluation found that key gaps include implementation guidance and support for HIV systems integration and convergence with wider health systems, and for operationalisation of HIV and PHC integration and linkages – specifically what and how to integrate in different epidemic and health system contexts. The evaluation identified some critical and time-sensitive actions where the Joint Programme can support countries and regions before development of the next UBRAF (for the period beyond 2026). These include:

- **Develop global guidance on HIV integration with respect broader health systems** and support countries with technical assistance to explore context specific opportunities to strengthen health systems more widely and for HIV responses to leverage health system strengthening efforts. This guidance could **draw on lessons from various contexts and from the COVID-19 response**. (Global level).
- **Engage in consultations with PLHIV and key population organisations and consider operational research** to identify and document the benefits and risks of increased integration of HIV services in primary care settings for key populations. (Global and regional levels)
- To achieve current targets related to integration of services, **support countries with technical assistance for country specific situational assessments and development of country roadmaps on what and how to integrate at country level**, building on the UNAIDS' HIV inequalities framework and toolkit and potential stigma index findings to inform feasible and appropriate integrated service delivery models. (Global and regional levels). Consider targeting priority countries for regional and country Joint Team support, based on consultation with country stakeholders and partners. This could also be informed by the consultation process that UNAIDS is facilitating with PEPFAR on sustaining the HIV response. (Global and regional level)

Recommendation 5: As a high priority, harmonise country Joint UN Team on AIDS plans with national health sector plans, strengthen coordination, enhance advocacy for inclusion of HIV services in health benefit packages and social contracting mechanisms, and assess and monitor equity dimensions. (Action: UNAIDS Secretariat and Joint Teams at country levels, by end December 2024)

The evaluation identified critical areas for the Joint Teams to work on at country level to enhance alignment, sustainability and equity concerns in relation to HIV and PHC integration efforts.

- **Align country Joint Team plans, with national health sector plans** to strengthen sustainability and to leverage existing mechanisms, for example, country envelope funding, and technical support mechanisms.
- **Ensure a coordinated Joint Team approach to HIV and PHC integration efforts by leveraging existing partner platforms**, including e.g., country health sector partners' coordination

mechanisms, SDG3 GAP where applicable, and UNSDCF. Ensure HIV stakeholders and key population involvement and dialogue with UHC stakeholders, platforms, and fora.

- **Strengthen advocacy for inclusion of HIV services, including prevention interventions, in health benefits packages**, and establish frameworks for social contracting to enable governments to fund civil society organizations to deliver sustainable HIV services for PLHIV and key populations.
- **Ensure human rights, gender, and equity considerations are prioritised in all HIV integration efforts** through assessments, consultations, analysis of data to understand country needs and contexts, and delivery of tailored support to ensure no-one is left behind.

Recommendation 6: In the process of developing the next Global AIDS Strategy and the next UBRAF (including Country Envelopes) specify the HIV and PHC integration priorities of the Joint Programme with clear actions in the UBRAF alongside a detailed Theory of Change (ToC). *(Action: UNAIDS Secretariat and relevant Cosponsors - Global level, by end December 2025)*

Actions to be prioritised based on where the Joint Programme can most add value:

- **Providing thought leadership and generating evidence** to make the case for context-specific HIV and PHC integration and linkages, including operational research to identify and address barriers to HIV and PHC convergence.
- **Building political commitment for sustainable HIV financing** in the context of PHC, essential health service packages and UHC and for greater convergence of HIV and PHC in health policy, systems, programmes and service delivery.
- **Providing coordinated support to countries for HIV and PHC integration and linkages**, based on country priorities, including provision of technical assistance for assessment of integration aspects, and implementation guidance, in collaboration with other partners and platforms, including the Global Fund, PEPFAR, and SDG 3 GAP.
- **Conducting policy dialogue and monitoring** to ensure that integration approaches take account of equity, human rights and gender issues and systems and services continue to meet the needs of key populations.
- **Continuing to champion the rights and needs of PLHIV, key populations, women and young people** and support community involvement and community-led service delivery, and monitoring the implications and impact of HIV and PHC integration on service access and uptake, including using strategic information.
- **Documenting and sharing approaches and lessons** that have the potential to improve HIV and wider health outcomes, including tailored responses and decentralised service delivery, strategies for reaching marginalised and vulnerable populations, use of virtual approaches, and documenting and sharing effective models of HIV and primary care integration.

The Joint Programme (Secretariat and relevant Cosponsors) should review and prioritise these areas based on the following criteria:

- Which of these areas of activity will contribute most to achieving the intended objectives?
- Which are a priority at global level? Which are a priority at regional level? Which are a priority at country level?
- Where can the Joint Programme most add value together, at global, regional and country levels? What can be left to other actors and initiatives?
- What can the Joint Programme realistically do with available resources and capacity, at global, regional and country levels?

Recommendation 7: Strengthen accountability for HIV and PHC integration and linkages within the next UBRAF indicator framework by ensuring that key Joint Programme and individual Cosponsor actions and results are monitored. (*Action: Led by UNAIDS Secretariat, Global level, by end December 2025*)

Aligned to the next Global AIDS strategy and UBRAF (beyond 2026), the corresponding UBRAF indicator monitoring framework should present clear outcome and output indicators related to HIV and PHC integration and linkages, while ensuring appropriate milestones.

Key areas of monitoring/ indicators for the Joint Programme could be around:

- HIV service integration into health benefits packages
- Social contracting indicators
- Health system level integration indicators
- Health services integration indicators
- Human rights, gender, and equity indicators on integrated service delivery models
- Donor resources for HIV and PHC integration efforts, including through PEPFAR, the USAID Primary Impact Initiative, and Global Fund Resilient and Sustainable Systems for Health (RSSH) funding.

1. Introduction

1.1 Background

The HIV response has historically, in most low- and middle-income countries (LMICs), been implemented through a disease-specific programme approach, with funding from external donors rather than from domestic financing. The establishment of such programmes reflected the need, initially, for an emergency response to HIV and resulted in the establishment of separate HIV clinics, services delivered by specialised HIV providers, and parallel HIV data information and laboratory systems. While this is reported to have reduced AIDS-related deaths through the effective roll out of HIV treatment¹, it has also, in some contexts, distorted health budgets, priorities and infrastructure and contributed to health system inefficiencies and fragmentation.^{2 3 4} There have also been concerns about the sustainability of HIV-specific programmes and the extent to which these programmes meet the needs of people living with HIV over the life-course.⁵ A recent meta-analysis shows that integration of HIV services and other health services can improve HIV and health systems outcomes, while simultaneously supporting progress towards the Sustainable Development Goals (SDGs) and universal health coverage (UHC).⁶ Another review highlights missed opportunities for vertical programmes to build stronger health systems.⁷

More recently, the funding landscape and service delivery have evolved, with major donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the United States President's Emergency Plan for AIDS Relief (PEPFAR) increasingly supporting health system strengthening, and several countries now providing HIV services through primary care. This reflects developments over the past decade including an increased share of domestic financing of HIV and governments looking for more sustainable ways of funding the HIV response in addition to global commitments made to Health for All, captured in SDG 3, to UHC as a means to achieve SDG 3, and a reinvigoration of the Primary Health Care (PHC) approach (see Box 1). In addition, the COVID pandemic put spotlight on the need to build more resilient health systems and increased momentum for PHC.

¹ [UNAIDS update September 2021: Global roll-out of HIV treatment has saved millions of lives](#)

² Regan L, et al. The journey to UHC: how well are vertical programmes integrated in the health benefits package? A scoping review. *BMJ Global Health*. 2021; 6(8):e005842. doi: <http://dx.doi.org/10.1136/bmjgh-2021-005842>

³ Ooms, G., Van Damme, W., Baker, B.K. *et al.* The 'diagonal' approach to Global Fund financing: a cure for the broader malaise of health systems?. *Global Health*. 2008; 4:6. doi: <https://doi.org/10.1186/1744-8603-4-6>

⁴ Biesma RG, et al. The effects of global health initiatives on country health systems: a review of the evidence from HIV/AIDS control. *Health Policy Plan*. 2009;24(4):239-52. doi: <https://doi.org/10.1093/heapol/czp025>

⁵ Bulstra CA, et al. Integrating HIV services and other health services: A systematic review and meta-analysis. *PLoS Med*. 2021; 18(11):e1003836. doi: <https://doi.org/10.1371/journal.pmed.1003836>

⁶ Bulstra CA, et al. Integrating HIV services and other health services: A systematic review and meta-analysis. *PLoS Med*. 2021; 18(11):e1003836. doi: <https://doi.org/10.1371/journal.pmed.1003836>

⁷ Rao KD, et al. When do vertical programmes strengthen health systems? A comparative assessment of disease-specific interventions in India. *Health Policy Plan*. 2014;29(4):495-505. doi: <https://doi.org/10.1093/heapol/czt035>

Box 1: The PHC approach and its components⁸

PHC is “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”.

1. **Integrated health services with an emphasis on primary care and public health functions:** meeting people’s health needs through comprehensive promotive, protective, preventive, curative, rehabilitative and palliative care throughout the life course, strategically prioritizing key health care services aimed at individuals and families through primary care and the population, with essential public health functions as the central elements of integrated health services.
2. **Multisectoral policy and action:** systematically addressing the broader determinants of health (including social, economic and environmental factors, as well as individual characteristics and behaviour) through evidence-informed policies and actions across all sectors.
3. **Empowered people and communities:** empowering individuals, families, and communities to optimize their health, as advocates of policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and caregivers.

The global health community has identified PHC as central to the achievement of UHC, through building more resilient health systems that will deliver quality, affordable health care to all, especially the most vulnerable. PHC is at the heart of several global accords, including the Declaration of Astana (2018), which identifies the three components as the basis of the PHC approach.⁹ The 2023 UN High Level Meeting on UHC on 21 September 2023 highlighted the critical importance of PHC, with the Political Declaration recognising the fundamental role of PHC in achieving UHC and other Sustainable Development Goals and targets.¹⁰ In October 2023, at the International Conference on Primary Health Care in Astana, 70 countries committed to step up primary health care investments by 2030.

The 2020 WHO-UNICEF Operational Framework for Primary Health Care translates the Astana Declaration and PHC approach into 14 strategic and operational levers, aimed at reorientating country health systems towards PHC and accelerating progress towards UHC.¹¹

In 2016, in the 2016-2021 Unified Budget, Results and Accountability Framework (UBRAF), the Joint United Nations Programme on HIV/AIDS (Joint Programme) committed to people-centred HIV and health services integrated in the context of stronger systems for health. A new UBRAF for the period 2022-2026 was developed in 2021, which has a stronger focus on “integrating HIV with PHC”. “PHC” is directly mentioned under the UBRAF areas for priority as follows:

- Fully funded and sustainable HIV responses: Provide technical advice, capacity building and analytical work to help countries get greater value from existing resources and better integrate HIV and COVID-19 services into essential primary health-care services (e.g., through allocative efficiency, cascade analytics, inclusion of HIV in health benefits packages and improved support in primary health care).
- Community-led responses: Strengthen collaboration and alignment between the health systems and community systems to improve access to quality, people-centered, and integrated HIV services (SRH/TB/sexually transmitted infections (STIs)/non-communicable diseases (NCD)) at the primary health care level, within the health sector in order to achieve universal health coverage.

⁸ [Operational Framework for Primary Health Care](#). Geneva: WHO and UNICEF; 2020.

⁹ [Operational Framework for Primary Health Care](#). Geneva: WHO and UNICEF; 2020.

¹⁰ Political Declaration of the HLM on UHC. 78/4. Resolution adopted by the General Assembly 5 October 2023.

¹¹ [Operational Framework for Primary Health Care](#). Geneva: WHO and UNICEF; 2020.

These priority areas do not fully reflect the PHC approach or components, and the UBRAF does not include any additional detail about specific activities or areas of work or result areas for the Joint Programme related to the PHC approach.¹²

Also in 2016, at the United Nations General Assembly, Member States adopted the Political Declaration on HIV and AIDS¹³, which includes the overarching theme of “taking AIDS out of isolation”. Among the commitments made by Member States is the “delivery of more integrated services for HIV, TB, viral hepatitis, sexually transmitted infections, NCDs, including cervical cancer, drug dependence, food and nutrition support, maternal, child and adolescent health, men’s health, mental health and sexual and reproductive health, and to address gender-based and sexual violence...”. The 2021 Political Declaration on HIV and AIDS¹⁴ has a stronger focus on multisectoral action, communities and health systems, includes targets for 2025 related to UHC and integration and specific indicators for monitoring progress through Global AIDS Monitoring.

The UNAIDS 2016-2021 strategy¹⁵ called for expanding HIV-sensitive UHC and social protection and urged countries to address UHC dimensions in planning HIV responses. The Global AIDS Strategy 2021-2026¹⁶ applies an inequalities lens to closing the gaps that are preventing progress towards ending AIDS and highlights the need for:

- innovative alliances, with and within governments’ health and other sectors, community-led organisations, donors, programme implementers and other partners;
- linkages between HIV and the broader efforts on strengthening systems for health;
- reaching UHC;
- improving sexual and reproductive health;
- addressing communicable diseases other than HIV, NCDs; and
- other health issues frequently associated with HIV, in order to end AIDS as a public health threat by 2030.

The Strategy includes a specific strategic priority of ensuring resilient and sustainable systems for health and integrated people-centred systems and services (Result Area 9)¹⁷, calls for fully recognized, empowered, resourced and integrated community-led HIV responses for a transformative and sustainable HIV response (Result Area 4), and highlights the contribution of HV-PHC to achieving UHC. Integrated people-centred and local context specific systems and services are also a critical part of Result Area 2.

The UNAIDS Secretariat, together with four Joint Programme Cosponsors (UNFPA, UNICEF, WHO, and the World Bank) commissioned Euro Health Group (EHG) to conduct an independent evaluation of the Joint Programme’s work on HIV integration and interlinkages with PHC to assess progress and identify opportunities for the Joint Programme to strengthen HIV and PHC outcomes in the future. The evaluation was being carried out as part of the 2022-2023 evaluation plan approved by the UNAIDS Programme Coordinating Board (PCB) in December 2021.¹⁸

The evaluation was coordinated with a concurrent evaluation of the WHO Special Programme on PHC which was also conducted by EHG. There has been an intentional overlap of evaluation team members and evaluation reference group (ERG) members across the two evaluations as well as synergies on data collection methods, data analysis and reporting.

¹² [2022-2026 UBRAF Outputs and Indicators](#). Geneva: Joint United Nations Programme on HIV/AIDS; 2021.

¹³ [Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030](#). Geneva: United Nations General Assembly; 2016

¹⁴ [Political declaration on HIV and AIDS: ending inequalities and getting on track to end AIDS by 2030](#)

¹⁵ [On the Fast-Track to end Aids](#). Geneva: Joint United Nations Programme on HIV/AIDS; 2015.

¹⁶ [Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS](#). Geneva: Joint Programme; 2021.

¹⁷ Strategic Priority 3: fully resource and sustain efficient HIV responses and integrate them into systems for health, social protection, humanitarian settings and pandemic responses.

¹⁸ [Annual report on Evaluation and Evaluation plan 2022-2023](#). Geneva: Joint Programme; 2021.

1.2 Objectives and scope of the evaluation

The evaluation has been primarily designed for learning and planning purposes. The main objective was to conduct a forward-looking process evaluation that identified opportunities for the Joint Programme to strengthen HIV and PHC integration and linkages, at the same time as assessing, as far as possible, what the Joint Programme has achieved. Specifically, and according to the TORs (Annex 1) the evaluation is expected to:

- Identify how Joint Programme efforts to address HIV have been – conceptually and operationally – linked to the PHC approach, how the Joint Programme has supported integration of HIV into PHC and how this potentially has improved HIV prevention, testing and treatment outcomes but also how this may have strengthened PHC outcomes more broadly, e.g., improving the ability of health systems to care for people with chronic illnesses.
- Provide clear recommendations to accelerate and prioritise Joint Programme actions related to HIV and PHC including what it could do better, differently or more of in future and how it can support the sustainability of HIV responses and ensure reaching 2025 HIV targets and UHC by integrating HIV into PHC where and when this is appropriate.

The evaluation objectives are reflected and elaborated in the evaluation questions (EQs) and sub-questions (see section 2.4).

The temporal scope of the evaluation covered the period January 2020 to end of July 2023. The geographical scope included global, regional (mainly through key informant interviews) and country levels, with country data collected mainly through four in-depth country case studies (Angola, Botswana, Indonesia and Pakistan). The evaluation assessed the contribution, role and activities of the Joint Programme focusing on the UNAIDS Secretariat and four Cosponsors (WHO, UNICEF, UNFPA and the World Bank) in line with the TORs (see Annex 1). Through country case studies, the evaluation included all relevant Cosponsors at country level.

The technical scope considers the PHC approach with three main components: primary care and essential public health functions as a core of integrated health services; multisectoral policy and action; and empowered people and communities (Box 1). The evaluation explored evidence on Joint Programme actions in relation to all three PHC components. However, with respect to multisectoral policy and action, it was not feasible to cover all activities of the Secretariat and the four Cosponsors in all sectors at all levels. Action related to other sectors beyond the health sector were only considered in the country case studies. This scope restriction was agreed in the approved inception report to manage a potentially very large scope for this evaluation.

The evaluation does not include a scoping review or a systematic review of peer-reviewed articles, although published research in the form of systematic reviews and meta-analyses since 2018 has been reviewed for evaluation questions that explored issues beyond the context of the Joint Programme. Furthermore, at country level, the evaluation was not able to assess the current state of PHC and systems for health in respective countries to make a specific case for what to integrate HIV into/with as this requires substantive assessments which were not feasible within the resource and timeframe for the evaluation. Finally, the evaluation was not intended to include a detailed assessment of UNAIDS Secretariat and Cosponsor capacity.

2. Evaluation design, approaches and methodology

2.1 Theory based process evaluation

The design of the evaluation was primarily that of a **process evaluation**, which is typically applied to examine the nature and quality of implementation of an intervention/programme/strategy. A process evaluation is also appropriate for evaluating ongoing strategy implementation, with a focus on the mechanisms for change – ‘how’ and ‘why’ change occurred, or not – as well as on questions of what happened, when and for whom and identifying barriers and/or facilitating factors.

The evaluation was based on a **theoretical framework – a constructed Theory of Change (ToC)** (see Annex 2) and sought to test the links in the causal chain laid out in the ToC. The focus was on the links from input to output and intermediate outcome levels, as well as the assumptions upon which the theory is based. The evaluation analysed available evidence and data to assess whether the ToC and the assumptions were sound and relevant to the future direction for the Joint Programme.

2.2 Utilization-focused and gender, equity and social inclusion responsive approach

The evaluation adopted a utilisation-focused evaluation¹⁹ approach which aims to ensure that the evaluation process, findings and recommendations are owned and used by the Joint Programme. This approach is intended to enable global, regional, and country stakeholders to reflect on the relevance, coherence, efficiency, and effectiveness of the work of the Joint Programme on HIV and PHC. A key aspect has been the engagement of the Secretariat and relevant Cosponsors in the evaluation design, implementation, and analysis. This engagement has been operationalised through:

- **The UNAIDS Evaluation Office** who has helped steer and facilitate the evaluation and provide overall quality assurance. The evaluation team has engaged with the UNAIDS Evaluation Office on a regular basis to ensure the technical and managerial direction of the evaluation remained on track.
- **The Evaluation Reference Group (ERG)** who has provided advice throughout the evaluation including reviewing the ToRs, ToC and evaluation questions; reviewing the inception and draft final report; and acting as a source of knowledge for the evaluation. The team has engaged with the ERG at critical junctures during the evaluation process including on matters related to the evaluation approach and design, findings, and conclusions.
- **The Evaluation Management Group** who has ensured that all reports are of high quality; provided oversight and helped guide the evaluation team especially during the inception phase and facilitated the evaluation while ensuring the independence of the evaluation.

The evaluation was also designed and implemented in a way that is gender, equity, and social inclusion (GESI) and human rights responsive and gives due consideration to assessing potential gender or equity concerns. The evaluation incorporated GESI and human rights principles through:

- having a dedicated evaluation question (EQ4) related to exploring gender, equity and human rights aspects.
- having a designated team member responsible for leading efforts to integrate this approach throughout the evaluation’s methods, tools, analysis, and findings.
- triangulating data sources to help interpret quantitative data findings on health equity, gender equality, inclusion, and human rights.

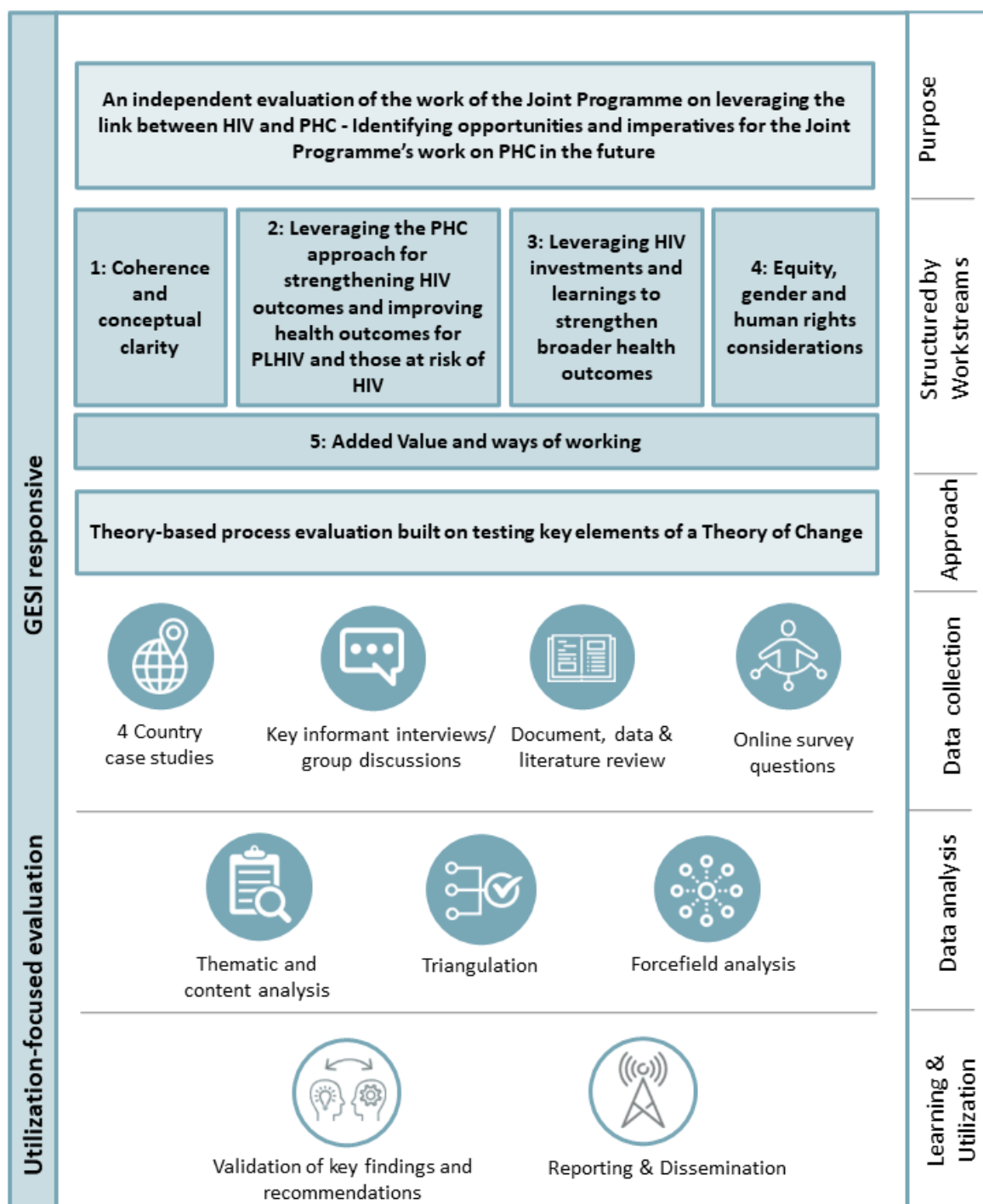
¹⁹ [Utilisation-focused evaluation](#). Better Evaluation; 2021.

- ensuring that all diverse group of stakeholders was consulted and treated with integrity and respect for confidentiality, and upholding ethics standards²⁰ to ensure protection of human rights during the conduct of the evaluation.
- disaggregated data presentation and analysis provided whenever available and relevant.
- having a gender-focused team with multiple women in senior roles.

Figure 1 provides an overview of the evaluation including its purpose, workstreams, approach, and data collection and analysis methods.

²⁰ UNEG Ethical Guidelines for Evaluation, 2020 (<https://www.unevaluation.org/document/detail/2866>)

Figure 1. Evaluation framework



2.3 Theory-driven evaluation

The evaluation is theory-driven and involved the development of a theory of change (ToC) (see Annex 2) which has served as an overall analytical framework for the evaluation. During the inception period the team developed a ToC outlining the relationships between the Joint Programme activities and interventions and how these are expected to strengthen HIV and PHC integration and linkages, and related assumptions and risks. The process of developing the ToC involved:

- Document review of key frameworks, policies, and UBRAF documents to enable the evaluation team to ‘back map’ the results chain from impact and outcomes to inputs and develop the assumptions.

- Group discussions/key informant interviews with Secretariat and cosponsor representatives and the ERG to gather inputs to inform the ToC.
- Iteration of the ToC, following further consultations and comments received from the ERG on the first draft ToC.

To generate evidence for the evaluation questions (see Table 1), related assumptions about how change is expected to happen were developed along with the ToC and these have assisted in the collection, analysis and synthesis of data and evidence from all sources. The theory of change also provides the foundation for the evaluation matrix’s assumptions, indicators, and data sources (see Annex 4), as well as structuring the tools for data collection including the documents to be reviewed, the question guides, and the formats for the case study reporting. The synthesis and reporting phase of this evaluation focused on validating or refuting theory of change assumptions, developing findings informed from all sources of data and developing conclusions and recommendations. An assessment of the ToC is provided in Annex 3.

It is important to note that this ToC has a wider scope than that of this evaluation. The evaluation focused on specific aspects of the ToC in line with the ToR (the evaluation questions are mapped on to the ToC including the critical assumptions – See Annex 2).

2.4 Evaluation questions

Five evaluation questions (EQs) and 13 sub-questions, based on adapted OECD DAC evaluation criteria, the ToR and the ToC, were identified to enable the scope and objectives of the evaluation to be achieved (see table below). These should be read in conjunction with the TOC and evaluation matrix (See Annex 4) which presents evaluation question with related critical assumptions, key performance indicators and data/evidence sources.

Table 1: Evaluation questions

Workstream 1: Coherence and conceptual clarity
EQ1: To what extent is there conceptual clarity and internal coherence within the Joint Programme (WHO, UNICEF, UNFPA, World Bank, and the Secretariat) and external coherence with other actors in relation to leveraging HIV and PHC integration and linkages? (Relevance/Coherence)
<p>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?</p> <p>1.2 To what extent are relevant goals, plans, strategies, and activities harmonised and aligned internally within the Joint Programme at global, regional and country levels?</p> <p>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 (e.g., PEPFAR, Global Fund)?</p>
Workstream 2: Leveraging the PHC approach for strengthening HIV outcomes and improving health outcomes for PLHIV and those at risk of HIV
EQ2: To what extent is the Joint Programme applying the PHC approach 21 to HIV responses and what are the achievements and lessons learned? (Relevance/Effectiveness/Sustainability)
2.1 What has been achieved since 2020 in terms of applying a PHC approach to HIV responses (primary care and essential public health functions as the core of integrated health services ²² , multisectoral policy and action ²³ , empowering people and communities)?

21 PHC approach defined as: (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.

²² E.g. strengthen health and community systems that deliver HIV specific goals and strengthen PHC, including integrated delivery of HIV services with other services (limitations as per scope limitation section)

²³ Multisectoral policy and action only considered in the four country case studies and possibly in the additional country for some data collection in synergy with the WHO evaluation as per scope limitations.

<p>2.2 What is the Joint Programme doing to build political commitment for sustainable HIV financing in the context of PHC?</p> <p>2.3 What are the main enablers and barriers to integrating HIV into PHC in various contexts? How is the Joint Programme addressing these at country level?</p>
<p>Workstream 3: Leveraging HIV investments and learnings to strengthen broader health outcomes</p>
<p>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? (Relevance/Effectiveness/Efficiency)</p>
<p>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 outcomes²⁴? Are there any untapped opportunities?</p> <p>3.2 To what extent is the Joint Programme using and promoting wider adoption of adaptations in service delivery developed in response to COVID-19²⁵ to improve broader health outcomes?</p>
<p>Workstream 4: Equity, gender, and human rights considerations</p>
<p>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? (Relevance/Equity)</p>
<p>4.1 Which locations and population groups are potentially benefitting or being left behind?</p> <p>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?</p>
<p>Workstream 5: Added value and ways of working</p>
<p>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? (Effectiveness/Efficiency)</p>
<p>5.1 What is the added value of the Joint Programme in terms of leveraging HIV and PHC interlinkages? (Joint Programme ways of working, collaboration, synergies, and comparative advantages)?</p> <p>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?</p>

²⁴ e.g. chronic disease management, health systems strengthening, etc.

²⁵ e.g. telemedicine, digital technology, community-based responses, differentiated service delivery models etc.

3. Evaluation methods

3.1 Data collection methods

The evaluation used a mixed method approach combining qualitative and quantitative methods for data collection, review, triangulation, and analysis. Evidence generated from different sources has been consolidated in evidence matrices structured around the evaluation questions and sub-questions. This facilitated triangulation and analysis, as well as allowing evidence for the recommendations in the final report to be ‘traced’ to the data upon which they are based.

Document and data review – included a comprehensive and structured review of key policies, strategies, frameworks, technical briefs, normative guidance, documents, plans, reports, meetings notes, and webinars since January 2020. Dashboards and databases were also reviewed to assess progress on available related indicators. An overview of the documents and databases reviewed with a complete list of documents reviewed can be found in Annex 12.

Stakeholder mapping – was undertaken to guide the final selection of stakeholders to be consulted. A summary of the stakeholder groups can be found in the table below with a more detailed overview of the type of stakeholder consulted found in Annex 7.

Key informant interviews and group discussions – served as a critical data source for the evaluation. Key informants were identified at the country level through a stakeholder mapping developed in consultation with the UNAIDS Country Director and Cosponsors. At the global level, the UNAIDS Secretariat Evaluation Office developed an initial list of key informants based on the stakeholder mapping that was supplemented by suggestions from Cosponsors and Evaluation Reference Group members. A limited number of interviews were developed through ‘snowball’ sampling. Interview guides for the principal stakeholder groups were developed and adapted to different country contexts and audiences. A summary of the number of key informants by stakeholder group and level (global, regional, and country) is found in the table below. A more detailed list of key informants at global and regional level is available in Annex 11, and in country case study reports.

Interviews with stakeholders at global and regional levels were conducted virtually, whereas interviews and focus group discussions were conducted face to face at country level in the four case study countries. Altogether, 491 people had an opportunity to share their experiences and opinions through the evaluation. (Table 2) Of key informants at global/regional level, 56% identified as female²⁶.

Table 2: Number of informants interviewed or participating in focus group discussions

	Global level	Regional level	4 country case studies
UNAIDS Secretariat	9	15	25
Cosponsors	13	21	75
Governments	1	N/A	87
Civil Society	7	0	117
International partners/ Donors	10	0	38
Academia	1	0	7
Health facility			64
Private sector			1
Total number of informants	41	36	414

²⁶ Gender disaggregated data were not comprehensively available for informants at country level

Country case studies – a structured case study approach in four countries has provided more detailed information and analysis of Joint Programme interventions, results, and outcomes across different contexts, and has enabled a more comprehensive nuanced understanding of Joint Programme support and contribution to ensuring HIV integration and interlinkages in PHC. The rationale for the countries selected is outlined in Box 2 with more details in Annex 10.

Box 2: Summary of country case study selection

The countries for this evaluation were purposively selected to identify countries with differing HIV contexts, different regions, socioeconomic contexts, and presence of Cosponsor engagement. The following criteria were used to generate the sample of case study countries:

- Criteria 1:** Representing different regions.
- Criteria 2:** Representing different HIV contexts (countries with a high burden of HIV as well as countries with concentrated HIV epidemics) and population groups (including key populations and young people)
- Criteria 3:** Representing different health system contexts.
- Criteria 4:** Presence of the UNAIDS Secretariat and at least WHO, UNICEF and UNFPA offices and country office capacity to support the evaluation.

Based on the above criteria, the following countries were selected and have undertaken country case studies:

Country	Region
■ Angola	East and Southern Africa
■ Botswana	East and Southern Africa
■ Indonesia	South-East Asia
■ Pakistan	Eastern Mediterranean Region

Data collection methods for country case studies included: document and data review; key informant interviews; focus group discussions; and field visits. The methodology for country case studies is included in Annex 10 and the four country case study reports are included in a separate document Volume II: Country Reports.

Online survey – an online survey was conducted to collect data on the progress and opportunities for integration and interlinkages of HIV across countries and regions focusing on certain evaluation questions. A set of eight questions was formulated and translated from English to Spanish and French. The questions were distributed in two ways using the online tool Survey Monkey.

The first mode of distribution entailed sharing the survey with UNAIDS Secretariat and Cosponsor staff (n=847 potential respondents). The second mode of distribution entailed embedding the questions in the concurrent Evaluation of the WHO Special Programme on PHC (SP-PHC) online survey implemented by EHG. This second step was undertaken to generate additional data and evidence for some of the EQs at regional and country level. To that extent the survey was sent to WHO PHC Policy Advisors and Country Representatives, some of which forwarded the survey to Ministry of Health representatives (104 countries in total; total number of potential respondents is not known). Both surveys were live from 21 July to 31 August 2023. Three reminder emails were sent to survey respondents during this period.

In total, 174 responses were received through the UNAIDS specific evaluation survey corresponding to a 21.5% response rate. In addition, 54 respondents completed the questions through the SP-PHC evaluation survey. Therefore, in total 228 individuals responded to the eight questions. Of the total number of respondents 110 (49%) identified as female. The survey questions along with the key results can be found in Annex 6.

3.2 Data analysis, synthesis, and development of recommendations

For all data collected through the methods described above, the evaluation employed a range of approaches to analyse, validate and synthesize the evidence including the ToC and its assumptions. OECD DAC evaluation criteria were also used to analyse the design and interventions related to HIV integration and interlinkages within PHC including the activities at country level. All raw data were collected in evidence matrices based on the assumptions and evaluation questions. This ensured the analysis considered and triangulated all relevant secondary and primary data collected, thereby reducing the risk of evaluation bias, and improving the robustness of findings. The evaluation team also undertook analysis of evidence and findings within and across country case studies and synthesis of global findings against the theory of change.

The core evaluation team undertook a data analysis/findings workshop in early September to review the evidence from all sources, conduct structured analysis of findings based on key areas of the evaluation framework and ToC, and identified key findings, conclusions, and recommendations across all evaluation questions.

3.3 Limitations

Highlighted below in Table 3 are a range of key limitations encountered during the evaluation process and related mitigation strategies that will help aid in the interpretation of this report.

Table 3: Limitation and mitigating actions

Limitations	Mitigation strategies
Limited number and choice of case studies given the diversity of contexts in which integration and interlinkages efforts are undertaken, having four countries as a basis for the case studies somewhat limits the evaluation's ability to draw conclusions on how the findings may be applied to other settings.	Recognition of the context-specific nature of HIV responses; identification of critical factors influencing responses in different contexts; where possible, drawing out common themes across the case studies to ensure some degree of generalization. Engaging in regional discussions to expand the country voice.
Limited time to collect new data, including through key informant interviews, and to analyse a large volume of information. Limited time and resources for the evaluation meant that the evaluation team could not conduct a systematic assessment of Joint Programme capacity and skills at global, regional and country levels.	Prioritization of the sample of key informants for interview and of documents to review. Review of Joint Programme capacity and skills was based, at the recommendation of UNAIDS Evaluation Office, on the capacity assessment conducted in 2021-2022.
Terminology challenges existed related to the understanding of PHC and primary care which was often interpreted as the same thing. This affected discussions and it often took some time to align conversations around the topic.	Tools for data collection included the applied definition of PHC and primary care. (Key informant interviews guides and online survey). Probing and explanations were also provided by the interviewer.

Limitations	Mitigation strategies
<p>Quantitative data scope and data gaps The Joint Programme does not currently have a specific strategy or workplan with dedicated targets or milestones for its work on HIV and PHC integration and linkages and lacks a fully developed set of indicators, In addition most outcome related indicators related to HIV and PHC and integration did not have progress reported. This limited the extent to which the evaluation was able to assess progress.</p>	<p>The UBRAF Indicator Matrix 2022-2026²⁷ provides three indicators which are directly relevant²⁸ the evaluation also considered other available UBRAF data on PHC-related aspects. Individual Cosponsors covered by this evaluation also have targets and indicators, for example, WHO’s global health sector strategies with targets for 2025 and 2030, and the evaluation considered available data related to these.</p>
<p>Assessing allocative efficiency, was not feasible due to lack of data. It was also not possible to estimate the investment of the Joint Programme in integration of HIV into PHC (nor in broader investments linked to PHC), since data are not sufficiently disaggregated.</p>	<p>However, the country case studies explored financing models for HIV and primary care and how allocative procedures facilitate or inhibit integration.</p>
<p>Low response rate to online survey The online survey targeted a broad variety of stakeholders at the country level, which is also assumed to have compromised the response rate (21.5%)</p>	<p>To increase response rates to the survey, Euro Health Group sent three reminders and kept the survey open for almost two additional weeks beyond the original deadline. Due to the relatively low response rate, and the related risk of selection bias, quantitative data from the survey has been interpreted with caution. The evaluation team have mainly used qualitative comments provided through the survey.</p>
<p>Bias prone methods The evaluation methods applied are generally prone to both selection and social desirability bias²⁹. The evaluation followed a strategy of purposive sampling with informants selected based on their ability to provide rich and diverse opinions and information.</p>	<p>Introduction of selection bias was minimized through ensuring a diversity of informants, a relatively large number of informants/respondents. To mitigate the impact of social desirability bias and to stimulate honest answers, all informants including survey respondents were guaranteed confidentiality. Furthermore, triangulation was applied during the analysis to minimize this bias by comparing information across different categories of key informants, the document and data review and the survey results. Saturation was met with very little new information emerging during the last interviews conducted presenting an important indicator of sample size adequacy.</p>

²⁷ [UBRAF Indicator Matrix 2022.2026](#)

²⁸ Indicator 3.2.2. Number of countries supported by the Joint Programme which have HIV services for children integrated into at least 50% of Primary Health Care (PHC) sites. Indicator 9.1.1. Number of countries supported by the Joint Programme to have HIV antiretroviral services, for both treatment and prevention purposes, organized and financed as part of overall health systems, including through Primary Health Care. Indicator 9.1.2: Number of countries supported by the Joint Programme, that have included cervical cancer screening and treatment for women living with HIV in the national strategies, policies, plans or guidelines for HIV, cancer, cervical cancer, noncommunicable diseases or other health areas.

²⁹ Social desirability bias: respondents may distort information to present what they perceive as a more favourable impression.

4. Evaluation findings

This section is structured according to the five high level evaluation questions and EQ sub-questions. Key findings are highlighted in a summary box followed by a more descriptive section on the evidence for each key finding.

4.1 Key findings EQ1

<p>EQ1: To what extent is there conceptual clarity and internal coherence within the Joint Programme (WHO, UNICEF, UNFPA, World Bank, and the Secretariat) and external coherence with other actors in relation to leveraging HIV and PHC integration and linkages? (Relevance/Coherence)</p> <ul style="list-style-type: none"> ▪ 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? ▪ 1.2 To what extent are relevant goals, plans, strategies, and activities harmonised and aligned internally within the Joint Programme at global, regional, and country levels? ▪ 1.3 How does the Joint Programme’s work on leveraging HIV and PHC integration and linkages complement and harmonise with the efforts of national governments and external actors? 	
High-level findings	There is agreement within the Joint Programme on the importance of applying a PHC approach to achieve HIV goals, but less clarity about what the Joint Programme aims to achieve.
	Lack of conceptual clarity and a common understanding of definitions of “PHC”, “primary care” and “integration” among Joint Programme stakeholders has contributed to limited progress in taking forward the HIV and PHC integration agenda.
	Joint Programme guidance on HIV and PHC integration largely focuses on integration of specific <i>health services</i> and, while there are similarities across strategies and guidelines there are also some differences. There is further limited guidance with respect to integration of HIV with broader health systems or other aspects of PHC.
	The Joint Programme’s global strategies are broadly harmonised with those of key HIV funding agencies with respect to integration and linkages, and efforts have been stepped up recently, including through global consultations, however there is scope for further alignment.
	Country case studies identified missed opportunities for closer alignment and harmonization of Joint Team and government efforts as well as of efforts within the Joint Programme.
Theory of change	<p>The theory of change assumes that the Joint Programme has coherent strategies and action plans at global and country level, with clear objectives and targets for its work on HIV and PHC interlinkages and integration, conceptual clarity on the PHC approach and monitors progress.</p> <p>Summary assessment: The evidence indicates that such strategies and action plans have not been in place, with an overall lack of conceptual clarity on the PHC approach and HIV and PHC integration and insufficient monitoring of progress. However, work is ongoing to address this by WHO.</p>

EQ 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?

There is agreement within the Joint Programme on the importance of applying a PHC approach to achieve HIV goals, but less clarity about what the Joint Programme aims to achieve. The current Global AIDS Strategy³⁰ notes that global HIV targets can only be met through person-centered,

³⁰ Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS. Geneva: Joint United Nations Programme on HIV/AIDS; 2021 (https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf, accessed 24 April 2023).

integrated service delivery, multisectoral policy and action, and empowering people and communities. This fundamentally constitutes the “PHC approach” as defined by WHO (see Box 3). In line with this most informants, in particular those working on HIV, primarily see the benefits of HIV and PHC integration and linkages in terms of achieving HIV goals.

