

Communities, Rights & Gender TB Tools Adaptation & Implementation In Pakistan



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Disclaimer

STOP-TB and APLHIV-Pakistan would like to reiterate that the report and the content therein presents a cumulative picture of the existing situation of gender and human rights based programming and impacting of social and legal factors in access of key populations to TB services in Pakistan and that the inferences made premise on the responses of the respondents and do not necessarily reflect the views of either consultants and both partners. We also declare that consent was obtained from each respondent involved and confidentiality of the information obtained was ensured in the best possible manner.

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FOREWORD

The purpose and intention of this study is to provide information to health care providers, health managers, stakeholders and affected communities and general population regarding enhanced community empowerment by analyzing existing situation of gender barriers, stigma, lack of protection of health and human rights and denial of services and ways to cope up with these issues for key population.

This year marks a special milestone for the fight to end AIDS as the world commemorated 30th anniversary of first world AIDS day that was initiated in 1988 by the WHO and the theme is 'know your status', I would like to add to this 'and be free from TB. Despite progress in its retroviral treatment coverage, nearly half of those fall ill with HIV associated TB and lose their lives from it. TB is preventable and curable, including among people living with HIV.

Tuberculosis (TB) is one of the greatest threats to the health of people living with HIV in resource-poor settings. There is an urgent need to engage communities and to respond to the burden of TB on people living with HIV and to mobilize more global, national, and local resources to fight TB. Being free from TB should not just be an aspiration for every person living with HIV but an ensured imperative, as we have the tools and resources available throughout the country and backed by high level commitments.

One of the key commitments of 2018-2022 is to successfully screen 102205 TB patients for HIV. It is now time for concerted action to accelerate the response to both epidemics. Advocacy at local, national, or global levels for additional human, financial, and material resources for TB/HIV to meet the needs of affected communities is of utmost importance. The following four priority areas for action can lead to quick gains.


1. **Integrated person-centered catering all levels.** The frequent miss match in distribution between TB and HIV services offer opportunities for NTP and NACP to come together, expand and decentralize integrated delivery to PHC, community level for reaching key affected population. Activities relating to TB and HIV contract tracing and prevention at home, or among vulnerable

populations, could be combined and carried out by same community health care worker.

2. **Expanding access to preventive treatment:** despite the evidence that TB preventive treatment reduces mortality by close to 40%, coverage still remains low, the new guidelines in 2018 offers more options including fixed dose combination, shorter and more patient friendly regimens, high burden TB and HIV countries uptake of these recommendations by programmes will help accelerate scale up towards the targets.
3. **Maximizing use of limited resources:** Global initiative to find missing people with TB, to scale up TB treatment and prevention, and to ensure people living with HIV know their status and on ART, could be aligned at country level to maximize use of available resources. Fertility based TB screening could be leveraged to expand HIV testing services, and should be used for expansion of TB screening and onward referral for diagnosis or prevention.
4. **Roll out and uptake of innovations:** Roll out of fixed and mobile digital x-rays strategic placement of gene X-perts and scale up of WHO recommended diagnostics lateral flow urine lipoarabinomannan assay within HIV services will help address the gaps in detecting HIV associated TB.

I would like to show my gratitude to APLHIV-Pakistan for this valued partnership and collaborative effort. The devotion and commitment of the study team especially the lead consultant Dr Aurang Zeib and leadership of Asghar Satti National Coordinator of the APLHIV and Uzair Tariq Deputy National Coordinator of the APLHIV is commendable. It is my sincere belief that this partnership will be further strengthened in the years to come and will translate into saving lives of thousands from needless sufferings and deaths. It is now time to join forces to capitalize on this and break the trajectory of both the epidemics.

I am positive that all stakeholders will yield maximum benefit from this and support us to further strengthen our efforts in combating these diseases. With their support, we would be able to achieve a better future, and build a healthier, more prosperous community.


Dr Aurangzaib Quadir Baloch
Manager
NTP Pakistan

2. MESSAGE FROM STOP TB PARTNERSHIP

The tuberculosis (TB) response needs a paradigm shift – becoming people and community centered, gender sensitive and human rights based. There is a need for country specific data and strategic information key, vulnerable and marginalized populations. There is a need to facilitate an enabling environment to effective prevention, diagnosis, treatment and care – which requires legal and gender related barriers to be analyzed, articulated and alleviated. The Stop TB Partnership CRG Assessments are the tool for National TB Programmes to better understand and reach their epidemics. With TB being the leading cause of infectious disease deaths globally, and with over 10 million people developing TB each year, this disease continues to be a public health threat and a real major problem in the world.

The Stop TB Partnership's Global Plan to End TB and the World Health Organization (WHO) End TB Strategy link targets to the Sustainable Development Goals (SDGs) and serve as blueprints for countries to reduce the number of TB deaths by 95% by 2030 and cut new cases by 90% between 2015 and 2035 with a focus on reaching key and vulnerable populations. The Strategy and the Plan outline areas for meeting the targets in which addressing gender and human rights barriers and ensuring community and people centered approaches are central.

Ending the TB epidemic requires advocacy to achieve highly-committed leadership and well-coordinated and innovative collaborations between the governments sector (inclusive of Community Health Worker programs), people affected by TB and civil society. Elevated commitment to ending TB begins with understanding human rights and gender-related barriers to accessing TB services, including TB-related stigma and discrimination. It has been widely proven that TB disproportionately affects the most economically disadvantaged communities. Equally, rights issues that affect TB prevention, treatment and care TB are deeply rooted in poverty. Poverty and low socioeconomic status as well as legal, structural and social barriers prevent universal access to quality TB prevention, diagnosis, treatment and care.

In order to advance a rights-based approach to TB prevention, care and support, the Stop TB Partnership developed tools to assess legal environments, gender and key population data, which have been rolled-out in thirteen countries. The findings and implications from these assessments will help governments make more effective TB responses and policy decisions as they gain new insights into their TB epidemic and draw out policy and program implications. This provides a strong basis for tailoring national TB responses carefully to the country's epidemic – the starting point for ending discriminatory practices and improving respect for fundamental human

rights for all to access quality TB prevention, treatment, care and support services. The development of these tools could not be more timely, and the implementation of these tools must be a priority of all TB programmes.

Lucica Ditiu,

Executive Director





The Association Of People Living With HIV [APLHIV]-Pakistan

PREFACE

The Association of People Living with HIV (APLHIV) in partnership with STOB-TB is pleased to present the report on Communities, Rights and Gender (CRG) tool kit, its adaptation and implementation in Pakistan at a time when a community centred intervention is deemed to guide the control of tuberculosis in a country like Pakistan where despite meticulous efforts the disease burden is yet to see a significant decline.

The condition of social determinants; legal support; respect for human rights as well as gender equality along with community participation altogether play critical role in ascertain the likelihood of both acceptance as well as uptake of service in any health program. The lack of information and familiarity of stakeholders with all these aspects adversely affects both planning and implementation which ultimately impacts the success of intervention.

The CRG tools enabled the stakeholders to determine an avenue to plan and undertake an important study, ensuring optimal but diverse participation of key and vulnerable populations, in order to understand various but importantly three significant determinants including legal support, human rights based programming and gender equity in national TB response in Pakistan. The collaborative partnership between STOP-TB and APLHIV-Pakistan anchored by technical support from Core Group with tremendous support from both planners and community alike paved the way for timely initiation, planning and execution of this important study. The roll-out of CRG enabled stakeholders to understand and quantify the level of human rights and gender consideration in planning and implementation of TB program in Pakistan and the impact of such considerations on the access of key populations to TB services in Pakistan. The study also helped the planners and decision makers to assimilate the legislative and legal provisions in country context to support the health and human rights protection aimed at improved access to quality healthcare by key populations. The study also provided an opportunity to assess the availability of gender and age sensitive data means and methods of its collection and its usability

in making evidence based decisions for both policy formulation and programmatic planning.