Potential benefits of HIV and PHC integration and linkages mentioned by key informants and survey respondents included: improving efficiency, improving the use of human resources for health, increasing access to services, bringing services closer to communities, improving patient-centered care and meeting multiple needs over the life course, improving early detection of HIV and ART adherence, normalizing HIV and decreasing HIV stigma, and enhancing the sustainability of the HIV response. Investments in broader health systems and primary care are further by most informants across stakeholder categories considered to be potentially improving HIV outcomes, with some few informants expressing the opposite view. Potential disadvantages and risks of integration mentioned though the online survey and key informant interviews included: reversal of progress achieved by HIV programmes, adverse impact on the quality of HIV services, and reduced access to HIV services for key populations, men, young people and others who may be less likely to use government primary care services.

Fewer were clear about what the Joint Programme aims to achieve through leveraging HIV and PHC integration and linkages. This was a common theme in discussions with regional Joint Teams. A regional informant noted that “There needs to be clear agreement among the Secretariat and Cosponsors about where the Joint Programme is going and what it is doing on HIV and PHC” and this was echoed by several other key informants. Country case studies also highlighted the same issue. For example, the Botswana case study found that “Evidence suggests that Joint Programme agencies are largely operating in a siloed manner on HIV integration aspects and with alignment challenges, with the exception being PMTCT efforts... Different Cosponsors focus on aspects of integrated services most relevant to their mandate. It seems there is little conceptual clarity or consensus about what is to be achieved.”

Lack of conceptual clarity and a common understanding of definitions of “PHC”, “primary care” and “integration” among Joint Programme stakeholders has contributed to limited progress in taking forward the HIV and PHC integration.

Lack of conceptual clarity is marked by inconsistencies in the use of and definition of “PHC”, “primary care” and “integration” in strategies, guidelines, and frameworks across the Joint Programme. For example, the Global AIDS Strategy 2021-2026³¹, the UBRAF 2022-2026 and its corresponding UBRAF indicator matrix do not provide a clear definition of PHC and in some cases the interpretation of PHC is different from the definition provided in the WHO/UNICEF PHC operational framework – even within other WHO strategies (see Box 3).

³¹ Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS. Geneva: Joint United Nations Programme on HIV/AIDS; 2021 (https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf, accessed 24 April 2023).

Box 3: Joint Programme and Cosponsor definitions and use of PHC and primary care terminology

WHO/UNICEF PHC operational framework from 2020 provides the following definitions¹: PHC: “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”.

Primary care: “A key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care.”

WHO Global health sector strategy on HIV, viral hepatitis and STIs 2022-2030: no glossary, extensive mention of “PHC” including in its vision, but no clear definition of PHC provided, the closest to a definition of PHC is: “Primary health care covers the range of disease prevention, health promotion, treatment, rehabilitation and palliative care that are needed throughout the life course, delivered as close as feasible to people’s everyday environment. It is the foundation of universal health coverage and essential to advance health equity”.

Global AIDS Strategy 2021-2026: has a glossary, but no definitions of “PHC” and “primary care” are provided despite their (infrequent) use in the strategy.

UBRAF 2022-2026, no definition is provided, but the closest resembling of a definition of PHC is the following: “Provide technical advice, capacity building and analytical work to help countries get greater value from existing resources and better integrate HIV and COVID-19 services into essential primary health-care services (e.g. through allocative efficiency, cascade analytics, inclusion of HIV in health benefits packages and improved support in primary health care).”

UBRAF indicator matrix 2022-2026 indicators: provides no definition of PHC but use of PHC language through two indicators: i.e. “Indicator 3.2.2. Number of countries supported by the Joint Programme which have HIV services for children integrated into at least 50% of Primary Health Care (PHC) sites; indicator 9.1.1 Number of countries supported by the Joint Programme to have HIV antiretroviral services, for both treatment and prevention purposes, organized and financed as part of overall health systems, including through PHC”.

Joint Programme stakeholders interviewed also expressed a different understanding of the PHC approach, and primary care, resulting in confusion and a lack of clarity about what action is required to take forward the HIV and PHC integration and linkages agenda. PHC is commonly understood to be synonymous with primary care or primary care level facilities. Examples of selected quotes include the following:

“Need for a clear concept of what PHC is.”

“Even within WHO there is not coherence – not all will be able to articulate the three components of the PHC approach.”

“Confusion about the difference between PHC and primary care; a clear understanding of what it is will be needed to help countries determine how to operationalize.”

“Would be good to have a clear articulation of PHC.”

Despite frequent use of PHC language in the WHO’s latest HIV strategy³² there is limited reference to “primary care”, and when primary care is used it mainly refers to primary care facility level. The latest

³² Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030. Geneva: World Health Organization; 2022 (<https://www.who.int/publications/i/item/9789240053779>, accessed 24 April 2023).

WHO HIV guidelines³³ use the concept of “decentralization” of service delivery, which is defined as “services at peripheral health facilities such as primary health care facilities and outside health facilities in the community”.

There are also differing views among key informants about whether “primary care” and “PHC” includes community-based service delivery, with many informants alluding to primary care equalling primary care facilities. Although the WHO/UNICEF definition of PHC entails communities (Box 3), the recent WHO global HIV strategy provided examples where community-based services are separate to PHC, as exemplified through these quotes from the current WHO Global health sector strategy: “nonsymptomatic patients or those who are clinically stable may be served through primary health care and community-based services”. And “non-stigmatizing manner, including in primary health care settings, community settings and pharmacies.”³⁴

There is further a lack of clarity and common understanding across the Joint Programme about the concept of “integration”. Although integration is mentioned extensively in key Joint Programme documents including the Global AIDS Strategy and UBRAF documents, it is not defined in either. WHO provides a definition in its latest HIV guidelines³⁵ and has also placed a strong emphasis on multi-directional opportunities for collaboration, convergence and linkages rather than “integration” per se, and this is reflected in its recent publication.³⁶ The lack of clear understanding about the definition of integration was echoed during interviews with Joint Programme key informants at global, regional and country levels. Examples of quotes are provided in Box 4 below.

Box 4: Quotes from Joint Programme informants on HIV and integration

- “Confusion when talking about integration. Are we talking about integration of services, getting a range of services at the same point of care, or integration of systems. It is important to focus on what we want to achieve through integration”.
- “Lack of clarity about what integration means – services could be perceived as ‘integrated’ but the system in practice is still fragmented”.
- “Clarity also needed on link to health systems and on what we are talking about e.g., on integration of what, coordination of what, HIV with PHC, HIV within primary care - it’s not clear.”
- “The Joint Programme needs to answer the question of how they can integrate in a stronger way – hard when they have a good working system partially integrated in PHC with a lot more outside.”
- “The Joint Programme don’t currently help countries find the right balance between specialized HIV care and integration into PHC - this discussion does take place, driven by WHO, in countries with high prevalence, but not in countries with low prevalence, where there is no explicit discussion in country about what the appropriate form of integration and balance is.”

³³ Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789240031593>, accessed 24 April 2023).

³⁴ Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030. Geneva: World Health Organization; 2022 (<https://www.who.int/publications/i/item/9789240053779>, accessed 24 April 2023).;

³⁵ Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789240031593>, accessed 24 April 2023)

³⁶ Primary health care and HIV: convergent actions; Policy considerations for decision-makers. Geneva: WHO; n.d.

The evaluation found that lack of conceptual clarity coupled with limited understanding of how to operationalise integration has contributed to a lack of joint action. Regional Joint Programme key informants and country level informants reported that they were unsure about the rationale for integration and how to take forward HIV and PHC integration, including what and how to integrate. This lack of clarity and common understanding also suggests that there may be a lack of familiarity with existing guidance, which includes the WHO/UNICEF PHC operational framework, the WHO consolidated HIV guidelines 2021,³⁷ which provide a definition of integrated service delivery, and WHO HIV guidelines for key populations³⁸. The latter includes a table with three types of integration: at organizational level (organizations and departments within organizations plan and budget together), at service level (different clinical services integrated at organizational level through coordinated referral or linkages) and at site level (provision of multiple interventions at one site). WHO has also developed specific guidance on quality of care of integrated HIV services.³⁹ The recent WHO publication on PHC and HIV convergent actions⁴⁰ provides definitions and policy considerations for decision-makers and includes proposed HIV and PHC actions against the 14 levers of the PHC operational framework. Work is thus ongoing, especially by WHO, to address overall lack of conceptual clarity on the PHC approach and HIV and PHC integration/ convergence, but there is a need to streamline across the Joint Programme to establish a common understanding of the concepts.

1.2 To what extent are relevant goals, plans, strategies, and activities harmonised and aligned internally within the Joint Programme at global, regional, and country levels?

Joint Programme guidance on HIV and PHC integration largely focuses on integration of specific health services and, while there are similarities across strategies and guidelines there are also some differences. There is further limited guidance with respect to integration of HIV with broader health systems or other aspects of PHC.

There are nuanced differences in scope and approach across different Joint Programme and Cosponsor strategies and guidance. The Global AIDS Strategy 2021-2026 calls for: “a full range of health services to be integrated in primary health care settings, with special consideration to acceptability for marginalised and other populations who experience stigma and discrimination.”

The UBRAF 2022-2026 is the plan to operationalize the Global AIDS Strategy but lacks definition of actions in relation to integration of HIV services in primary health care settings. The latest WHO consolidated HIV guidelines⁴¹, a key reference documents for countries planning health sector responses to HIV, mainly focus on integration of HIV with specific services, yet includes ‘decentralization’ of service delivery to primary care or communities *where feasible*.

³⁷ Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789240031593>, accessed 24 April 2023).

³⁸ Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2022 (<https://www.who.int/publications/i/item/9789240052390>, accessed 24 April 2023)

³⁹ Maintaining and improving quality of care within HIV clinical services. Geneva, Switzerland: World Health Organization; 2019 (WHO/CDS/HIV/19.17). Licence: CC BY-NC-SA 3.0 IGO., (<https://www.who.int/publications/i/item/maintaining-and-improving-quality-of-care-within-hiv-clinical-services>, accessed 17 November 2023)

⁴⁰ Primary health care and HIV: convergent actions; Policy considerations for decision-makers. Geneva: WHO; n.d.

⁴¹ Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva: WHO; 2021 (<https://www.who.int/publications/i/item/9789240031593>, accessed 24 April 2023).

Provision of integrated HIV services with related disease services/programmes is promoted in Joint Programme and Cosponsor global strategies and plans.^{42 43 44 45 46 47} There appears to be agreement that HIV service integration with the following services should be promoted, depending on the context: TB, SRH/FP, cervical cancer, MNCH/ANC/PNC, and viral hepatitis. Different strategies and guidelines also refer to integration of HIV services, or in some cases linkages, with mental health, NCDs, STI services, harm reduction, GBV, and nutrition⁴⁸ (see Table 4). However, most strategies do not explicitly refer to HIV integration within essential health services packages, which would be a critical step towards integration within UHC.

Table 4: Services proposed for integration/linkages with HIV in global HIV strategies/guidelines

Reference to proposed service integration/linkages with HIV services	GAS 2021-2026 ⁴⁹	UBRAF 2022-2026 ⁵⁰	WHO GHSS HIV, STI, Hep ⁵¹	WHO HIV consolidated guidelines 2021 ⁵²
TB	X	X	X	X
Cervical cancer	X	X	(X)	X
STIs	(X)	X	X	X
SRH/FP	(X)	X	(X)	X
MNCH/ANC/PNC	X	X	X	X
Hepatitis	X	X	X	X
NCDs	(X)	(X)	(X)	X (diabetes and hypertension)
SGBV	(X)	X	(X)	

⁴² Global health sector strategies on, respectively, HIV, viral hepatitis, and sexually transmitted infections for the period 2022-2030. Geneva: WHO; 2022 (<https://www.who.int/publications/i/item/9789240053779>, accessed 24 April 2023)

⁴³ Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS. Geneva: Joint United Nations Programme on HIV/AIDS; 2021 (https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf, accessed 24 April 2023); UNFPA Strategic Plan 2022-2025. New York: United Nations Population Fund; 2022 (<https://www.unfpa.org/publications/unfpa-strategy-family-planning-2022-2030>, accessed 24 April 2023)

⁴⁴ Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva: WHO; 2021 (<https://www.who.int/publications/i/item/9789240031593>, accessed 24 April 2023).

⁴⁵ Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment, and care for key populations. Geneva: WHO; 2022 (<https://www.who.int/publications/i/item/9789240052390>, accessed 24 April 2023)

⁴⁶ UNICEF Strategy for Health, 2016 - 2030, United Nations Children's Fund; 2016 (<https://www.unicef.org/media/119736/file/UNICEF-Strategy-for-Health-2016-2030.pdf>)

⁴⁷ UNFPA Strategic Plan 2022-2025. New York: United Nations Population Fund; 2022 (<https://www.unfpa.org/publications/unfpa-strategy-family-planning-2022-2030>, accessed 24 April 2023).

⁴⁸ Example of use of "linkage" in GAS 2021-2026: 90% (of PLHIV) have access to integrated or linked services for HIV treatment and cardiovascular diseases, cervical cancer, mental health, diabetes diagnosis and treatment, education on healthy lifestyle counselling, smoking cessation advice and physical exercise.

⁴⁹ Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS. Geneva: Joint Programme; 2021 (https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf, accessed 24 April 2023).

⁵⁰ 2022-2026 unified budget results and accountability framework (UBRAF). Geneva: Joint Programme; 2021 (https://www.unaids.org/sites/default/files/media_asset/PCB_SS_2022_2026_UBRAF_Framework_EN.pdf, accessed 24 April 2023).

⁵¹ Global health sector strategies on, respectively, HIV, viral hepatitis and STIs for the period 2022-2030. Geneva: World Health Organization; 2022 (<https://www.who.int/publications/i/item/9789240053779>, accessed 24 April 2023).

⁵² Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789240031593>, accessed 24 April 2023).

Mental health	(X)	X	(X)	X
Harm reduction/OST	(X)		(X)	X
Nutrition		X		

Notes for table: X = “integrated” (X) = “integrated and/or linkages”

Some strategies guidelines differentiate between HIV prevention, testing and treatment services, and some recommended integration for only some population groups or in certain contexts, however this not presented in this table.

Overall, the evaluation found limited emphasis in global Joint Programme HIV-related strategies and guidelines/UBRAF on integration of HIV responses at *a system level*, despite that service and systems integration are interrelated aspects and with a need to streamline HIV building blocks (e.g. laboratory, procurement, strategic information, human resources for health, financing) when pursuing integrated service delivery. WHO’s 2022-2030 global health sector strategies on HIV, viral hepatitis and STIs do, however, include a focus on a systems-oriented approach that promotes synergies with primary health care, health governance, financing, workforce, commodities and service delivery,⁵³ and highlight the need for investment in strengthening primary health care infrastructure and the health workforce for successful integration of HIV, viral hepatitis and STI services. Yet there is not outcome dedicated to monitor the extent to which this occurs. In the case study countries “HIV service integration” tends to be higher on the national agenda than “HIV and health systems integration”, even though effective service integration requires integration of supporting systems (see Box 5).

Box 5: Missed opportunities for integration at system level – examples from Angola and Botswana

Angola country case study report: An opportunity exists to influence the PHC agenda through the integration of systems and services established under the HIV response. These include but are not limited to laboratory services, procurement, and supply chain management systems, monitoring and reporting systems, community activists and beyond. The integration of these well-established mechanisms, some of which is already happening, could help in establishing a holistic and well-functioning PHC government led effort.

Botswana country case study report: Most country respondents understood integration in terms of integrated service delivery or ‘one stop shops’. Respondents noted that integrated services should save clients time and money and that it was an efficient way of utilising resources and staff. There was almost no mention of integrating other health system building blocks which support service delivery.

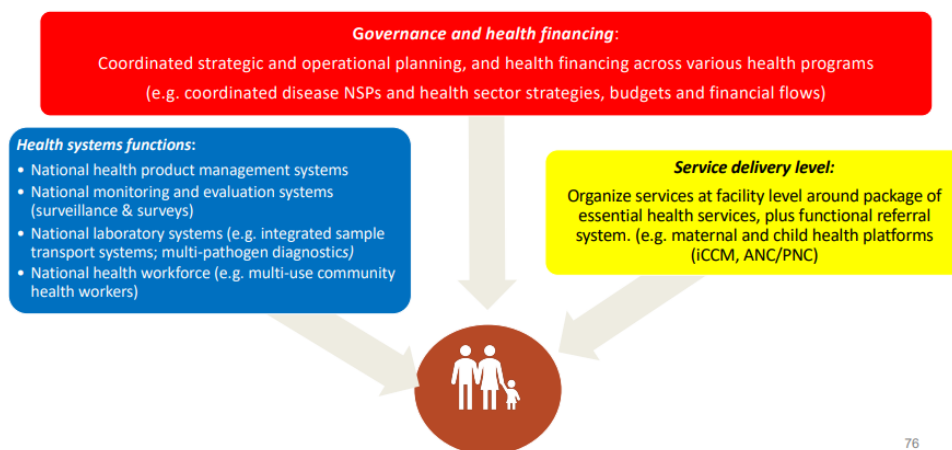
1.3 How does the Joint Programme’s work on leveraging HIV and PHC integration and linkages complement and harmonise with the efforts of national governments and external actors?

The Joint Programme’s global strategies are broadly harmonised with those of key HIV funding agencies with respect to integration and linkages, and efforts have been stepped up recently, including through global consultations, however there is scope for further alignment. Analysis of US government and Global Fund strategies and initiatives (see Figure 2 and Box 6) suggests an increased emphasis on applying a PHC approach and a stronger focus on strengthening health systems and integration of governance and systems. For example, Global Fund guidance for the 2023-2025 window emphasizes the need for integration at governance, health system and service delivery levels

⁵³ Global health sector strategies on, respectively, HIV, viral hepatitis and STIs for the period 2022-2030. Geneva: World Health Organization; 2022 (<https://www.who.int/publications/i/item/9789240053779>, accessed 24 April 2023).

(see Figure 2). In contrast, as discussed in the previous section, most Joint Programme global strategies and documents only to a limited extent refer to integration at system and governance levels.

Figure 2: Global Fund: Integration needed at governance, systems, and service delivery levels⁵⁴



76

Box 6: US Government and Global Fund strategies and initiatives

The new PEPFAR strategy 2022-2027⁵⁵ has five strategic pillars, of which the first three and most of their corresponding areas, relate to the PHC approach. For example, the strategy has a focus area of integration and sustainability with an emphasis on systems integration. The latest PEPFAR operational guidance document states: “PEPFAR will work toward strengthening linkages between HIV-program investments and broader public health delivery systems including partner-country government health budgets and data systems”.⁵⁶ The same operational guidance calls for country teams to work with governments and relevant stakeholders over the next two years to develop “Measurable Sustainability Roadmaps”.

The new Global Fund strategy 2023-2028⁵⁷ also has increased emphasis on integrated, people-centered services “...rising above disease silos to build resilient sustainable systems for health (RSSH) that protect people from multiple pathogens, address their holistic needs and underpin health and well-being for all.” In addition. The 2023 Global Fund technical information note on RSSH⁵⁸ provides good examples of RSSH interventions eligible for support and good practice examples.

The recently launched USAID Primary Impact initiative (2022)⁵⁹ presents a new strategic approach informed by COVID-19 lessons to regain global health progress and invest in primary health care workers.

⁵⁴ Integrated services [Webinar]. Joint United Nations Programme on HIV/AIDS; 2023.

⁵⁵ PEPFAR’s Five-year Strategy: Fulfilling America’s Promise to End the HIV/AIDS Pandemic by 2030. PEPFAR; 2022 (https://www.state.gov/wp-content/uploads/2022/11/PEPFARs-5-Year-Strategy_WAD2022_FINAL_COMPLIANT_3.0.pdf, accessed 24 April 2023).

⁵⁶ PEPFAR 2023 Country and Regional Operational Plan (COP/ROP) Guidance for all PEPFAR-Supported Countries ([PEPFAR-2023-Country-and-Regional-Operational-Plan.pdf](https://www.pepfar.org/2023-Country-and-Regional-Operational-Plan.pdf) (state.gov)

⁵⁷ Fighting Pandemics and Building a Healthier and More Equitable World, Global Fund Strategy (2023-2028). Geneva: Global Fund; 2021 (https://www.theglobalfund.org/media/11612/strategy_globalfund2023-2028_narrative_en.pdf, accessed 24 April 2023).

⁵⁸ Information Note Resilient and Sustainable Systems for Health (RSSH). The Global Fund; 2023 (https://www.theglobalfund.org/media/4759/core_resilientsustainablesystemsforhealth_infonote_en.pdf, accessed 24 April 2023).

⁵⁹ <https://www.usaid.gov/global-health/health-systems-innovation/health-systems-strengthening/primary-health-care>

The country case study in Indonesia reported this as an opportunity for the JP to further engage in HIV and PHC integration – as detailed in the following quote from the Indonesia case study report: “USAID has recently announced the inclusion of Indonesia in the Primary Impact Initiative, which aims to accelerate progress in primary health care through creating linkages between ongoing USAID programmes and initiatives, health workforce investments, engagement of civil society, and coordination to deliver PHC services. In Indonesia, this will build upon USAID’s existing connections with district-level *puskesmas* and *posyandus*. These shifts in strategic focus and corresponding activities could be a potential opportunity for alignment with Joint Programme advocacy and activities. These agencies are already engaged by the JUNTA, as evident in the engagement of UNAIDS in preparation of the Global Fund Funding Request (2024-2026, submitted in 2023) and direct support from USAID-PEPFAR and DFAT to UNAIDS. This could be an opportunity for further engagement regarding HIV and PHC, particularly in the current context”.

The UNAIDS secretariat has recently co-facilitated a series of global consultations and discussions with PEPFAR on the sustainability of the HIV response, focusing on political, programmatic and financial sustainability. So far, UNAIDS secretariat has convened two meetings, in the US and Botswana, in July and October 2023, involving representatives from governments, civil society and multilateral organisations, including the Global Fund, WHO, and the US government. Next steps include Joint Programme-PEPFAR support for country listening sessions to inform the development of HIV Response Sustainability Roadmap guidance, launch of the guidance in December 2023 in collaboration with the Global Fund and country stakeholders, and government-led country sustainability dialogues supported by the Joint Programme, with the aim of finalising country roadmaps in December 2024.

The Joint Programme – Secretariat and Cosponsors – has provided significant support to countries to develop Global Fund funding requests⁶⁰, including window 2 requests that have more focus on RSSH and equity, gender and human rights compared to window 1 (2020-2022).⁶¹ Country level examples of Joint Programme engagement on the PHC agenda with global HIV funding mechanisms are provided in the box below.

Box 7: Engagement and alignment with global financing mechanisms at country level

In Indonesia, the Joint UN Team on AIDS works closely with external partners, including the Global Fund, DFAT, and USAID-PEPFAR, who are increasingly shifting away from vertical disease programmes towards supporting primary health care and broader health systems strengthening. In accordance with the Global Fund’s 2023-2028 strategy, the most recent Global Fund funding request in Indonesia includes activities related to broader resilient and sustainable systems for health (RSSH) and its development was supported by the Joint UN team on AIDS. (Source: Indonesia country case study report, Vol II)

In Angola, UNDP, as the principal recipient of the HIV Global Fund grant, has made concerted efforts in the ongoing combined HIV, malaria, TB and resilient and sustainable systems for health (RSSH) grant, to expand the Government’s initiative to strengthen community health, which has been lacking as a structure in the PHC response. (Source: Angola country case study report, Vol. II)

⁶⁰ Sources: JPMS reporting, country case studies, KII

⁶¹ The Global Fund TRP observed strategic focus on Resilient & Sustainable Systems for Health (RSSH) in 85% of Window 2 funding requests recommended for grant-making. This is 8% higher than in Window 1 and 14% higher than Grant Cycle 6 (2020-2022 Allocation Period) overall, although focus is still more on system support. The TRP saw strong positive movement on equity in Window 2 funding requests.

In addition, a recent global webinar⁶² targeting country stakeholders organized by UNAIDS Secretariat in collaboration with Global Fund and WHO is a good example of alignment and harmonization around practical examples of entry points for integrated service delivery as well as integration at system and governance levels.

Despite these examples, overall, the evaluation found limited evidence on the extent to which the Joint Programme, as opposed to individual Cosponsors, has had meaningful and consistent engagement with key global partners on the HIV and PHC integration agenda.

Country case studies identified missed opportunities for closer alignment and harmonization of Joint Programme and government efforts as well as of efforts within the Joint Programme. In Indonesia and Pakistan, HIV responses – and the Joint Programme – are still largely applying a disease-specific approach at the same time as national health strategies are becoming more PHC-oriented (see country reports for more detail). In Botswana and Angola, more examples were identified of the Joint Programme, mainly individual Cosponsors, supporting government roll out integrating service delivery. Examples of missed opportunities (as per the evaluation team judgement) from the country case study reports are seen in the box below.

Box 8: Examples from country case studies on missed opportunities for closer alignment between efforts of the Joint UN team on AIDS and government

Angola: The Joint Team has served a critical role in assisting with conceptualisation of the most recent, as well as the past three, national HIV strategic plans (PEN VII) which reflects integrated service provision for three diseases in line with the tenants of PHC, yet it lacks a clear focus on PHC.

Botswana: Although the Joint Team has limited planned activities targeting the UBRAF HIV-PHC integration result area, UNAIDS and its Cosponsors are conducting some activities individually which support integration and taking the PHC approach in HIV programming... It was noted by informants that not having specific funded activities in the UBRAF workplan related to HIV integration aspects and global UBRAF outcomes have discouraged alignment of agency efforts.

Pakistan: The Joint Programme has not yet been substantially engaging as a collective group to assist government roll out PHC-oriented systems, although with recent examples of individual Cosponsor efforts and contributions (for example the “PHC model of care” implemented in 2 districts). 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.

Indonesia: The Indonesian government is currently shifting from a vertical, disease-focused approach to a PHC approach. MoH stakeholders identified limited UN engagement regarding the integration of HIV initiatives thus far but expressed a willingness to receive assistance from the Joint Team to do so. Other stakeholders highlighted the risk that HIV could get “lost” in the transformation if UNAIDS is not engaged in early advocacy, particularly in the current context of decreasing national attention to HIV.

The country case studies also highlighted that relevant platforms for Joint Programme synergies and harmonization on PHC and HIV integration with external partners exist at country level (CCMs, UN country teams, UNSDCF, SDG3 GAP, health sector coordination structures, UHC platforms, etc.), but these are not always leveraged. In addition, informants noted that the UNAIDS Secretariat and relevant Cosponsors are not always at the table when PHC/UHC is discussed - see examples in Indonesia and Pakistan country case study reports. A recent evaluation of the Joint Programme’s

⁶² Global Webinar: Integrated people-centred systems and services and RSSH: Key considerations for countries’ national strategies and country applications to the Global Fund in 2023-2025 funding cycle

work with Key populations also highlights this aspect: “HIV and key population communities infrequently engaging or ‘being at the universal health coverage table’”.⁶³ Limited time to prioritize engaging in such meetings was one explained reason, another reported factor included that UHC/PHC communities were not always inviting HIV representatives to attend in such engagements.

Furthermore, there was limited evidence of the Joint Programme acting as a *synergistic* collective programme to support Government on PHC-oriented health reforms. It was noted that while UN agencies continue to have credibility and influence, different agencies tend to have bilateral relationships with various national partners. For example, WHO with the Ministry of Health, World Bank with the Ministry of Finance, and the UNAIDS Secretariat with the National AIDS Committee, and this contributes to the lack of a coherent approach to UN country support around HIV and PHC and sustainable financing.

4.2 Key findings EQ2

<p>EQ2: To what extent is the Joint Programme applying the PHC approach to HIV responses and what are the achievements and lessons learned? (Relevance/Effectiveness/Sustainability)</p> <ul style="list-style-type: none"> ▪ 2.1 What has been achieved since 2020 in terms of applying a PHC approach to HIV responses and how is progress monitored by the Joint Programme? ▪ 2.2 What is the Joint Programme doing to build political commitment for sustainable HIV financing in the context of PHC? ▪ 2.3 What are the main enablers and barriers to integrating HIV into PHC in various contexts and how is the Joint Programme addressing these at country level? 	
<p>High level findings</p>	<p>The Joint Programme has applied the principles of two out of three pillars of the PHC approach (multisectoral policy and action and empowering people and communities) to improve HIV outcomes, this happened prior to the recent increased global focus on PHC.</p>
	<p>The Joint Programme has had less focus on HIV integration within primary care (the first pillar of the PHC approach). There are examples of integrated delivery of other health services with HIV services (for example, STI, SRH, TB, hepatitis, family planning and cervical cancer) and of integrating HIV services into primary care (for example, HIV testing, PMTCT, ART), but the extent to which the Joint Programme has taken an intentional or collective approach to this is difficult to determine.</p>
	<p>Available data suggest that there has been progress on specific indicators, but there is no overarching framework or agreed core set of indicators for monitoring Joint Programme action or results on HIV and PHC integration efforts.</p>
	<p>There is a role and mandate for the Joint Programme to build political commitment for sustainable HIV financing and sustainable financing for PHC and UHC that drives HIV impact, but how to operationalise this is not well defined and its potential role is not fully leveraged.</p>
	<p>The available evidence on the extent to which HIV services are being included in health benefits packages is mostly based on country self-reporting and sometimes contradictory, and progress appears to be highly variable across countries.</p>
	<p>The Joint Teams are assisting governments to establish legal frameworks around social contracting as a critical first step in sustainability of community-led HIV service delivery, efforts which need to be scaled.</p>
<p>Theory of change</p>	<p>The theory of change assumes that the Joint Programme systems, processes and ways of working enable and facilitate adequate donor and government resourcing, and effective implementation, good governance, and accountability at country level. It also assumes that governance, resourcing, policy frameworks and multi-stakeholder engagement and accountability mechanisms exist at the country level to facilitate achievement of outcomes. A third assumption associated with this EQ is that the enabling environment at country level</p>

⁶³ Joint evaluation of the UN Joint Programme on AIDS's work with key populations (2018-2021). UNAIDS, Geneva; April 2022 (<https://www.unaids.org/en/resources/documents/2022/joint-evaluation-un-joint-programme-aids-work-key-populations>)

is supportive of and conducive to systems strengthening and changes to processes and ways of working, with stakeholders uniting for an effective response (including meaningful involvement of people living with and affected by HIV). A further assumption is that community-led activities are sufficiently scaled and sustainably resourced.

Summary assessment: The findings indicate that financial sustainability of the HIV response is a critical concern and HIV prevention efforts delivered by communities are not currently sustainably resourced. In addition, the Joint Programme has not sufficiently strengthened these functions and processes for HIV and PHC at country level., although some efforts have taken place. Also, although highly variable, most countries have a commitment to UHC and desire to strengthen health systems albeit with a lack of resources to achieve the objective of stakeholders uniting for an effective response. Finally, although community-led activities have been a focus of the Joint Programme’s work, progress is limited.

The Joint Programme has applied the principles of two out of three pillars of the PHC approach (multisectoral policy and action and empowering people and communities) to improve HIV outcomes, this happened prior to the recent increased global focus on PHC. There are many examples of Joint Programme action around multisectoral policy and action for the HIV response, including support for and engagement with National AIDS Committees and the development of HIV National Strategic Plans, convening stakeholders from a wide range of government sectors as well as from civil society and the private sector, and leveraging other sectors to strengthen the HIV response. These actions also include longstanding advocacy on issues including human rights, gender, equity, and stigma and discrimination that influence HIV vulnerability and access to HIV services. The evaluation found strong triangulated evidence through the document review^{64 65}, JPMS data and key informant interviews of the Joint Programme adding value to multisectoral policy and action on HIV through the Secretariat and the mandates and wider work of its Cosponsors, which encompass sectors and thematic areas including health, education, finance, justice and human rights, gender, labour, drugs and prison settings, social protection, and humanitarian crises.

The Joint Programme has also had a strong and longstanding focus on empowering populations and communities most at risk of and affected by HIV. This has included strengthening the capacity of organizations and networks of people living with HIV and key populations, initiatives to empower women and young people, advocacy for community participation in policy and decision-making forums, and support for community-led service delivery and monitoring. This was widely acknowledged by key informants across stakeholder groups and evidenced through the document review^{66 67 68 69 70} and JPMS data reports. Key informants noted that HIV and PHC have similar foundational approaches (multiculturality and community engagement) and as such the HIV

⁶⁴ Organizational Report 2020-2021 Performance Monitoring Report. Geneva: Joint United Nations Programme on HIV/AIDS; 2022 (https://www.unaids.org/en/resources/documents/2022/PCB50_UBRAF_PMR_Organizational_Report, accessed 24 April 2023).

⁶⁵ Results report. UNAIDS 2022 results performance monitoring report. Geneva: Joint United Nations Programme on HIV/AIDS; 2023

⁶⁶ Organizational Report: UNAIDS 2020 performance monitoring report. Geneva: Joint United Nations Programme on HIV/AIDS; 2021 (https://open.unaids.org/sites/default/files/documents/PCB48_UBRAF_PMR_ORG_REPORT_EN.pdf, accessed 24 April 2023).

⁶⁷ Regional and Country Report: UNAIDS 2020 performance monitoring report. Geneva: Joint United Nations Programme on HIV/AIDS; 2022 (https://www.unaids.org/en/resources/documents/2022/PCB50_UBRAF_PMR_Regional_Country_Report, accessed 24 April 2023).

⁶⁸ Organizational Report 2020-2021 Performance Monitoring Report. Geneva: Joint United Nations Programme on HIV/AIDS; 2022 (https://www.unaids.org/en/resources/documents/2022/PCB50_UBRAF_PMR_Organizational_Report, accessed 24 April 2023).

⁶⁹ Regional and Country Report: UNAIDS 2020-2021 performance monitoring report. Geneva: Joint United Nations Programme on HIV/AIDS; 2022 (https://open.unaids.org/sites/default/files/documents/PCB50_PMR_Regional%20and%20Country%20Report_EN_FINAL.pdf, accessed 24 April 2023).

⁷⁰ Results report. UNAIDS 2022 results performance monitoring report. Geneva: Joint United Nations Programme on HIV/AIDS; 2023

response can be considered a “first mover” on applying the two PHC components of multisectoral action and community empowerment.

The Joint Programme has had less focus on HIV integration within primary care (the first pillar of the PHC approach). There are examples of integrated delivery of other health services with HIV services (for example, STI, SRH, TB, hepatitis, family planning and cervical cancer) and of integrating HIV services into primary care (for example, HIV testing, PMTCT, ART), but the extent to which the Joint Programme has taken an intentional or collective approach to this is difficult to determine. The evaluation found many examples of integration of other services into or with HIV services – for example, STI, SRH, TB, hepatitis, family planning and cervical cancer – and of integration of specific HIV services into primary care – for example, HIV testing, PMTCT, ART, point of care monitoring of viral load, and diagnosis and treatment of opportunistic infections.

Cosponsors have supported integration of service delivery in a range of settings in line with their mandates. WHO has provided normative and technical guidance for service integration, UNICEF has supported integration of PMTCT/EMTCT and MCH, and UNFPA has supported integration of HIV and SRH. Additionally, the World Bank is supporting integration efforts through its global health portfolio and health systems strengthening projects. One example is a project to strengthen health systems in Lesotho, Malawi, Mozambique, and Zambia, which has advanced HIV and TB service integration – in 2022, 96% of HIV patients were screened for TB.⁷¹

Many of the examples of integration of other health services with HIV services involve ‘clustering’ in which one or two programmes or services are added to HIV programmes. This makes sense for co-infections and co-morbidities of HIV such as TB or STIs etc (see Table 4) or where the same specific population is targeted for more than HIV services, such as PMTCT and ANC. It may also be pragmatic, i.e., taking a phased approach to integrating strong HIV programmes with weaker PHC systems. However, it does not necessarily build links with broader PHC services or integrate HIV systematically within essential health service packages, or intentionally support *health system level* integration (financing, data systems, procurement etc).

It is worth noting that the UBRAF indicators for ‘Integrated systems for health and social protection’ are all focused on ‘people living with, at risk of and affected by HIV’ so do not incentivize the Joint Programme to focus on achievement of health outcomes for the wider population.

According to the UNAIDS 2023 Global AIDS Update “The most common forms of integration involve HIV services and services for TB, MCH, SRH, and primary care services. Services for HIV, syphilis, viral hepatitis and other STIs are becoming more functionally integrated with ante-natal and postnatal services. There is also greater recognition of the need for closer integration with NCD programmes, especially for older people with HIV, and mental health services and support”.

Country level examples of integration of HIV and non-HIV services are provided in the Boxes 9 and 10 below.

⁷¹ UNAIDS, 2023. Performance Monitoring Report 2022.

Box 9: Example of integrating PrEP and STI services in Cambodia

In **Cambodia**, integrated PrEP and STI services were initiated in 2019, when the national HIV PrEP guidelines were developed. Fifteen facilities including family health, NGO and HIV treatment clinics provide integrated STI, HIV and PrEP services. All people seeking PrEP receive STI services, and all STI clients are offered PrEP. PrEP clients are routinely screened for STI symptoms in line with the PrEP national guidelines, and those presenting with signs and symptoms are promptly treated. PrEP clients are tested with rapid diagnostic tests for syphilis and hepatitis B and C at PrEP enrolment and at refill visits. Syphilis treatment is offered immediately, as is treatment for hepatitis B and C. Sexual partners of clients diagnosed with HIV or other STIs are encouraged to come for treatment, and HIV self-tests are offered to those whose partners are unwilling to come to the clinic. The country recently initiated PrEP delivery by community-based organizations that already provide screening for STI, HIV and hepatitis B and C and refer clients for clinical management.⁷²

The extent to which integration has been driven by the Joint Programme as opposed to by governments, donors or individual Cosponsors is difficult to assess. As one Cosponsor informant commented: “The Joint Programme is not working collectively on this – and agencies have contributed separately”. In most examples identified by the evaluation, action appears to have been taken by individual agencies using their own funding rather than under the auspices of the Joint Programme and with UBRAF funding. For example, the Botswana case study found that the Joint Team has no clear joint strategy or joint plan to integrate HIV with PHC in Botswana.

Box 10: PHC integration and linkages from evaluation case study countries

Angola does not have a specific PHC strategy, although steps have been taken to establish an agenda for PHC through the signing of the Luanda Declaration. The Joint Programme has engaged in dialogue with government around key aspects of HIV integration within a PHC approach. The draft community health strategy was developed with the technical and financial support of UNDP and WHO, and Joint Team agencies have been identified for provision of TA for the primary health care financing action plan, with the potential to help ensure that HIV financing is considered in the wider context of UHC. In addition, Cosponsors have been involved in capacity building for integration of HIV services into primary care services. For example, UNICEF has helped to strengthen the integration of SRH and HIV services in addition to the integration of PMTCT and early infant diagnosis within ANC settings, UNFPA has promoted HIV and SRHR integration. The World Bank’s health system strengthening project supports an integrated approach and has contributed to an increase in the proportion of pregnant women living with HIV receiving ART. These activities are funded outside of UBRAF funding.

In **Indonesia**, Cosponsors are implementing activities related to the integration of HIV services with testing and treatment for co-infections such as hepatitis, TB and syphilis, and related services such as SRH, ANC and GBV. WHO has assisted the MOH to deliver integrated surveillance, testing, and treatment for HIV and STIs through the provision of guidelines and technical support. UNICEF, together with other Cosponsors, has supported the MOH to integrate triple elimination into the overall life cycle strategy. UNFPA has supported the integration of HIV into SRHR through engaging community networks in activities related to gender-based violence and out-of-school comprehensive sexuality education. The World Bank is supporting efforts to improve TB services, including for people living with HIV.

⁷² Implementation tool for pre-exposure prophylaxis of HIV infection - Integrating STI services. Geneva: World Health Organization; 2022 (<https://www.who.int/publications/i/item/9789240057425>, accessed 24 April 2023).

No priorities or deliverables are identified for the Joint Team for integration of HIV and PHC in **Botswana**, and no funds have been allocated to this. Individually some Cosponsors are supporting PHC strengthening and integration of HIV into health systems, primary care, or with other services and other sectors, and partners acknowledge UN agencies' technical assistance to government on integration especially around development of guidelines and capacity building. WHO has provided pivotal support for PHC revitalisation, including for costing services and assessing the human resources requirements for the Essential Health Services Package and in health systems strengthening. UNFPA has led the drive for service integration, in particular of HIV and SRH services for adolescents, and has been instrumental in bringing partners together. UNICEF has provided support to strengthen capacity to scale up HIV testing, treatment and care and integrated services, and for integration of HIV, syphilis and hepatitis B testing and treatment during pregnancy to accelerate progress towards triple elimination.

Since 2020, as part of the Joint UN plan under UBRAF funding, WHO has supported the piloting of the "PHC model of care initiative" in two districts in **Pakistan**. A package of services for HIV, viral hepatitis and STIs is being implemented as part of the pilot at primary care 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. WHO, in helping to shape the Lady Health Worker Strategic Plan 2022-2028, advocated for the inclusion of HIV-related content in the revised curriculum. Collaborative efforts between WHO, UNICEF and UNAIDS have supported the integration of HIV interventions into the broader health care system, aligning with UHC and updates to the Pakistan's AIDS strategy. While not part of the activities of the Joint Team with UBRAF funding, WHO and UNICEF supported the development of the UHC BP for Pakistan and HIV interventions at the community and primary care level have been included (as a special initiative with Global Fund financing).