The reports provide the readers ample information to analyse the existing situation of legal, political, environmental and social determinants as well as human rights and gender inequities, which despite having crucial importance, have remained untouched upon ultimately impacting the access of key and vulnerable populations to TB services in Pakistan. The APLHIV also acknowledge and appreciate the commitment of team of consultants led by Dr. Aurang Zeib and consisting of Mr. Zaka Ullah Khan and Mr. Rizwan Baig for their commitment and devotion for timely completion of this important study. It is hoped that stakeholders will make best use of this evidence made to the audience available through a community perspective and future planning will be moulded keeping in view the felt needs of the key and vulnerable populations in national TB response in near future. The APLHIV also acknowledges and highly appreciates the support from National TB Program, National AIDS Control Program, Provincial TB Programs, UNAIDS WHO and USAID for their support, guidance and ownership. The APLHIV is indebted to the communities without whom this exercise would have not been possible. The APLHIV offer it special compliments to Stop TB Partnership and Global Fund for financial and technical support. The leadership and hard work of National Coordinator of the APLHIV Asghar Satti and Deputy National Coordinator/project Officer Uzair Tariq deserves big appreciations.

EXECUTIVE SUMMARY

Tuberculosis is among the top ten leading cause of death worldwide and is considered to be the 5th leading cause of the death among the Low Middle Income countries worldwide. Tuberculosis is the leading killer of HIV-positive people. In 2017 alone, 10 million people fell ill with TB, and 1.6 million died from the disease which included 0.3 million people with HIV. 08 countries account for two thirds of the total disease burden, with India leading the count, followed by, China, Indonesia, the Philippines, **Pakistan**, Nigeria, Bangladesh and South Africa. Unfortunately Pakistan has seen to have two third of the total disease burden in EMRO region. Globally of the estimated 10.4 million new cases, only 6.3 million were detected and notified in 2016, with 4.1 million cases failing to be reached and brought into treatment cascade. The global rate of TB case reduction remained at less than 2% and needs to accelerate to 4–5% by 2020 to reach the first of the "End TB Strategy" milestones.

STOP TB Partnership is an international entity with the expertise and mandate to align synergies all over the world to fight against tuberculosis. It has been working in many countries across the globe to make this world free from tuberculosis. The mission of the partnership is to ensure interruption in TB transmission by ensuring equitable access of patients suffering from tuberculosis to safe and effective diagnostic and treatment services by enabling them to be empowered not only in participation for planning and implementation of national TB control programs but also undertake significant roles in influencing policy shifts. The participation of a wide range of constituencies gives the STOP TB partnership the credibility and the broad range of medical, social and financial competencies needed to defeat TB. PLHIV- P: represents the voice and symbolizes the efforts of people living with HIV/AIDS. The Stop TB Partnership was launched in 2000 as a global movement to accelerate social and political action to stop the spread of TB. In 2014, the World Health Assembly unanimously approved the End TB Strategy; a 20-year strategy encompassing the period between 2016 and 2035. The purpose of the End TB Strategy was the "end the global TB epidemic", with the vision of a world with "zero deaths, disease and suffering due to TB" After 15 years of its establishment, the fourth edition - the Global Plan to End TB 2016-2020 was launched at the end of 2015 to expedite the greatest possible speed to reach the End TB targets endorsed by the world's Ministers of Health in 2014. The End TB strategy strives to reach 90% of the

people with TB; reach at least 90% of the key population in TB and achieve at least 90% of the treatment success.

STOP TB Partnership entered into a partnership with Association of People Living with HIV (APLHIV) in Pakistan to conduct an initial assessment of existing situation of gender sensitivity and human rights programming in planning, implementation and monitoring and evaluation of TB programs at national and sub-national levels. The partnerships also envisages to see how legal environment has been impacting the access of the key populations to clinical, diagnostic and preventive services as well as their rights to healthy living. Another important milestone, the partners would contribute to signify involves an assessment of the gaps in data related to key population and the findings of which will be used for advocacy for evidence based planning in near future.

Community, Rights and Gender (CRG) tools are compendium and is a structured set of guidelines and questions that can be used to guide and support the process of analyzing the extent to which national responses to *TB (and HIV) take into account the critical aspect of gender equality and human rights; evidence based planning; inclusion of KVPs in decision making and legal support for marginalized. the extent to which the national response recognizes gender (in) equality as a key determinant of HIV and TB burden and then acts upon that recognition. The set of these tools for strategic planning and are meant to provide support to countries and societies in assessment, planning, implementation and supportive monitoring with a particular focus on human rights based programming and gender transformative approach. In alignment with the strategic plan of Global Fund for ending TB 2016-20, the Stop TB Partnership envisaged to involve the communities at the centre of program execution. To understand the existing situation of gender barriers, stigma, lack of protection of health and human rights and denial of services to clinical and preventive services which result into lack of prioritization of the sub groups of key populations for programmatic interventions in TB and HIV programs in developing countries. To enable the stakeholders to assess the situation, the STOPTB Partnership with technical assistance from UNAIDS developed a compendium of three assessment tools; TB/HIV Gender Assessment tool; Legal Environment Assessment Tool and Data for Action Framework. The tools in entirety were adapted and a detailed assessment of three aspects of the existing situation in Pakistan.*