The degree of service integration, and what is integrated, varies between regions and countries, in some cases reflecting what is appropriate for the health system and epidemiological context. Some informants commented that there is still more to be done in contexts where integration of specific services would make improve HIV and broader health outcomes. For example, WHO informants noted that, in the PAHO region, PMTCT is still not integrated into ANC in some countries, while UNFPA informants noted that in many contexts women living with HIV do not always have access to key SRH services such as family planning and safe abortion care. Leveraging sexual health services as a specific and logical entry point for mainstreaming HIV into broader PHC was suggested by UNFPA stakeholders. Respondents and the documents review suggest that the mix of services to integrate depends on context. The WHO 2021 global progress report on HIV, viral hepatitis and sexually transmitted infections noted that: "Although an increasing number of countries are organising strategies and planning frameworks across HIV, viral hepatitis and STIs, most are missing important opportunities to integrate and link services and responses to provide people-centred services that also leverage efficiency at the primary health care and health system levels". The Global Fund TRP found: "... positive examples of integration in the following areas: laboratory optimisation, community health workers, community-led monitoring for the three diseases, human rights and gender, but concluded that further integration is desirable across the three diseases (HIV, TB, Malaria), RMNCAH, SRH, and PHC."⁷³

Available data suggest that there has been progress on specific indicators, but there is no overarching framework or agreed core set of indicators for monitoring Joint Programme action or results on HIV and PHC integration efforts. There are multiple different targets and indicators related to HIV and PHC integration in different strategies and different monitoring and reporting mechanisms – including the Global AIDS Strategy, JPMS data reported for UBRAF indicators, Global AIDS Monitoring (GAM) indicators, National Composite Policy Index (NCPI), WHO GHSS and other

⁷³ TRP Window 1 Debrief [unpublished]. The Global Fund; 2023.

cosponsor strategies (Annex 8 provides a detailed overview of PHC related indicators and progress reported). Many of the indicators relate to specific *service* integration – for example, integration of HIV and TB or HCV or cervical cancer services – some relate to multisectoral policy and action or empowered communities, and very few to wider health system integration. Data for some indicators is not available or is not reported on (see Annex 8). This, together with changes in targets and indicators over time, makes it difficult to see the overall picture and to assess progress or achievements with respect to HIV and PHC integration and interlinkages.

During the previous UBRAF period, 2016-2021, Result Area 8 related to “people-centred HIV and health services are integrated in the context of stronger systems for health”. The UNAIDS 2021 Strategic result area 8 HIV and health services integration report⁷⁴ provided data for two key indicators under this result area, suggesting positive trends:

- Percentage of countries delivering HIV services in an integrated manner. Target 80% of reporting countries deliver HIV services in an integrated manner – in 2021, 71% of 87 reporting countries with a UNAIDS presence: 77% deliver integrated HIV, SRH and GBV services; 90% integrated HIV and TB services; 95% integrated HIV and ANC.
- National health insurance (and social health insurance where distinct), life or critical illness insurance, cover people living with HIV – in 2021, 73% of 69 countries having national health insurance reported that their insurance cover people living with HIV, up from 67% in 2016.

The current UBRAF (2022-2026) has more focus on HIV and PHC integration-related targets and indicators than the UBRAF 2016-2021 with multiple output indicators related to the PHC approach and integration across several result areas (see Table 5), however with less clear links to outcome indicators monitoring change at a higher level and with one indicator relating directly to primary care settings (see Table 5 – indicator 3.2.2)

Available data on UBRAF output indicators suggest that progress is on track (see Table 5). However, some of the UBRAF targets appear unambitious (with most being achieved already in 2022) and the evaluation team questions if they lead to achieving the related results in the Global AIDS Strategy. The full set of relevant PHC related UBRAF 2022-2026 output indicators and their progress by 2022 are available in Annex 8.

Table 5: HIV and PHC integration and interlinkages – progress against selected UBRAF 2022-2026 targets and output indicators

UBRAF 2022-2026			
Result Area	Indicator (Output)	2026 Target ⁷⁵	Progress 2022 ⁷⁶
Result Area 2: HIV treatment	2.1.1 Number of countries supported by the Joint Programme that have implemented innovations to optimize access to integrated HIV and co-morbidity/co-infection services (Indicator based on WHO GHSS guidance)	50 countries adopt at least 2 key recommendations from the guidance by 2026	On track: WHO is developing the guidance for integrated service delivery and framework for collaborative action in 2023. WHO will develop a measurement that will be mapped to GAM reporting, with additional data efforts to track this area implemented directly with countries from end-2023. This will provide reporting for 2024 for intermediate reporting towards the 2026 target

⁷⁴ SRA 8: HIV and health services integration. Geneva: Joint United Nations Programme on HIV/AIDS; 2022 (https://open.unaids.org/sites/default/files/documents/SRA8_SRA%20report_2021_0.pdf, accessed 24 April 2023).

⁷⁵ Indicator Matrix for the 2022-2026 UBRAF and Indicators, milestones, targets and data sources for the 2022-2023 Workplan and Budget. Geneva: Joint United Nations Programme on HIV/AIDS; 2022 (https://www.unaids.org/en/resources/documents/2022/PCB50_Indicator_Matrix_UBRAF, accessed 24 April 2023).

⁷⁶ Indicator Scorecard: 2022 Performance Monitoring Report. Geneva: Joint United Nations Programme on HIV/AIDS; 2023

Result Area 3: Paediatric AIDS, vertical transmission	3.2.2 Number of countries supported by the Joint Programme which have HIV services for children integrated into at least 50% of PHC sites (Indicator linked to the Global Alliance to End AIDS in Children)	45 countries join the Global Alliance to End AIDS in Children and provide services for children with HIV that are integrated into Primary Health Care by 2026.	On track: In 2022, 72 countries had HIV services for children integrated into facilities providing PHC and the Joint Programme supported the integration of these services in primary health care sites in 63 countries
Result Area 7: Young people	7.1.1 Number of countries supported to scale-up multisectoral interventions that align with ministerial commitments to increase access to youth-friendly SRH services, including CSE, to improve young people's well-being	At least 40 countries supported by the Joint Programme implement ministerial commitments to scale-up multisectoral intervention to increase access to youth-friendly SRH services and quality education, including CSE by 2025	On track: In 2022, the Joint Programme supported 51 countries in scaling up multisectoral interventions that align with their ministerial commitments to increase access to youth friendly SRH services, including CSE to improve young people's well-being. Support provided by the Joint Programme included: policy guidance (55 countries); capacity building (68); strategic information/evidence generation and use (54); technical support (64); advocacy/communication support (63); financial support (42); sharing good practices and facilitating cross-country cooperation (40)
Result Area 8: Fully funded, sustainable HIV response	8.1.1 Number of countries supported by the Joint Programme that have developed and report implementation of measures advancing full and sustainable HIV financing	44 countries (baseline 32 countries plus 12 additional countries): 5 (2023), 5 (2025), 2 (2026)	On track: The Joint Programme provided support and guidance to 36 countries to identify HIV financing trends (e.g., NASA or NHA) as well as gaps and opportunities. Support provided by the Joint Programme included: HIV sustainability and/or transition plans (26 countries); HIV financing assessments (21); HIV financing integration into domestic budgets (20); community-led response financing and/or social contracting (23)
Result Area 9: Integrated systems for health and social protection	9.1.1 Number of countries supported by the Joint Programme to have HIV antiretroviral services, for both treatment and prevention purposes, organized and financed as part of overall health systems, including through PHC	60 countries supported by the Joint Programme to have key HIV services (ART, PEP and PrEP) included in the national health benefit package	On track: In 2022, the Joint Programme supported 67 countries to establish ART services organized and financed as part of the overall systems. The following services are included in primary health care services in these countries: combination ART for treatment of HIV (50 countries); PrEP (52 countries); PEP (44 countries); HIV drug sensitivity testing (19 countries).
Result Area 9: Integrated systems for health and	9.1.2 Number of countries supported by the Joint Programme, that have included cervical cancer screening and treatment	At least 80 countries supported by the Joint Programme to include cervical cancer screening and	On track: In 2022, 48 countries received support from the Joint Programme to include cervical cancer screening and treatment for women living with HIV in

social protection	for women living with HIV in the national strategies, policies, plans or guidelines for HIV, cancer, cervical cancer, noncommunicable diseases or other health areas	treatment for women living with HIV in the national strategies, policies, plans or guidelines for HIV, cancer, cervical cancer, NCDs or other health areas	national strategies, policies, guidelines and/or plans for HIV, cervical cancer, NCDs or other health areas. In these countries, cervical cancer is included in one or more of the following: national strategy, policy, plan, or guidelines for cancer (including any cervical cancer specific ones) (49 countries); broader response to NCDs (35 countries); national strategic plan governing the HIV response (41 countries); national HIV treatment and/or testing guidelines (43 countries).
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The UBRAF 2022-2026 includes high-level actions to achieve results for Joint Programme Result Area 9: Integrated systems for health and social protection, and the UBRAF 2022-2023 workplan includes specific outputs and Joint Programme areas of interventions that relate to HIV and PHC integration aspects. However, it is unclear how implementation of these actions and interventions is monitored (see Box 11).

Box 11: HIV and PHC integration– relevant UBRAF outputs and Joint Programme proposed actions⁷⁷

Joint Programme Result Area 9 in the UBRAF 2022-2026 at output level is: Increased access for people living with, at risk of and affected by HIV to integrated health services, health technologies and social protection.

Joint Programme high-level actions to achieve results include:

- Supporting country stakeholders to strengthen inclusive systems for health for integration and linkages of HIV services in testing, treatment and care for other diseases and co-morbidities such as TB, viral hepatitis, and sexually transmitted infections, and in mental health, sexual and reproductive health and family planning, non-communicable diseases, primary health care, community health systems, universal health coverage and social protection;
- Leveraging in-country capacity to ensure that HIV is reflected in national universal health coverage and social protection agendas, including building capacity in planning, financing, implementation, monitoring and evaluation; and
- Supporting and guiding health system strengthening to reduce inequalities, eliminate stigma and discrimination, implement integrated and differentiated services, improve health information systems, support and integrate community-led responses, and strengthen consolidated procurement, supply management and multipurpose laboratory systems.

Specific outputs and Joint Programme areas of interventions (deliverables) relevant to HIV and PHC integration in the UBRAF 2022-2023 workplan and budget are:

Outcome 1: HIV prevention – The Joint Programme’s areas of interventions for 2022-2023 include:

- Promoting stronger integration and scale-up of SRH services with HIV prevention for women and girls, and men and boys (including VMMC).

⁷⁷ 2022-2026 unified budget results and accountability framework (UBRAF). Geneva: Joint United Nations Programme on HIV/AIDS; 2021 (https://www.unaids.org/sites/default/files/media_asset/PCB_SS_2022_2026_UBRAF_Framework_EN.pdf, accessed 24 April 2023).

Output 2: HIV testing and treatment – The Joint Programme’s areas of interventions for 2022-2023 include:

- Supporting countries to set up or strengthen referral systems (including protection for safe disclosure) and promote integration of stigma-free HIV testing in a broad array of health services and health-enabling services (related Outcome indicator: Stigma and discrimination - Percentage of people living with HIV who report experiences of HIV-related discrimination in health-care settings Data source: GAM 6.4);
- Promoting and support integrated, people-centred, context-specific services and service delivery approaches, including integration with or links to services for TB, viral hepatitis, cervical cancer, NCDs, mental health, STI prevention and treatment, contraception and other sexual and reproductive health, CSE and in the context of primary health care and universal health coverage.

Output 3: Paediatric HIV and vertical transmission – The Joint Programme’s areas of interventions for 2022-2023 include:

- Strengthening systems to effectively integrate prevention services (including PrEP) for HIV-negative pregnant and lactating women and their partners; integrate HIV testing and the use of optimal regimens in maternal and child health programmes and primary health care; improve retention in care and adherence to HIV treatment during pregnancy and breastfeeding; and ensure support for treatment adherence among adolescents, especially those who were born with HIV and are under long-term antiretroviral treatment and their transitioning to adult treatment programme;
- Provide technical support, guidance and advocacy to strengthen the integrated implementation of HIV, maternal and child health, expanded programme on immunization (EPI), sexual and reproductive health and rights (including contraception, prevention and control of sexually transmitted infections), comprehensive sexuality education and other relevant programmes to provide a seamless continuum of care and service delivery that meets the needs of girls and women and their children within primary health-care and universal health coverage frameworks.

Output 9: Integration and social protection– The Joint Programme’s areas of interventions for 2022-2023 include:

- Providing normative and technical guidance for identifying and addressing health inequities; capacity building for integrating HIV, health and social protection programmes; continued support to countries to monitor who is being left behind in the provision of HIV services; and remove barriers to HIV services;
- Supporting and guide the strengthening of the building blocks of strong health systems. This includes integrated and differentiated health services delivered through primary health-care facilities and/or community-led organizations; improved health information and procurement management system to ensure efficient HIV and other health service delivery; investments in HIV prevention and treatment interventions as part of overall health financing, as enablers for broader development and as key contributors to universal health coverage; and capacity building to improve consolidated effective procurement supply management and to optimize a multipurpose laboratory systems;
- Providing normative and technical guidance and capacity building in planning, financing and monitoring of social protection and contribute to people-centred, rights-based and integrated health services (e.g., HIV, TB, viral hepatitis, STIs, SRH, cervical cancer, NCDs, GBV, mental health at primary health-care level, and linkages to social protection and economic support) for the health and well-being of people living with, at risk of and affected by HIV and other key populations.

Promoting, guiding and monitoring system-wide training for the elimination of the multiple, intersecting forms of stigma and discrimination in health care systems.

The Global AIDS Strategy 2025 targets that are most relevant to integration are:

- Ensure that 90% of people living with HIV receive preventive treatment for TB by 2025.
- Reduce numbers of TB-related deaths among people living with HIV by 80% by 2025.
- Invest in robust, resilient, equitable and publicly funded systems for health and social protection systems that provide 90% of people living with, at risk of and affected by HIV with people-centred and context-specific integrated services for: HIV and other communicable diseases; NCDs; SRH care; GBV; mental health; palliative care; treatment of alcohol dependence; drug use legal services; and other services they need for their overall health and well-being.

The first of these is reflected in GAM and the second in global TB monitoring, the third is only partially reflected in different indicators and monitoring and reporting mechanisms. The UNAIDS 2023 Global AIDS Update reports that between 2005 and the end of 2021, 16 million people living with HIV were initiated on TB prevention treatment, less than half of the 38.4 million people estimated to be living with HIV and far short of the 90% target. It also reports that in 2021 there were 67% fewer TB-related deaths among people living with HIV compared with 2010.

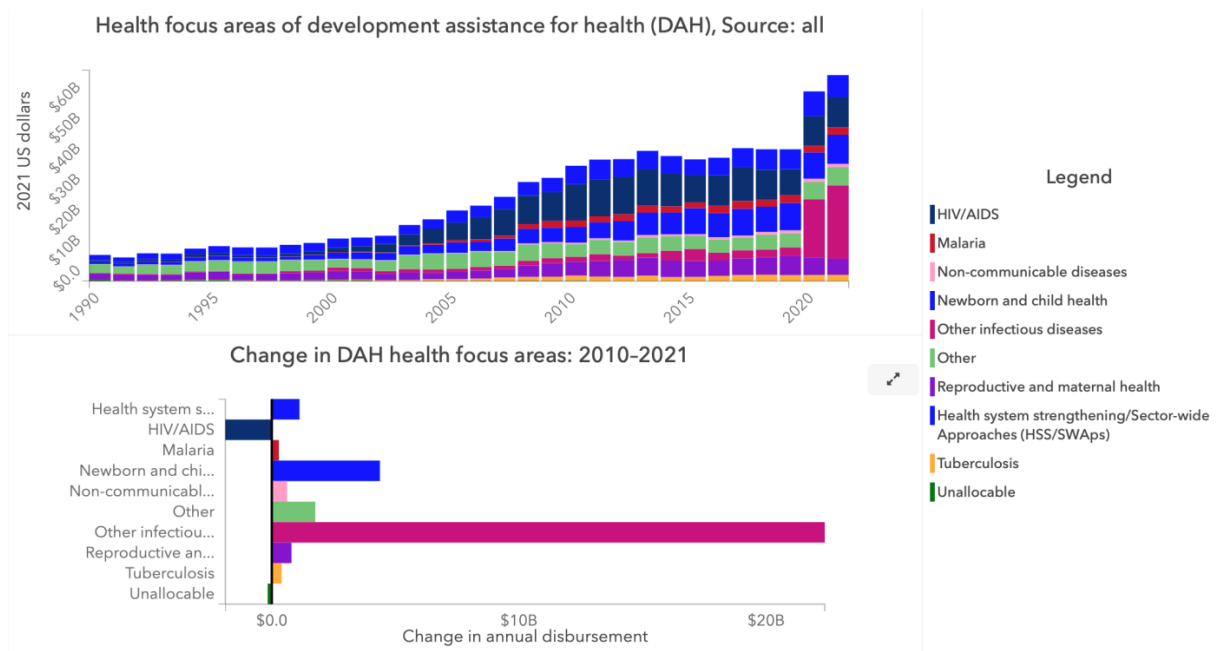
The UNAIDS Performance Monitoring Report 2022 reports that monitoring of domestic financing for HIV and HIV/TB in 64 countries improved due to the UNAIDS Secretariat's collection of data on expenditures, government budgets and ARV prices through the GAM. However, data on inclusion of HIV in UHC and health benefits packages is scattered, mostly based on country self-reporting and sometimes contradictory. The World Bank is working to address this through datasets such as the Health Equity and Financial Protection Indicators, the Health, Nutrition and Population Data Portal, and the Primary Health Care Performance initiative, which is also supported by UNICEF and WHO.

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

Financial sustainability for the HIV response is a significant concern. The substantial progress made against HIV/AIDS over time has been facilitated by significant international and domestic financing (see Figure 3). Progress has been strongest in the countries and regions with the greatest financial investments, such as in eastern and southern Africa where new HIV infections have been reduced by 57% since 2010.⁷⁸ However, as shown at the bottom of Figure 3, development assistance for health for HIV/AIDS declined between 2010 and 2021, whereas it increased for all other health areas.

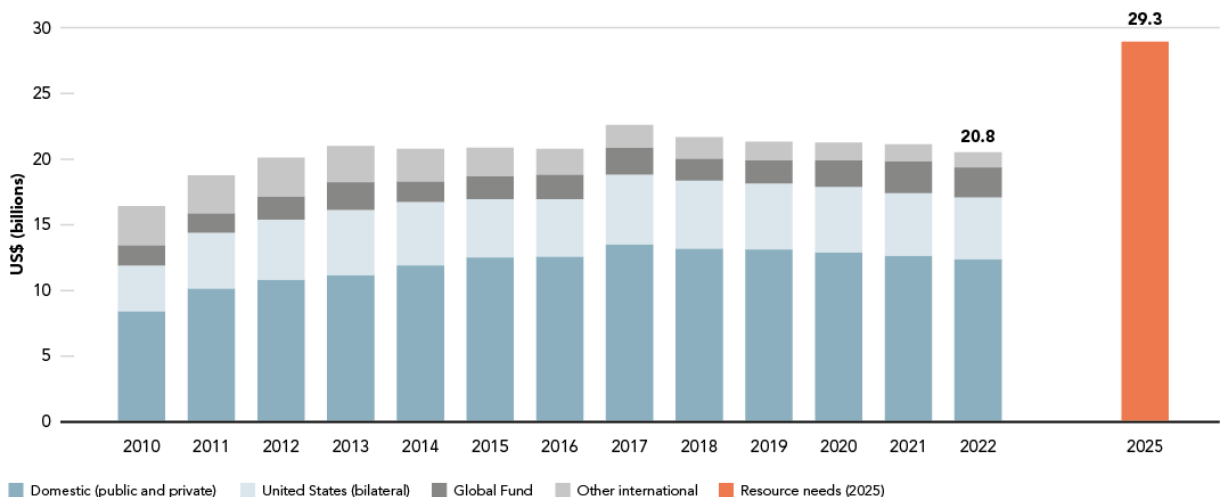
⁷⁸ UNAIDS. The path that ends AIDS: UNAIDS Global AIDS Update 2023. Geneva: Joint United Nations Programme on HIV/AIDS; 2023. Licence: CC BY-NC-SA 3.0 IGO.

Figure 3: External/international resources for the HIV response over time⁷⁹



As shown in Figure 4 below, funding for HIV further declined in 2022 from both international and domestic sources, falling back to the same level as in 2013, creating a widening global HIV funding gap. While domestic investments increased to 60% of total resources in 2022 from about 50% in 2010, this remains at odds with financing patterns for overall health spending in low- and middle-income countries (LMICs), which is financed almost exclusively domestically. Fiscal constraints and competing claims on public spending further explain why almost half of the 62 countries that reported trends to UNAIDS in their public budget allocations for HIV for 2024 anticipate that their annual HIV budgets will be at 2023 levels or lower.⁸⁰

Figure 4: Resource availability for HIV in LMICs by source of funding, 2010–2022 and 2025 target⁸¹



⁷⁹ Institute for Health Metrics and Evaluation (IHME). Financing Global Health. Seattle, WA: IHME, University of Washington, 2023. Available from <http://vizhub.healthdata.org/figh/>. (Accessed 1 August 2023).

⁸⁰ UNAIDS. The path that ends AIDS: UNAIDS Global AIDS Update 2023. Geneva: Joint United Nations Programme on HIV/AIDS; 2023. Licence: CC BY-NC-SA 3.0 IGO.

⁸¹ Ibid

Domestic resource mobilisation remains the key driver of sustainable financial resources for HIV in LMICs. UNAIDS notes that further progress will require increased domestic revenue mobilisation, through progressive tax reforms and control of tax evasion, and through the introduction of targeted health taxes (such as “sin taxes” for alcohol or tobacco use or excessive carbon emissions). However, there remains a strong need to sustain international financing, including through innovative financing mechanisms such as trust funds, social impact bonds and blended financing, for HIV programmes.⁸²

There is a role and mandate for the Joint Programme to build political commitment for sustainable HIV financing and sustainable financing for PHC and UHC that drives HIV impact, but how to operationalise this is not well defined and its potential role is not fully leveraged. Financing for HIV features in both the UNAIDS 2016-2021 Strategy and the current Global AIDS Strategy 2021-2026. However, while successive global AIDS strategies have recognised that the current financing agenda is not about HIV alone but situated within the UHC and SDG contexts, there is a lack of clarity about what this means in practice and how it relates to the work of the Joint Programme. The challenge of developing a coherent and shared vision of the Joint Programme’s role in building political commitment for sustainable HIV financing in the context of PHC/UHC is exacerbated by a subtle but important difference in how the Joint Programme approaches sustainable HIV financing (which is focused on financing for the HIV response within a PHC/UHC approach) vis-à-vis the mandates of cosponsor agencies (which are more broadly focused on health and development, and on financing UHC and the SDGs with HIV as a priority therein).

The Joint Programme has played an important role in building political commitment for HIV in countries through a range of activities (see Box 12). However, more could be done to resolve the gap between political commitments made and material change to domestic financing overall and for key aspects of the response, for example, HIV prevention and services for key populations.⁸³ The recent evaluation of UNAIDS work on key populations found that, in most of its county case study countries, “Although sustainable financing and programming mechanisms to support key population-led responses is recognized globally as essential, this has not been a priority area of work for Joint Programme teams”.⁸⁴

A 2022 evaluation of the Joint Programme’s work on efficient and sustainable financing⁸⁵ found that its potential comparative advantages for building political commitment for sustainable HIV financing in the context of UHC are not always fully leveraged. This reflects issues with coordination across the Joint Programme, which can result in the UNAIDS Secretariat assuming responsibility for functions despite Cosponsors being better placed. One example is tax reform within the macroeconomic financing agenda, for which the UNAIDS Secretariat has limited capacity, but the role of Cosponsors that do have expertise and ongoing programmes of support – for example, UNDP and the World Bank – is often unclear.⁸⁶ A particular missed opportunity exists where the World Bank is actively engaged in health financing reform with ministries of finance and tax and revenue authorities, yet coordination with the Joint Programme is weak, such as in Tanzania.⁸⁷ Some informants for this evaluation accordingly noted that the Joint Programme had not sought to mobilise civil society’s potential advocacy role.

Another barrier to building political commitment for sustainable HIV financing within the context of PHC is the historic high level of HIV financing compared to other health priorities. Evidence suggests that this has created a sense among some agencies that health financing reform should not focus

⁸² UNAIDS. The path that ends AIDS: UNAIDS Global AIDS Update 2023. Geneva: Joint United Nations Programme on HIV/AIDS; 2023. Licence: CC BY-NC-SA 3.0 IGO.

⁸³ CEPA (2022) Joint evaluation of the UN Joint Programme on AIDS’s work on efficient and sustainable financing. UNAIDS. Available at: <http://www.unaids.org/en/whoweare/evaluation>.

⁸⁴ UNAIDS, March 2022. Joint evaluation of the UN Joint Programme on AIDS’ work on key populations (2018-2021)

⁸⁵ Evaluation Offices of UNAIDS and UNFPA, March 2022. Joint Evaluation of the UN Joint Programme on AIDS’ work on efficient and sustainable financing.

⁸⁶ It is understood that part of the issue is related to a fundamental flaw in the cosponsor model for the financing workstream, where programme departments are represented rather than health financing departments.

⁸⁷ CEPA (2022) Joint evaluation of the UN Joint Programme on AIDS’s work on efficient and sustainable financing. UNAIDS.

explicitly on HIV but on other less well-resourced areas. This issue has been exacerbated by reduced UBRAF funding over time which has reduced Cosponsors' ability to pay attention to HIV financing.⁸⁸

Box 12: Examples of the Joint Programme's work to build political commitment for sustainable HIV financing in the context of PHC^{89,90}

- **Global fora:** the UNAIDS Secretariat and a number of cosponsor agencies are members of the WHO-hosted UHC2030 Sustainability and Transitions working group and the SDG3 Global Action Plan Accelerator theme on 'Sustainable health financing', where HIV is a core issue positioned amongst other SDG3 priorities. These fora and other global level engagement help to build a coherent movement among global agencies, contributing to political commitment being built at the country level.
- **High-level engagement:** A key role of the Joint Programme is to engage with senior politicians to advocate directly for sustainable financing, which can be a powerful tool. This can involve in-country staff liaising with government and senior international delegations visiting countries.
- **Convening:** The Joint Programme is widely recognised to have an ability to bring together different agencies, government as well as civil society, to build consensus and political commitment, for increased, diversified, and sustained HIV financing but also to some extent for PHC. In Vietnam, Joint Programme work to convene partners around an HIV investment case for 2012-2015 laid the ground for negotiations for government to gradually take on ARV costs through Social Health Insurance.
- **Strategic information:** The generation and collation of strategic information, specifically the epidemiological information that supports financing allocations, but also financing information at global, regional and country levels (e.g., via NASAs) is considered to be important.
- **National strategic planning:** Drawing in part on the strategic information noted above, the Joint Programme has a significant role in the development of NSPs and longer-term investment cases which express political commitment to financing by setting out financial needs. In turn they are used to raise domestic and external resources, and to guide resource allocation.
- **Cost effectiveness and efficiency analyses:** A range of work is conducted by partners, including the UNAIDS Secretariat, World Bank, Global Fund and PEPFAR on cost-effectiveness/efficiency analyses of specific interventions as well as programme responses.⁹¹ There is often little coordination of this work and more is required, particularly around domestic resources. A coordinated campaign was, however, conducted through the UN 2gether 4 SRHR Programme.⁹²
- **Analyses of social enablers and barriers to HIV programme effectiveness:** The Joint Programme's work in this area, led by UNDP, is part of an effort to build the evidence base and country experience in intersectoral co-financing for UHC and to reach the SDGs.⁹³
- **Financing sustainability and transition plans:** A range of work is conducted by the Joint Programme in this area, often with Global Fund support (as the Botswana case study highlights).⁹⁴ Reporting against UBRAF indicators suggests that in 2022 the Joint Programme

⁸⁸ CEPA (2022) Joint evaluation of the UN Joint Programme on AIDS's work on efficient and sustainable financing. UNAIDS.

⁸⁹ Ibid

⁹⁰ UNAIDS (2023) Results for organisation: 2022 performance monitoring report.

⁹¹ Regional and Country Report: UNAIDS 2020-2021 performance monitoring report. Geneva: Joint United Nations Programme on HIV/AIDS; 2022.

⁹² 2020 Annual Narrative Report. Geneva: Joint United Nations Programme on HIV/AIDS, United Nations Population Fund, x WHO; 2020 (https://esaro.unfpa.org/sites/default/files/pub-pdf/2020_annual_narrative_report_final_1.pdf, 24 April 2023).

⁹³ Stangl A. Manuscript Draft. "Removing the societal and legal impediments to the HIV response: an evidence-based framework for 2025 and beyond" PLOS One.

⁹⁴ Organizational Report 2020-2021 Performance Monitoring Report. Geneva: Joint Programme; 2022 (https://www.unaids.org/en/resources/documents/2022/PCB50_UBRAF_PMR_Organizational_Report, accessed 24 April 2023).

provided support and guidance to 36 countries to identify HIV financing trends (e.g. NASA or NHA) as well as gaps and opportunities, including HIV sustainability and/or transition plans in 26 countries, HIV financing assessments in 21 countries, and HIV financing integration into domestic budgets in 20 countries. However, this is often ad hoc and without coordination across partners or with sufficient consideration of the wider health context. Transition remains a challenging issue for countries to deal with.

- **Engaging civil society:** The Joint Programme’s work to engage civil society in dialogue and key processes is recognised as important for channelling financing to CSOs to support service provision. This is further supported by UNDP’s work, and the work of other Cosponsors, on social contracting.^{95,96} UBRAF reporting suggests that in 2022 the Joint Programme provided support and guidance to 23 countries for community-led response financing and/or social contracting. However, there is limited evidence that this work was to strengthen CSO capacity to engage with government systems (although the Indonesia case study does highlight some evidence of this).
- **Strengthening financing systems:** The Joint Programme works to strengthen health financing systems, including through the Alliance for Anti-Corruption, Transparency and Accountability in Health, which works with governments and communities to institutionalise appropriate anticorruption mechanisms.⁹⁷ The presence of strong financing systems can act as a precursor to further political commitment to health financing.
- The importance of the Joint Programme’s work in these areas is often amplified as countries transition from donor support, for example in Kazakhstan, Cambodia, and Vietnam. These examples also demonstrate the importance of the Joint Programme working at the sub-national level in devolved systems of governance where local governments are responsible for domestic resource allocation.⁹⁸

The case studies in Indonesia and Pakistan conducted for this evaluation highlight that this is, however, inconsistent across countries.

The available evidence on the extent to which HIV services are being included in health benefits packages is mostly based on country self-reporting and sometimes contradictory; and progress appears to be highly variable across countries. Integration of HIV and other relevant health services can enhance the accessibility and uptake of services in an equitable manner enabling stigma-free access to key populations and a people-centred approach to care.⁹⁹ The 2022 evaluation of the Joint Programme’s work on efficient and sustainable financing found that, despite the emphasis on PHC/UHC in its Global Strategies and positive work in building political will, HIV services are not yet included in health benefits packages in many countries scaling or introducing UHC, often because these services are well funded by external donors.¹⁰⁰ Often the key challenge is transition from external funding to inclusion of HIV services in domestic financing mechanisms.

The 2022 UNAIDS UBRAF performance monitoring report states that 67 countries have ART services, for both treatment and prevention purposes, organised and financed as part of overall health systems, including through primary health care.¹⁰¹ The UNAIDS Laws and Policies Database suggests

⁹⁵ <https://www.undp-capacitydevelopment-health.org/en/transition/social-contracting>; UNAIDS (2023) Results for organisation: 2022 performance monitoring report.

⁹⁶ Financing community-led HIV responses: social contracting—using domestic resources to fund HIV service delivery by community-led organizations. Geneva: Joint Programme; 2023 [forthcoming]. Cited in UNAIDS 2023 Global AIDS Update.

⁹⁷ UNAIDS (2021) SRA 7: Investment and efficiency: SRA report 2020.

⁹⁸ CEPA (2022) Joint evaluation of the UN Joint Programme on AIDS’s work on efficient and sustainable financing. UNAIDS.

⁹⁹ Economist Impact, 2023. A triple dividend: The health, social and economic gains from financing the HIV response in Africa.

¹⁰⁰ CEPA (2022) Joint evaluation of the UN Joint Programme on AIDS’s work on efficient and sustainable financing. UNAIDS.

¹⁰¹ PrEP (52 countries), combination ART (50 countries), PrEP (44 countries), and HIV drug sensitivity testing (19 countries). UNAIDS (2023) Results for organisation: 2022 performance monitoring report.

that benefits packages for universal health insurance schemes include ARVs in 48 countries (of 72 reporting) and PrEP in 21 countries (of 76 reporting).¹⁰² However, even in Vietnam and Kazakhstan, where ARV costs are now covered by social health insurance (SHI), efforts to integrate HIV into UHC financing and broader work on UHC are reportedly poorly coordinated.^{103,104} A recent UNAIDS review of health insurance schemes in the Asia-Pacific region found that five of the six countries studied had a national health insurance scheme that included HIV treatment, but coverage of HIV prevention services is absent, except for some services in Thailand, which is internationally recognised for successfully integrating HIV services into a benefits package as part of its Universal Coverage Scheme.¹⁰⁵ Further, a range of barriers impede key population enrolment into these insurance schemes.¹⁰⁶

The Joint Teams are assisting governments to establish legal frameworks around social contracting as a critical first step in sustainability of community-led HIV service delivery, efforts which need to be scaled. Through the TSM, the Joint Programme is assisting in establishing social contracting mechanisms in 85 countries including work on costing and integrating community-led delivery in Thailand's UHC package. Examples of successful social contracting developed with support of the Joint Programme include delivery of HIV prevention services by a community-based organisation in Vietnam and of prevention and testing services by a sex worker-led organisation in Guyana.¹⁰⁷ Despite these and the documented successes, only 45 of the 80 countries reporting on the existence of legal frameworks for social contracting mechanisms allowing for domestic funding to community-led organisations, highlighting the fact that scope for government funding of non-government organisations depends considerably on the country regulatory, and political, context.¹⁰⁸

2.3 What are the main enablers and barriers to integrating HIV into PHC in various contexts and how is the Joint Programme addressing these at country level?

The evaluation identified a range of political, policy, institutional, financing, health system, legal and other enablers and barriers to applying the PHC approach to HIV responses. The most common enablers and barriers, identified by key informants, survey respondents and during country visits, have been broadly categorised into those that relate to the Joint Programme and those that relate to the country and wider context. These are summarized in Table 6 below.

¹⁰² <https://lawsandpolicies.unaids.org/topics?lan=en>.

¹⁰³ In Vietnam, the Joint Programme played a key role in supporting government to transition ARV costs to the social health insurance scheme. Current efforts are focused on advocacy for integration of PrEP, building on the results of a pilot.

¹⁰⁴ CEPA (2022) Joint evaluation of the UN Joint Programme on AIDS's work on efficient and sustainable financing. UNAIDS.

¹⁰⁵ Services include counselling and testing, PMTCT, lab testing to monitor HIV treatment, and positive prevention (i.e., a method of reducing HIV transmission by involving people with HIV in prevention strategies). Integration of HIV and AIDS services took place in 2006. Key factors that enabled Thailand's success include sustained political commitment, sound public financing, national ownership and strong engagement from civil society. Economist Impact, 2023. A triple dividend: The health, social and economic gains from financing the HIV response in Africa.

¹⁰⁶ UNAIDS (2022) Key populations are being left behind in UHC: landscape review of health insurance schemes in the Asia-Pacific region.

¹⁰⁷ Made possible through the Thai National Health Security office making available \$US6 million to CSOs (mainly KPs)

¹⁰⁸ Organizational Report 2020-2021 Performance Monitoring Report. Geneva: Joint Programme; 2022

Table 6: Commonly cited enablers and barriers to applying the PHC approach to HIV responses

	Joint Programme	Country context
Enablers	<ul style="list-style-type: none"> ▪ Commitment in the Global AIDS Strategy and, specifically, Results Areas 8 and 9. ▪ Added value of the Joint Programme (see EQ5). ▪ Some normative and technical guidance already developed e.g., WHO PHC and HIV: convergent actions; WHO and UNAIDS implementation guidance on integrating NCDs in HIV, TB and SRH programmes. ▪ The Joint Programme is a multisectoral platform and UNAIDS as pioneers of community engagement and empowerment strategies. ▪ The Joint Programme and Cosponsors have complementary skills with potential for synergies. 	<ul style="list-style-type: none"> ▪ Global, regional and country commitments to HIV integration and PHC e.g., Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030; Astana Declaration on Primary Health Care. ▪ Government leadership e.g., Botswana, Ethiopia, Namibia, Rwanda. ▪ Policy frameworks for PHC and integrated service delivery e.g., Indonesia health transformation initiative; Botswana EHSP and revitalisation of PHC; Pakistan UHC Benefit package. ▪ Existing infrastructure e.g., Pakistan primary care facilities and frontline workforce. ▪ SOPs and tools for health facilities. ▪ Increased scope to manage HIV at the decentralized level and adoption of differentiated service delivery approaches and virtual interventions. ▪ Incentives to integrate.
Barriers	<ul style="list-style-type: none"> ▪ Lack of common understanding, joint plans, agreed core global indicators. ▪ Lack of clarity about what to integrate and how, and how to determine the appropriate combination of integrated and specialised services in different contexts. ▪ Weak leadership on HIV and PHC integration – fragmented efforts. ▪ Focus on the HIV response taking a PHC approach rather than integration of HIV within a PHC response. ▪ UNAIDS with no mandate on broader health issues. ▪ Concerns about reversing gains, compromising quality of HIV care and HIV data, and exclusion of key populations. ▪ Competition between agencies for resources and turf issues. ▪ Limited funding and lack of incentives for Joint Teams to prioritize HIV and PHC integration. ▪ Limited engagement of World Bank in Joint Teams and of WHO in HIV in some countries. ▪ Different approaches to the ‘community’ PHC pillar e.g., UNAIDS focus on community-led service delivery vs. WHO (and MOH, AU, Africa CDC) focus on CHWs delivering frontline services who are managed and supervised by professional health workers. 	<ul style="list-style-type: none"> ▪ Lack of political commitment to PHC. ▪ Concerns about loss of funding among government and CSO HIV stakeholders. ▪ Donor agendas, vertical funding and incentives to maintain the status quo. ▪ Parallel HIV systems for e.g., service delivery, procurement, laboratory services, M&E. ▪ Weak coordination between MOH and NAC and within MOH; capacity of MOH to lead a multisectoral approach. ▪ Underfunding and weak capacity of primary care; where the focus is on Maternal and child health and communicable diseases, not well placed to manage chronic conditions. ▪ Health system investment in tertiary levels, rather than primary care facilities. ▪ Primary care facilities not client-centred e.g., not male or youth friendly, inflexible opening hours, lack of privacy and confidentiality. ▪ Shortages of HRH at primary care level; lack of HIV knowledge and skills of primary care health workers in low prevalence contexts; negative and discriminatory health worker attitudes; costs associated with training, sensitizing and supervising primary care workers. ▪ Stigma and discrimination towards people living with HIV and key populations in health care settings; criminalization and discriminatory laws; other barriers to accessing health care e.g., for women and young people. ▪ Minimum package approach to UHC benefits packages and a focus on diagnostics and treatment. ▪ Government inability or reluctance to fund CBOs; CBO concerns about strings attached to government funding.

Key enablers and barriers identified by country case studies for this evaluation are described in more detail below in the box below.

Box 13: Enablers and barriers to integration from country case studies

Indonesia: Supportive policy framework for PHC, but health system weaknesses pose challenges for HIV integration

The government's health transformation initiative aims to transform the health care system to a PHC approach.¹⁰⁹ This presents an opportunity for advocacy by the Joint Team to ensure that HIV is included in integrated primary care services, in multisectoral policy and action (e.g., the involvement of different ministries in initiatives such as school- and work-based health education) and in community engagement (e.g. training for volunteer community health workers). There are also opportunities for the Joint Team to leverage existing mechanisms for cross-sector coordination and to build on strong cross-government leadership on national responses to TB and stunting.

Existing weaknesses in the health care system, for example, in supply chain management and laboratory services, pose challenges to the integration of HIV. The 2020-2022 Joint National HIV and STI Control Programme review highlighted the need to strengthen the logistics system to ensure uninterrupted supply of commodities and to strengthen the capacity of district and provincial health programme managers. The capacity of primary care systems and the effectiveness of implementation of the national HIV programme varies by location due to the decentralised health system and dependence upon local government priorities and budgeting. Health care access also varies, depending on health facility coverage and availability of health workers. Indonesia has a number of laws that affect provision of and access to services for key populations, including the criminalisation of sex workers, people who inject drugs and men who have sex with men.

Angola: Opportunities for the Joint Programme to support HIV and PHC integration and to enhance coordination efforts

In Angola, the new UN Sustainable Development Cooperation Framework (UNSDCF 2024-2028) has a more prominent focus on PHC, which includes addressing social protection, inequalities, human rights, gender, and youth. According to informants, this commitment to the government presents an opportunity to further HIV integration into PHC and strengthen the PHC agenda and for the UN (including the Joint Programme) to strengthen its engagement with government on a whole of society approach. More specifically, there are opportunities for the Joint Team to support HIV and PHC integration, building on previous cosponsor support for government PHC-related policy, planning and financing strategies. "Joint Team agencies have been identified for provision of technical assistance under the primary health care financing action plan and are therefore in a position to help ensure that HIV financing is looked at in the context of PHC financing and the wider context of UHC financing, building on existing costing exercises, ensuring that HIV is part of a basic benefit package." The First Lady's Initiative, which focuses on PMTCT and which the Joint Programme helped to design, implement and monitor, serves as an example of cultivating a champion for the convergent HIV and PHC agenda. Other opportunities identified include the involvement of the private sector and scope for the Joint Programme to facilitate dialogue between the Ministry of Health and the Ministry of Mining and Petrol.