The whole process of assessment was preceded by the endorsements and approval obtained from important stakeholders including the national TB Control program and a core-group which comprised of the technical and professional experts of TB and HIV programs as well as human rights. With support from the core group the prioritization workshop was held to select the three important key populations on an ore-defined set of criteria for national TB response in Pakistan. These three key populations included the people living with HIVAIDs (PLHIV) including the TB/HIV co-infected population; men having sex with men (MSM) population and trans-communities in three out of the four provinces of Pakistan. In total 20 in-depth interviews; 09 key informant interview and 09 focus group discussions were held in Lahore, Rawalpindi, Islamabad, Karachi and Peshawar involving the prioritized groups. The qualitative methods of data collection enabled the gathering of essential information related to social determinants and gender aspects which could help the stakeholders engender the intervention in near future with maximization of equity and responsiveness. In particular the following aspects were covered.

- The level of human rights and gender consideration in planning and implementation of existing programs in TB and how it has been impacting the access of key population to TB and HIV services.
- What are the legislative and legal provisions in country context to support the health and human rights protection as well as access to quality healthcare for key populations?
- Do the programs have ample and accurate information on the key populations to develop plans to tackle disease burden of TB.

After contextualization of the tools, the tools were pretested and data collectors were trained on both administrative essentials as well as technical aspects of the field work related to data collection.

1- FGD Guide was used for focus groups discussions with PLHIV (including the co-infected), MSMs, and TGs

2- Key Informant Interview Questionnaire was used for the specific responses from program managers, planers, service providers, funding agencies, ministries, human

rights entities and civil society organizations working in health interventions; gender and human rights.

3- In-depth Interviews with individuals affected /remained affected with TB, TB/HIV.

The data was collected and analyzed with triangulation to reduce the risks of errors and omissions and then sequenced to yield the themes and sub themes and then inferences were made. Following themes were generated.

1. Disease Burden and Behavioural information
2. Social and Environmental determinants impacting the access to information and services and protection of health rights
3. Legal and Political Factors affecting TB response
4. Gender (IN) Equality and Human Rights Approach in TB response
5. Inclusion of KVP (in planning, decision making and M&E)
6. Equitable Resource Distribution
7. Social protection
8. Protection, Privacy and Confidentiality
9. Delivery and Acceptability of TB related services

As envisaged the assessment exercise helped the researchers to obtain ample information which were sequenced to generate the recommendations in addition to the recommendations made directly by the community representatives of key and vulnerable populations as well as service providers and advocates of human rights. The findings were shared with the stakeholders in a validation workshop providing an opportunity to stakeholders to reflect on what was discussed during the whole process of planning and implementation and how the inferences made would help in provision of recommendations.

Disease Burden and Behavioural Information: National level gender desegregated data on all key population in Pakistan is not available at country level. The proportion of various key populations under TB response at national level, therefore, cannot be ascertained. There are a significantly important proportion of miners, prisoners, migrants, refugees and internally displaced population in Pakistan which requires attention of the stakeholders as the vulnerability of this key population along with the MSMs, trans-communities and the PLHIVs exists to deteriorate the