Strengthening the coordination capacity of the MOH, both internally and externally with other ministries and key stakeholders, is required to accelerate integration efforts at all levels. For example, the ministerial decree in 2018 defined the path for integration of HIV and TB service

¹⁰⁹ The Omnibus Health Bill passed in June 2023 has PHC as the first pillar of its Health Transformation Initiative; efforts by the Indonesian government to implement a holistic primary health care system are still in early stages.,

delivery, using a one-stop shop service model that has had some success at reference hospitals. There is a need for further investment in capacity building and for clear leadership and coordination at provincial and municipal levels. The Joint Programme provided technical assistance for the one-stop shop service model at central level and to some provinces, and there is potential to expand this.

Pakistan: Supportive policy and UHC context but significant barriers to integration to be overcome

The main enablers include existing policy for PHC and integration of HIV with the UHC Benefits Package (UHC BP). The National Health Vision for Pakistan (2016-2025)¹¹⁰ recognises the importance of primary health care and proposes to increase investments and institute pro-poor social protection initiatives to facilitate access to essential primary and secondary care services. It also recognises the potential of health care delivered at community level by Lady Health Workers, community midwives and other community-based workers. Pakistan also has a large infrastructure of PHC facilities across the country. HIV interventions at community and primary care level have been included in the UHC BP, but as a special initiative, which means that these services are funded entirely by external resources (Global Fund). HIV programming remains largely separate, but the Pakistan AIDS Strategy IV (2022-2026) proposes establishing coordination mechanisms at provincial level led by the Department of Health with the involvement of AIDS, TB, malaria, MCH, SRH and hepatitis programmes, as well as key stakeholders from other sectors, civil society, PLHIV and key population representatives. The UNSDCF 2023-2027 explicitly identifies strengthening the HIV response in Pakistan under the health domain and includes a focus on UHC and eliminating HIV-related stigma and discrimination.

The main barriers to HIV and PHC integration are lack of political commitment, limited health funding, lack of comprehensive strategies, and stigma and discrimination. The government only spends 1.2% of GDP on health and only 38% of government health spending is spent on primary health care.¹¹¹ Stigma and discrimination associated with HIV and key populations may deter people from seeking care at primary care facilities. In addition, according to most key informants, health workers at primary care facilities do not have the knowledge and skills to manage HIV patients.

Botswana: Policy environment supportive of PHC and integration, but lack of clarity about implementation

The high-level policy framework in Botswana is the most significant enabler. PHC and integration is a priority and policies are being updated to reflect this. The National Development Framework identifies enhancing the integration of health services in priority areas (such as HIV, TB, SRH, MCH and mental health) and revitalization of PHC as key strategies for achieving health goals and targets. The Essential Health Services Package (EHSP), developed in 2010 to guide provision of high-quality services towards attainment of UHC, includes SRH, child health, communicable diseases, NCDs and HIV. Botswana is also undertaking a comprehensive process that includes the development of a UHC roadmap, updating the EHSP, review of the draft Health Financing Strategy, a National Health Insurance Feasibility Study, and development of an HRH Strategy and Health Sector Monitoring and Evaluation Plan. There is a strong focus on the community. The strategy to revitalise PHC includes a refocus on traditional community structures, the PHC-CHW Coordination Strategy was adopted in 2017 and reflects the commitment to institutionalize CHWs as part of the health sector, and national guidelines for implementation of integrated community-based health services were launched in 2020. Regional commitments, such as the ESA Ministerial Commitment, and lessons from a regional joint programme funded by SIDA (2gether4SRHR) have also been instrumental in driving the integration agenda forward in Botswana.

¹¹⁰ National Health Vision for Pakistan (2016-2025).

<https://phkh.nhsr.pak/sites/default/files/2020-12/National%20Health%20Vision%20Pakistan%202016-2025.pdf>

¹¹¹ PHC Vital signs for Pakistan 2022, Ministry of National Health Services and Regulation, Pakistan.

Informants reported that while there is high-level policy commitment and integration is working well at district level, this is not the case for programmes and technical teams. “Programming at central MOH is still not that integrated, with each programme planning and implementing separately ... We need to bring structures together at the top.” “There are no synergies between different technical teams working on integration.” There is also a perception that some programme and technical staff are resistant to integration because of fear of losing their positions and specialist expertise. While the overall government vision for integration is clear, informants highlighted the lack of understanding of what exactly integration is and the form it should take. One noted that implementation is a challenge and “is not well thought through ... integration needs to be planned as a phased approach where some services take a slow process of integration and others remain with dedicated staff and resources”, while another highlighted the lack of operational guidance for implementation. The situation is exacerbated by different strategies and approaches to integration among different agencies and implementing partners. Lack of a clear shared vision and of effective coordination, and confusion about the respective roles of MOH and the National AIDS and Health Promotion Agency (NAPHA), are also critical barriers. Some informants suggested that HIV programmes are less easy to integrate into other programmes and services because of the parallel structures that have been established and noted that the health system is not integrated or designed to support integrated service delivery.

There is limited evidence in the Joint Programme guidance documents about enablers and barriers to integrating HIV with PHC, with a notable exception of the UNAIDS and WHO implementation guidance¹¹² which identifies interventions that facilitate integration of service delivery for NCDs, TB and HIV and reports on examples of integration facilitators and barriers with respect to the workload of health workers. “Greater clinical efficiency was seen with a positive shift in workload, with measurable improvement in patient management. Clinicians considered that integrated medical adherence clubs for HIV and NCDs freed them to concentrate on patients who required specialized clinical support; however, pharmacists were concerned about the increased workload of pre-packaging medication for such clubs.” Conversely, “Workload shifts may be seen as burdensome, with insufficient time for consultation with patients in integrated services. For example, community health workers in the United Republic of Tanzania who were responsible for both HIV and maternal health patients had difficulty in time management and in deciding which group to prioritize.

4.3 Key findings EQ3

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? (Relevance/Effectiveness/Efficiency)

- 3.1 To what extent is the Joint Programme leveraging HIV investments, knowledge, tools, infrastructure, approaches, and innovative models developed by the HIV response to strengthen broader health outcomes¹¹³? Are there any untapped opportunities?
- 3.2 To what extent is the Joint Programme using and promoting wider adoption of adaptations in service delivery developed in response to COVID-19¹¹⁴ to improve broader health outcomes?

High-level findings

HIV resources could and should be applied to strengthen the wider health system and broader health outcomes. However, the extent to which this has happened is mixed and in many cases HIV investments remain siloed.

¹¹² UNAIDS and WHO, 2023. Integrating the prevention and control of non-communicable diseases in HIV/AIDS, tuberculosis, and sexual and reproductive health programmes: implementation guidance.

¹¹³ E.g. chronic disease management, health systems strengthening.

¹¹⁴ E.g. telemedicine, digital technology, community-based responses, differentiated service delivery models.

	At country level, despite examples of Joint Programme and individual Cosponsor actions contributing to broader health outcomes, there is little evidence of a strategic and proactive approach by the Joint Programme to leverage the HIV response to achieve this.
	The COVID-19 response presents a good example of leveraging HIV investments for broader health gains. However, limited evidence was found of the Joint Programme promoting adoption of adaptations in HIV service delivery developed in response to COVID-19 to improve broader health outcomes (beyond HIV and COVID-19).
	Lessons from HIV programming (for example, related to community-led interventions, strategies for reaching marginalised and vulnerable populations, including virtual interventions, and activism and accountability) could be adapted and applied more widely.
Theory of change	The theory of change assumes that lessons from HIV responses are captured and influence broader health system approaches. Summary assessment: The evidence indicates that the Joint Programme has done this to only a limited extent, and mainly in response to the COVID-19 pandemic.

3.1 To what extent is the Joint Programme leveraging HIV investments, knowledge, tools, infrastructure, approaches, and innovative models developed by the HIV response to strengthen broader health outcomes?

HIV resources could and should be applied to strengthen the wider health system and broader health outcomes. However, the extent to which this has happened is mixed and in many cases HIV investments remain siloed. There is evidence in the global literature about how the HIV response has strengthened wider health systems. For example, the 2016 Political Declaration on HIV and AIDS states that: “...the AIDS response has been transformative, demonstrating outstanding global solidarity and shared responsibility, advancing innovative cross-sectoral and people-centred approaches to global health.”¹¹⁵ The 2021 Political Declaration reiterated: “the HIV response has transformed global health responses, strengthened health systems”.¹¹⁶ Similarly, in country policies there is often an expectation that HIV can be used as a platform for wider systems strengthening. Botswana’s policy on integration is clear that the country’s strong HIV programme should provide a platform for strengthening other services, including NCD services, by building on the HIV programme’s experience, skills and systems, and this is explicitly stated in the National Strategic Framework on HIV & AIDS.¹¹⁷

This evaluation found a strong perception that HIV responses have strengthened PHC and health systems and to some extent this was confirmed by examples provided by informants. More than half (57%) of respondents to the online survey agreed or strongly agreed that HIV investments, knowledge, tools, infrastructure, approaches and innovative models have been leveraged for broader health gains/strengthening the PHC approach. Some respondents cited specific instances of where HIV investments – in human resources for health, community engagement, logistics, service delivery, and demand creation – have strengthened PHC. Examples from the evaluation survey respondents are provided in the box below.

¹¹⁵ UNGA, 2016. Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030.

¹¹⁶ UNGA, 2021. Political Declaration on HIV and AIDS: Ending inequalities and getting on track to end AIDS by 2030.

¹¹⁷ The Third Botswana National Strategic Framework on HIV & AIDS: Enhancing Efficiencies through an Integrated Approach 2019-2023. Government of Botswana; 2019.

Box 14: Examples of how HIV responses have strengthened PHC and health systems

- “The human resources made available to structures in the fight against AIDS have made a major contribution to the implementation of vaccination activities in certain health districts.”
- “Strong focus on the demand side with increased interest in potential obstacles (to broader health issues) such as human rights including stigma, gender, social and economic inequalities, etc.”
- “The systems established for the development and distribution of ART and innovative strategies to deliver treatment to people living with HIV, as well as prevention for those in need, have paved the way for similar strategies for other diseases. The HIV investments in ART systems created a solid infrastructure that was integrated into the country’s UHC system and has ensured the availability of treatment.”
- “Some of the investments and the platforms developed by the HIV response have been leveraged for PHC interventions. For example, the HIV programme has developed social media platforms that have been leveraged for adolescent health programming including for HPV vaccination.”
- “HIV experience of the use of data to inform programming decisions has led to the development of a range of tools for allocative efficiency modelling that are now being applied across the sector.”

However, analysis of the examples provided suggests that this question was understood by some to refer to decentralising the HIV response to primary care and community levels rather than to strengthening PHC or wider health outcomes. Examples of this include: “HIV-related investments have brought health care closer to the community. This has meant re-energizing and strengthening communities in HIV case management” and “Rapid HIV testing is now available in PHC.”

Further analysis shows that survey respondents from the Joint Programme (UNAIDS Secretariat and Cosponsor staff involved in the HIV response and registered as JPMS users)¹¹⁸ were far more likely than the WHO SP-PHC respondents (WHO PHC Policy Advisors and WHO Country Representatives)¹¹⁹ to agree or strongly agree that HIV investments have been leveraged for broader health gains/strengthening the PHC approach, suggesting that those whose work focuses on HIV programmes perceive them as benefiting the health system more than those who work on PHC or health more broadly.

Around 25% of the comments from WHO respondents (WHO PHC Policy Advisors and Country Representatives) referred to the fact that HIV programmes and systems remain vertical: “Having been in seven WHO offices, I have witnessed people move where the money is. When HIV received funding in one country, the entire MCH workforce migrated to HIV... devastating the core primary care programme. While the Global Fund has attempted to move toward improving HSS and MCH, the initial programme [HIV], having much to lose, continues to exert authority to keep the funding where it is.” Only 10% of Joint Programme respondents made similar comments, although one stated: “While it is generally agreed that HIV resources can and should be applied more strategically to improve the health system and strengthen the PHC approach, concrete plans are not made to achieve this and so HIV investments remain mostly siloed and even often weaken the health system by incentivising attention to HIV issues only.”

Many key informants noted that, while there has been a shift in global rhetoric to an increasing focus on integration, progress at country level has generally been much slower. This was also a point made in responses to the online survey. For example, “The HIV programme is currently implemented as a stand-alone programme. Recently, the government has decided to shift from this approach to more

¹¹⁸ 174 responses.

¹¹⁹ 54 responses.

integrated service delivery ... This policy shift is to help government to prepare the health system for eventual exit of donor resources. However, this remains as an intention. Government knows what it wants to do but there is no clear-cut strategy as to how it would implement it or any evidence-informed model to apply.”

At country level, despite self-reported examples of Joint Programme and individual Cosponsor actions contributing to broader health outcomes, there is little evidence of a strategic and proactive approach by the Joint Programme to leverage the HIV response to achieve this. The UNAIDS 2020-2021 Performance Monitoring Report includes a range of examples of Joint Programme support for wider health outcomes. Some of these examples, which have not been independently verified, are provided in the box below.

Box 15: Joint Programme and individual Cosponsor reported actions related to contributing to broader health outcomes¹²⁰

- “In West and Central Africa, “During the biennium, the regional Joint Team continued to provide technical support to strengthen national health services. In Ghana, this included strengthening maternal and child health and nutrition service delivery through the use of community-based health and nutrition services.”
- “In 2020-2021, a health system strengthening project supported by the Joint Programme continued to provide financial and technical support to advance HIV integration in the broader health care system and achieve UHC. For example, in Paraguay, the project aided the scaling up of primary and micro health care networks and interventions aimed at improving access to maternal and child health services, HIV testing for men and boys aged 15 years and older, and treatment for HIV, STIs, TB, cervical cancer and other diseases.”
- “In Peru, a health system strengthening project [by the Joint Programme] reinforced GBV surveillance systems in targeted health facilities and improved access to essential health services, including HIV services for survivors of GBV. In Brazil and El Salvador, support was provided to improve municipal social assistance systems aimed at addressing GBV.”
- “The regional Joint Team leads the effort to identify and respond to the main barriers that prevent refugees and migrants from the Bolivarian Republic of Venezuela from accessing essential health services, including treatment for TB, HIV and STIs, as well as sexual and reproductive health care.”

Some key informants highlighted the contribution that the HIV response has made to other primary care services, for example, through decentralising diagnostics and treatment, scaling up access to point of care testing, and introducing concepts such as treatment literacy and client confidentiality. Some also suggested that HIV responses have contributed to improving wider health outcomes. Many informants noted that the systems established for the HIV response – for example, community systems, health workers, infrastructure, laboratories, supply systems – have strengthened health systems and primary care. However, it is difficult to verify the causal links and even more difficult to attribute these contributions to the Joint Programme. At global level, the Global Fund TRP has noted opportunities for integration of supply chains and data management systems,¹²¹ but informants pointed out that, while integrating these systems could strengthen PHC more widely, additional investment in staffing, capacity building and quality assurance would be needed to achieve effective integration.

¹²⁰ Regional and Country Report: UNAIDS 2020-2021 performance monitoring report. Geneva: Joint Programme; 2022. (https://open.unaids.org/sites/default/files/documents/PCB50_PMR_Regional%20and%20Country%20Report_EN_FINAL.pdf, accessed 24 April 2023).

¹²¹TRP Window 1 Debrief [unpublished]. The Global Fund; 2023.

Some Cosponsor informants were less positive about the contribution that HIV has made to other health outcomes and questioned the extent to which the HIV response has strengthened health systems. For example, informants cited examples of PEPFAR-supported countries that have received significant funding for HIV and have had an effective HIV response, but which have poor indicators otherwise for health.

Examples identified by the evaluation country case studies of where the Joint Programme or individual Cosponsors have used HIV investments, learnings or platforms to strengthen health systems and PHC are given below.

Box 16: Examples from country case studies of using HIV investments, learnings or platforms to strengthen health systems and PHC

In **Angola**, the Global Fund HIV grant administered by UNDP is supporting the integration agenda and contributing through health systems strengthening activities that target laboratories, the supply chain, and quality of care improvement.

In **Indonesia**, community organizations engaged by the Joint Team have been influential in connecting key populations and PLHIV to health services in general and strengthening government accountability for health and development through community-led monitoring.

In **Botswana**, the UNFPA-supported integrated community-based care guidelines and community services model builds on the experience of the HIV home-based care programme and community service delivery. WHO is supporting the central medical stores to replicate HIV quantification processes for TB and cervical cancer commodities, while the drug forecasting committee, which was initially mainly focused on ARVs, now has a wider mandate and this is helping to strengthen the supply chain for many services. WHO has also supported TB-HIV integration and this has generated lessons for integration of NCDs.

Lessons from HIV programming could be adapted and applied more widely – in most cases these concerned potential opportunities to strengthen PHC and broader health outcomes in future rather than examples of what has been achieved. Country case studies identified examples of where lessons from the HIV response are being more widely applied, but not necessarily due to the initiative of the Joint Programme. In Botswana, examples include: the contact tracing system for STIs which is now based on the HIV cascade model; the establishment of peer groups in schools, using the HIV experience of peer educators, which are sharing broader health messages; and the use of district multi-sectoral AIDS coordination bodies as broader health planning forums.

Examples suggested by key informants of aspects of the HIV response where lessons could potentially be adapted and more widely adopted in future include:

- Tailored responses, including differentiated service delivery (DSD), based on individual needs and robust data;
- Person-centred strategic information, including person-centred monitoring and data systems;¹²²
- Use of digital technology and virtual approaches, especially to reach young people and key populations;
- Community-based and community-led interventions and service delivery, in particular for prevention programming and for countering stigma and discrimination;
- Strategies for reaching marginalised and vulnerable populations; and

¹²² Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization; 2022 (<https://www.who.int/publications/i/item/9789240055315>, accessed 24 April 2023).

- Activism and accountability, including empowering and engaging communities in their own health.

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?

The COVID-19 response presents as a good example of leveraging HIV investments for broader health gains. Much of the literature on HIV and COVID-19 has been generated by the Joint Programme and suggests that HIV investments have played an important role in contexts where health systems were unable to respond because of, for example, weaknesses in laboratory infrastructure, supply chain logistics and demand creation.

The Global AIDS Strategy further describes how HIV investments have supported the COVID-19 response and could support the response to future pandemics, “... the Strategy aims to leverage the HIV response to prepare for and respond to future pandemics and enhance synergies with other global health and development movements. Decades of investment in the HIV response have created platforms that are proving useful against COVID-19, just as they were in responding to the 2014-2015 Ebola outbreak in western and central Africa ... Guidance on how to combat stigma and discrimination during COVID-19 also draws on 40 years of experience from the HIV response.”¹²³

According to the 2021 Political Declaration on HIV and AIDS, “HIV-related investments in leadership, expertise, research and development, community responses, large cadres of community health workers, enhanced health information and laboratory systems and strengthened procurement and supply chain management systems now play important roles in the response to the COVID-19 pandemic, including the development of COVID-19 vaccines”.¹²⁴

The UNAIDS 2020-2021 Performance Monitoring Report states that: “In sub-Saharan Africa, countries used existing HIV and TB laboratory infrastructure, sample transportation, quality assurance mechanisms and staff to provide COVID-19 testing, although in some cases this led to delays in testing for other diseases in the early phase of the response.”¹²⁵

Many examples were provided to the evaluation team of the learning from, and architecture of, the HIV response being leveraged to ensure continuity of services and an effective response to COVID-19. Key informants noted that many LMIC COVID-19 responses were built on the structures, systems and approaches developed by HIV programmes including laboratory services, community systems and home self-testing. One informant pointed out that some countries with a high HIV burden had been able to respond to COVID-19 relatively well because they could build on experience to conduct surveillance, share information about reducing risk of transmission, and mobilise demand for vaccination.

The actions of the Joint Programme and individual Cosponsors in supporting the COVID-19 response show how HIV platforms and lessons can be leveraged in response to a public health emergency, and also highlight opportunities for strengthening wider health outcomes in future. Examples include:

- In Botswana, UNICEF HIV volunteers became part of district response activities for COVID-19.
- In Lesotho, UNICEF supported the Risk Communication and Community Engagement Technical Working Group to develop and broadcast messaging and information on COVID-19 through social

¹²³ UNAIDS, Global AIDS Strategy 2021-2026. End Inequalities. End AIDS

¹²⁴ UNGA, 2021. Political Declaration on HIV and AIDS: Ending inequalities and getting on track to end AIDS by 2030. 8 June.

¹²⁵ Organizational Report 2020-2021 Performance Monitoring Report. Geneva: Joint United Nations Programme on HIV/AIDS; 2022 (https://www.unaids.org/en/resources/documents/2022/PCB50_UBRAF_PMR_Organizational_Report, accessed 24 April 2023).

media, radio, and other channels, including targeted messaging for key stakeholders and at-risk groups based on community risk perceptions.¹²⁶

- In Angola, UNDP, as the Principal Recipient for the Global Fund, was able to lend the laboratory service infrastructure built under the grant to the COVID-19 response, as well as to provide access to the UNDP procurement platform and expert procurement advice.

However, limited evidence was found of the Joint Programme promoting adoption of adaptations (for example, MMD, home delivery of drugs, use of online platforms and telemedicine) in HIV service delivery developed in response to COVID-19 to improve broader health outcomes (beyond HIV and COVID-19). Informants described examples of HIV programme responses and adaptations to COVID-19, but not of how the Joint Programme has promoted wider adoption of these adaptations by other health priorities/programmes. Similarly, there are multiple examples of adaptations to COVID-19 by HIV programmes described in the literature but examples of these adaptations being applied in other health areas were hard to find.

Some respondents commented that there was little thinking beyond HIV during COVID-19 – for example, while HIV programmes adopted MMD for ART, there are few examples of the same approach being taken to treatment for other chronic diseases. Similarly, while innovative methods were used for home delivery of HIV drugs, there is little evidence of other essential drugs or consumables being delivered in these way.

However, individual Cosponsors are looking to apply adaptations in response to COVID-19 in other programme/health areas. For example, the UNFPA Family Planning strategy looks to digital technology and community-based approaches to build resilience and improve adaptation,¹²⁷ while UNICEF also cites the accelerated shift to digital services and platforms.¹²⁸ Case studies for this evaluation also identified opportunities for COVID-19 responses to strengthen wider health outcomes. For example, multiple initiatives to maintain HIV testing and treatment adherence were developed at the national and sub-national level in Indonesia during the COVID-19 pandemic and, if adopted and sustained, these approaches could contribute to improving broader health outcomes. Lessons learned from adaptations in service delivery to meet the needs of populations who could not come to clinics may be also more widely applicable for other health issues and other populations.

Finally, some Joint Programme respondents identified effects of the COVID-19 pandemic which could support PHC in the future. One, for example, noted more of a focus on working horizontally since COVID-19 which should be beneficial to public health and PHC, together with a lot more cross-fertilisation between departments and thinking more in terms of holistic programmes. Others pointed out that the understanding of what is feasible has changed – before, decision-makers might have been risk averse about home testing, MMD and other innovations, but this became accepted and routine during COVID-19.

¹²⁶ UNICEF's HIV Programming in the Context of COVID-19: Building back better for children, adolescents, and women. Nairobi: UNICEF; 2021 (<https://www.unicef.org/esa/media/9516/file/UNICEF-HIV-Programming-Context-COVID19-2021.pdf>, accessed 24 April 2023).

¹²⁷ UNFPA Strategy for Family Planning, 2022-2030: Expanding Choices – Ensuring Rights in a Diverse and Changing World. New York: UNFPA; 2022 (<https://www.unfpa.org/publications/unfpa-strategy-family-planning-2022-2030>, accessed 24 April 2023).

¹²⁸ Prospects for children: A global outlook. New York: UNICEF; 2021-2025 (<https://www.unicef.org/globalinsight/media/1516/file/UNICEF-Global-Insight-5year-Outlook-2021.pdf>, accessed 24 April 2023).

4.4 Key findings EQ4

<p>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? (Relevance/Equity)</p> <ul style="list-style-type: none"> ▪ 4.1 Which locations and population groups are potentially benefitting from integrated service delivery at primary care level - or being left behind? ▪ 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 primary care settings? 	
High-level findings	The Joint Programme has made significant efforts to generate strategic information related to key populations but has done less to identify which populations might potentially benefit from service delivery in primary care settings and which might be left behind.
	The Joint Programme has supported country efforts to improve monitoring of stigma and discrimination in health care settings and to deliver stigma and discrimination-free services, but progress towards the global target of reducing the percentage of key populations who experience stigma and discrimination to less than 10% is off track.
	The Joint Programme support for the PLHIV Stigma Index surveys, in particular from the UNAIDS Secretariat, has been critical and the results of these surveys serve as a key resource for shaping integrated service delivery models.
	Key populations are at risk of being left behind if HIV services are only provided through primary care facilities in public health systems therefore a contextualised approach to integration, together with HIV and key population literacy in primary care contexts, are needed.
	Integration of HIV services within primary care can potentially improve person-centred care over a life course if managed carefully.
Theory of change	<p>The theory of change assumes that human rights, gender equality and equity are applied consistently as cross-cutting issues.</p> <p>Summary assessment: The evidence indicates that although this has been a focus of the Joint Programme’s work, there is little evidence that this has been applied consistently at country level in relation to HIV and primary care integration.</p>

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 primary care settings?

The Joint Programme has made significant efforts to generate strategic information related to key populations but has done less to identify which populations might potentially benefit from service delivery in primary care settings and which might be left behind. Routine health management information systems (HMIS) at country level do not generally capture data on service coverage or access disaggregated by key populations or wealth quintile. In order to fill this gap, the Joint Programme has supported the implementation of IBBS surveys which provide critical data on key populations, including service coverage data.¹²⁹ Other initiatives to address data gaps include updating the UNAIDS online Key Population Atlas in 2022¹³⁰ to include data for key populations on STIs and hepatitis indicators (including testing and vaccination rates), drawing on data from sources

¹²⁹ <https://aidsinfo.unaids.org/>

¹³⁰ https://www.unaids.org/en/resources/presscentre/featurestories/2022/january/20220106_new-indicators-key-pop-atlas

such as large-scale internet surveys.¹³¹ However, this data does not reflect where services are provided.

Since 2020, the Joint Programme has conducted or supported relatively few reviews or studies on the extent to which integration of HIV with PHC/UHC has affected service access and uptake for key and vulnerable populations and any gender dimensions or gender bias. That said, a few notable and important examples include: a 2022 review¹³² which found that key populations were at risk of being left behind in the roll out of health insurance packages because services they need may not be covered, the right providers are not contracted, or because of administrative challenges or concerns about confidentiality and privacy. Another example is the WHO guidance on key populations, which was updated in 2022.¹³³ In addition, UNAIDS' HIV inequalities framework and toolkit includes an annex on addressing HIV-related inequalities.¹³⁴ There is scope to further build on this annex to include guidance on actions.

The Joint Programme has supported country efforts to improve monitoring of stigma and discrimination in health care settings and to deliver stigma and discrimination-free services, but progress towards the global target of reducing the percentage of key populations who experience stigma and discrimination to less than 10% is off track. Key populations continue to face many barriers that prevent them from using primary care facilities, one of the most frequently cited being stigma and discrimination in health care settings.¹³⁵ The Joint Programme has supported a range of actions to improve monitoring of stigma and discrimination in health care settings including establishing and monitoring the 10% target¹³⁶ and supporting implementation of the Stigma Index survey and community-led monitoring efforts.

The UNAIDS Secretariat, UNDP and UN Women are co-convenors of the Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination.¹³⁷ WHO leads on the health sector within the Global Partnership and there has been an increased WHO-funded focus on stigma and discrimination in the health sector, with regional progress reported in EMRO and PAHO in particular. Participating countries assess and take action to eliminate HIV-related stigma and discrimination in six settings (health care; education; workplace; legal and justice systems; individuals, households and communities; and emergency and humanitarian settings), with a focus on populations left behind.¹³⁸ The UNAIDS Secretariat, in collaboration with others, has provided support to countries to develop, implement and monitor operational plans to reduce HIV-related stigma and discrimination including under the auspices of the Global Partnership.¹³⁹

As of 2022, 16 of the 34 Global Partnership participating countries were implementing operational plans, with key interventions integrated into Global Fund funding requests and PEPFAR operational plans, representing good progress towards the 2026 target of 45 participating countries with at least 20 implementing operational plans. As of 2022, the Joint Programme reported providing support to

¹³¹ European MSM Internet Survey (EMIS) and Latin America MSM Internet Survey (LAMIS) from 2018

¹³² Key populations are being left behind in universal health coverage: landscape review of health insurance schemes in the Asia-Pacific region. Geneva: Joint United Nations Programme on HIV/AIDS; 2022 (https://www.unaids.org/sites/default/files/media_asset/key-populations-universal-health-coverage-asia-pacific_en.pdf, accessed 24 April 2023).

¹³³ Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. WHO, 2022. <https://www.who.int/publications/i/item/9789240052390>

¹³⁴ A framework for understanding and addressing HIV-related inequalities. Geneva: Joint United Nations Programme on HIV/AIDS; 2022 (https://www.unaids.org/sites/default/files/media_asset/framework-understanding-addressing-hiv-related-inequalities_en.pdf)

¹³⁵ WHO, 2021. Global progress report on HIV, viral hepatitis and sexually transmitted infections, 2021. Accountability for the global health sector strategies 2016–2021: actions for impact

¹³⁶ Less than 10% of people living with HIV and key populations experience stigma and discrimination by 2025;

¹³⁷ Indicator Scorecard: 2022 Performance Monitoring Report. Geneva: Joint United Nations Programme on HIV/AIDS; 2023 <https://www.unaids.org/en/topic/global-partnership-discrimination>

¹³⁸ Indicator Scorecard: 2022 Performance Monitoring Report. Geneva: Joint United Nations Programme on HIV/AIDS; 2023

¹³⁹ Indicator Scorecard: 2022 Performance Monitoring Report. Geneva: Joint United Nations Programme on HIV/AIDS; 2023

82 countries to address stigma and discrimination in health care settings.¹⁴⁰ Country case studies conducted for this evaluation include the following examples of the support provided:

- In Angola, UNDP has leveraged the support of the Global Partnership to provide technical, policy, advocacy and capacity building support to reduce HIV-related stigma and discrimination in community and health care settings.
- In Indonesia, the Joint Team takes a leading role on collecting strategic information on stigma and discrimination in service delivery settings using a community-led monitoring model to generate data on service delivery and quality for advocacy purposes.
- In Botswana, there was recognition of Joint Team actions to address stigma and discrimination, as well as of TSM support for development of a stigma and discrimination action plan.

The evaluation also identified other examples of Joint Programme support for stigma and discrimination-free services. Thailand for example, has developed an e-learning curriculum for health care workers to address stigma and discrimination in health facilities, which builds on the facility-based HIV-related stigma and discrimination reduction intervention package, developed with support from the Joint Team.¹⁴¹ In the Central African Republic, the Joint Programme, under the auspices of the Global Partnership, assisted the country to revise training programmes for health professionals to include ethics and human rights.

Despite these efforts, progress towards the global target is off track. According to Stigma Index surveys conducted over the period 2017-2021, only six of 23 countries met the target of reducing stigma and discrimination of PLHIV and key populations in health care settings to less than 10%.¹⁴²

Joint Programme support for the PLHIV Stigma Index surveys,¹⁴³ in particular from the UNAIDS Secretariat, has been critical and the results of these surveys serve as a key resource for shaping integrated service delivery models. During 2020-2022, 16 countries implemented stigma surveys¹⁴⁴, and 16 countries are in the process of finalizing their surveys in 2023.¹⁴⁵ These surveys provide important evidence for advocacy and policy change. For example, the Regional Report on the Stigma Index of People Living with HIV in West Africa, 2023, for which the UNAIDS Secretariat provided technical and financial support, is based on data from seven countries and will be used for policy change and programmatic interventions as well as development of regional policies to protect the rights of people living with HIV.¹⁴⁶ Of note, the Stigma surveys are conducted by PLHIV and serve as an example of Joint Programme meaningful engagement with PLHIV and key populations. However, there was limited evidence available to the evaluation team of other significant Joint Programme efforts to engage in consultations with PLHIV and key population organisations to identify the benefits and risks of increased integration of HIV services in primary care.

4.1 Which locations and population groups are potentially benefiting from integrated service delivery at primary care level - or being left behind?

¹⁴⁰ Indicator Scorecard: 2022 Performance Monitoring Report. Geneva: Joint United Nations Programme on HIV/AIDS; 2023

¹⁴¹ The impact of stigma and discrimination participatory training in health care facilities, October 2019

¹⁴² Related to global strategy sub-targets of less than 10% of PLHIV reporting experience S&D in healthcare and community settings by 2025; UNAIDS update 2022: In danger. Geneva: Joint United Nations Programme on HIV/AIDS; 2021 (https://www.unaids.org/sites/default/files/media_asset/2022-global-aids-update-summary_en.pdf, accessed 24 April 2023).

¹⁴³ <https://www.stigmaindex.org/>

¹⁴⁴ Belarus, Côte d'Ivoire, Iran, Kazakhstan, Kyrgyzstan, Mauritania, Morocco, Nepal

¹⁴⁵ Indicator Scorecard: 2022 Performance Monitoring Report. Geneva: Joint United Nations Programme on HIV/AIDS; 2023

¹⁴⁶ Stigma Index of People Living with HIV 2.0, Regional Report West Africa, 2023.

During interviews conducted for this evaluation, informants voiced strong concerns about key populations being left behind as a result of increased integration of HIV and primary care, and the following elaborates on this.

Key populations are at risk of being left behind if HIV services are only provided through primary care facilities in public health systems, therefore a contextualised approach to integration, together with HIV and key population literacy in primary care contexts, are needed. Although integration of HIV services through primary care facilities in a public health system may increase availability and accessibility of these services for some populations, this approach may not meet the HIV and other needs of key populations, as well as of other population groups, such as young people. There is a risk that as services become more “government centric”, key populations will not access them due to stigma and discrimination, legal and other barriers.¹⁴⁷ Many informants raised significant concerns about the potential adverse effects of integrating HIV services into primary care and highlighted the need to sustain and expand specialized service delivery for key populations in some contexts.

The potential barriers highlighted by informants and the literature include: inflexible opening hours of public health facilities, confidentiality and privacy concerns, mistrust in quality of service, capacity and attitudes of public health care staff, legal frameworks, incomplete coverage of health benefit packages (e.g. HIV prevention services are often excluded, and undocumented migrants may not be entitled to receive care), and stigma and discrimination.¹⁴⁸ In the face of these barriers, in particular stigmatising and discriminatory attitudes among health providers in public facilities, many key population members prefer to use HIV specialised services and other health care services provided by community or non-government organisations.

The evaluation identified other populations, in addition to key populations, who could be at risk of being left behind through increased integration of HIV services within public health systems. Informants noted that men, who are generally less likely to use primary care facilities than women, and young people, might be left behind if not strategically targeted.

Fear of criminalisation was also identified as a reason to not seek services from primary care facilities. Although the Joint Programme has engaged in efforts to address criminalisation and harmful laws, more will need to be done to ensure these do not prevent certain population groups from accessing integrated HIV care from public health facilities. Informants commented that the Joint Programme could do more to use its voice and power (which comes from concerted action taken together by a number of agencies) to advocate and engage governments in dialogue around criminalisation and stigma and discrimination.

The recent evaluation of Joint Programme’s work on key populations¹⁴⁹ makes a case for a balance of investments both for continued and scaled-up of HIV-specific key population programming and for the integration of HIV services, including within UHC frameworks, with an enhanced and tailored focus on key populations. It notes that: “However, Joint Programme key population programming and strategic direction in many countries have yet to adjust to new initiatives towards universal health coverage with HIV and key population communities infrequently engaging or being at the universal health coverage table”. A key recommendation made by key informants is to increase key population involvement and dialogue with UHC stakeholders, platforms, and forums.

¹⁴⁷ 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)

¹⁴⁸ 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)

¹⁴⁹ UNAIDS, March 2022. Joint evaluation of the UN Joint Programme on AIDS’ work on key populations (2018-2021).

In addition to assessing who might be left behind by integration of HIV services in primary care facilities, this evaluation question also assessed who might benefit from this approach. This is explored below.

Integration of HIV services within primary care can potentially improve person-centred care over a life course if managed carefully. The reported advantages of integration of HIV services within public health systems at primary care facilities include the potential to provide person-centred care, addressing multiple needs over the life course, including HIV co-infections and co-morbidities. According to systematic reviews and meta analyses conducted within the last five years, integrating HIV services with selected services (for example, TB, NCDs, STIs, and OST) has generally proven effective to improve HIV and broader health outcomes, as well as being cost-effective and potentially sustainable.^{150 151 152 153} Other systematic reviews also found that not only did HIV outcomes improve, but also that treatment success for non-HIV-related diseases and conditions and uptake of non-HIV services were higher in models providing integrated services.^{154 155} However, many of the studies included in these systematic reviews did not only consider primary care settings. There is also weak evidence from some regions on the integration of HIV services with other services, including in primary care, and an overall limited evidence base on delivering integrated services.¹⁵⁶

Careful triangulation data from all sources¹⁵⁷ suggests that integration of HIV in primary care settings is most likely to be appropriate in contexts with a high burden of HIV, strong public health systems and a substantial and capacitated primary care workforce (including community-led service delivery), where HIV services are included in national health benefits packages, and where key populations or certain behaviours are not criminalised.¹⁵⁸ Even in such settings, attention will be needed to ensure quality of care, including stigma and discrimination-free services, and that the specific needs of key populations are addressed. In certain country contexts, some key populations, for example, people who use drugs, will remain unlikely to use government primary care services, and it may not be cost-effective to provide comprehensive care for these populations in all primary care facilities.

Accordingly, HIV integration into primary care facilities is likely to be more challenging in contexts with weak health systems, where HIV is concentrated in key populations and these populations and HIV are highly stigmatised, where key populations or certain behaviours are criminalised, and where HIV services are not fully covered in health benefits packages. It is noted that in such contexts it may be more appropriate to maintain specific population-focused services for certain populations, for example, through sexual health or STI clinics and harm reduction centres, and to ensure that these provide a core range of health services and referral for other care.

¹⁵⁰ Bekker LG, et al. Advancing global health and strengthening the HIV response in the era of the Sustainable Development Goals: the International AIDS Society-Lancet Commission. *Lancet*. 2018 Jul 28;392(10144):312-358. doi: 10.1016/S0140-6736(18)31070-5. Epub 2018 Jul 20. PMID: 30032975; PMCID: PMC6323648.

¹⁵¹ Bulstra CA, et al; UNAIDS Expert Group on Integration; Atun R, Bärnighausen T. Integrating HIV services and other health services: A systematic review and meta-analysis. *PLoS Med*. 2021 Nov 9;18(11):e1003836. doi: 10.1371/journal.pmed.1003836. PMID: 34752477; PMCID: PMC8577772.

¹⁵² Grant-Maidment T, Kranzer K, Ferrand RA. The Effect of Integration of Family Planning Into HIV Services on Contraceptive Use Among Women Accessing HIV Services in Low and Middle-Income Countries: A Systematic Review. *Front Glob Womens Health*. 2022 Feb 24;3:837358. doi: 10.3389/fgwh.2022.837358. PMID: 35284908; PMCID: PMC8907733.

¹⁵³ Patel P, et al; NIH HIV/NCD Project Disease Condition Technical Operating Group. Noncommunicable diseases among HIV-infected persons in low-income and middle-income countries: a systematic review and meta-analysis. *AIDS*. 2018 Jul 1;32 Suppl 1(Suppl 1):S5-S20. doi: 10.1097/QAD.0000000000001888. PMID: 29952786; PMCID: PMC6380891.

¹⁵⁴ Kileel EM, et al; Does engagement in HIV care affect screening, diagnosis, and control of noncommunicable diseases in sub-Saharan Africa? A systematic review and meta-analysis. *medRxiv [Preprint]*. 2023 Jun 8:2023.01.30.23285196. doi: 10.1101/2023.01.30.23285196. PMID: 36778439; PMCID: PMC9915817.

¹⁵⁵ Bulstra CA, et al; Integrating HIV services and other health services: A systematic review and meta-analysis. *PLoS Med*. 2021 Nov 9;18(11):e1003836. doi: 10.1371/journal.pmed.1003836. PMID: 34752477; PMCID: PMC8577772.

¹⁵⁶ Ibid

¹⁵⁷ KIs, online survey, country case studies, Joint Programme documents and data from systematic reviews since 2020

¹⁵⁸ Kadia BM, Dimala CA, Fongwen NT, Smith AD. Barriers to and enablers of uptake of antiretroviral therapy in integrated HIV and tuberculosis treatment programmes in sub-Saharan Africa: a systematic review and meta-analysis. *AIDS Res Ther*. 2021 Nov 16;18(1):85. doi: 10.1186/s12981-021-00395-3. PMID: 34784918; PMCID: PMC8594459.

The need for a country context-specific approach to integrating HIV services in primary care facilities with specific efforts to ensure quality of care is evident. This will require careful analysis of HIV epidemiology, key affected populations and possible access barriers, the capacity of the health system, existing HIV service delivery models and coverage to determine appropriate combinations of services and service delivery platforms for key populations in particular. This also calls for Joint Programme support for more operational research in settings where integration has been pursued, as well as support from country Joint Teams to governments to strike the right balance between specialised services, community-led service delivery and services integrated in primary care facilities.

4.5 Key findings EQ5

<p>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?</p> <ul style="list-style-type: none"> ▪ 5.1 What is the added value of the Joint Programme in terms of leveraging HIV and PHC interlinkages? (Joint Programme ways of working, collaboration, synergies and comparative advantages)? ▪ 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? 	
<p>High-level findings</p>	<p>The Joint Programme has added value to the overall HIV response through its ways of working, comparative advantage, collaboration and synergies, but there is less consensus about whether the Joint Programme brings the same added value to HIV and PHC integration and interlinkages or to a PHC approach that addresses HIV effectively, and most informants are of the view that it has yet to make a significant contribution.</p>
	<p>The Joint Programme has not been sufficiently strategic about its role in strengthening HIV and PHC integration and linkages, both globally and in specific country contexts, based on where its comparative advantages lie in part due to an unclear Division of Labour (DoL) on the PHC approach and limited leadership of the UNAIDS secretariat.</p>
	<p>The Joint Programme could potentially add value to the HIV and PHC agenda through its experience of multisectoral policy and action and community empowerment and participation, and through bringing a human rights, gender and equity lens to bear on primary care and within a UHC context.</p>
	<p>Increasingly constrained financial and human resources have limited the capacity of the Joint Programme to contribute to strengthening HIV and PHC integration and linkages.</p>
<p>Theory of change</p>	<p>The theory of change assumes that the Joint Programme’s efforts focus on its mandate and comparative advantage and are coordinated and complement the efforts of external partners. It also assumes that the Joint Programme has adequate and appropriate capacity, skills, and resources at global and country level to contribute to strengthening HIV and PHC integration and linkages.</p> <p>Summary assessment: The evidence indicates that the Joint Programme has not systematically drawn on its comparative advantage to contribute to HIV and PHC integration and linkages, and that efforts have been hindered by limited capacity, skills, and resources at global and country levels.</p>

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

The Joint Programme has added value to the overall HIV response through its ways of working, comparative advantage, collaboration and synergies, but there is less consensus about whether the Joint Programme brings the same added value to HIV and PHC integration and interlinkages or to a PHC approach that addresses HIV effectively, and most informants are of the view that it has yet to make a significant contribution.

Key informants consistently identified a number of areas where the Joint Programme has added value to the overall HIV response. These include:

- Coordinating, bringing together and leveraging the respective expertise of different UN agencies and using the UN's credibility to influence governments.
- Convening multiple sectors and partners and supporting multisectoral policy and action.
- Advocating successfully for resources.
- Highlighting human rights, gender, and equity perspectives.
- Championing community leadership and involvement in the HIV response.
- Strengthening strategic information and monitoring and reporting on progress.
- Providing catalytic funding, normative and technical guidance, and technical assistance.

Country case studies highlighted similar areas of added value. In Indonesia, for example “the Joint Programme brings together skills and strengths of Cosponsors and, in Pakistan “its unique value lies in its ability to leverage the specialized expertise of each agency involved. The UN is seen as a respected neutral partner, because of its ability to provide technical advice and guidance.” In Botswana “Unlike bilateral donors it is not seen as political or pushing certain agendas” and the provision of technical assistance was the area of added value mentioned most. “A strength of the UN agencies is that they can bring in technical assistance, often at short notice, and this is highly appreciated.”

Other sources identify the same areas of added value of the Joint Programme in general. For example, an evaluation of the Joint Programme's work on efficient and sustainable financing¹⁵⁹ concluded that: “the comparative advantage of the UNAIDS Secretariat with regards to efficient and sustainable financing is in terms of its convening power and political advocacy role, and for the Joint Programme as a whole in the provision of analytical products, advisory services, and generation of strategic information. Joint Programme epidemiological data adds significant value at both global and country level by providing evidence in support of advocacy for HIV resource mobilisation.” Many informants for this evaluation also highlighted the Joint Programme's contribution to strengthening data and strategic information in general, noting that this has had wider value, for example, with respect to demographic, policy and financing metrics.

While there is evidence as highlighted above of the Joint Programme adding value to the overall HIV response, there is less consensus about whether the Joint Programme brings the same added value to HIV and PHC integration and interlinkages or to a PHC approach that addresses HIV effectively.

With respect to bringing together and leveraging the respective expertise of different UN agencies, country case studies in Angola, Botswana, Indonesia and Pakistan¹⁶⁰ suggest that there is little evidence of a Joint Programme approach or of Joint Team plans or activities related to strengthening HIV and PHC interlinkages and integration. The Secretariat is not consistently playing a coordinating role in this area, and, in practice, cosponsor agencies are working individually on HIV and PHC integration and linkages at country level often using non-UBRAF funding.

The extent to which the Joint Programme has provided catalytic funding for HIV and PHC integration and linkages at country level appears to be limited. As discussed earlier, Cosponsors' activities, including technical assistance to countries for different aspects of HIV and PHC integration and

¹⁵⁹ Evaluation Offices of UNAIDS and UNFPA, March 2022. Joint Evaluation of the UN Joint Programme on AIDS' work on efficient and sustainable financing.

¹⁶⁰ see Volume II evaluation report.

linkages and for strengthening PHC, have in most cases not been under the auspices of the Joint Programme or with UBRAF funding, and there is little evidence that Joint Programme mechanisms, such as country envelope funding, have been leveraged to contribute to this agenda.

The UNAIDS Technical Support Mechanism¹⁶¹ provides country-driven technical assistance. The evaluation team reviewed assignments conducted since 2020¹⁶² using the following search terms to identify those related to HIV and PHC integration and linkages: primary care, essential public health functions, integrated health services; multisectoral policy and action; empowered people and communities; health system strengthening; sustainable financing; and health benefits packages and insurance schemes. The review (see Table 7) found that assignments were most likely to be related to multisectoral policy and action (96), sustainable financing (74) and empowered people and communities (49). There were relatively few assignments related to primary care and essential public health functions (11) and fewer related to health system strengthening (6). No assignments related to health benefit packages or insurance schemes were identified.

Table 7: Summary of relevant TSM assignments conducted since 2020

	Primary care and essential public health functions as the core of integrated health services	Multisectoral policy and action	Empowered people and communities	Health system strengthening	Sustainable financing	Health benefit packages or insurance schemes
Asia-Pacific	5	20	19	3	13	
East and Southern Africa	4	41	22	2	18	
West and Central Africa	1	31	7	1	36	
Latin America and Caribbean		2				
Global/Regional	1	2	1		7	
Total	11	96	49	6	74	0

Of the 11 assignments related to primary care and essential public health functions as the core of integrated health services, only two – both in Indonesia – were specifically to support mainstreaming HIV into health and development programmes. More than one-third of the assignments in the multisectoral policy and action category related to development or review of HIV National Strategic Plans. Only one assignment, in Tanzania, was related to development of an integrated health

¹⁶¹ The TSM is a country driven UNAIDS mechanism for provision of targeted technical support to priority countries, funded through an agreement with USAID. The TSM includes the Technical Assistance Fund (TAF) and Last Mile First Initiatives. The Technical Assistance Fund has a primary focus on effective and efficient implementation of Global Fund grants and progress towards ending AIDS.

¹⁶² Based on information on TSM assignments provided by Oxford Policy Management for the Asia-Pacific, East and Southern Africa, West and Central Africa regions, additional examples from the Latin America and Caribbean region and global and/or regional assignments.

strategy, for HIV, hepatitis, STI, TB and leprosy.¹⁶³ Almost two-thirds of the assignments related to sustainable financing were to support development of Global Fund proposals, funding requests and GC7 requests. Nine country assignments were specifically related to financial sustainability: Transition Readiness Assessment and Sustainability Roadmap in Botswana; investment scenario analysis in Cambodia; investment case development in Bangladesh and Ghana; NASAs in Kenya, Pakistan and Zambia; HIV financing sustainability plans in Ghana and Uganda. The findings suggest that countries are not requesting technical support from the TSM for HIV and primary care integration and are only doing so to a very limited extent for financial sustainability. It is unclear, beyond the examples of bilateral Cosponsor support identified by this evaluation, whether and to what extent countries are sourcing technical assistance on these issues elsewhere.

There is limited documentation on the integration of HIV and primary care services (beyond PMTCT efforts) and the integration of HIV systems with wider health systems, and a lack of lessons learned and shared, leading to uncertainty about how to pursue integration. The World Bank is currently documenting primary care service delivery models for NCDs and evidence of impact in a range of contexts and plans to publish a compendium of models of care to support decision makers. So far, following a systematic review, 60 short case studies and 15 in-depth case studies have been developed. Seven of these have specific relevance for HIV and PHC integration, including integrated care in South Africa, leveraging HIV infrastructure to reorient the health system to manage NCDs; decentralised NCD care in Eswatini; and using HIV infrastructure to advance NCD primary care in Malawi. Key lessons include the need to adapt models to the context and leveraging existing structures for integrated NCD care.

The Joint Programme has not been strategic about its role in strengthening HIV and PHC integration and linkages, both globally and in specific country contexts, based on where its comparative advantages lie, in part due to an unclear DoL on the PHC approach and limited leadership of the UNAIDS secretariat. Some informants raised concerns that without sufficient clarity about the Joint Programme’s comparative advantage and mandate on PHC there is a risk of potential duplication of effort with individual Cosponsors, in particular WHO, and with Cosponsor efforts through the SDG3 GAP. “The Joint Programme is already over-stretched – before it engages in this area, it needs to ask if another actor or platform is better placed to do this”.

The 2020 GAP progress report highlights similarities in approach: “Implementation of the GAP is driven by the signatory agencies’ commitment to engage with countries and provide support in a more coordinated way in one or more of the seven GAP accelerator themes... tailored to country demand ... In some countries, the agencies have begun to develop work-plans for joint support”. According to the 2022 GAP progress report, the number of countries engaged with the GAP had increased to more than 50. In addition, the recent MOPAN highlighted the need for the UNAIDS Secretariat to remain focused, concluding that: “The Secretariat leadership pursues an advocacy agenda that deviates from the HIV pandemic, the Joint Programme’s core mandate. This has resulted in criticism of its core function of global leadership and also in accusations of mission creep”.¹⁶⁴

Some informants highlighted potential opportunities for the Joint Programme – Secretariat and Cosponsors working together – to leverage donor funding for strengthening HIV and PHC integration. These opportunities include the new PEPFAR 5-year strategy focus on health systems and community-based approaches and the reorientation of PEPFAR’s approach to sustainability, which includes the integration of HIV efforts into country health systems, the USAID Primary Impact Initiative, and Global Fund RSSH funding. Others suggested that the Joint Programme – the Secretariat in particular – could more effectively leverage its technical assistance capacity, for example, to ensure that Global Fund proposals strengthen HIV and PHC integration and that technical assistance supports appropriate HIV and PHC integration rather than keeping HIV separate.

¹⁶³ TSM 50-050. Integrated HIV, Hepatitis, STI, TB and Leprosy Strategy Development & HIV Multisectoral HIV Strategy Revision, Tanzania.

¹⁶⁴ MOPAN Assessment of UNAIDS Secretariat. Multilateral Organisation Performance Assessment Network; 2023 (<https://www.mopanonline.org/assessments/un aids2021/index.htm>, accessed 24 April 2023).

Most informants are of the view that there has been little Joint Programme engagement on HIV and PHC integration and linkages at global, regional, and country levels. The issue has not been on the agenda of the PCB and UNAIDS Secretariat advocacy around HIV and primary care integration is perceived to have been limited. One informant commented that UNAIDS did not make a contribution at the recent IAS Conference where WHO launched PHC and HIV: convergent actions – policy considerations for decision-makers. However, WHO informants commented that the UNAIDS Secretariat has contributed to the global debate and the development of normative guidance, including the convergent actions document.

None of the country case studies in the 2020 SDG3 GAP progress report¹⁶⁵ mention HIV, integration or the Joint Programme. The 2022 progress report¹⁶⁶ refers to UNAIDS' role in relation to specific integration of HIV and other health services in the PHC package, but no examples of action through the GAP platform on integration are included.

Country case studies and informant interviews suggest that HIV and PHC integration is not perceived to be a priority for the Joint Programme. Lack of Secretariat leadership is a critical factor. As one country informant commented: “Nothing will happen unless UNAIDS Secretariat country directors are supportive”.

The Joint Programme could potentially add value to the HIV and PHC agenda through its experience of multisectoral policy and action and community empowerment and participation, and through bringing a human rights, gender and equity lens to bear on primary care and within a UHC context. While a few informants suggested that the Joint Programme brings little added value to the HIV and PHC integration and linkages agenda, most believe it can add value in specific areas, drawing on the experience of the HIV response.

WHO is seen as the lead agency on the ‘primary care and essential public health functions as the core of integrated health services’ component of PHC, with WHO, UNICEF and UNFPA playing a central role in service integration at primary care level. WHO has traditionally been less engaged in the other two components of PHC – multisectoral policy and action and empowered people and communities. It was suggested that the Joint Programme could add value to the ‘empowered people and communities’ component, building on its advocacy and support for community leadership and involvement in the HIV response, including community-led service delivery and monitoring and community participation in policy dialogue. Specific areas suggested where the Joint Programme could add value to HIV responses with a PHC approach, and to PHC more broadly, included strengthening the links between community organizations and primary care, promoting community-led approaches in PHC, and strengthening PHC accountability. As one informant noted: “Ensuring that the links with the community and CBOs are maintained – this could be an important role for UNAIDS”.

The Joint Programme could also potentially add value by highlighting HIV-related human rights, gender and equity perspectives in the context of PHC, and specifically integration in primary care settings, providing a ‘critical voice’ on the risks of HIV integration and strategies to mitigate risks. As one informant commented: “There is a need for open dialogue about where and who it won’t work for and the models that won’t work. If this isn’t done by the Joint Programme, where will it happen?” Another said that: “The Joint Programme addresses wider issues beyond HIV including gender, human rights, equity, social protection, community voice – it will continue to be important to ensure these issues are not forgotten”. To achieve this, some key informants for this evaluation suggested that the Joint Programme could leverage more effectively Secretariat and Cosponsor membership of the WHO-hosted SDG3 Global Action Plan (GAP) community and civil society, determinants of health, and gender equality working groups.

¹⁶⁵ WHO, 2020. Stronger collaboration, better health: 2020 progress report on the GAP for Healthy Lives and Well-being for All.

¹⁶⁶ WHO, 2022. Stronger collaboration for an equitable and resilient recovery towards the health-related Sustainable Development Goals, incentivizing collaboration: 2022 progress report on the GAP for Healthy Lives and Well-being for All.

There is a need to evaluate experience so far, document successes, and share lessons learned more widely across various contexts. The Global Fund TRP recommended to technical partners that: “Meaningful harmonisation and coordination is needed to foster integration within country programmes” and that “Further guidance is needed on i) what to integrate, ii) where to integrate, and iii) why (with a focus on outcomes noting integration is not an end in itself)”.¹⁶⁷ It was suggested by some informants that another area of potential added value of the Joint Programme is support for a coordinated approach to learning including documenting and sharing models of integration and generating evidence to demonstrate that integration delivers results, in terms of health and efficiencies.

There is also a perception that the UNAIDS Secretariat remains focused on advocacy for HIV financing, rather than on increased investment in health more widely and some informants are of the view that this has contributed to vertical and fragmented financing for the health sector. Others, however, consider that the Joint Programme – Secretariat and Cosponsors working together – could make an important contribution to strategic positioning of HIV within UHC and engagement with policymakers on social contracting. Civil society informants also highlighted the importance of ensuring that key HIV interventions are included in UHC and of sustained financing for HIV services for key and vulnerable populations, suggesting that the Joint Programme can add value through advocacy and support for community organizations to engage in UHC and health benefits packages discussions.

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?

Increasingly constrained financial and human resources have limited the capacity of the Joint Programme to contribute to strengthening HIV and PHC integration and linkages. The Joint Programme has faced resource constraints in recent years. Cosponsors experienced a 37% decrease in core UBRAF budget allocation between 2016-2017 and 2018-2019 from US\$175m to US\$109.5m, and the Secretariat’s total UBRAF budget was reduced by 13.6% from \$370m to \$320m in the same period.¹⁶⁸ This has not been reversed and the UBRAF is not fully funded.

For 2020 and 2021, the Joint Programme had an approved annual budget of US\$242 million. In 2020, it raised US\$194 million and, in 2021, only US\$170 million.¹⁶⁹ At country level the Joint Programme lacks the financial resources to support concerted Joint Team action on HIV and PHC integration and linkages, so activities related to this agenda are largely implemented by individual agencies with their own budgets.

A recent UNAIDS Joint Programme capacity assessment found that, as a result of reduced UBRAF funding, Cosponsors have fewer staff working on HIV at all levels – reducing their capacity to influence, engage in the Joint Programme and provide support to countries, as well as to engage on issues such as PHC and UHC.¹⁷⁰ As Table 8 shows, Cosponsors capacity allocated to Result Areas 8 and 9 is limited. The capacity assessment also found that: “Many Cosponsor staff at country level are now multi-functional, covering a range of other issues in addition to HIV” and that “Limited capacity ... has implications for Cosponsor ability to leverage their comparative advantage to effectively integrate HIV into wider agendas that are relevant to the new Global AIDS Strategy, such as UHC and PHC”.

¹⁶⁷ TRP Window 1 Debrief [unpublished]. The Global Fund; 2023.

¹⁶⁸ OPM, 2022. UNAIDS Joint Programme Capacity Assessment.

¹⁶⁹ Implementation of the Declaration of Commitment on HIV/AIDS and the political declarations on HIV/AIDS Tackling inequalities to end the AIDS pandemic. Report of the Secretary-General.2022.

¹⁷⁰ OPM, 2022. UNAIDS Joint Programme Capacity Assessment.

Table 8: Cosponsor FTE staff allocation to Global AIDS Strategy Results Areas¹⁷¹

Results Area (RA)	HR capacity at HQ level (estimated FTE)	HR capacity at regional level (estimated FTE)	HR capacity at country level (estimated FTE)	Total HR capacity at all levels (estimated FTE)
RA1: Primary HIV prevention for key populations, adolescents and other priority populations, including adolescents and young women and men in locations with high HIV incidence	25,4	21,1	87,4	133,9
RA 2: Adolescents, youth and adults living with HIV, especially key populations and other priority populations, know their status and immediately offered and retained in quality, integrated HIV treatment and care that optimize health and well-being	18,7	4,5	40,0	63,2
RA 3: Tailored, integrated and differentiated vertical transmission and pediatric service delivery for women and children, particularly for adolescent girls and young women in locations with high HIV incidence	5,7	6,8	60,6	73,1
RA 4: Fully recognized, empowered, resources and integrated community-led HIV responses for a transformative and sustainable HIV response	1,9	0,0	0,9	2,8
RA 5: People living with HIV, key populations, and people at risk of HIV enjoy human rights, equality and dignity, free of stigma and discrimination	6,9	10,5	42,1	59,9
RA 6: Women and girls, men and boys, in all their diversity, practice and promote gender equitable social norms and gender quality, and work together to end gender-based violence and to mitigate the risk and impact of HIV	9,3	8,6	37,4	55,4
RA 7: Young people fully empowered and resources to set new direction for the HIV response and unlock the progress needed to end inequalities and end AIDS	9,6	13,2	140,5	163,3
RA 8: Fully funded and efficient HIV response implemented to achieve the 2025 targets	4,4	3,4	31,1	38,9
RA 9: Integrated systems for health and social protection schemes that support wellness, livelihood and enabling environments for people living with, at risk of and affected by HIV to reduce inequalities and allow them to live and thrive	3,9	8,7	38,1	50,7
RA 10: Fully prepared and resilient HIV response that protects people living with, at risk of and affected by HIV in humanitarian settings and from adverse impacts of current and future pandemics and other shocks	2,3	3,5	5,8	11,5
Total Staff FTEs for all RAs	88,1	80,3	483,9	652,3

¹⁷¹ OPM, 2022. UNAIDS Joint Programme Capacity Assessment.

Reduced funding has also affected the Secretariat, resulting in reduced staffing at all levels. Although there is a strong integration team at Secretariat HQ that works with other HQ teams, as well as with regional and country offices, some informants questioned whether the Secretariat has allocated adequate resources to take forward the HIV and PHC integration and linkages agenda. At country level there are also perceived to be capacity constraints. According to one donor: “UNAIDS Secretariat teams in country ... are good on advocacy and strategic information but don’t necessarily have the expertise and capacity to provide support around PHC and HIV integration especially with respect to how this might be operationalised”.

According to the evaluation of the Joint Programme’s work on efficient and sustainable financing:¹⁷² “It is widely acknowledged that the Secretariat is stretched on the Joint Programme efficiency and sustainable financing agenda. A restructure and addition of Executive-level leadership is viewed as helping to bring additional capacity and greater visibility within the Secretariat to the financing efficiency and sustainability agenda. However there remain key questions on Secretariat capacity and “At country level, several respondents view the present UNAIDS Secretariat competencies as insufficient to engage in the technical aspects of health financing, such as resource prioritisation and engaging on UHC financing”¹⁷³. However, technical aspects of health financing fall within the remit of Cosponsors, in particular the World Bank and WHO, under the Division of Labour,¹⁷⁴ so the critical issue is where the Joint Programme overall, and the Secretariat specifically, can add value on sustainable financing and UHC.

Country case studies for this evaluation also highlighted Joint Programme financial and human resource constraints as seen in the box below.

Box 17: Joint Programme financial and human resource constraints in country case studies

The **Angola** country case study found that, although in principle well placed to do so, the Joint Programme lacks the necessary resources to further HIV and PHC integration and linkages, whilst simultaneously strengthening the PHC response in line with commitments in the UNSDCF to the Government of Angola. UNAIDS and UNDP are the only organisations with full time positions funded through the UBRAF. WHO receives only 5% funding for one position and 10% for another through the UBRAF despite playing a critical role in normative guidance and advocacy with government and other key stakeholders on integration and UHC.

The **Indonesia** country case study identified limited and decreasing UBRAF funding for joint activities to be a key challenge, and the **Pakistan** case study noted that current Joint Programme financial and human resources are inadequate to effectively support HIV integration into PHC.

The **Botswana** case study found that the Joint Programme’s ability to be strategic is constrained by limited, decreasing and earmarked funding. Related to declining budgets, almost all informants highlighted low levels of UN agency staffing in country. While efforts are made to recruit people who can cover a wide range of areas, this can lead to individuals being a focal point for too many issues and affect the quality of support provided. As one informant commented: “I think they are thin on the ground ... one agency is barely available to put together significant support, and another has one person advising on too many areas, so they are not able to deliver”. In addition to undermining the quality of support, staff constraints and reliance on consultants limit the ability to build relationships with national partners.

¹⁷² Evaluation Offices of UNAIDS and UNFPA, March 2022. Joint Evaluation of the UN Joint Programme on AIDS’ work on efficient and sustainable financing.

¹⁷³ Evaluation Offices of UNAIDS and UNFPA, March 2022. Joint Evaluation of the UN Joint Programme on AIDS’ work on efficient and sustainable financing.

¹⁷⁴ https://www.unaids.org/sites/default/files/media_asset/UNAIDS-Division-of-Labour_en.pdf

Declining funding for HIV has also created insecurity about the future among Joint Programme staff, in particular the UNAIDS Secretariat, and this is not conducive to enthusiasm for taking forward the HIV and PHC integration agenda or Joint Programme collaboration. “Integration is deeply uncomfortable because it means that people have to give up certain powers” and “there is anxiety among HIV organizations, including the UNAIDS Secretariat, about HIV integration and its implications for their funding and jobs”.

5. Conclusions

The following are the main conclusions from the evaluation:

Conclusion 1: The Joint Programme has the potential to add value but has not worked optimally to leverage HIV and PHC integration and linkages due to: limited leadership coupled with a lack of conceptual clarity, joint strategic frameworks, tracking and accountability mechanisms, and compounded by resource constraints.

There is a consensus that the Joint Programme has the potential to add value to the HIV and PHC integration agenda through its areas of comparative advantage, including leveraging the respective expertise of different UN agencies, convening multiple sectors and partners, generating strategic information, highlighting human rights, gender and equity perspectives, and championing community leadership and voice. However, the evaluation findings show that the Joint Programme has not worked optimally to leverage HIV and PHC integration and linkages, both to improve HIV outcomes and to improve wider health outcomes. This is for a number of interrelated reasons:

- *Lack of leadership and unclear roles:* The Joint Programme is viewed as having had little engagement on HIV and PHC integration and linkages. The issue has not been on the agenda of the PCB and is not seen as a priority for the leadership of the UNAIDS Secretariat at global, regional or country levels. The current DoL is not clear on the roles of the Joint Programme agencies with respect to the three pillars of the PHC approach.
- *Lack of mutual agreement on objectives and definitions:* Although the Global AIDS Strategy sets out broad goals, there is a lack of clear and agreed objectives for the Joint Programme's work on HIV and PHC integration and linkages. There is no common understanding or agreed definitions of PHC or of HIV and PHC "integration" within the Joint Programme and this lack of conceptual clarity has hindered progress.
- *Absence of a joint framework, workplan and accountability mechanism:* Although HIV and PHC integration and linkages is a priority in the Global AIDS Strategy, there is no joint plan to take this agenda forward and it is not mainstreamed within existing Joint Programme mechanisms, for example, the UBRAF, regional and country plans, country envelope funding, and the technical support mechanism. There is also no overarching framework or agreed core set of indicators for monitoring Joint Programme action and progress on HIV and PHC integration. There are multiple targets and indicators in different global strategies and monitoring and reporting mechanisms, but also significant gaps in available data. Existing indicators relate to the three pillars of PHC, but there are few indicators that relate to systems integration.
- *Capacity and resource constraints:* UBRAF is not fully funded and Secretariat and Cosponsor UBRAF funding has decreased in recent years. At country level the Joint Programme lacks the financial resources to support joint action on HIV and PHC integration and linkages. The UNAIDS Secretariat has resource constraints at global, regional and country levels. As a result of reduced funding, Cosponsors have fewer staff working on HIV at all levels – reducing their capacity to engage in the Joint Programme and provide support to countries, as well as to engage on issues such as HIV and PHC integration.

Conclusion 2: There has been limited intentional or collective Joint Programme action to promote HIV and PHC integration and linkages. Existing Joint Programme guidance largely focuses on integration of specific health services and there is limited guidance on HIV and PHC integration and linkages with respect to health systems.

There is little evidence of a coordinated Joint Programme or Joint Team approach to HIV and PHC integration efforts supported by UBRAF funding or planning. The Joint Programme has had a longstanding focus on multisectoral policy and action and empowering people and communities in HIV responses, but action on integration of HIV within primary care has mostly been driven by individual Cosponsors, based on their specific mandates and using their own funding. The evaluation

identified a range of political, policy, institutional, financing, health system, legal and other enablers and barriers to HIV and PHC integration and linkages, but little evidence of Joint Programme action to systematically identify or address such enablers and barriers.

Many examples of integration efforts promoted in Joint Programme global guidance documents involve 'clustering' where one or two services or programmes are added to HIV service delivery or vice-versa. This makes sense for HIV co-morbidities and may be pragmatic as part of a phased approach, but it does not necessarily build links with broader PHC services, integrate HIV systematically with essential health service packages, or support health system level integration. Furthermore, there is a lack of knowledge and consensus on what works, for whom, and in what contexts and the evaluation found few examples of Joint Programme support to countries to assess the implications of service integration or to operationalize integration in a way that meets the needs of populations and is appropriate to the country epidemiological and health system context.

Conclusion 3: There is limited documented evidence that the HIV response has strengthened wider health systems. Many lessons from the HIV response, including adaptations in response to COVID-19, have potential applicability to a successful PHC approach, but these have not been systematically promoted or adopted for the achievement of broader health outcomes.

The extent to which HIV investments, infrastructure, capacity, and systems established for the HIV response – for example, community and other health workers, laboratories, supply systems, and infrastructure – have strengthened wider health systems is unclear. Although there is a widely held perception that the HIV response has strengthened national health systems, there is limited robust and well-documented evidence to support this thinking. However, there are documented examples of this related to COVID-19. The actions of the Joint Programme and individual Cosponsors in supporting the COVID-19 response demonstrate how HIV platforms and lessons can be leveraged for other disease programmes and in response to a public health emergency.

The evaluation identified areas where lessons from the HIV response could be adapted and applied more widely to benefit other health areas and further the PHC approach. These included: differentiated service delivery; person-centred strategic information; use of digital technology and virtual approaches; multisectoral action; community-based and community-led interventions; strategies for reaching marginalised and vulnerable populations; and activism and accountability.

Conclusion 4: The Joint Programme has had a strong focus on the financial sustainability of the HIV response, including promoting HIV services in health benefit packages for UHC and supporting countries to establish frameworks for social contracting.

Successive global AIDS strategies have recognised that the current financing agenda is not about HIV alone but situated within the context of UHC. However, there is a lack of clarity about what this means in practice apart from HIV services being included in health benefit packages.

The extent to which HIV services are included in country health benefits packages is highly variable and, in some cases this has yet to happen because HIV programmes continue to be well funded by external donors. While many countries report that ART services, for both treatment and prevention, are financed as part of overall health systems, other HIV services – especially HIV prevention – are not consistently included in health benefits packages in countries scaling or introducing UHC and the Joint Programme could do more to advocate for this. The Joint Programme has been active in supporting countries to establish frameworks for social contracting to enable governments to fund civil society organizations to deliver HIV services, but such approaches need to be stepped up to ensure the sustainability of services for key populations, in particular HIV prevention services.

Conclusion 5: The Joint Programme has a critical role to play in promoting and protecting the delivery of HIV services for key populations and ensuring that human rights, gender and equity issues are addressed within PHC oriented health systems.

Integration of HIV services within primary care facilities has the potential to increase the availability and accessibility of these services, in addition to improving person-centred care, addressing multiple health needs and improving HIV outcomes. However, key populations are at risk of being left behind. The evaluation highlighted significant concerns about the potential adverse effects of integrating HIV services into primary care facilities and identified a need for a context-specific approach to integration and linkages, including sustaining specialised service delivery and community-led services for key populations in parallel with primary care setting integration efforts.

The Joint Programme has a strong track record in supporting key populations, in highlighting equity, gender and human rights issues that influence HIV vulnerability and access to services, and in supporting efforts to monitor and address stigma and discrimination in health care settings. The evaluation found that the Joint Programme also has a critical role to play in promoting and protecting the delivery of HIV services for key populations in the context of HIV and PHC integration and convergence efforts. Yet, there were few examples of proactive efforts to date by the Joint Programme to ensure that the needs of key populations and equity, gender, and human rights issues are addressed in the context of integrating HIV within primary care settings.

6. Recommendations

The evaluation recommends the following steps between now and 2026 to strengthen HIV and PHC outcomes through leveraging convergence points and the comparative advantage of the Joint Programme.

Recommendation 1: As an urgent priority, ensure conceptual clarity, shared understanding, and consistent application of relevant established definitions (PHC, primary care, integration, and convergence), and develop a shared vision on HIV and PHC integration and convergence. (Action: UNAIDS Secretariat and Cosponsors - Global level, by end June 2024)

The Joint Programme (Secretariat and relevant Cosponsors) should first ensure that they have a common understanding of established definitions of PHC, primary care, integration and linkages, and convergence. These definitions should be clearly aligned in key guidance documents and strategies developed by the Secretariat and Cosponsors going forward.

The Joint Programme (Secretariat and relevant Cosponsors) should further articulate its vision and overall objectives in relation to HIV and PHC integration and linkages and sustainability in the context of the current Global AIDS Strategy and UBRAF – both for HIV outcomes and wider health outcomes. This should reflect the ToC and underlying assumptions developed for this evaluation.

Recommendation 2: As an urgent priority, revisit the Division of Labour (DoL) in relation to the three pillars of the PHC approach and ensure buy-in of leadership. (Action: UNAIDS Secretariat to lead ensuring all Cosponsors involvement - Global level, by end June 2024).

A precondition for successful work on the HIV and PHC integration agenda will be to ensure buy-in from the UNAIDS Secretariat and Cosponsor leadership at global, regional, and country levels and agreement on the DoL. Building on global level discussions in relation to recommendation 1, the Joint Programme should review the DoL in relation to the three pillars of the PHC approach, and agree on roles and responsibilities.

Recommendation 3: As an urgent priority, review and update UBRAF PHC related 2025 milestones and 2026 targets as part of the implementation of the 2024–2025 Biennial Workplan and Budget. (Action: UNAIDS Secretariat to lead, involving all relevant Cosponsors - Global level, by end June 2024)

Most 2025 milestones and 2026 targets for UBRAF indicators related to the PHC approach have already been reached. To meet Global AIDS strategy targets, the Joint Programme should set more ambitious milestones and targets for such indicators for the 2025 and 2026.

Recommendation 4: As a high priority, develop global guidance on HIV integration with broader health systems, engage people living with HIV (PLHIV) and key population organisations in the HIV and PHC integration agenda and support countries with situational assessments, sustainability planning and country roadmaps for integration based on equity considerations. (Action: UNAIDS Secretariat and WHO leading in collaboration with relevant Cosponsors - Global and regional levels, by end December 2024)

The evaluation found that key gaps include implementation guidance and support for HIV systems integration and convergence with wider health systems, and for operationalisation of HIV and PHC

integration and linkages – specifically what and how to integrate in different epidemic and health system contexts. The evaluation identified some critical and time-sensitive actions where the Joint Programme can support countries and regions before development of the next UBRAF (for the period beyond 2026). These include:

- **Develop global guidance on HIV integration with respect broader health systems** and support countries with technical assistance to explore context specific opportunities to strengthen health systems more widely and for HIV responses to leverage health system strengthening efforts. This guidance could **draw on lessons from various contexts and from the COVID-19 response**. (Global level).
- **Engage in consultations with PLHIV and key population organisations and consider operational research** to identify and document the benefits and risks of increased integration of HIV services in primary care settings for key populations. (Global and regional levels)
- To achieve current targets related to integration of services, **support countries with technical assistance for country specific situational assessments and development of country roadmaps on what and how to integrate** at country level, building on the UNAIDS’ HIV inequalities framework and toolkit and potential stigma index findings to inform feasible and appropriate integrated service delivery models. (Global and regional levels). Consider targeting priority countries for regional and country Joint Team support, based on consultation with country stakeholders and partners. This could also be informed by the consultation process that UNAIDS is facilitating with PEPFAR on sustaining the HIV response. (Global and regional level)

Recommendation 5: As a high priority, harmonise country Joint UN Team on AIDS plans with national health sector plans, strengthen coordination, enhance advocacy for inclusion of HIV services in health benefit packages and social contracting mechanisms, and assess and monitor equity dimensions. (Action: UNAIDS Secretariat and Joint Teams at country levels, by end December 2024)

The evaluation identified critical areas for the Joint Teams to work on at country level to enhance alignment, sustainability and equity concerns in relation to HIV and PHC integration efforts.

- **Align country Joint Team plans, with national health sector plans** to strengthen sustainability and to leverage existing mechanisms, for example, country envelope funding, and technical support mechanisms.
- **Ensure a coordinated Joint Team approach to HIV and PHC integration efforts by leveraging existing partner platforms**, including e.g., country health sector partners’ coordination mechanisms, SDG3 GAP where applicable, and UNSDCF. Ensure HIV stakeholders and key population involvement and dialogue with UHC stakeholders, platforms, and fora.
- **Strengthen advocacy for inclusion of HIV services, including prevention interventions, in health benefits packages**, and establish frameworks for **social contracting** to enable governments to fund civil society organizations to deliver sustainable HIV services for PLHIV and key populations.
- **Ensure human rights, gender, and equity considerations are prioritised in all HIV integration efforts** through assessments, consultations, analysis of data to understand country needs and contexts, and delivery of tailored support to ensure no-one is left behind.

Recommendation 6: In the process of developing the next Global AIDS Strategy and the next UBRAF (including Country Envelopes) specify the HIV and PHC integration priorities of the Joint Programme with clear actions in the UBRAF alongside a detailed Theory of Change (ToC). (Action: UNAIDS Secretariat and relevant Cosponsors - Global level, by end December 2025)

Actions to be prioritised based on where the Joint Programme can most add value:

- **Providing thought leadership and generating evidence** to make the case for context-specific HIV and PHC integration and linkages, including operational research to identify and address barriers to HIV and PHC convergence.
- **Building political commitment for sustainable HIV financing** in the context of PHC, essential health service packages and UHC and for greater convergence of HIV and PHC in health policy, systems, programmes and service delivery.
- **Providing coordinated support to countries for HIV and PHC integration and linkages**, based on country priorities, including provision of technical assistance for assessment of integration aspects, and implementation guidance, in collaboration with other partners and platforms, including the Global Fund, PEPFAR, and SDG 3 GAP.
- **Conducting policy dialogue and monitoring** to ensure that integration approaches take account of equity, human rights and gender issues and systems and services continue to meet the needs of key populations.
- **Continuing to champion the rights and needs of PLHIV, key populations, women and young people** and support community involvement and community-led service delivery, and monitoring the implications and impact of HIV and PHC integration on service access and uptake, including using strategic information.
- **Documenting and sharing approaches and lessons** that have the potential to improve HIV and wider health outcomes, including tailored responses and decentralised service delivery, strategies for reaching marginalised and vulnerable populations, use of virtual approaches, and documenting and sharing effective models of HIV and primary care integration.

The Joint Programme (Secretariat and relevant Cosponsors) should review and prioritise these areas based on the following criteria:

- Which of these areas of activity will contribute most to achieving the intended objectives?
- Which are a priority at global level? Which are a priority at regional level? Which are a priority at country level?
- Where can the Joint Programme most add value together, at global, regional and country levels? What can be left to other actors and initiatives?
- What can the Joint Programme realistically do with available resources and capacity, at global, regional and country levels?

Recommendation 7: Strengthen accountability for HIV and PHC integration and linkages within the next UBRAF indicator framework by ensuring that key Joint Programme and individual Cosponsor actions and results are monitored. (Action: Led by UNAIDS Secretariat, Global level, by end December 2025)

Aligned to the next Global AIDS strategy and UBRAF (beyond 2026), the corresponding UBRAF monitoring framework should present clear outcome and output indicators related to HIV and PHC integration and linkages, while ensuring appropriate milestones.

Key areas of monitoring/ indicators for the Joint Programme could be around:

- HIV service integration into health benefits packages
- Social contracting indicators
- Health system level integration indicators
- Health services integration indicators
- Human rights, gender, and equity indicators on integrated service delivery models
- Donor resources for HIV and PHC integration efforts, including through PEPFAR, the USAID Primary Impact Initiative, and Global Fund RSSH funding.

ANNEXES

Annex 1: Terms of Reference Independent Evaluation

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

Overview	
Content	Independent evaluation of the UNAIDS Joint Programme’s work on leveraging the HIV and Primary Health Care interlink.
Reference to 2021-2026 Global AIDS Strategy (UNAIDS Strategy)	Strategic Priority 3: Priority 3—Fully resource and sustain efficient HIV responses and integrate them into systems for health, social protection, humanitarian settings and pandemic responses. Result Area 9: Ensuring people-centred integrated resilient and sustainable systems for health
2022-2026 UBRAF Outputs	Output 2 (on communities’ capacity) and Output 9 (on integrated systems for health) of the 2022–2026 UBRAF
Responsible office	UNAIDS Independent Evaluation Office
Lead Cosponsors	UNFPA, WHO, UNICEF and the World Bank
Estimated budget	<i>Ref. UNAIDS 2020-2021 Budget and UNAIDS 2022-2023 Budget</i> It is not possible to estimate the investment of the Joint Programme on integration of HIV into PHC (nor on broader investments linked to PHC), since data are not sufficiently disaggregated, and because funds relevant to PHC may come from other programmes than those that are HIV-specific.
Estimated budget for the evaluation	US\$ 214,365
Timeframe of the evaluation	2020 to 2023 (to date)
Type of Evaluation	Independent joint evaluation - with a management group composed of UN evaluation experts (from UNAIDS, UNFPA, UNICEF and WHO) and a reference group composed of UN HIV and health experts
Expected Starting and End Date of Evaluation	February – November 2023
Expected users	UNAIDS Joint Programme (Cosponsors and Secretariat) at all levels, UNAIDS Programme Coordinating Board (PCB) constituencies, UNAIDS partners such as PEPFAR, USAID and the Global Fund given their focus on integrated people-centred systems and services.

CONTEXT

THE 2021-2026 GLOBAL AIDS STRATEGY

[The Global AIDS Strategy 2021-2026 - End Inequalities. End AIDS](#) is a bold approach using an inequalities lens to close the gaps that are preventing progress towards ending AIDS. The Global AIDS Strategy prioritizes people who are not yet accessing HIV services, interventions that have high impact and addressing health and other systems, societal and other barriers to equity in access to and uptake of services, ensuring best HIV and health outcomes. The Strategy sets out evidence-based priority actions and targets – including targets on HIV integration - to get every country and every community on-track to [ending AIDS by 2030 as a public health threat](#). This will require innovative alliances, with and within governments' health and other sectors, community-led organizations, donors, programme implementers and other partners to break the siloes and creating linkages between HIV and the broader efforts on strengthening systems for health, reaching Universal Health Coverage, improving sexual and reproductive health, addressing communicable diseases other than HIV, noncommunicable diseases and other health issues that are frequently associated with HIV. The Strategy is also a call to action for the UNAIDS Joint Programme to advance its leadership role in the global HIV response.

Ensuring resilient and sustainable systems for health and integrated people-centred systems and services is a distinct result area of the 2021–2026 Global AIDS Strategy - Result Area 9: Ensuring people-centred integrated resilient and sustainable systems for health under Strategic Priority 3 for fully resources and sustainable efficient HIV responses and their integration into systems for health, social protection, humanitarian settings and pandemic response. It is also considered as a cross-cutting priority across all the strategic and programmatic areas. Integrated people-centred and local context specific systems and services are also a critical part of the Result Area 2: Adolescents, youth and adults living with HIV, especially key populations and other priority populations, know their status and are immediately offered and retained in quality, integrated HIV treatment and care that optimize health and well-being under Strategic Area 1: Maximize equitable and equal access to HIV services and solutions. The Strategy calls for a full range of health services for achieving best HIV and health outcomes and wellbeing to be integrated into primary health-care settings, with special consideration to acceptability for marginalized and other populations who experience stigma and discrimination.

The primary Health Care (PHC) approach and HIV

The primary health care approach, as outlined in the 1978 Declaration of Alma-Ata and again 40 years later in the 2018 WHO/UNICEF document [A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals](#) is a whole-of-government and whole-of-society approach to health that combines the following three components: multisectoral policy and action; empowered people and communities; and primary care and essential public health functions as the core of integrated health services¹⁷⁵.

Building on the principles of the Declaration of Alma-Ata, the Declaration of Astana was adopted at the Global Conference on Primary Health Care in October 2018. In the Declaration of Astana, Member States reaffirmed their commitment to primary health care as a cornerstone of sustainable

¹⁷⁵ Please note the distinction between primary care and PHC: 1) [Primary care](#) is a key process in a health system that provides promotive, protective, preventive, curative, rehabilitative, and palliative services throughout the life course. Primary care is a model of care that supports first-contact, accessible, continuous, comprehensive and coordinated person-focused care. 2) [Primary health care \(PHC\)](#) is a broader whole-of-society approach with three components: (a) primary care and essential public health functions as a core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities.

health systems for the achievement of universal health coverage and the health-related Sustainable Development Goals.

An [Operational Framework for Primary Health Care, WHO and UNICEF, 2020](#) proposes 14 levers needed to translate the global commitments made in the Declaration of Astana into actions and interventions. Focused and flexible attention to the PHC operational framework is a compass for country action. The 14 levers (4 strategic¹⁷⁶ and 10 operational¹⁷⁷) provide guidance to countries as they forge their country-specific pathways on PHC. Such actions and interventions can be used to accelerate progress in strengthening primary health care-oriented systems. Emphasis is placed on the inter-dependence of each of the levers – none should be seen in isolation. These interdependent levers may be useful to explore interlinkages with HIV.

Following the Review of [40 years of Primary Health Care implementation at country level](#), by the WHO Evaluation Office, in 2020, WHO established a Special Programme on PHC, with three main coordination functions (evidence and innovation, policy and partnership and country impact), that is currently being evaluated (ref. to WHO evaluation of the Special Programme on PHC). The governance function is also placed within the SP-PHC and transition arrangements are currently being put in place.

Of note, the PHC Accelerator of the Global Action Plan for SDG3, that is a multiagency group co-chaired by WHO and UNICEF, identifies concrete joint actions at global, regional and country level to assist governments identify bottlenecks and strengthen systems “levers”, to build and expand service delivery models that are inclusive of the most vulnerable groups ([WHO PHC accelerator discussion frame](#)). Reaching Sustainable Development Goal 3 will require health services to be user-centred, respectful, accessible, affordable and used¹⁷⁸. Moreover, other sectors than health need to be engaged and citizens and communities empowered to both produce health at home and demand good services. However, the present situation is characterized by inequities between and within countries on all these accounts, including marginalized communities such as rural remote, urban poor, migrants and displaced, and minority populations.

The 2022-2030 WHO’s Global health sector strategies on HIV, viral hepatitis and STIs [Global HIV, Hepatitis and STIs Programmes \(who.int\)](#) aspire to a common vision to end epidemics and advance universal health coverage, PHC and health security in a world in which all people have access to high-quality evidence-based people-centred health services and can lead healthy and productive lives. The strategies focus on optimizing systems, sectors and partnerships for impact by strengthening health service delivery and optimizing other health system functions in collaboration with partners under a universal health coverage and PHC framework. The WHO strategies call for promoting the integration of HIV, viral hepatitis and STIs services and their key co-infections and comorbidities into PHC platforms where feasible and appropriate, including through decentralized and community-based service delivery, and contributing to jointly strengthening these platforms for sustainable progress towards universal health coverage.

Relevant resources include UNAIDS Cosponsors’ strategies with the reference to PHC – e.g., those of UNICEF, UNFPA and the World Bank – as well as the above mentioned PHC operational framework and the associated [Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens \(who.int\)](#).

¹⁷⁶ The four strategic levers relate to: political commitment and leadership; governance and policy; funding and resources; and community and stakeholder engagement.

¹⁷⁷ The 10 operational levers relate to models of care; PHC workforce; infrastructure; medicines and health products; private sector engagement; purchasing and payment systems; digital technologies for health; quality of care; PHC research; and M&E.

¹⁷⁸ Please see WHO fact sheet on Quality of Care (<https://www.who.int/news-room/fact-sheets/detail/quality-health-services>) as well as the WHO-World Bank-OECD global publications. Here the WHO Quality Toolkit Link: [What is quality of care \(who.int\)](#) and the link to the document Delivering quality health services: a global imperative for universal health coverage (<https://www.who.int/publications/i/item/9789241513906>).

The UNAIDS publication [AIDS Response and Primary Health Care: linkages and opportunities, 2018](#) links aims in PHC with the needs and contribution of the AIDS response over time. The publication shows that the AIDS response has generated many valuable lessons which are relevant to scaling-up and operationalizing PHC. The AIDS response can serve as a pathfinder for further progress on PHC, while helping to ensure that PHC remains true to its values of human rights and social justice. At the same time, the integration of HIV services into PHC, where feasible and appropriate, will be critical to ensure a continuum of both HIV prevention and care, optimal access to ART and ongoing chronic care that is properly coordinated with other primary care needs of people living with HIV.

Overall, a recent meta-analysis, shows that integration of HIV services and other health services tends to improve health and health systems outcomes. Despite some scientific limitations, the global evidence shows that service integration can be a valuable strategy to boost the sustainability of the HIV response and contribute to the goal of 'ending AIDS by 2030', while simultaneously supporting progress towards universal health coverage ([Integrating HIV services and other health services: A systematic review and meta-analysis - PubMed \(nih.gov\)](#)).

How HIV programming can be truly integrated – including at the decentralised level – in countries where it remains largely donor-funded remains a challenge. HIV dedicated services have played a critical role in ensuring stigma-free services for key populations and other priority groups. Equity considerations are, therefore, essential when HIV services are integrated into PHC, to ensure access, uptake, and quality across populations groups, and the most vulnerable.

At the same time, the HIV/PHC interface should not be understood as a phenomena that is undergoing a linear one-directional journey, which is limited to HIV integrated into primary health care. WHO (and the Joint Programme) does not advocate for full integration, or a one size fits all approach. WHO supports and advocates for optimal synergies and integration between HIV and PHC that is context specific and driven by data and policy dialogue that involves the right people. Affected communities are often at the heart of this. In other words, *integration "where it makes sense"*. It is also important to be mindful of unintended consequences that may emerge from overly focusing on PHC and/or overly focusing on HIV. It might be that some contexts undergo rigorous strategic and consultative processes to review opportunities for bringing HIV and PHC more closely together and decide that the timing may not be right to push for significant additional integration.

UNAIDS Joint Programme work on HIV and PHC

The [2016–2021 Unified Budget, Results and Accountability Framework](#) (UBRAF) has guided UNAIDS' operational planning at global, regional and country levels by identifying the expected results of the Joint Programme and has provided the framework for budgetary allocations and accountability through 2021. As part of this framework, in 2016, the Joint Programme committed to people-centred HIV and health services are integrated in the context of stronger systems for health, including by supporting the training of service providers and government agencies to offer services at primary care level, through task shifting and task sharing and other relevant modalities, and support programmes that shift HIV and related services to communities where feasible.

A new UBRAF for the period 2022-2026 was developed in 2021. The [2022-2026 UBRAF](#) offers stronger focus for integrating HIV and PHC, although no specific activities or areas for the Joint Programme within the broader mention of "integrating HIV into PHC" are provided.

In the UBRAF, Strategy Result Area 9 gets translated at the output level as "Increased access for people living with, at risk of and affected by HIV to integrated health services, health technologies and social protection", with the following activities, that are relevant in this context: *support country stakeholders to strengthen inclusive systems for health for integration and linkages of HIV services in testing, treatment and care for other diseases and comorbidities such as TB, viral hepatitis, and sexually transmitted infections, and in mental health, sexual and reproductive health and family planning, noncommunicable diseases, primary health care, community health systems, universal health coverage and social protection.*

Primary health care is also mentioned under the UBRAF areas for priority, and namely:

1. Fully funded and sustainable HIV responses: Provide technical advice, capacity building and analytical work to help countries get greater value from existing resources and better integrate HIV and COVID-19 services into essential primary health-care services (e.g., through allocative efficiency, cascade analytics, inclusion of HIV in health benefits packages and improved support in primary health care); and
2. Community-led responses: Strengthen collaboration and alignment between the health systems and community systems to improve access to quality, people-centered, and integrated HIV services (SRH/TB/sexually transmitted infections/non-communicable diseases) at the primary health care, within the health sector in order to achieve universal health coverage. However, no further detail is provided on what integration into PHC implies.

The [UBRAF Indicator Matrix 2022.2026](#) provides two relevant indicators for PHC:

- *Indicator 3.2.2.* Number of countries supported by the Joint Programme which have HIV services for children integrated into at least 50% of Primary Health Care (PHC) sites.
- *Indicator 9.1.1.* Number of countries supported by the Joint Programme to have HIV antiretroviral services, for both treatment and prevention purposes, organized and financed as part of overall health systems, including through Primary Health Care.

Annex 1 of this TORs presents a general theory of change (TOC) of the work of the Joint Programme in relation to HIV integration, linkage and synergies with PHC (Source: 2022-2026 UBRAF). At the inception phase the evaluation team will need to reconstruct a specific TOC, based on this general TOC, a desk review, and on discussions with key stakeholders, as well as frameworks such as the PHC operational framework.

The Joint Programme contribution to integration of HIV into primary health care, linkages and synergies are crucial for achieving 2025 global HIV targets and reaching universal health coverage (UHC). At the same time, discussions with key informants (UNAIDS programme staff) at the time of drafting the TOR for this evaluation, show that HIV integration into PHC has not been really a Joint Programme priority or a specific focus yet. The situation may change with the new Global AIDS Strategy and the WHO's new Global health sector strategies on HIV, viral hepatitis and STIs, UNAIDS', WHO's, Global Fund's, PEPFAR's and other partners' emphasis on integrated people-centred cross-disease and health systems and service delivery approaches, including through PHC. As such, there is urgent need for identifying opportunities and imperatives for the Joint Programme work on PHC in the future, and this evaluation comes in a timely manner to feed into this reflection.

PURPOSE AND SCOPE OF THE EVALUATION

Purpose. An independent evaluation of the work of the UNAIDS Joint Programme on leveraging the link between HIV and PHC is carried out as part of the 2022-2023 UNAIDS evaluation plan ([UNAIDS 2022-2023 Evaluation Plan](#)) approved by UNAIDS Programme Coordinating Board in December 2021.

The evaluation should identify how efforts to address HIV have been – conceptually and operationally – linked to the PHC approach and how this can be further strengthened. The evaluation should capture the HIV-PHC interface, drawing on where things stand based on current experience and where things could stand by reorienting health systems towards PHC, which is called for by WHO and Member States. The evaluation will not only assess how the Joint Programme has supported integration¹⁷⁹ of HIV into primary health care and how HIV integration has improved HIV prevention,

¹⁷⁹ Integration that is appropriate for better HIV and health outcomes and for individual and communities of concern and local contexts.

testing and treatment outcomes but also how this has strengthened primary health care outcomes more broadly, e.g., improving the ability of PHC to care for people with chronic illnesses.

The evaluation is designed both for accountability and learning purposes. The evaluation is expected to provide clear recommendations to accelerate and prioritise Joint Programme actions related to HIV and PHC. It is important to understand what the Joint Programme has achieved in supporting countries' efforts in integrating HIV into primary health care and what it could do better, differently or/and more of. The evaluation is critical for identifying ways in which the Joint Programme should support the sustainability of HIV programmes and ensuring reaching 2025 HIV targets and Universal Health Coverage by integrating HIV into PHC for relevant population groups across the life-course, including those most vulnerable and marginalized.

The evaluation will use the previous 2016-2021 and the current 2022-2026 UNAIDS Strategy and UNAIDS Unified Budget, Results and Accountability Framework (UBRAF) as a reference to assess the work of the Joint Programme, with a forward-looking approach. The evaluation is expected to contribute to future planning of HIV integration into PHC to strengthen inclusion of people living with HIV and other key and vulnerable populations, including young people among them; and support to PHC more broadly.

Scope. The evaluation covers the work of the Joint Programme at the global level and across regions and selected countries over the period 2020-2023 (to date). The evaluation should consider the variety of contexts in which HIV is or should be integrated into primary health care and how this can be dealt with from a methodological point of view within the resource envelope available for the evaluation.

The evaluation will be conducted concurrently with a formative evaluation of the **Special Programme on Primary Health Care** of the World Health Organisation. The two evaluations will adopt a synergistic approach, for instance, regarding the selection of countries as case studies and by ensuring close collaboration between the evaluation teams. While the aim of the WHO evaluation is to assess the contribution of the Special Programme on PHC at global, regional and country level, there are common elements with the UNAIDS evaluation, such as lessons from HIV-specific contexts; an assessment of how the Special Programme works with HIV, and the lens on equity and sustainability of health gains for the most vulnerable populations.

The evaluation will take stock of the results of recent UNFPA evaluations findings on integration (e.g. Evaluation of the UNFPA support to the HIV response 2016-2019) and is expected to feed into a planned UNICEF global evaluation of their work on primary health care.

EVALUATION AREAS OF ENQUIRY

The evaluation utilizes the Organisation for Economic Co-operation and Development, Development Assistance Committee (OECD DAC) evaluation criteria as defined below¹⁸⁰:

- **Relevance** – Relevance examines the extent to which the Joint Programme’s work is consistent with country needs related to HIV and primary health care.
- **Coherence** - Coherence examines the extent to which the Joint Programme’s work supports or undermines other actors’ interventions and vice versa. Coherence includes complementarity, harmonization, and coordination within and beyond the Joint Programme.
- **Effectiveness** – Assessment of the extent to which the Joint Programme’s interventions have achieved or are expected to strengthen HIV and primary health care outcomes
- **Sustainability** – Assessment of how the Joint Programme’s work is contributing to sustainable HIV responses and primary health care programmes.

In addition, the evaluation will consider the cross-cutting theme of **Equity**. Gender equality and human rights¹⁸¹ shall be explicitly addressed throughout the evaluation and the analysis should assess the extent to which actions and interventions contribute to addressing inequalities.

Evaluation key areas of enquiry

The evaluation will examine the strategic priorities and work of the Joint Programme based on a set of evaluation questions.

During the inception phase the evaluation team is expected to review the evaluation questions, in consultation with the reference group and management group of the evaluation, and based on a reconstructed theory of change.

In consultation with the reference group (and with reference to WHO guidance), the evaluation team will need to “unpack” what HIV integration means and what areas it involves, and reflect on the HIV PHC interlink and which specific issues the evaluation can cover bearing in mind available resources.

The evaluation should also include a brief landscape and data analysis to understand the needs on integrating HIV into PHC, what the existing commonalities and shared assets of the HIV responses and primary health care programmes are – in different contexts - and what and where the gaps are. However, the focus remains on UN agencies’ actions, in terms of achievements but also in terms of current and future opportunities. The evaluation team will need to select criteria by which the level, modalities and actual results of the integration can be evaluated.

¹⁸⁰ Applying Evaluation Criteria Thoughtfully. [Applying Evaluation Criteria Thoughtfully | en | OECD](#)

¹⁸¹ UNEG and UNAIDS guidance on *Integrating Human Rights and Gender Equality in Evaluation*.

Proposed evaluation questions (to be reviewed at the inception phase)	Criteria
To what extent and how has the Joint Programme (WHO, UNICEF, UNFPA, World Bank, and the Secretariat) supported integration of HIV into primary health care (in different contexts)? <i>This should include SRHR, PMTCT integration into MNCH, adolescent health and comorbidities, including TB, paediatric HIV treatment and care and examine specific populations.</i>	Relevance, effectiveness
To what extent are vertical disease (HIV) and PHC approaches of the UN system coherent?	Relevance, coherence
To what extent and how has the Joint Programme contributed to strengthening primary health care through learning, assets and infrastructure developed as part of the HIV response?	Relevance, effectiveness
How equipped (in terms of human resources, policies, investments, guidance and technical support) is the Joint Programme to deal with HIV integration into PHC?	Effectiveness
To what extent has the COVID-19 pandemic led the Joint Programme to consider new ways of integrating HIV into primary health care? Are there examples that demonstrate benefits of integration?	Effectiveness
Which locations and population groups are being left behind by the current Joint Programme PHC efforts (and to what extent)? <i>Consider breakdown by sex and age.</i>	Equity
How can future investments in primary health care support HIV goals (i.e., lower HIV incidence and greater treatment initiation and adherence) and what should the role of the Joint Programme be?	Sustainability

The evaluation team should identify **lessons learned**, e.g., on strengthening HIV and primary health care and the experience of the Joint Programme of enhancing the ability of primary health care to deal with and provide services for HIV prevention and testing and managing chronic diseases.

Recommendations for the Joint Programme should be presented by type of country needs/regions and consider the risks of HIV integration, such as less focus on differentiated services, on key populations and on the social determinants of HIV. Recommendations should cover specific and operational ways in which the Joint Programme should support HIV integration, but also primary health care systems to strengthen sustainable and inclusive high-quality HIV programmes in the future, i.e., effectively contribute to lower HIV incidence and greater treatment initiation and adherence as well as reduced stigma and discrimination of people at risk of or living with HIV.

METHODOLOGY

The evaluation will use a mix of qualitative and quantitative methods, to be defined and approved as part of the inception phase of the evaluation.

A **theory of change** will be reconstructed at the beginning of the evaluation to help clarify what the inputs and expected outputs of the work of the Joint Programme on HIV and primary health care are, and to help organize and prioritise evaluation questions. The TOC should be based on the general one presented in the current 2022-2026 UBRAF and on discussions with key stakeholders. See https://www.unaids.org/en/resources/documents/2021/PCBSS_2022-2026_UBRAF_Framework and Annex 1.

The inception report will clarify the use of the TOC in the evaluation and include an evaluation matrix with a description of the methods to be used to answer each of the evaluation questions and sources of data to be used. The evaluation matrix must also include the assumptions for verification and the

indicators. The methodology is expected to describe the process and tools for data collection at the global, regional and country level.

Global and regional levels: desk review, individual and group interviews with key informants. The desk review at the global and regional level should cover strategic documents, policies and guidance as well as implementation and monitoring reports. The desk review will be complemented by interviews with internal and external stakeholders.

Country level: four countries – desk review, individual and group interviews with key informants and focus group discussions. Data collection for selected countries will include a document review, (face-to-face or virtual) interviews and focus group discussions with UN staff and other stakeholders including government, civil society and community-led organizations, PLHIV, key and other populations, donors and other partners. The desk review will include work plans and reports of Joint Teams at country level, other Joint Programme and UN documents on PHC. Joint Programme efforts at the country level will be assessed against capacity and country needs to highlight good practices and examples of barriers. The evaluators should examine available information in the PHC programmes from country case studies that have been collated, and draw out any key learning from any such case studies, and examine country case studies that have focused on a particular operational lever, for example, systems for improving quality of care.

The selection of countries will be purposive, with respect of some regional representation (three to four regions): ESA, WCA, AP, LAC¹⁸² and be carried out at the inception phase in coordination with the management group for the WHO Special Programme on PHC evaluation, including countries where the Special Programme on PHC has initiated policy dialogue. At least two countries are expected to be in common for the two evaluations, to assess the coherence of a vertical disease programme and PHC approaches.

The evaluation will cover settings with a high burden of HIV as well as countries with concentrated HIV epidemics since integration into primary health care presents different challenges in different epidemic contexts. The country selection will also make sure that the evaluation can look at the variety of population group needs, like for key populations and young people among them.

The case studies should represent diverse contexts and allow the analysis to provide some sort of typology about the interface between HIV and PHC.

Since the evaluation focuses on the work of the Joint Programme, country presence of UNAIDS Secretariat and Cosponsors is a prerequisite to country selection, as well as logistical feasibility. Also, to avoid overburdening UNAIDS country offices and Joint Teams, countries with recent Joint Programme evaluations (i.e., evaluations of key populations, efficiency and sustainability and social protection) will be de-prioritised.

Data sources will include relevant evaluations and reviews from Cosponsor agencies. Another source of data is the *Joint Programme Planning and Monitoring System* (JPMS). A web-based tool that facilitates collecting, collating and analysing of performance information for the Joint Programme. Data entry starts at the country level and is undertaken by Joint United Nations Teams on AIDS. For each of the countries where the Joint Programme operates, it is possible to access a description of activities carried out jointly and by individual Cosponsors under specific Result Areas. The JPMS also includes data on the regional and global levels. In addition to JPMS, the evaluation needs to consider UNAIDS annual performance monitoring reports and country profiles on the transparency portal as well as agency specific PHC related reports or other annual health reports, covering MCH and SHRH interventions that may not be reflected in the HIV specific reporting, and this in particular for WHO, UNFPA and UNICEF.

¹⁸² From discussions with programme specialists in UNAIDS it seems that the Joint Programme may not have sufficient leverage on PHC in EECA, and findings from countries in MENA may be less generalizable across the countries in the region.

Some challenges with the evaluation

The quality of the data is uneven across countries and levels and there might be very little reporting or disaggregation of activities in relation to PHC. Also, despite the introduction of two new indicators in UBRAF to assess integration into PHC at the country level, information on achievements and results is scant. Since some of the interventions in this area go beyond the work of the Joint Programme—it may be underreported in the JPMS, beyond the well-established integration of PMTCT services into antenatal care. Evaluators will need to reach out to UN staff beyond the HIV programme, like staff in charge of health programmes (youth health, MCH, SHRC, health finance) within WHO, UNICEF and UNFPA.

GOVERNANCE OF THE EVALUATION

The UNAIDS Evaluation Office

The UNAIDS evaluation office has overall responsibility for steering the evaluation from start to completion in a credible, transparent, and utilization-focused manner – in adherence with UNEG norms and standards – and the day-to-day management in accordance with the agreed terms of reference.

UNAIDS country offices will facilitate access to information and provide necessary logistical and organizational support in countries where data will be collected and facilitate contact with country officials and key stakeholders.

The management group for the evaluation

Senior staff of the evaluation offices of UNAIDS Cosponsors (*UNFPA, WHO, UNICEF*) whose role is to:

- Validate the terms of reference;
- Approve the selection of the evaluation team;
- Ensure that the inception and draft and final reports are of high quality;
- Provide oversight and help guide the evaluation team and facilitate the evaluation;
- Ensure the independence of the evaluation.

Members will provide comments on key evaluation products (terms of reference, inception and draft and final reports) focusing on the evaluation design and methods.

The reference group for the evaluation

Staff working on HIV but also staff working on MCH and SHRH from Cosponsors should be equally engaged in the evaluation. The reference group will be composed of representatives from:

- UNAIDS: staff with expertise on PHC and on health financing at global, regional and country level
- WHO: staff with HIV expertise (Global Coordinator/Focal point on HIV) and staff with PHC expertise (Special Programme on PHC) and health financing expertise
- UNFPA: staff with HIV expertise (Global Coordinator/Focal point on HIV) and staff with SHRH expertise
- UNICEF: staff with HIV expertise (Global Coordinator/Focal point HIV) and staff with PHC/MCH expertise
- World Bank: staff with HIV expertise (Global Coordinator/Focal point on HIV) and health systems and PHC expertise

Representatives from agencies can be based at different geographical levels.

The work of the reference group will be facilitated by the UNAIDS evaluation office and the group will have the following responsibilities:

- Review the terms of reference and formulate the initial evaluation questions in the ToR;

- Review the inception report as well as the preliminary findings, draft and final reports;
- Act as a source of technical and programmatic expertise for the evaluation;
- Contribute to dissemination and facilitation of use of evaluation findings.

TEAM OF CONSULTANTS, QUALIFICATIONS AND EXPERIENCE

The evaluation will be carried out by a team of consultants, offering a mix of evaluation experience and expertise as well as experience and expertise on primary health care and HIV, and the work of the UN system. National and local experience and expertise is expected to be tapped into for the data collection at country level.

Mix of experience and expertise of the evaluation team (to form the basis for the skills and profiles for individual team members):

- Relevant professional qualification, preferably at the academic (master's or PhD) level
- At least 10 years of experience in conducting country-level programme evaluations in the field of public health and development.
- Demonstrated knowledge of the HIV epidemic and response in countries;
- Background and expertise in public health, in general, and primary health care, in particular;
- Proven experience with qualitative and quantitative data collection methods, analysis of public health data and experience in handling data limitations;
- Ability and record of bringing gender equality, human rights and other equity issues into an evaluation including data collection and analysis;
- Previous experience with evaluations of programmes and projects of UN organisations;
- Strong interpersonal skills and ability to work with people from different backgrounds to deliver high quality products within a short time period;
- Excellent writing, analytical and communication skills.

Language: Demonstrated excellent report writing skills in English. Ability of some team members to work in and communicate in French and Spanish.

CONTRACTORS RESPONSIBILITIES AND DELIVERABLES

The evaluation team (contractors) will be responsible for:

- The design, planning and implementation of the evaluation and the evaluation report, using an approach to be agreed in the inception phase, and for delivering in accordance with the UNAIDS's specifications and timeline;
- Consulting and liaising regularly with UNAIDS evaluation office, management group and reference group and any partners to ensure satisfactory completion of all deliverables;
- Scheduling and conducting all meetings, interviews, and focus group discussions with stakeholders.

The consultants are expected to carry out the evaluation with a high degree of independence and manage their own travel and other administrative arrangements.

Deliverables

Deliverable 1: Inception report with methodology

To be submitted to the UNAIDS evaluation office presented to the management and reference groups of the evaluation.

The inception report should detail the evaluators' understanding of what is being evaluated and why and include:

- analysis and reconstruction of a theory of change;
- a refined list of evaluation questions, with rationale, link to evaluation criteria, assumptions for verification, indicators and source of information;
- a complete evaluation matrix, showing how each evaluation question will be answered by way of proposed methods and sources of data;
- a proposed schedule of activities and deliverables; and
- a final list of countries for case studies.

Deliverable 2: Preliminary findings and draft evaluation report

To be submitted to the UNAIDS evaluation office and presented to members of the management and reference groups for review and inputs. Country reports will feed into the overall global report and be published as a separate volume.

Deliverable 3: Final evaluation report with country case study annex, evaluation brief and PowerPoint presentation together with a financial report*

To be submitted to the UNAIDS evaluation office. The report, brief and slides should be submitted in English. The quality of the report will be determined based on quality standards (ref. UNAIDS quality checklist for evaluation reports). The report should include a lessons learned section. Country reports should be included as an annex to the final report.

SPECIAL TERMS AND CONDITIONS

This evaluation will comply with UN norms and standards for evaluation and ensure that ethical safeguards concerning the independence of the evaluation will be followed. Please refer to the UNEG code of conduct: <http://www.unevaluation.org/document/detail/100>

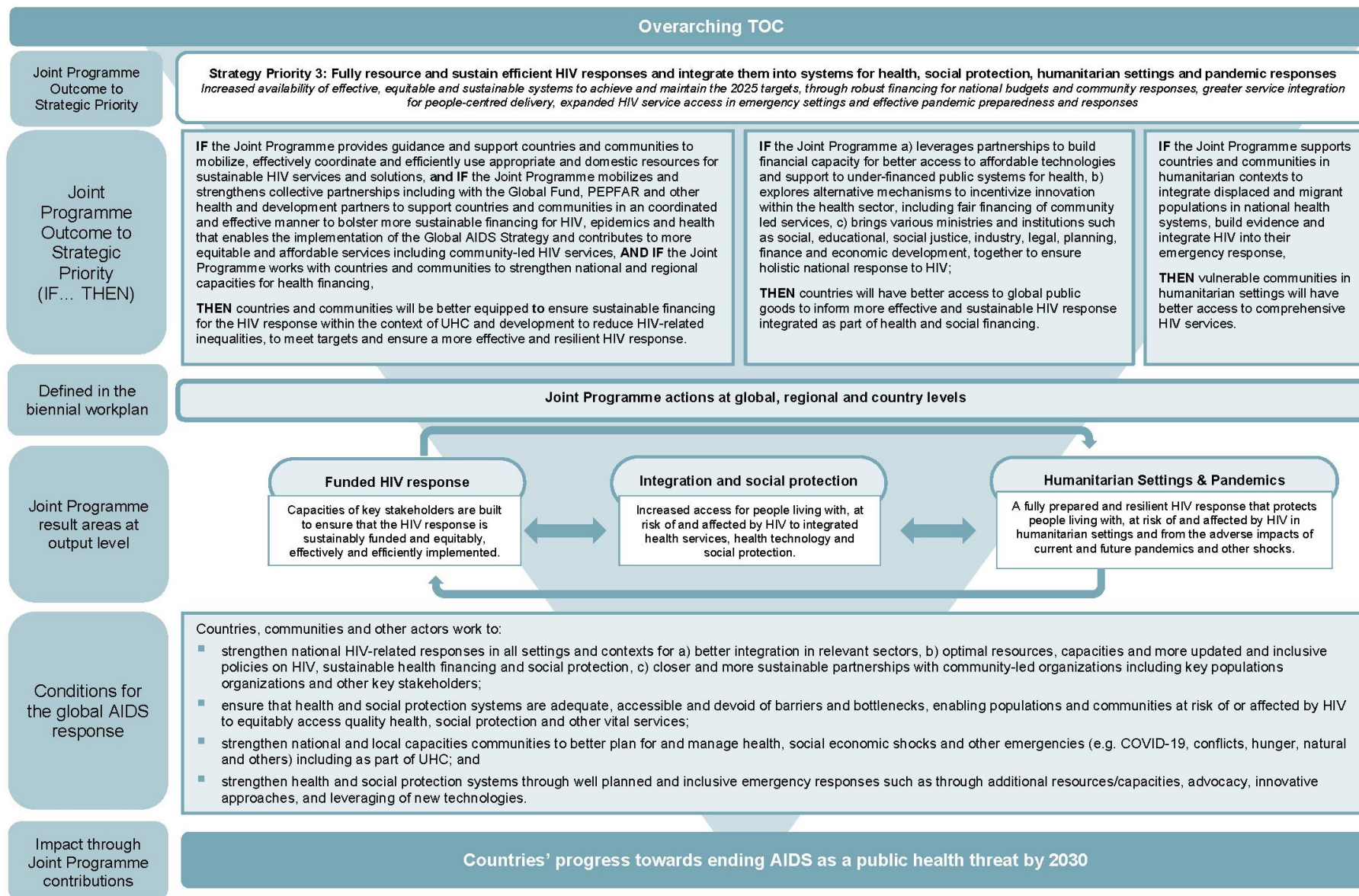
All draft and final outputs, including supporting documents, analytical reports and raw data should be provided in electronic form. All data and information received from UNAIDS for this assignment must be treated confidentially and are only to be used in connection with the execution of these terms of reference. All intellectual property rights arising from the execution of these terms of reference are assigned to UNAIDS. Use of the data for publication and other presentation can only be made with the agreement of UNAIDS. Key stakeholders can make appropriate use of the evaluation report in line with the original purpose and with appropriate acknowledgement.

All travel-related costs are reimbursable subject to actual expenditures incurred upon submission of a detailed financial report along with original proof of purchases, receipts, boarding passes and relevant travel documents. Air tickets are to be purchased as early as possible or at least 10 working days before departure, by the most direct and least expensive route in economy class, and per diem should not exceed the UN standard rate as per UNAIDS travel policy.

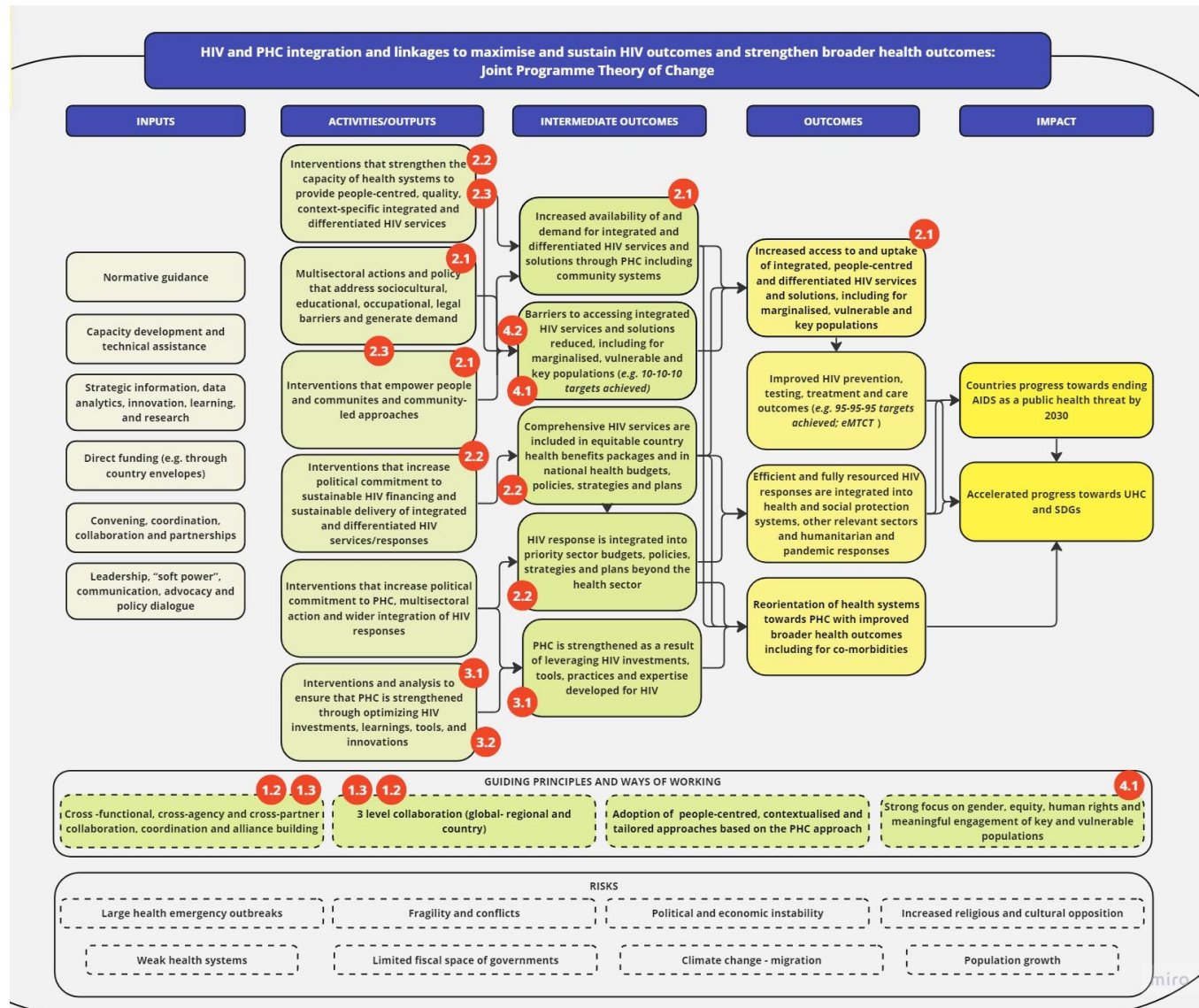
TIMELINE AND SCHEDULE OF DELIVERABLES

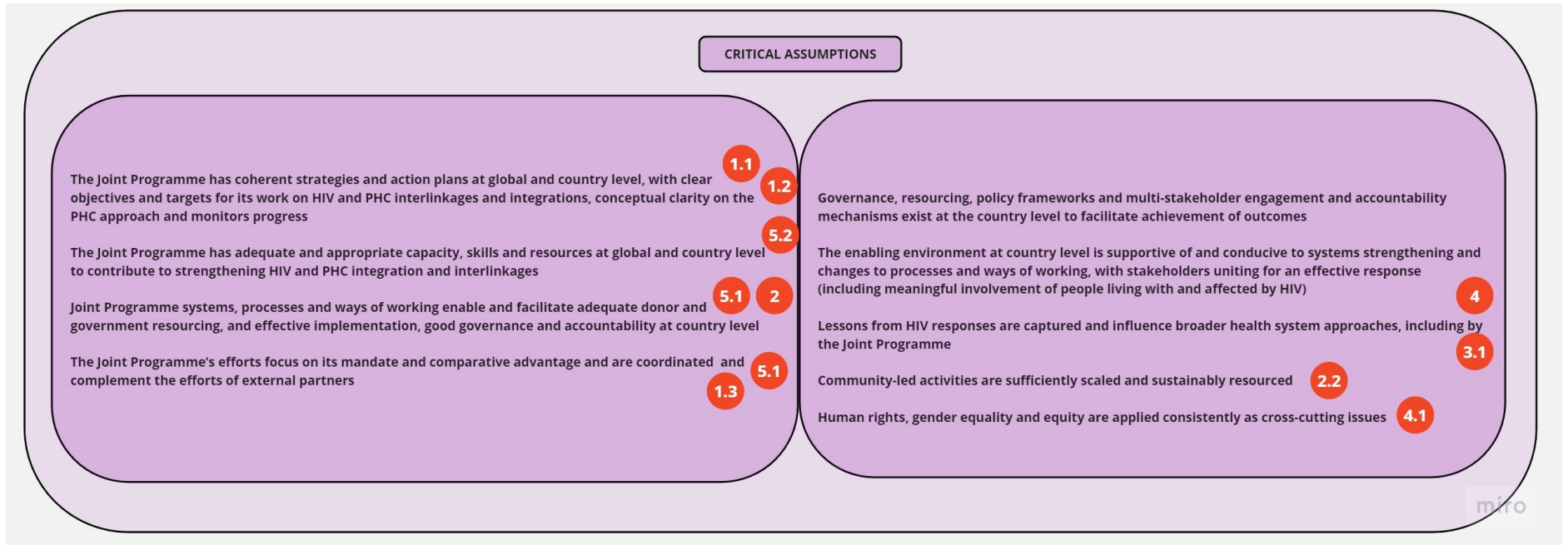
Tentative timeline	Steps / Deliverable
March 2023	Desk review Draft inception report: <ul style="list-style-type: none"> ■ Proposed evaluation framework, reconstructed theory of change and evaluation questions ■ Proposed list of countries for data collection ■ Data collection and analysis methods
April 2023	Finalization of inception report and evaluation plan Deliverable 1: Inception report with methodology
May-June 2023	Data collection and analysis
July-August 2023	Report writing and finalization of draft report
September 2023	Deliverable 2: Submission of draft evaluation report Workshop to validate evaluation findings and recommendations
October 2023	Review of draft report by management group and reference group Integration of comments and finalization of evaluation report
November 2023	Deliverable 3: Submission of final evaluation report with country case studies as an annex, brief and slide set

ANNEX 1 – TOC relevant to integration of HIV into Primary Health Care (source: 2022-2026 UBRAF)



Annex 2: Theory of Change





Annex 3: ToC assessment

Overall, the programme logic as expressed in the ToC has held. However, the assumptions underpinning the model have not, which help to explain why the Joint Programme has not worked in the manner intended. The evaluation findings suggest that when the inputs are provided and activities are implemented in the manner intended, intermediate outcomes can be achieved and in turn this can contribute the achievement of outcomes and impact. However, as set out in the Table below, the assumptions underpinning the model have not held true. This has affected both what the Joint Programme and Cosponsors have implemented and how the Joint Programme's work on PHC has been operationalised in relation to its ways of working. Most notably this relates to a lack of cross-functional, cross-agency and cross-partner collaboration, coordination and alliance building.

Table 9: Assumptions underpinning the ToC

Assumptions	Summary of evidence
Assumptions related to inputs, and activities/outputs	
The Joint Programme has coherent strategies and action plans at global and country level, with clear objectives and targets for its work on HIV and PHC interlinkages and integrations, conceptual clarity on the PHC approach and monitors progress	Such strategies and action plans have not been in place, with an overall lack of conceptual clarity on the PHC approach and HIV and PHC integration and insufficient monitoring of progress
The Joint Programme has adequate and appropriate capacity, skills and resources at global and country level to contribute to strengthening HIV and PHC integration and interlinkages	The Joint Programme has limited capacity, skills and resources at global and country levels to contribute to HIV and PHC integration and linkages
Joint Programme systems, processes and ways of working enable and facilitate adequate donor and government resourcing, and effective implementation, good governance and accountability at country level	The financial sustainability of the HIV response is a critical concern and a key reason for a lack of resourcing within the Joint Programme
The Joint Programme's efforts focus on its mandate and comparative advantage and are coordinated and complement the efforts of external partners	The Joint Programme's work on PHC has suffered from a lack of clarity about its comparative advantage with respect to HIV and PHC, weak coordination and limited action to complement the efforts of external partners
Assumptions related to outcomes and impact	
Governance, resourcing, policy frameworks and multi-stakeholder engagement and accountability mechanisms exist at the country level to facilitate achievement of outcomes	The Joint Programme has not strengthened these functions and processes for HIV and PHC at country level
The enabling environment at country level is supportive of and conducive to systems strengthening and changes to processes and ways of working, with stakeholders uniting for an effective response (including meaningful involvement of people living with and affected by HIV)	Although highly variable, there is in most countries a commitment to UHC and desire to strengthen health systems albeit with a lack of resources to achieve this objective
Lessons from HIV responses are captured and influence broader health system approaches, including by the Joint Programme	This has only been done to a limited extent
Community-led activities are sufficiently scaled and sustainably resourced	Although this has been a focus of the Joint Programme's work, progress with community-led HIV and PHC activities is limited
Human rights, gender equality and equity are applied consistently as cross-cutting issues	Although this has been a focus of the Joint Programme's work, there is little evidence that this has been applied consistently at country level in relation to HIV and primary care integration

Annex 4: Evaluation matrix

EQ1: To what extent is there conceptual clarity and internal coherence within the Joint Programme (WHO, UNICEF, UNFPA, World Bank, and the Secretariat) and external coherence with other actors in relation to leveraging HIV and PHC integration and linkages? (Relevance/Coherence)			
Sub-Questions	Key Assumptions	Indicators	Sources of Evidence
<p>EQ 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?</p> <p>EQ 1.2 To what extent are relevant goals, plans, strategies and activities harmonised and aligned internally within the Joint Programme at global, regional and country levels?</p> <p>EQ 1.3 How does the Joint Programme’s work on leveraging HIV and PHC integration and linkages complement and harmonise with the efforts of national governments and external actors (e.g., PEPFAR, Global Fund)?</p>	<ul style="list-style-type: none"> The Joint Programme has coherent strategies and action plans at global, regional and country level, with clear objectives and targets for its work on HIV and PHC integration and interlinkages, and monitors progress. 	<ul style="list-style-type: none"> Evidence of a common vision, understanding of and objectives and targets for HIV and PHC integration and linkages within the Joint Programme in key global and regional strategies and JP country plans Evidence of conceptual clarity and agreement around the PHC approach among (and within) Joint Programme Cosponsors and others working at the interface of disease-focused initiatives and PHC Evidence of Joint Programme action to ensure its work on HIV and PHC integration and linkages is aligned and harmonised with the objectives and actions of external funders and other global partners. 	<p><u>Data and document review</u></p> <ul style="list-style-type: none"> Joint Programme and Cosponsor¹⁸³ policy and strategy documents, normative guidance, plans, data and reports (including: ICPD25, White Paper, PHC Accelerator reports) Joint Programme MOU, meetings, webinars, reports and examples of joint action with key external actors GF and PEPAR reports Key external actor strategies, plans and reports Joint Team plans and reports <p><u>Interviews and group discussions</u></p> <ul style="list-style-type: none"> UNAIDS Secretariat and cosponsor staff RSTs and country Joint Teams Key external actors and donors e.g., GF, PEPFAR, BMGF, bilateral donors <p><u>Country case studies</u></p> <p><u>Online survey (EQ1.2 and 1.3)</u></p>

¹⁸³ WHO, UNICEF, UNFPA, WB

EQ2: How is the Joint Programme applying the PHC approach¹⁸⁴ to HIV responses and what are the achievements and lessons learned? (Relevance/Effectiveness/Efficiency/Sustainability)

Sub-Questions	Key Assumptions	Indicators	Sources of Evidence
<p>EQ 2.1 What has been achieved since 2020 in terms of applying a PHC approach to HIV responses (primary care and essential public health functions as the core of integrated health services¹⁸⁵, multisectoral policy and action¹⁸⁶, empowering people and communities)? And how is progress monitored by the Joint Programme?</p> <p>EQ2.2 What is the Joint Programme doing to build political commitment for sustainable HIV financing in the context of PHC?</p> <p>EQ 2.3 What are the main enablers and barriers to integrating HIV into PHC in various contexts? How is the Joint Programme addressing these at country level?</p>	<ul style="list-style-type: none"> ▪ Joint Programme advocacy, policy dialogue, normative guidance, technical support and capacity building contribute to strengthening the PHC approach ▪ Joint Programme leadership, advocacy and policy dialogue influence donor and government commitment and financing for HIV ▪ National stakeholders are willing and able to engage with the Joint Programme on HIV and PHC integration and to translate commitments into action ▪ The Joint Programme is using its strategic information and analytic capacity to monitor progress and identify enablers and barriers to integration ▪ Joint Programme leadership, advocacy, policy dialogue, funding 	<ul style="list-style-type: none"> ▪ Evidence of the Joint Programme contributing (through leadership, advocacy, policy dialogue, convening, funding, guidance, technical support, strategic information at global, regional and country levels) towards PHC oriented HIV responses ▪ The Joint Programme are monitoring relevant indicators related to service integration, community empowerment and multisectoral actions and policies ▪ Evidence of Joint Programme support at country level to strengthen health and community systems for HIV and PHC integration ▪ Evidence 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) 	<p><u>Data and document review</u></p> <ul style="list-style-type: none"> ▪ Joint Programme and cosponsor global, regional and country reports ▪ JPMS data on relevant UBRAF indicators ▪ Joint Programme meeting reports ▪ GF country applications and reports ▪ UNAIDS Laws and Policies Database ▪ SRHR and HIV Linkages Index¹⁸⁷ and score cards ▪ UNAIDS HIV Financial Dashboard ▪ World Bank Databank and programme data, IHME Development Assistance for Health Database ▪ UNAIDS TSM plans and reports (Technical Assistance Fund and Last Mile First Initiatives) ▪ GAM reporting on relevant indicators ▪ GHSS monitoring including related targets (reports due in 2024, 2026, 2028 and 2031, some baseline data exists) ▪ UHC service coverage index¹⁸⁸ ▪ Stigma index data related to health care settings

¹⁸⁴ PHC approach: (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.

¹⁸⁵ E.g. strengthen health and community systems that deliver HIV specific goals and strengthen PHC, including integrated delivery of HIV services with other services (limitations as per scope limitation section).

¹⁸⁶ Multisectoral policy and action only considered in the four country case studies and possibly in the additional country for some data collection in synergy with the WHO evaluation as per scope limitations.

¹⁸⁷ Includes 30 indicators to measure country progress towards a linked response to SRHR and HIV.

¹⁸⁸ Includes composite indicators based in part on HIV data but not on HIV integration.

EQ2: How is the Joint Programme applying the PHC approach ¹⁸⁴ to HIV responses and what are the achievements and lessons learned? (Relevance/Effectiveness/Efficiency/Sustainability)			
Sub-Questions	Key Assumptions	Indicators	Sources of Evidence
	and partnerships leverage legal, political and socio-cultural change with the aim of reducing stigma and discrimination	<ul style="list-style-type: none"> ▪ Evidence of Joint Programme assessment and analysis of enablers and barriers to integration of HIV into primary care and PHC ▪ Examples of Joint Programme action at country level to address stigma and discrimination and other barriers to accessing HIV services delivered in primary care facilities 	<ul style="list-style-type: none"> ▪ SDG 3 GAP reports ▪ Country health benefits packages (inclusion of HIV prevention, testing, treatment etc. and co-morbidities), ▪ UBRAF budget and funding allocation 2020-2022 ▪ UNAIDS capacity assessment report ▪ Joint Programme, Secretariat and cosponsor staff capacity building reports ▪ Previous Joint Programme evaluations <p><u>Interviews and group discussions</u></p> <ul style="list-style-type: none"> ▪ UNAIDS Secretariat and cosponsor staff ▪ RSTs and country Joint Teams ▪ Key external actors and donors e.g., GF, PEPFAR, BMGF, bilateral donors ▪ Key population networks, PCB NGO representatives ▪ International NGOs and technical agencies <p><u>Country case studies</u></p> <p><u>Online survey: (EQ2.3)</u></p>

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? (Relevance/Effectiveness/Efficiency)			
Sub-Questions	Key Assumptions	Indicators	Sources of Evidence
<p>EQ 3.1 To what extent is the Joint Programme leveraging HIV investments, knowledge, tools, infrastructure, approaches and innovative models developed by the HIV response to strengthen broader health outcomes¹⁸⁹? Are there any untapped opportunities?</p> <p>EQ 3.2 To what extent is the Joint Programme using and promoting wider adoption of adaptations in service delivery developed in response to COVID-19¹⁹⁰ to improve broader health outcomes?</p>	<ul style="list-style-type: none"> ▪ The Joint Programme captures lessons from HIV responses ▪ The Joint Programme disseminates and uses lessons to influence broader health outcomes, including for co-morbidities 	<ul style="list-style-type: none"> ▪ Evidence of Joint Programme action to capture, document and disseminate innovative approaches and service delivery models developed by the HIV response that can strengthen PHC ▪ Evidence of the Joint Programme promoting the use of HIV infrastructure, investments, tools, practices and expertise for broader health gains, including for co-morbidities¹⁹¹ 	<p><u>Data and document review</u></p> <ul style="list-style-type: none"> ▪ Joint Programme and cosponsor reports ▪ WB workstream on models of care and allocative efficiency tools ▪ Joint Programme related tools and lessons learned reports ▪ External actor reports e.g., GF ▪ TSM reports ▪ COVID-related documents <p><u>Interviews, group discussion</u></p> <ul style="list-style-type: none"> ▪ UNAIDS Secretariat and cosponsor staff ▪ RSTs and country Joint Teams ▪ Partnerships e.g., GPC ▪ Key external actors and donors e.g., GF, PEPFAR, BMGF, bilateral donors ▪ Key population networks ▪ International NGOs and technical agencies <p><u>Country case studies</u></p> <p><u>Online survey (EQ 3.1)</u></p>

¹⁸⁹ E.g. chronic disease management, health systems strengthening, etc

¹⁹⁰ e.g. telemedicine, digital technology, community-based responses, differentiated service delivery models etc

¹⁹¹ For example, differentiated service delivery models, management of chronic illness, service delivery for marginalised and vulnerable populations, community engagement, human rights-based approaches, HIV cascade analysis, decentralised diagnostics.

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? (Relevance/Equity)

Sub-Questions	Key Assumptions	Indicators	Sources of Evidence
<p>EQ 4.1 Which locations and population groups are potentially benefitting from integrated service delivery at primary care level - or being left behind?</p> <p>EQ 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 primary care?</p>	<ul style="list-style-type: none"> ▪ The Joint Programme is using its strategic information and analytic capacity and its partnerships with PLHIV and Key population networks to identify and assess potential benefits and risks ▪ Joint Programme activities contribute to an enabling environment for equitable access to integrated HIV services ▪ Community demand exists or can be generated for integrated HIV services ▪ Governance and multi-stakeholder engagement mechanisms exist at country level to facilitate Joint Programme support ▪ The Joint Programme has a clear strategy for country support that is tailored to different epidemic and health system contexts 	<ul style="list-style-type: none"> ▪ Evidence of Joint Programme action to identify and analyse the potential benefits and risks of applying a PHC lens to HIV responses ▪ Evidence of Joint Programme consultation with PLHIV and key population organisations and networks to identify benefits and risks of increased integration of HIV services in primary care ▪ Evidence of Joint Programme assessment, consultations, analysis of data to understand country needs and context and delivery of tailored support to ensure no-one is left behind ▪ Examples of Joint Programme monitoring and action to ensure equitable access to HIV services delivered through PHC (e.g., disaggregated data collection, efforts to reduce legal barriers, stigma and discrimination, to ensure equitable delivery of health benefit packages, community-based service delivery) ▪ Evidence of Joint Programme promotion of social contracting where feasible 	<p><u>Data and document review</u></p> <ul style="list-style-type: none"> ▪ Joint Programme and cosponsor reports ▪ Joint Programme related tools and lessons learned reports ▪ Joint Programme review of HIV and health insurance schemes in Asia ▪ External actor reports e.g., GF ▪ TSM reports ▪ Technical briefs, guidance/toolkits addressing human rights, gender inequality and equity issues <p><u>Interviews, group discussion</u></p> <ul style="list-style-type: none"> ▪ UNAIDS Secretariat and cosponsor staff ▪ RSTs and country Joint Teams ▪ Key external actors and donors e.g., GF, PEPFAR ▪ Key populations networks, PCB NGOs ▪ International NGOs and technical agencies <p><u>Country case studies</u></p>

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? (Effectiveness/Efficiency)			
Sub-Questions	Key Assumptions	Indicators	Sources of Evidence
<p>EQ 5.1 What is the added value of the Joint Programme in terms of leveraging HIV and PHC interlinkages? (Joint Programme ways of working, collaboration, partnerships, synergies, and comparative advantages)?</p> <p>EQ 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?</p>	<ul style="list-style-type: none"> ▪ The Joint Programme can use its mandate and comparative advantage to add value to the HIV and PHC integration agenda ▪ The Joint Programme is allocating financial, human and other resources to support HIV and PHC integration and linkages at global regional and country levels ▪ The Joint Programme is investing in capacity and skills at global, regional and country levels to support HIV and PHC integration 	<ul style="list-style-type: none"> ▪ Examples of mechanisms and partnerships that promote effective coordination and collaboration on HIV and PHC interlinkages and integration within the Joint Programme and with external partners ▪ Examples of synergies of Joint Programme’s HIV and PHC efforts ▪ Examples of UBRAF funding allocated to support HIV and PHC integration ▪ The JP Secretariat and cosponsor staff at global, regional and country levels have sufficient capacity on HIV responses provided with a PHC lens 	<p><u>Data and document review</u></p> <ul style="list-style-type: none"> ▪ Joint Programme and Cosponsor¹⁹² policy and strategy documents, normative guidance, plans, data and reports ▪ Joint Programme MOU, meetings, webinars, reports and examples of joint action with key external actors ▪ GF and PEPAR reports ▪ Key external actor strategies, plans and reports ▪ Joint Team plans and reports ▪ UBRAF budget allocations <p><u>Interviews and group discussions</u></p> <ul style="list-style-type: none"> ▪ UNAIDS Secretariat and cosponsor staff ▪ RSTs and country Joint Teams ▪ Key external actors and donors e.g., GF, PEPFAR, BMGF, bilateral donors ▪ Key populations networks, PCB NGOs ▪ International NGOs and technical agencies <p><u>Country case studies</u></p>

¹⁹² WHO, UNICEF, UNFPA, WB

Annex 5: Key informant interview/group discussion guides

Key informant interview/Group discussion guide Virtual interviews – Global/regional levels Joint Programme key informants

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

Euro Health Group has been contracted by UNAIDS to conduct an evaluation of the UN Joint Programme's contribution to leveraging the HIV and PHC¹⁹³ interlinkages in order to strengthen HIV and broader health outcomes and to identify opportunities for future work of the Joint Programme in this area. The evaluation will focus on the work of the Joint Programme (specifically WHO, UNICEF, UNFPA and the World Bank, in addition to the UNAIDS Secretariat) during the timeframe January 2020 to June 2023.

The evaluation will assess how the Joint Programme has supported delivery of HIV responses with a PHC approach and also how the Joint Programme has leveraged on HIV investments for broader health gains.

All information provided to the evaluation team during interviews will be kept confidential, and comments and opinions will not be attributed to specific people interviewed.

Thank you for your willingness to talk to us.

List of potential questions (NB not all questions will be asked each KI, questions from this comprehensive list will be selected based on the profile, capacity and experience of the KI)

1. Does the Joint Programme have a common understanding and clear, agreed plan for HIV and PHC integration and linkages? *internally* within the Joint Programme (UNAIDS Secretariat, WHO, UNICEF, UNFPA, WB) at the global/ regional levels? How are the agencies collaborating around this topic? And *externally*? (government, Global fund, PEPFAR etc.?)
2. Can you describe how the Joint Programme has contributed to strengthen:
 - integrated service delivery centered on primary care¹⁹⁴?
 - empowerment of communities?
 - multisectoral action and policy?Examples of key achievements since 2020?
How is progress tracked by the Joint Programme?
3. What might be the benefits of increased integrated service delivery centered on primary care approaches? How could this support/ improve HIV outcomes? How can it support broader health outcomes?
4. What are the *main barriers/ or risks related* to integrated service delivery centered on primary care approaches/? and how is the Joint Programme identifying and addressing such barriers, at global/regional level?
5. What are the *key enablers* to advance HIV and PHC integration? Is the Joint Programme tapping into these?
6. Are you aware of any examples of Joint Programme activities to build political commitment for sustainable financing and delivery of HIV services in the context of PHC and UHC?
7. How is the Joint Programme using its *comparative advantage*, resources and ways of working to support HIV and PHC integration and linkages at global/regional level? (Joint Programme

¹⁹³ 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.

¹⁹⁴ Primary care: A key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care.

leadership, advocacy, policy dialogue, convening, funding, guidance, technical support, strategic information at global, regional and country levels)

8. Where/how does the Joint Programme *add value* through its joint ways of working on HIV and PHC integration and linkages? (e.g., convening power, network, collaboration, synergies etc.)
9. 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?
10. How is the Joint Programme using HIV approaches, investments, infrastructure, innovative programme and service delivery approaches *developed for or by the HIV response* (including HIV service delivery adaptations in response to COVID-19) to strengthen broader health outcomes? Any specific examples?
11. 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?
12. Where should the Joint Programme focus its *efforts in the future* on HIV and PHC integration and linkages to maximise HIV and broader health outcomes? What should it do better or differently going forward?

Key informant interview/Group discussion guide Virtual interviews – Global/regional levels Non-Joint Programme Key Informants

Evaluation: The UN Joint Programme on HIV/AIDS contribution to strengthening HIV and Primary Health Care outcomes: interlinkages and integration

Euro Health Group has been contracted by UNAIDS to conduct an evaluation of the UN Joint Programme's contribution to leveraging the HIV and PHC¹⁹⁵ interlinkages in order to strengthen HIV and broader health outcomes and to identify opportunities for future work of the Joint Programme in this area. The evaluation will focus on the work of the Joint Programme (specifically WHO, UNICEF, UNFPA and the World Bank, in addition to the UNAIDS Secretariat) during the timeframe January 2020 to June 2023.

The evaluation will assess how the Joint Programme has supported delivery of HIV responses with a PHC approach and also how the Joint Programme has leveraged on HIV investments for broader health gains.

All information provided to the evaluation team during interviews will be kept confidential, and comments and opinions will not be attributed to specific people interviewed.

Thank you for your willingness to talk to us.

Interview questions (to be selected/tailored to the specific KI's experience)

1. What might be the benefits of increased integrated HIV service delivery centered on primary care¹⁹⁶ approaches? How could this support/ improve HIV outcomes? How can it support broader health outcomes? What are the *key enablers* to advancing HIV integration primary care?
2. What are the *main barriers/ or risks related* to integrated service delivery centered on primary care approaches /? and how is the Joint Programme identifying and addressing such barriers, at global/regional level? Who might be adversely affected?

¹⁹⁵ 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.

¹⁹⁶ Primary care: A key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care.

3. Are you aware of *Joint Programme strategies, plans, activities* at global, regional or country level that have made a contribution to:
 - integrated service delivery centered on primary care?
 - empowerment of communities?
 - multisectoral action and policy?Examples of key achievements since 2020?
4. Can you give any examples of *collaboration with the Joint Programme* related to HIV and PHC integration and linkages? (plans, harmonization, platforms, advocacy etc.)
5. Are you aware of any examples of Joint Programme activities to build political commitment for sustainable financing and delivery of HIV services in the context of PHC and UHC?
6. What *role* do you think the Joint Programme could play in strengthening HIV and PHC integration and linkages? How could it use its *comparative advantage and ways of working* (e.g., leadership, advocacy, policy dialogue, convening, networking, funding, guidance, technical support, strategic information) to *add value*?
7. Are you aware of any examples of Joint Programme support to countries to integrate HIV into health systems in a way that is appropriate to the epidemic context, equitable and that takes account of the needs of key and vulnerable populations? Are you aware of any examples of Joint Programme work to ensure access to health services that are free from stigma and discrimination?
8. Can you think of any examples of the Joint Programme using or leveraging innovative programme and service delivery approaches *developed for or by the HIV response* (including HIV service delivery adaptations in response to COVID-19) to strengthen health systems/broader health outcomes?
9. To what extent do you think the Joint Programme has the necessary *skills and resources* to contribute to strengthening HIV and PHC integration and linkages? What, if any, are the main gaps, and where should the Joint Programme strengthen its capacity?
10. Where should the Joint Programme focus its *efforts in the future* on HIV and PHC integration and linkages to improve HIV and broader health outcomes? What should it do better or differently going forward?

Annex 6: Online survey analysis

Introduction to the survey

An online survey was conducted to collect data on the progress and opportunities for integration and interlinkages of HIV across countries and regions. A set of eight questions was formulated and translated from English to Spanish and French. The questions were distributed in two ways using the online tool Survey Monkey.

The first mode of distribution entailed sharing the survey with UNAIDS Secretariate staff in addition to Cosponsor staff (n=847 potential respondents). The second mode of distribution entailed embedding the questions in the concurrent Evaluation of the WHO Special Programme on PHC (SP-PHC) online survey as implemented by EHG. This second step was undertaken to generate additional data and evidence for some of the EQs at regional and country level. To that extent the survey was sent to WHO PHC Policy Advisors and Country Representatives who forwarded the survey to Ministry of Health representatives (104 countries in total; however, the number of potential respondents is not known). Both surveys were live between July 21st and August 31st, 2023. Three reminder emails were sent to survey respondents during this period.

In total, 174 responses were received through the UNAIDS evaluation specific survey corresponding to a 21.5% response rate. In addition, 54 respondents completed the questions through the SP-PHC evaluation survey. Therefore, in total 228 individuals responded to the eight questions.

The below sections presents a combined analysis of the results from the two sets of data as well as a comparison of the results across the data sets.

Section 1: Overview analysis

A. Overview of the survey respondents background and demographics (questions 1 – 3)

In the initial three questions of the survey the respondents were asked to indicate their gender, the organisation they work for as well as the country or region where they are located.

Table 10: Survey results – gender, organisation and country (Q1-Q3)

Survey questions	Quantitative responses
Q1: Please indicate what type of organization you work for.	Merged: WHO/PAHO 32%, UNAIDS 22%, UNICEF 18%, UNFPA 13%, UNDP 10%, 6% other (mainly MoH's)
Q2: In which country or regional office are you based?	UNAIDS survey: Highest representation Malawi (5%), Madagascar (4%), Zimbabwe (3%) - Responses from 77 countries out of 113 targeted. WHO survey: Highest representation AFRO 12%, EMRO 5%, Ethiopia 5% - Responses from 44 countries and 5 regional offices. Merged: Highest representation Malawi (4%), Madagascar (3%), AFRO (3%) Responses from 87 countries and 5 regional offices.
Q3: Please indicate your gender.	UNAIDS survey: 48% Female, 51% Male and 1% Other WHO survey: 50% Female, 50% Male Merged: 49% Female, 50% Male and 1% Other

B. Overview of qualitative and quantitative survey responses (questions 4-8)

There were two exclusively qualitative, open-ended questions in the survey (Q6 and Q7), two quantitative questions with the option to elaborate qualitatively (Q4 and Q8) and one strictly quantitative question (Q5). Responses were provided anonymously. A summary of the responses can be found in Table 11 below.

Table 11: Summary analysis Q4-Q8

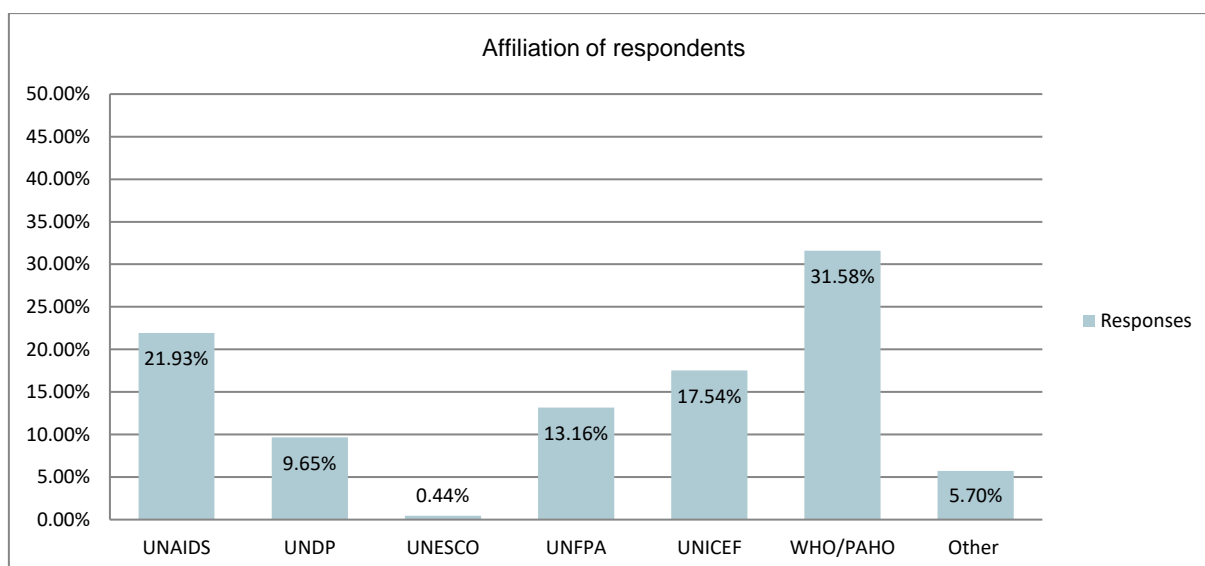
Survey questions	Summary analysis of qualitative responses (based on most frequent responses/comments)	Quantitative responses
<p>Q4: To what extent do you agree that HIV investments (infrastructure, learnings, tools etc) have been leveraged for broader health gains/strengthening the Primary Health Care (PHC) approach?</p>	<p>Progress:</p> <ul style="list-style-type: none"> ▪ Increase in multisectoral collaboration, involvement of civil society and beneficiaries ▪ Training and support for health workers <p>Remaining challenges:</p> <ul style="list-style-type: none"> ▪ HIV/Aids program remains very vertical and siloed ▪ Limited or earmarked funding ▪ Lack of equipment and human recourses 	<p>UNAIDS survey: 10% Strongly disagree, 11% disagree, 11% neutral, 49% agree, 18% strongly agree, 1% no opinion</p> <p>WHO survey: 3% Strongly disagree, 14% disagree, 47% neutral, 31% agree, 5% strongly agree, 0% no opinion</p> <p>Merged: 8% Strongly disagree, 12% disagree, 23% neutral, 43% agree, 13% strongly agree, 1% no opinion</p>
<p>Q5: Does the government/Ministry of Health in your country/region have a clear strategy or plan for integration of HIV responses/services within primary care?</p>	N/A	<p>UNAIDS survey: 68% yes, 24% no, 8% don't know</p> <p>WHO survey: 49% yes, 28% no, 23% don't know</p> <p>Merged: 64% yes, 25% no, 11% don't know</p>
<p>Q6: What are the potential benefits of providing HIV services within primary care in your country/region? Please provide specific examples or comments.</p>	<ul style="list-style-type: none"> ▪ Alleviates burden on tertiary care facilities ▪ More accessible and affordable services: Health Equity ▪ Reduction of stigma around HIV ▪ More effective and sustainable use of recourses ▪ Focus on preventive care and education <p>Reduction in morbidity and mortality because of increased efficiency and accessibility</p>	N/A
<p>Q7: What are the potential barriers to/risks of providing HIV services within primary care in your country/region? Please provide specific examples or comments.</p>	<ul style="list-style-type: none"> ▪ Stigma and discrimination: Concern of confidentiality ▪ Lack of funding and human recourses (burden on health care workers) ▪ Risk of reduced quality of HIV care (less focus on the specific needs of HIV patients) 	N/A

Survey questions	Summary analysis of qualitative responses (based on most frequent responses/comments)	Quantitative responses
	<ul style="list-style-type: none"> Implementation gap between the normative, regulatory and technical guidelines and frameworks 	
<p>Q8: Does your country have “social contracting” agreements - the direct funding of civil society organizations by government – to provide HIV services?</p>	<ul style="list-style-type: none"> Most grants are GF funding and do not come from the government directly Where there are governmental grants, they are usually managed through UN agencies Existing grants tend to be aimed at community-level actions in raising awareness, information and peer education on HIV prevention, treatment access and quality of care 	<p>UNAIDS survey: 41% yes, 42% no, 17% don’t know</p> <p>WHO survey: 18% yes, 38% no, 44% don’t know</p> <p>Merged: 34% yes, 38% no, 24% don’t know</p>

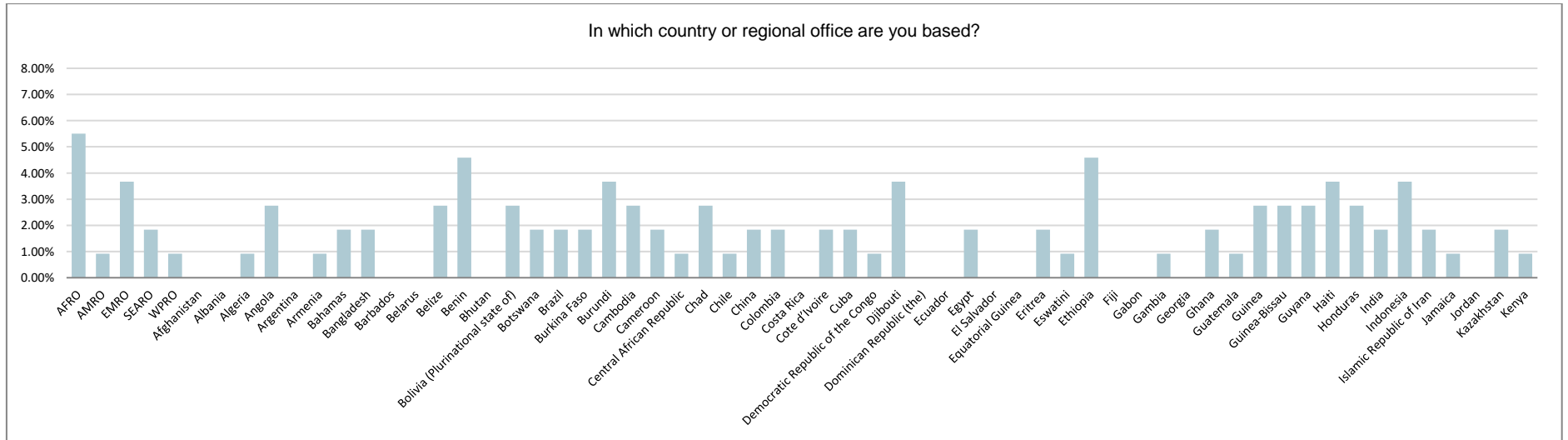
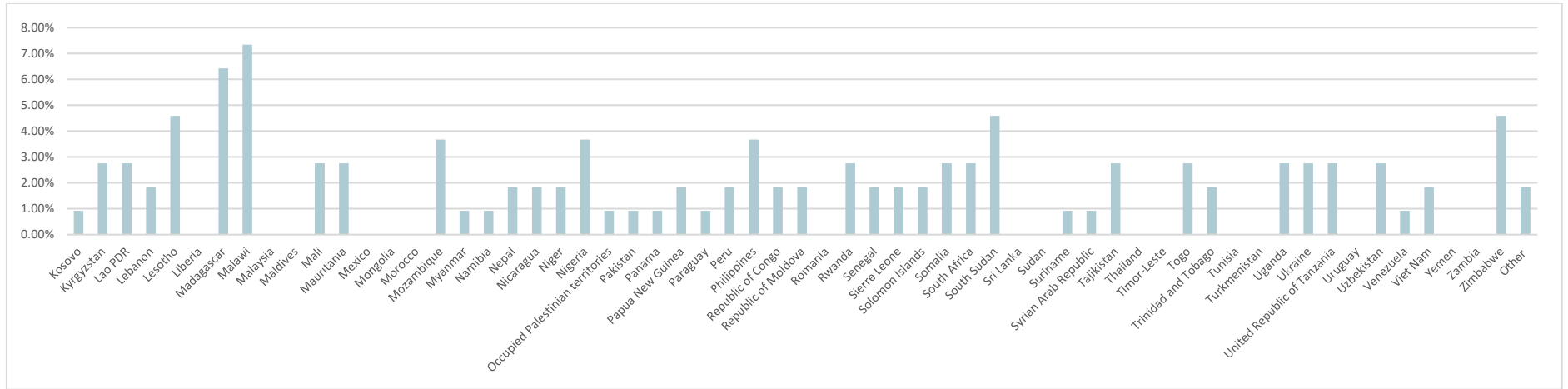
Section 2: Detailed responses

Q1: Please indicate what organization you work for.

The survey was shared with staff from various UN organizations as well as ministries of health in the targeted countries. There is high representation of WHO/PAHO as well as UNAIDS, UNICEF and UNFPA staff. The high response rate from WHO can be explained by the data collected through the WHO SP-PHC evaluation which was mainly targeted at WHO staff.

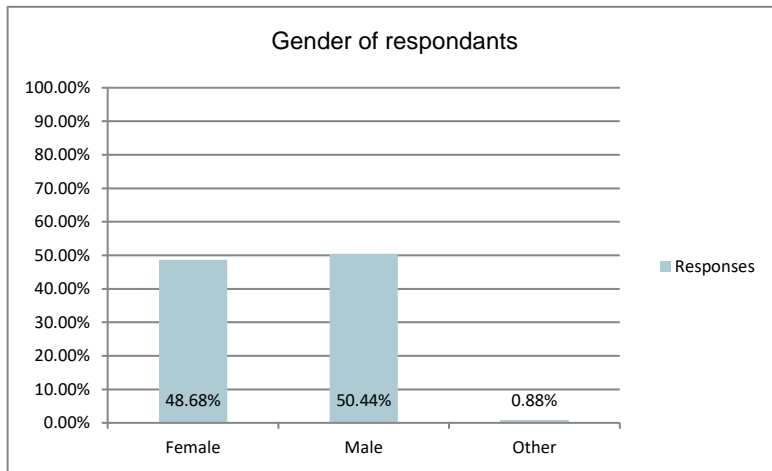


Q2: In which country or regional office are you based?



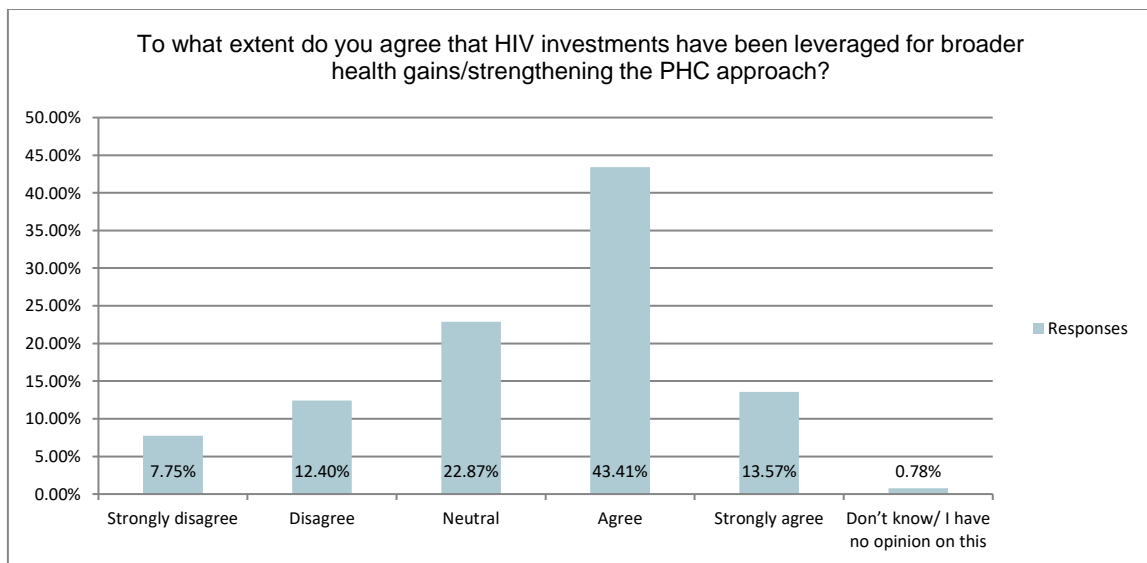
With data from both surveys combined responses were received from 87 countries and 5 country offices. The combination of both surveys made it possible to collect data from most of the countries and regions targeted. This sample provided a broad overview of the successes, challenges and opportunities of HIV integration into PHC

Q3: Please indicate your gender



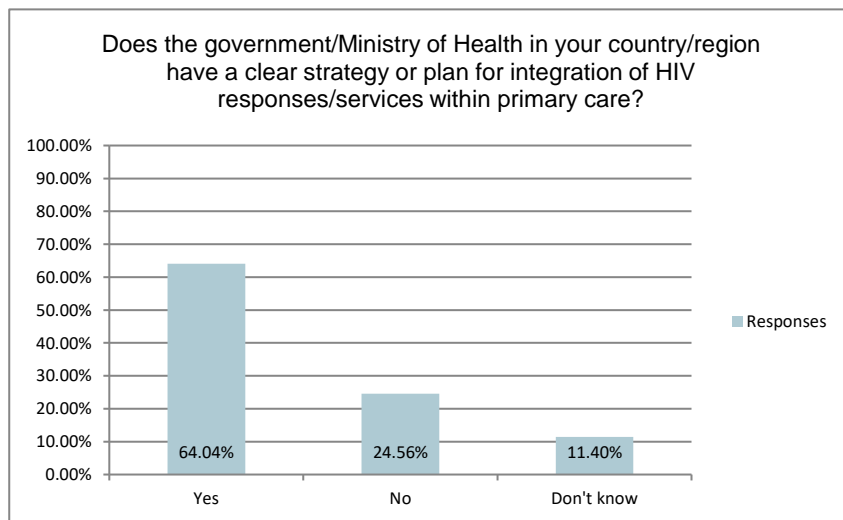
There was an equal gender distribution among the respondents.

Q4: Extent HIV investments have been leveraged for broader health gains



Most respondents agree or strongly agree that HIV investments have been leveraged to strengthen the PHC approach, there are however remaining challenges as detailed above.

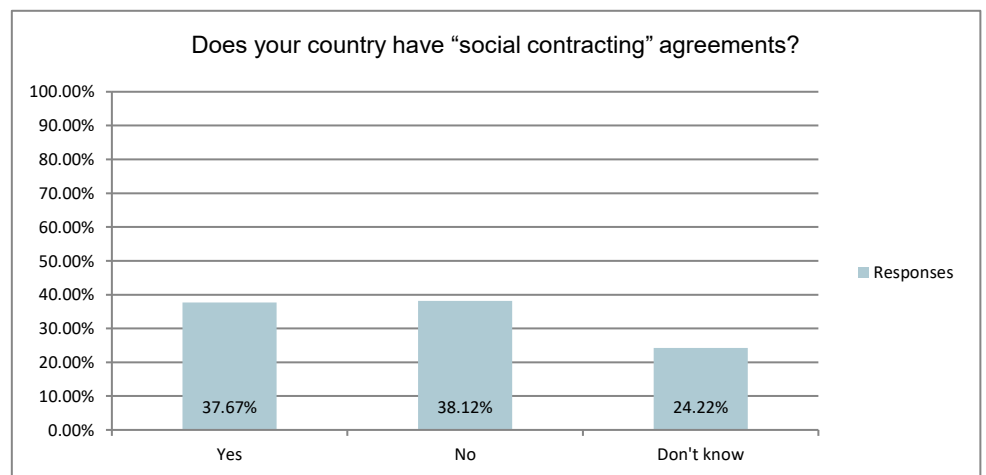
Q5: Does a clear strategy/plan for integration exist?



The majority of respondents indicated that their government has an HIV integration strategy, however almost a quarter indicated that no such strategy exists in their region or country.

Q8: Does your country have social contracting agreements?

Social contracting agreements are limited in many of the countries and regions targeted as elaborated above.



Annex 7: Stakeholder mapping

Level	Key stakeholders
<p>Global/ regional level</p>	<p>Joint Programme at global and regional levels:</p> <ul style="list-style-type: none"> ▪ UNAIDS: e.g., Sustainable Financing; Human Rights, Gender, RSSH, Communities; Partnerships and Influencing; Strategic Information; UNAIDS Regional Support Teams ▪ UNICEF HQ and regional level ▪ UNFPA HQ and regional level ▪ WHO HQ and regional level ▪ World Bank ▪ Joint regional programmes e.g., 2gether4SRHR integration programme in East and Southern Africa (UNFPA, WHO, UNICEF, UNAIDS) <p>Donors and financing mechanisms:</p> <ul style="list-style-type: none"> ▪ Global Fund – RSSH, CSS, HIV, TB DSD SI ▪ USAID, PEPFAR, CDC ▪ BMGF ▪ GFF ▪ Key bilateral donors supporting PHC, HSS, UHC; key PCB bilateral donors <p>Partnerships/Platforms:</p> <ul style="list-style-type: none"> ▪ SDG3 GAP ▪ Inter-Agency Task Team (IATT) on elimination of Mother-to-Child Transmission (eMTCT) ▪ IATT on HIV and Young People ▪ IATT on HIV/SRHR integration ▪ Global Prevention Coalition (GPC) ▪ Global Partnership to Eliminate Stigma and Discrimination ▪ UHC partnership ▪ UHC2030 ▪ Health Data Collaborative ▪ Alliance for Health Policy and Systems Research <p>Civil society and NGOs:</p> <ul style="list-style-type: none"> ▪ PCB NGO representatives ▪ People living with HIV networks e.g., ICW, GNP+, Global Network of Young People living with HIV ▪ Advocacy and Key population organisations e.g., Global Coalition on Women and AIDS, International Harm Reduction Network, International Treatment Preparedness Coalition, NSWP, INPUD, ▪ Civil society organizations with PHC mandate: Jhpiego, PATH, IFRC, African Forum for Primary Health Care ▪ International NGOs and technical agencies <p>Academia and advisory groups:</p> <ul style="list-style-type: none"> ▪ LSHTM ▪ Centre for Global Development ▪ Ghent University (WHO collaborating center for PHC)
<p>Country level</p>	<p>Government:</p> <ul style="list-style-type: none"> ▪ Ministry of Health: Planning, MCH, SRH, Logistics/supply chain, HRH, PHC, HIV and TB Depts ▪ National AIDS Co-ordinating Committee ▪ Other relevant MOH or MOP committees related to UHC ▪ Ministry of Finance ▪ Local government representatives <p>Service providers:</p> <ul style="list-style-type: none"> ▪ Facility in charges and HIV programme staff ▪ Private sector providers, pharmacies etc.

	<ul style="list-style-type: none">▪ Community health workers (CHW) and community development office staff providing services▪ International NGOs active in country (e.g., Frontline AIDS, FHI 360, PSI etc.) field staff <p>Civil society/communities:</p> <ul style="list-style-type: none">▪ International NGOs active in country (e.g., Frontline AIDS, FHI 360, PSI)▪ People living with HIV networks▪ Local Advocacy and Key population organisations▪ CSO and community organisations working on UHC, co-morbidities <p>Joint Programme:</p> <ul style="list-style-type: none">▪ UNAIDS▪ UNICEF▪ UNFPA▪ WHO▪ World Bank▪ UNDP▪ ILO <p>Donors and financing mechanisms</p> <ul style="list-style-type: none">▪ Global Fund – Principal Recipient and Sub-recipients for HIV▪ USAID, PEPFAR, CDC▪ BMGF (if in country)▪ Key bilateral donors supporting PHC, HSS, UHC in country e.g., UK, Germany, Japan, etc.
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Annex 8: Overview of relevant indicators

UBRAF 2022-2026 – indicators related to the PHC approach		
Indicator ¹⁹⁷	Progress 2022 ¹⁹⁸	Target 2026
2.1.1: Number of countries supported by the Joint Programme that have implemented innovations to optimize access to integrated HIV and comorbidity / coinfection services (i.e. adopted at least 2 key recommendations from the guidance for integrated service delivery of HIV and comorbidities)	On track; WHO is developing the guidance for integrated service delivery and framework for collaborative action in 2023. WHO will develop a measurement that will be mapped to GAM reporting, with additional data efforts to track this area implemented directly with countries from end-2023. This will provide reporting for 2024 for intermediate reporting towards the 2026 target.	50 countries adopt at least 2 key recommendations from the guidance by 2026.
3.2.2. Number of countries supported by the Joint Programme which have HIV services for children integrated into at least 50% of Primary Health Care (PHC) sites.	On track: 63 countries; In 2022, 72 countries had HIV services for children integrated into facilities providing primary health care and the Joint Programme supported the integration of these services in primary health care sites in 63 countries.	(An additional 15 partner countries join the Global Alliance to End AIDS in Children and provide services for children with HIV that are integrated into Primary Health Care by 2026.) – Target under revision
4.1.1. Number of countries where the Joint Programme provides technical support for community-led HIV responses	On track: 2 guidance documents on the new definition of community-led responses and community-led organizations developed and expected to be launched in mid-2023. 77 countries where Joint Programme provided technical support and guidance for community-led organizations from at least 3 of the most significantly affected communities in the country.	In at least 30 countries, Joint Programme provided technical support and guidance for community-led organizations from at least 3 of the most significantly affected communities in the country for the community led HIV response by 2026.
4.2.1. Number of countries where the Joint Programme provides support to national and/or subnational government and other stakeholders for the incorporation and expansion of community-led HIV responses	On track: 84 countries; 84 countries received support from the Joint Programme to national and/or subnational governments and/or other stakeholders for the incorporation and expansion of community-led HIV responses.	At least 50 countries supported in activities to remove or amend punitive and discriminatory laws and policies and/or develop protective laws and policies affecting the HIV response

¹⁹⁷ Indicator Matrix for the 2022-2026 UBRAF and Indicators, milestones, targets and data sources for the 2022-2023 Workplan and Budget. Geneva: Joint United Nations Programme on HIV/AIDS; 2022 (https://www.unaids.org/en/resources/documents/2022/PCB50_Indicator_Matrix_UBRAF, accessed 24 April 2023).

¹⁹⁸ Indicator Scorecard: 2022 Performance Monitoring Report. Geneva: Joint United Nations Programme on HIV/AIDS; 2023

<p>5.1.1. Number of countries supported by the Joint Programme in activities to remove or amend punitive and discriminatory laws and policies, and/or develop protective ones affecting the HIV response.</p>	<p>On track: 60 countries; In 2022, 60 countries were supported by the Joint Programme to amend or remove punitive and discriminatory laws and policies and/or to develop protective ones. The types of support provided included: technical assistance (48 countries); advocacy and communications (47 countries); policy guidance (39 countries); capacity building (33 countries); strategic information generation and use (32 countries); financial support (28 countries); and sharing of good practices and facilitating cross-country cooperation (26 countries).</p>	<p>At least 50 countries supported in activities to remove or amend punitive and discriminatory laws and policies and/or develop protective laws and policies affecting the HIV response.</p>
<p>5.2.1. Number of countries supported by the Joint Programme for actions to reduce stigma and discrimination in any of the six settings defined under the Global Partnership for action to end all forms of HIV-related stigma and discrimination</p>	<p>On track: 77 countries supported in at least 2 of 6 settings.; In 2022, 77 countries were supported by the Joint Programme to reduce stigma and discrimination in at least 2 of the 6 settings defined under the Global Partnerships for action to end all forms of HIV-related stigma and discrimination. The Joint Programme supported these countries in the following settings: health care (82 countries); education (55 countries); workplace (46 countries); legal and justice systems (52 countries); individual households and communities (66 countries); and emergency and humanitarian settings (43 countries). The most common types of support were technical assistance (71 countries); advocacy (70 countries); capacity building (66 countries); and strategic information (61 countries).</p>	<p>At least 40 countries report Joint Programme supported (technical and/or policy support) to reduce stigma and discrimination in at least 3 of the 6 settings as promoted by the Global Partnership for Action to Eliminate HIV Related Stigma and Discrimination.</p>
<p>7.1.1. Number of countries supported to scale-up multisectoral interventions that align with ministerial commitments to increase access to youth-friendly sexual and reproductive health (SRH) services, including comprehensive sexuality education (CSE), to improve young people’s well-being</p>	<p>On track: 51 countries; In 2022, the Joint Programme supported 51 countries in scaling up multisectoral interventions that align with their ministerial commitments to increase access to youth-friendly sexual and reproductive health SRH services, including CSE to improve young people’s well-being. In most of these countries, types of support provided by the Joint</p>	<p>54 countries supported by the Joint Programme to implement ministerial commitments to scale-up multisectoral interventions to increase access to youth-friendly SRH services and quality education, including CSE.</p>

	<p>Programme included: policy guidance (55 countries); capacity building (68 countries); strategic information /evidence generation and use (54 countries); technical support (64 countries); advocacy / communication support (63 countries); financial support (42 countries); and sharing good practices and facilitating cross-country cooperation (40 countries).</p>	
<p>8.1.1. Number of countries supported by the Joint Programme that have developed and report implementation of measures advancing full and sustainable HIV financing</p>	<p>On track: 36 countries; The Joint Programme provided support and guidance to 36 countries to identify HIV financing trends (such as National AIDS Spending Assessments or national health accounts), as well as gaps and opportunities.</p> <p>The support and/or guidance provided by the Joint Programme included: HIV sustainability and/or transition plans (26 countries); HIV financing assessments, i.e. financing vulnerabilities, funding landscape assessments (21 countries); HIV financing integration into domestic budgets (20 countries); and community-led response financing and/or social contracting (23 countries).</p>	<p>44 countries [baseline 32 countries plus additional countries:</p> <ul style="list-style-type: none"> ■ 5 (2023) ■ 5 (2025) ■ 2 (2026)
<p>9.1.1 Number of countries supported by the Joint Programme to have HIV antiretroviral services, for both treatment and prevention purposes, organized and financed as part of overall health systems, including through Primary Health Care</p>	<p>On track: 67 countries; In 2022, the Joint Programme supported 67 countries to establish HIV ART services organized and financed as part of the overall systems. The following services are included in the primary health care services in these countries:</p> <p>(i) combination ART for line treatment of HIV. One of the following combinations individually for concomitant use or in fixed-dose combination: efavirenz + emtricitabine + tenofovir disoproxil fumarate or efavirenz + lamivudine + tenofovir disoproxil fumarate (50 countries);</p> <p>(ii) pre-exposure prophylaxis for HIV (PrEP) (52 countries);</p> <p>(iii) post-exposure prophylaxis for HIV (44 countries);</p> <p>(iv) HIV drug sensitivity testing (19 countries).</p>	<p>60 countries supported by the Joint Programme to have key HIV services (ART, PEP and PrEP) included in the national health benefit package.</p>

<p>9.1.2 Number of countries supported by the Joint Programme, that have included cervical cancer screening and treatment for women living with HIV in the national strategies, policies, plans or guidelines for HIV, cancer, cervical cancer, noncommunicable diseases or other health areas</p>	<p>On track, 48; In 2022, 48 countries received support from the Joint Programme to include cervical cancer screening and treatment for women living with HIV in national strategies, policies, guidelines and/or plans for HIV, cervical cancer, noncommunicable diseases or other health areas. In these countries, cervical cancer is included into one or more of the following:</p> <ul style="list-style-type: none"> (i) the national strategy, policy, plan or guidelines for cancer (including any cervical cancer specific ones) (49 countries); (ii) the broader response to noncommunicable diseases (in 35 countries); (iii) the national strategic plan governing the HIV response (in 41 countries); (iv) the national HIV treatment and/or testing guidelines (in 43 countries). <p>In addition, further to the integration of cervical cancer-HIV indicators as part of the 2022 GAM, 80 countries reported data in 2022, setting a baseline for tracking progress toward achieving the 2025 global HIV integration targets and the 2030 global cervical elimination targets.</p>	<p>At least 80 countries supported by the Joint Programme to include cervical cancer screening and treatment for women living with HIV in the national strategies, policies, plans or guidelines for HIV, cancer, cervical cancer, NCDs or other health areas.</p>
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WHO GHSS 2016-2021 – Integration indicators		
Target/Indicator ¹⁹⁹	Reported data	Source
90% of women living with HIV have access to integrated or linked services for HIV treatment and cervical cancer	No data	WHO, 2021. Global progress report on HIV, viral hepatitis and STIs
90% of women, adolescent girls and young women have access to SRH services, including for HPV and cervical cancer, that integrate HIV prevention, testing and treatment services	No data on this indicator, but the following was reported: About 90% of countries offer HIV and syphilis screening to all pregnant women, and 59% had included the HPV vaccine in national immunization schedules	WHO, 2021. Global progress report on HIV, viral hepatitis and STIs
70% of key populations for HIV have access to a full range of	No data	WHO, 2021. Global progress report on HIV, viral hepatitis and STIs

¹⁹⁹ Global health sector strategy on HIV: 2016-2021: Towards ending AIDS. Geneva: World Health Organization; 2016 (<https://www.who.int/publications/i/item/WHO-HIV-2016.05>, accessed 24 April 2023).

services relevant to STIs and HIV, including condoms		
70% of countries provide access to STI services or links to such services in all primary, HIV, reproductive health, family planning and antenatal and postnatal care services	Countries provided link to STI services in other health services, such as primary health care (88%), HIV services (91%, reproductive health services (84%), family planning (77%), and pre- and postnatal services (89%) in 2019-2020	Target met. WHO, 2021. Global progress report on HIV, viral hepatitis and STIs
GAS 2021-2026 Integration-related indicators		
	Target/indicator²⁰⁰	Reported data²⁰¹
90% of people living with HIV and people at risk are linked to people-centred and context-specific integrated services for other communicable diseases, noncommunicable diseases, sexual and gender-based violence, mental health and other services they need for their overall health and well-being		
PLHIV	95% of women of reproductive age have their HIV and sexual and reproductive health service needs met	Based on data from 68 countries, 56% of women currently married or in union make their own decisions regarding sexual relations, contraceptive use and their own health care
PLHIV	90% of patients entering care through HIV or TB services are referred for TB and HIV testing and treatment at one integrated, co-located or linked facility, depending on the national protocol	No data
PLHIV	90% of people living with HIV receive TB preventive treatment	The annual number of people living with HIV who receive TB preventive treatment has risen steeply but is still well short of the 90% coverage
PLHIV	90% have access to integrated or linked services for HIV treatment and cardiovascular diseases, cervical cancer, mental health, diabetes diagnosis and treatment, education on healthy lifestyle counselling, smoking cessation advice and physical exercise	No data
Children (0–14 years)	95% of HIV-exposed newborns and infants have access to integrated services for maternal and newborn care, including prevention of the triple vertical	No data

²⁰⁰ Global AIDS Strategy 2021-2026 — End Inequalities. End AIDS. Geneva: Joint United Nations Programme on HIV/AIDS; 2021 (https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf, accessed 24 April 2023).

²⁰¹ The path that ends AIDS: UNAIDS Global AIDS Update 2023. Geneva: Joint United Nations Programme on HIV/AIDS; 2023. Licence: CC BY-NC-SA 3.0 IGO.

	transmission of HIV, syphilis and hepatitis B virus	
Adolescent boys and young men (15–24 years) Adult Men (25+)	90% of adolescent boys and men (aged 15–59 years) have access to voluntary medical male circumcision integrated with a minimum package of services and multidisease screening within male-friendly health-care service delivery in 15 priority countries	No data
School-aged young girls (9–14 years)	90% of school-aged young girls in priority countries have access to HPV vaccination, as well as female genital schistosomiasis (<i>S. haematobium</i>) screening and/or treatment in areas where it is endemic	No data
Adolescent girls and young women (15–24 years) Adult women (25+ years)	90% have access to sexual and reproductive health services that integrate HIV prevention, testing and treatment services. These integrated services can include, as appropriate to meet the health needs of local population, HPV, cervical cancer and STI screening and treat, female genital schistosomiasis (<i>S. haematobium</i>) screening and/or treatment, intimate partner violence (IPV) programmes, sexual and gender-based violence (SGBV) programmes that include post-exposure prophylaxis (PEP), emergency contraception and psychological first aid.	No data
Pregnant and breastfeeding women	95% of Pregnant and breastfeeding women have access to maternal and newborn care that integrates or links to comprehensive HIV services, including for prevention of the triple vertical transmission of HIV, syphilis and hepatitis B virus	No data
Gay men and other men who have sex with men	90% of Gay men and other men who have sex with men have access to HIV services integrated with (or linked to) STI, mental health and IPV programmes, SGBV programmes that include PEP and psychological first aid	No data
Sex workers	90% of sex workers have access to HIV services integrated with (or linked to) STI, mental health and IPV programmes, SGBV	No data

	programmes that include PEP and psychological first aid	
Transgender people	90% of transgender people have access to HIV services integrated with or linked to STI, mental health, gender-affirming therapy, IPV programmes, and SGBV programmes that include PEP, emergency contraception and psychological first aid	No data
People who inject drugs	90% of PWID have access to comprehensive harm reduction services integrating or linked to hepatitis C, HIV and mental health services	No data
People in prisons or closed settings	90% have access to integrated TB, hepatitis C and HIV services	No data
10-10-10 societal enabler targets		
Less than 10% of countries have punitive legal and policy environments that deny or limit access to services		The world is not on track to ensure less than 10% of countries have punitive legal and policy environments
Less than 10% of people living with HIV and key populations experience stigma and discrimination		A median of 15% of gay men and other men who have sex with men (12 reporting countries) and 22% of sex workers (11 reporting countries) say they have experienced stigma and discrimination in the past six months. A median of 30% of people who inject drugs (five reporting countries) and 72% of transgender people (five reporting countries) report similar experiences Across key populations, at least 33% of countries with recent survey data reported that more than 10% of respondents avoid accessing health care due to stigma and discrimination; this is particularly concerning among sex workers (29 reporting countries), people who inject drugs (14 reporting countries) and transgender people (12 reporting countries), where more than half of the reporting countries stated it was the case (see factsheets on key populations)
Global AIDS Strategy sub-target: less than 10% of people living with HIV experience stigma and		According to People Living with HIV Stigma Index surveys in 2020–2023, more than 10% of people

discrimination in healthcare and community settings by 2027		living with HIV experienced stigma and discrimination in community settings in 12 of 17 countries with available data and in health-care settings in 10 of 12 countries (see societal enablers factsheet)
Less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence		
Other indicators	Source of data	Progress by 2022
Ensure 90% of people living with HIV receive preventive treatment for tuberculosis (TB) by 2025	2022 Global AIDS Monitoring; Global tuberculosis report. Geneva: World Health Organization; 2022	Between 2005 and the end of 2021, a total of 16 million people living with HIV were initiated on TB preventive treatment. Given that 38.4 million people were estimated to be living with HIV, this is still much lower than the 90% target set for 2025
Reduce by 80% (from 2010 baseline) TB deaths among people living with HIV	Global tuberculosis report. Geneva: World Health Organization; 2022	Between 2010 and 2021 there has been a 67% reduction in numbers of TB-related deaths globally among people living with HIV
90% of people in humanitarian settings have access to integrated TB, hepatitis C and HIV services, in addition to programmes to address gender-based violence, including intimate-partner violence, that include HIV post-exposure prophylaxis, emergency contraception and psychological first aid.		No data
30% of testing and treatment services to be delivered by community-led organizations, with focus on: enhanced access to testing, linkage to treatment, adherence and retention support, treatment literacy, and components of differentiated service delivery, e.g. distribution of ARV (antiretroviral treatments) 34		No data
80% of service delivery for HIV prevention programmes for key populations to be delivered by community-led organizations ³⁵		No data
80% services for women, including prevention services for women at increased risk to		No data

<p>acquire HIV, as well as programmes and services for access to HIV testing, linkage to treatment (ART), adherence and retention support, reduction/elimination of violence against women, reduction/elimination of HIV related stigma and discrimination among women, legal literacy and legal services specific for women-related issues, to be delivered by community-led organizations that are women-led.</p>		
<p>60% of the programmes supporting the achievement of societal enablers, including programmes to reduce/eliminate HIV-related stigma and discrimination, advocacy to promote enabling legal environments, programmes for legal literacy and linkages to legal support, and reduction/elimination of gender-based violence, to be delivered by community-led organizations.</p>		<p>No data</p>
<p>WHO GHSS HIV, Hep, STI 2022-2030 integration -related indicators</p>		
<p>Target/indicator²⁰²</p>	<p>Reported data</p>	<p>comments</p>
<p>% of girls fully vaccinated with human papillomavirus vaccine (HPV) by 15 years of age</p>	<p>No data available as yet</p>	
<p>% of women screened for cervical cancer using a high-performance test, by the age of 35 years and again by 45 years % screened and identified as having pre-cancer treated or invasive cancer managed</p>	<p>No data available as yet</p>	
<p>% of PLHIV and people at risk who are linked to integrated health services, including STIs and viral hepatitis</p>	<p>No data available as yet</p>	
<p>% of PLHIV, viral hepatitis and STIs and priority populations who experience stigma and discrimination</p>	<p>No data available as yet</p>	

²⁰² Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030. Geneva: World Health Organization; 2022 (<https://www.who.int/publications/i/item/9789240053779>, accessed 24 April 2023)

% of PLHIV who receive preventive therapy for TB	No data available as yet	
Number of countries validated for the elimination of vertical (mother-to-child) transmission of either HIV, hepatitis B, or syphilis	No data available as yet	
NCPI²⁰³		
Indicator	Target	Progress 2023 (2022 data)
Is cervical cancer screening and treatment for women living with HIV recommended in the following? (dif national strategies)/ Have the recommendations for women living with HIV in the 2021 World Health Organization (WHO) Guidelines for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention been adopted in your country's national guidelines?	N/A	Of the 80 low- and middle-income countries that have reported data, 66 already recommend integrated cervical cancer screening and treatment for women living with HIV in a national strategy or policy. 52 of 78 reporting countries have integrated cervical cancer screening and treatment for women living with HIV into their national AIDS plans
What coinfection policies are in place in the country for adults, adolescents and children?	N/A	No data
Does your country have a universal health insurance scheme?	N/A	No data
If yes, does the benefits package include the following? (ART/PrEP)	N/A	No data

²⁰³ Note. Discontinued collection of data on: health facilities delivering integrated services (ART and chronic NCDs; ART and outpatient care; ART and TB treatment; HIV and harm reduction services; HIV CT and chronic NCDs/outpatient care; HIV treatment and care and SRH; PMTC and ANC/MCH).

Annex 9: Country selection criteria

Country	Region	GDP per capita [†] 2020(US\$)	HIV burden Adults (15-49) prevalence	HIV epidemic type/key populations	PHC and health systems context	Health expenditures 2020 [‡]	Feasibility and country utility	Presence of UNAIDS and Cosponsors in country	Recent UNAIDS evaluation
Angola	WHO: African Region UNICEF: Eastern and Southern Africa UNFPA: East and Southern Africa UNAIDS: East and Southern Africa	1,743	1,6 % in 2021*	HIV burden above 1% in general population. Most affected key populations: MSM and sex workers**	Within the recent years significant investments in the health sector, with emphasis on increasing the workforce, improving health infrastructure and strengthening the capacity to respond to public health emergencies. However, still challenges to reach UHC and SDGs.#	Health spending per capita in 2020 (US\$): 51 PHC spending as % of current health expenditure: N/A Government health spending % health spending: 42% External aid per capita in 2020 (US\$): 2.1 Out of pocket spending % health spending: 37%	Very high	UNAIDS WHO UNICEF UNFPA WB	no
Botswana	WHO: African Region UNICEF: Eastern and Southern Africa UNFPA: Eastern and Southern Africa UNAIDS: East and Southern Africa	5,863	18,6 % in 2021*	HIV burden above 1% in general population. Most affected key population: sex workers***	Most HIV service delivery take place at primary care level. Recent national guidelines and strategies: National Guidelines on Health Service Integration 2021 & the Community-Based Health Strategy and guidelines launched as part of the effort to	Health spending per capita in 2020 (US\$): 363 PHC spending as % of current health expenditure: N/A Government health spending % health spending: 75%	High	UNAIDS WHO UNICEF UNFPA WB	no

					revitalize primary health care ^{##}	External aid per capita in 2020 (US\$): 20,5 Out of pocket spending % health spending: 5%			
Indonesia	WHO: South-East Asia Region UNICEF: East Asia and Pacific UNFPA: Asia and the Pacific UNAIDS: Asia and Pacific	3,894	0,3 % in 2021*	Concentrated epidemic among key populations. Most affected key populations: MSM and people who inject drugs [§]	Four sets of reforms to strengthen PHC have been implemented, including reforms on universal health coverage, service delivery, public policy, and leadership Under the National Health Security Act the universal health coverage programme was initiated. A health workforce strategy oriented towards universal health coverage and a monitoring and evaluation system for UHC was implemented ^{###}	Health spending per capita in 2020 (US\$): 133 PHC spending as % of current health expenditure: N/A Government health spending % health spending: 55% External aid per capita in 2020 (US\$): 0.7 Out of pocket spending % health spending: 32%	High	UNAIDS WHO UNICEF UNFPA WB	no
Pakistan	WHO: Eastern Mediterranean Region UNICEF: South Asia UNFPA: Asia and the Pacific UNAIDS: Asia and Pacific	1,292	0,2 % in 2021*	Concentrated epidemic among key populations. Most affected key populations: People who inject drugs ^{§§}	Large primary health care infrastructure. Yet lack of integration, each health condition specific programme currently has an independent organizational structure at the federal, provincial, district and first-level care facility levels ^{####}	Health spending per capita in 2020 (US\$): 36 PHC spending as % of current health expenditure: 58% Government health spending % health spending: 36%	Very high (security situation potential risk)	UNAIDS WHO UNICEF UNFPA	no

						External aid per capita in 2020 (US\$): 2.4			
						Out of pocket spending % health spending: 54%			
Kazakhstan	WHO: European Region UNICEF: Eastern Europe and Central Asia UNFPA: Eastern Europe and Central Asia UNAIDS: Eastern Europe and Central Asia	9,014	0,3 % in 2021*	Concentrated epidemic among key populations. Most affected key populations: MSM, people who inject drugs and prisoners ^{§§§}	Multidisciplinary teams using holistic approaches have driven PHC activities closer to root causes of illness and upstream health determinants; and made it possible to better address the psychosocial aspects of health problems. Focus shift to prevention which lowered the overall health burden ^{#####}	Health spending per capita in 2020 (US\$): 342 PHC spending as % of current health expenditure: 40% Government health spending as % health spending: 66% External aid per capita in 2020 (US\$): N/A Out of pocket spending % health spending: 27%	Low to middle (due to current capacity of UNAIDS country office) – useful if part of the WHO SP-PHC evaluation	UNAIDS WHO UNICEF UNFPA WB	no

Annex 10: Methodology for country case study

Evaluation of the UN Joint Programme contribution to strengthening HIV and Primary Health Care outcomes: interlinkages and integration Country case study protocol

Purpose of country case studies

The purpose of carrying out country case studies for this evaluation is to generate evidence on evaluation questions and learnings from the different ways in which the Joint Programme has supported countries to leverage Primary Health Care (PHC) and HIV linkages across various contexts. The case studies will explore the extent to which HIV responses are delivered through a PHC lens, how this is working in practice, and identify the achievements, challenges, risks and opportunities and share examples of best practice. The country case studies aim to provide suggestions on the way forward to accelerate and prioritise Joint Programme actions related to HIV-PHC interlinkages and integration.

Operation, timing and duration

Four countries have been selected based on criteria such as: relevance of evaluation topic for UNAIDS country offices, the UN Joint Programme and government; representing geographic diversity, and a diversity in maturity of health system and HIV contexts.

The expected period for the country mission is 1 June – 31 July 2023 and the expected duration is 5 days (see template for schedule in the table below).

Table 12: Example of 1 week mission schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
9:00	Introductory meeting with the UNAIDS Country Office Staff	Interviews UNAIDS cont.	Meetings with Government staff	Visit to District Health Office	Visit to partner organizations of the Cosponsors or research/academia
10:00	Interviews with UNAIDS Country office staff	Meeting with WHO		Visit to health facility, interviews with service providers	
11:00		Meeting with UNICEF			
12:00	Meeting with UN RC	Meeting with UNFPA		Debrief with UNAIDS Country Office staff	
13:00	Lunch	Lunch	Lunch	Lunch	Lunch
14:00	Meeting with the Joint UN Team on AIDS	Meeting with WB	Meetings with key development partners/donors of PHC and HIV	Group discussions/ Interviews with CSOs, PLHIV/ Key populations	Evaluation team follow up meeting to go over findings and map out gaps and additional data collection needs
15:00		Meetings with CSOs and community representatives			
16:00					
17:00	Evaluation team meeting to review inputs and feedback from meetings, possible deep dives, key informants, and schedule				

Evaluation questions

The country case studies will explore country level evidence related to the five following evaluation questions:

1. To what extent is there conceptual clarity and internal coherence within the Joint Programme (WHO, UNICEF, UNFPA, World Bank, and the Secretariat) and external coherence with other actors in relation to leveraging HIV and PHC integration and linkages? (Relevance/Coherence)
2. To what extent is the Joint Programme applying the PHC approach²⁰⁴ to HIV responses and what are the achievements and lessons learned? (Relevance/Effectiveness/Sustainability)
3. 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? (Relevance/Effectiveness/Efficiency)
4. 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? (Relevance/Equity)
5. 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? (Effectiveness/Efficiency)

Data collection methods

The country case studies will apply a mixed methods approach and collect evidence across the following data sources:

- Literature and data review: Key literature and data related to the evaluation topic (see list in next section)
- Key informant interviews: In each country, the evaluation team will conduct key informant interviews (preferably face-to-face) with around 15-25 key stakeholders. (see proposed list of key informants in the following section).
- Focus Group Discussions: To the extent possible, focus group discussions will be conducted with additional relevant staff from Ministry of Health, UN country offices, district level health staff, Civil society representatives as applicable. (see proposed list in the following section)

Literature and data review

The evaluation team will need access to the following country documents and data two weeks before the planned mission:

Country documents and data related to HIV integration into PHC since 2020

- Country HIV and health strategy documents, plans, frameworks, and targets related to HIV and PHC/Universal Health Coverage
- National level PHC and HIV indicators
- JPMS data
- Joint Programme plans and frameworks, country reports
- Joint Team plans and reports
- Global fund - funding requests etc.
- Meeting notes from high level meetings on HIV and PHC integration
- Previous PHC, UHC, health system related case studies, reviews, and evaluations

²⁰⁴ PHC approach defined as: (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

- Health insurance schemes/ health benefits packages that includes HIV services including for co-morbidities
- Specific programme documents related to integrating HIV into PHC
- Integrated service delivery score cards if applicable
- Documentation on best practice, innovation etc. on the topic
- HMIS data on integrated service delivery of HIV with other services if available
- Other relevant documents/data

List of potential key informants for interviews/FGDs

Government (Exact departments will depend on MoH structure and context)

- Ministry of Health: PHC, HIV departments, other departments: Planning, MCH, SRH, Logistics/supply chain, HRH, Other relevant MOH or MOP committees related to UHC
- Ministry of Finance
- Other sector ministries as applicable to local context on HIV integration into other sectors and multisectoral policies/actions where the JP has contributed
- National AIDS Co-ordinating Committee if applicable
- Local government representatives

UN and Joint Programme relevant staff

- UN Resident Coordinator
- Representatives from UNAIDS, UNICEF, WHO, UNFPA and World Bank with responsibilities for PHC and HIV
- Other members of the country level Joint UN Team on HIV/AIDS²⁰⁵

Service Providers

- Facility in-charges and HIV service providers
- Private sector providers, pharmacies etc.
- Community health workers and Community development officers staff providing services
- International NGOs providing services in country (e.g., International HIV/AIDS Alliance, FHI 360, PSI) field staff

Donors and financing mechanisms

- Global Fund – Principal Recipient and Sub-recipients for HIV
- USAID
- PEPFAR/CDC
- EU
- BMGF (if in country)
- Key bilateral donors supporting PHC, HSS, UHC in the country (e.g., UK, the Netherlands, Germany, Japan, etc.)
- Other key donors of HIV and PHC

Civil society/communities

²⁰⁵ These might include other Cosponsors such as UNDP, UNODC, UNESCO, UNHCR, WFP and ILO and others depending on context.

- CSOs
- PLHIV networks
- Local Advocacy and Key population organisations

Other key partners

- Research, academia, others

Expected output of the country case studies

Country case study reports will be generated after the country visit. Country level stakeholders will have possibility to comment on and validate the draft reports. The country case reports can be utilised by key stakeholders in country by providing evidence on achievements, challenges, risk and opportunities as well as suggestions on the way forward on leveraging HIV and PHC interlinkages. The reports will further inform and contextualize the findings of the global evaluation report.

Annex 11: Key informants at global and regional level

UNAIDS Secretariat HQ Key informant interviews	
Key informant	Position
Angeli Achrekar	Deputy Executive Director, Programmes
Ani Shakarishvili	Special Advisor, Team Lead: Integrated Services and Systems for HIV and Health
Archana Patkar	Head, Gender Equality
Christine Stegling	Deputy Executive Director, Policy, Advocacy and Knowledge
Emily Christie	Senior Advisor on Human rights and law
Fodé Simaga	Senior Executive Advisor
Gang Sun	Senior Advisor
Iris Semini	Manager, Country and Regional Impact,
Jacek Tyszko	Partnerships and Influencing
UNICEF HQ KIIs Key informant interviews	
Anurita Bains	Associate Director HIV/AIDS
Lakshmi Balaji	Senior Adviser and Chief of Primary Health Care and Health Systems Strengthening
Shaffiq Essajee	Senior Advisor HIV
WHO HQ Key informant interviews	
Andy Seale	HIV, STIs and Hepatitis department
Faraz Khalid	Special Programme on PHC Research Officer
Susan Sparkes	Technical Officer, Health Financing
Shamsuzzona Babar Syed	Special Programme on PHC, Unit Head
Tova Tampe	Special Programme on PHC, Consultant
UNFPA HQ Key informant interviews	
David Sunderland	Technical Officer and Focal Point to UNAIDS
Elizabeth Benomar	HIV/AIDS Global Coordinator UNFPA
World Bank Key informant interviews	
David Wilson	Program Director, Health Nutrition & Population
Katherine Ward	DDS team member, Health, Nutrition & Population and focal point to UNAIDS
Nicole Fraser-Hurt	Monitoring and Evaluation Specialist
UNAIDS Regional Offices Key informant interviews	
Eamonn Murphy	Regional Director, Asia Pacific and Eastern Europe and Central Asia regions
Salil Panakadan	Regional Adviser, Prevention and Treatment, Asia-Pacific regional office

WHO Regional Offices Key informant interviews	
Hortencia Peralta	Advisor, HIV/STI Prevention Communicable Diseases and Environmental Determinants of Health Department, PAHO/WHO
Joumana George Hermez	Regional Advisor, WHO EMRO
Omar Sued Gustavo	Regional Advisor, HIV Treatment and Care, PAHO/WHO
Ruben Mayorga-Sagastume	Chief of, HIV, Hepatitis, Tuberculosis, and Sexually Transmitted Infections Unit PAHO/WHO
Stela Bivol	Strategic Adviser on Infectious Diseases, WHO EURO
UNFPA Regional Offices Key informant interviews	
Cholpona Egeshova	Programme Analyst on HIV, EECA
Natalia Zakareishvili	Chief, SRH Branch, EECA
Richard Delate	Programme Manager, ESA
Rosemary Kindyomunda	SRH/HIV Specialist, ESA
Tim Sladden	Senior HIV Adviser, AP
Asia Pacific Joint Programme Regional Team Focus group discussion	
Ye Yu Shwe	Data Specialist, UNAIDS AP Regional Office
Heather Marie Ann Schmidt	Regional Advisor, UNAIDS AP Regional Office
Tiara Nisa	Technical Officer HIV/Hepatitis/STI, WHO SEARO
Ahmed Sabry	Technical Officer, WHO EMRO
Kiyohiko Izumi	Technical Officer HIV/Hepatitis/STI, WHO WPRO
Kathryn Johnson	Human rights and gender equality consultant, UNDP Regional Hub Bangkok
Adriana Rietsema	Health Specialist, UNICEF Regional Office for South Asia
Salwa Al-Eryani	Health and Nutrition Specialist, UNICEF Lebanon
ESA Joint Programme Regional Team Focus group discussion	
Anne Githuku- Shongwe	Director, UNAIDS Regional Support Team ESA
Chris Mallouris	Senior Adviser, Equality and Rights for All, UNAIDS Regional Support Team ESA
Koech Rotich	Regional Adviser (Equitable Financing) UNAIDS Regional Support Team ESA
Cynthia Lungu	Senior Adviser, Gender, UNAIDS Regional Support Team ESA
Gatien Ekanmian	Senior Strategic Information Advisor, UNAIDS Regional Support Team ESA
Henry Damisoni	Senior Strategic Information Advisor, UNAIDS Regional Support Team ESA
Charlotte Feitscher	Partnership, HIV in Humanitarian Settings, and Coordination Support in Regional Director, UNAIDS Regional Support Team ESA
Pride Chigwedere	Senior Policy and Strategy Advisor, UNAIDS Regional Support Team ESA
Muhammad Saleem	Senior Regional Programme Advisor, UNAIDS Regional Support Team ESA
Narmada Dhakal	Regional Programme Adviser, UNAIDS Regional Support Team ESA
Sanele Masuku	Technical Officer, Program Monitoring, UNAIDS Regional Support Team ESA

Alice Armstrong	HIV specialist adolescents, Eastern and Southern African regional office UNICEF
Amitrajit Saha	Manager HIV & Health Group, Africa UNDP
Boniface Wilunda	Programme Management Officer, UNODC
Xaba Nonhlanhla	Regional Programme Policy Officer, WFP
Hassan Abdi	Public Health Officer, UNHCR regional office Nairobi
International partners/ Donors	
Key informant interviews	
Catherine Godfrey	PEPFAR, Senior Technical Advisor Adult Care and Treatment
Maureen Barte	PEPFAR, Senior Advisor for Health Systems and Health Security
Siobhan Crowley	Head of HIV, The Global Fund to Fight AIDS, Tuberculosis and Malaria
Maxim Berdnikov	Portfolio Manager, The Global Fund to Fight AIDS, Tuberculosis and Malaria
Pratima Raghunathan	CDC, Deputy Director for Programs, Division of HIV/AIDS
Diana Frymus	USAID, Director, Accelerating Primary Health Care Collaborative (APHC-C)
Jean Kagubare	BMGF, Deputy Director, Global Primary Health Care Systems
Ethan Wong	BMFG, Senior Program Officer, PHC
Geoff Garnett	BMGF Dep. Director for Global Health, TB & HIV team
Neeta Bhandari	BMGF Senior Program Officer, HIV Sustainability, Global Health, TB & HIV
Binod Mahanty	German government representative, MoH Germany, UNAIDS Bureau and PCB Chair
Civil Society	
Key informant interviews	
Leora Pillay	Frontline AIDS - HIV Prevention Advocacy
Maxima Jokonya	Y+ Global, HER Voice Fund Coordinator
Jules Kim	NSWP (global network of sex workers) Secretariat
Judy Chang	INPUD (International Network of People who Use Drug) Executive Director
Andrew Spieldenner	MPACT Global action for Gay men's health and rights, Executive Director
Erika Castellanos	GATE (Global Action for Trans Equality) Executive Director
Georgina Caswell	GNP+ (Global network of people living with HIV) Head of Programmes
Academia	
Key informant interviews	
Miriam Rabkin	Associate Professor of Epidemiology and Medicine at the Columbia University Medical Center (ICAP)

Annex 12: List of key documents and Databases

Level	Key documents and databases reviewed
<p>Global/ Regional</p>	<p>Documents:</p> <ul style="list-style-type: none"> ▪ UNAIDS global and regional high level strategy documents, plans, frameworks, and reports related to PHC and HIV integration and linkages ▪ UNAIDS TSM plans and reports (Technical Assistance Fund and Last Mile First Initiatives) ▪ WHO and UNICEF PHC operational and measurement frameworks ▪ Joint Programme Cosponsor’s policy and strategy documents, normative guidance, plans, data and reports related to PHC and HIV integration and linkages (e.g., guidance, strategies, ICPD25, White Paper, SDG 3 GAP reports and PHC Accelerator reports, WHO pulse surveys, 2gether4SRH programme reports etc.) ▪ Joint Programme MOU, meetings, webinars and examples of joint action with key external actors ▪ Technical briefs, guidance/toolkits addressing human rights, gender inequality and equity issues ▪ Existing compendiums of PHC-related learning/case studies concerned with HIV ▪ UBRAF budget and funding allocation 2020-2022? ▪ Relevant sections of PMR annual UBRAF reports ▪ GF Information Note on Resilient and Sustainable Systems for Health, GF modular framework handbook, GF country applications ▪ PEPFAR reports related to HIV and PHC integration ▪ Key external actor strategies, plans and reports ▪ Previous related JP evaluations: UNAIDS capacity assessment report; review of HIV and health insurance schemes in Asia; UNAIDS Key populations evaluation ▪ Systematic reviews/ Meta-analysis on integration of HIV service delivery <p>Dashboards and databases:</p> <ul style="list-style-type: none"> ▪ JPMS data on relevant UBRAF indicators, ▪ UNAIDS Laws and Policies Database, ▪ UNAIDS HIV Financial Dashboard ▪ World Bank Databank and programme data ▪ IHME Development Assistance for Health Database ▪ SRHR and HIV Linkages Index and score cards ▪ UHC service coverage index ▪ Global AIDS Monitoring reporting
<p>Country case studies</p>	<p>Documents:</p> <ul style="list-style-type: none"> ▪ Country HIV and health strategy documents, plans, frameworks, and targets ▪ Joint Programme plans and frameworks, country reports ▪ Joint Team plans and reports ▪ Meeting notes from high level meetings on HIV and PHC integration ▪ PHC, UHC, health system related case studies, reviews, and evaluations ▪ Health insurance schemes/ health benefits packages ▪ Peer-reviewed articles on HIV and PHC ▪ Documentation on best practice, innovation etc. <p>Dashboards and databases:</p> <ul style="list-style-type: none"> ▪ National level indicators ▪ JPMS data on relevant UBRAF indicators, ▪ UNAIDS Laws and Policies Database, ▪ UNAIDS HIV Financial Dashboard ▪ World Bank Databank and programme data

- | | |
|--|---|
| | <ul style="list-style-type: none">▪ IHME Development Assistance for Health Database▪ SRHR and HIV Linkages Index and score cards▪ UHC service coverage index▪ Global AIDS monitoring reporting |
|--|---|

Annex 13: Documents reviewed: Global and regional level

2020 Annual Narrative Report. Geneva: Joint United Nations Programme on HIV/AIDS, United Nations Population Fund, x World Health Organization; 2020 (https://esaro.unfpa.org/sites/default/files/pub-pdf/2020_annual_narrative_report_final_1.pdf, accessed 24 April 2023).

2021 MHTF Annual Report: Strengthening Health System Resilience in the COVID-19 Era. Geneva: United Nations Population Fund; 2022 (<https://www.unfpa.org/publications/maternal-and-newborn-health-thematic-fund-annual-report-2021>, accessed 24 April 2023).

2021 progress report on the Global Action Plan for Healthy Lives and Well-being for All. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789240026209>, accessed 24 April 2023).

2022-2026 UBRAF Outputs and Indicators [Virtual Presentation]. Geneva: Joint United Nations Programme on HIV/AIDS; 2021.

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2022-2026 unified budget results and accountability framework (UBRAF): 2022-2023 Workplan and Budget. Geneva: Joint United Nations Programme on HIV/AIDS; 2021 (https://www.unaids.org/en/resources/documents/2021/PCB49_2022-2023_Workplan_Budget, accessed 24 April 2023).

2022-2026 unified budget results and accountability framework (UBRAF): Indicator Matrix Summary. Geneva: Joint United Nations Programme on HIV/AIDS, United Nations Development Fund, United Nations Children's Fund, United Nations Population Fund, World Health Organization, et.al.; 2020

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A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. Geneva: United Nations Children's Fund and World Health Organization; 2018 (<https://apps.who.int/iris/handle/10665/328065>, accessed 24 April 2023).

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Addressing Gender-Based Violence Across Contexts: Gender-Based Violence Interagency Minimum Standards and the Essential Services Package for Women and Girls Subject to Violence. New York: United Nations Population Fund; 2022 (<https://www.unfpa.org/publications/addressing-gender-based-violence-across-contexts-gender-based-violence-interagency>, accessed 24 April 2023).

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