national TB response. In Punjab province, diagnostic services under provincial TB control program are being catered but effectiveness is feared to be hampered by the lack of conducive environment. The data collected from the common program unit of the global fund supported initiatives covering TB, Malaria and HIV/AIDS revealed, in alignment with the findings of the Global TB report of WHO, that disease burden of TB in Pakistan is significantly high. Pakistan shares 62% of the disease burden of Eastern Mediterranean region of WHO. The disease kills almost 44000 Pakistanis every year and causes considerable economic loss. Pakistan with estimated disease case load of 525,000 new sensitive TB cases annually ranks 5th and with caseload of 27000 drug resistant TB cases ranks 6 among 30 high-burden countries. The incidence rate is 267 per 100,000 populations. NTP along with PTP's notify, diagnose and treat about 366,061. Whereas the missing drug sensitive cases remain at about 166,000. The national TB response does not have an established mechanism of data collection and analysis with gender and age specific distribution of TB in all areas of Pakistan. The standard reporting format fails to capture this type of information. There are only two categories for both gender and ages – male and females and age below 14 years and above 14 year in current system of management information system. The existing information base in national TB control program however can provide information on distribution of TB with major types; health facilities providing the TB services; TB case notifications and treatment outcomes. As per the data of National TB Control Program in 2017, a total of 368,979 cases were notified as confirmed TB with 26,150 (7%) screened for HIV. UNAIDS Data 2018' indicates that estimated 150,000 people are suffering from HIV/AIDS (all ages) across the Pakistan. There are 857 HIV positive people currently taking anti-tuberculosis regimens for treatment concomitantly.

Awareness On Signs And Symptoms and Disease Transmission: Majority of the participants shared that PLHIVs (esp. and MSMs (ranging between 20-80%) are more aware of the signs and symptoms as well as spread of TB and preventive measures.

They shared that as less as 5% Transgenders had any adequate awareness of the accurate information (symptoms, spread, risk factors and right place of treatment) regarding the disease (TB). Major determinants of the awareness level quoted were literacy level of an individual and society and opportunities and access to information for behavioural change.

Relationship Between HIV and TB: 30-40% of the key populations especially the MSMs and PLHIV were reported to have known about the relationship of TB with HIV but reported these participants are the ones who were informed about this relationship during any training or orientation conducted by civil society. Moreover less than 40% of PLHIV (co-infected group) shared that they believed there is relationship but were found unable to explain further. The information regarding the relationship was vague and less accurate logically.

Factors Associated With Spread of TB: participants responded that factors such as unemployment, poor health Seeking Behaviour; malnutrition; air pollution; sharing common workplace; weak immunity and stress contribute in spread of TB.

Areas Of High Prevalence: Majority of the respondents added that TB prevalence was found to be higher in rural areas because of lack fo access to both knowledge and services, other argued that in urban setting where people live in congested localities are more vulnerable to acquire TB.

Social & Environmental Determinants Which May Increase Vulnerability To TB: when asked about the social and environmental factors which may increase a person's (key population) vulnerability to tuberculosis, the respondents added that economic vulnerability / lack of economic opportunities or poverty are most important determinants followed by the Illiteracy resulting in stigma and discrimination. Almost all key populations considered that joint family system sharing kitchen, utensils and common living areas are also determinately contributing factors and similarly poor housing; poor water and sanitation and transport systems and poor ventilation; crowded spaces; and lack of nutritious food affect. Household and environmental smoke, smog and fog were also considered by some as contributing factors.

Behavioural Determinants Which May Increase Vulnerability To TB: When asked about what personal, family or societal factors contribute in acquisition of tuberculosis; the participants of the study ranked the poor health seeking behaviours as the most important determinant. Other determinants included smoking; lack of prioritization of personal health; poor dietary habits; lack of prioritization of health at household level and poor environmental and personal hygiene.

Legal & Political Factors Affecting TB Response: Majority of the groups at different locations shared identical responses like there are no specific policies included in the health sector which are meant to empower and enable the different groups of key populations/communities in planning through implementation and observation of enactment of legal apparatus and laws in this country with a particular and explicit focus on access to healthcare. There are articles of constitution/Laws related to Human and Health Rights in Pakistan including the Principles of Policy which casts an obligation on the state Articles of the constitution 29, 30, 31-40 under principles of policy are meant to provide protection of family; protection of minorities but it does not provide the protection to sexual minorities including the MSMs and TGs

Article (8) of the constitution indicates that Laws inconsistent with or in derogation of fundamental rights to be void. Article (9) is related to security of a person and article (10A) is related to right to fair trial. Importantly the article (19A) provides the right to information and article 25 reflects on equality of citizens and article (26) provides protection on non-discrimination in respect of access to public places. Importantly health itself is not considered to be a right in constitutions and state has not been bound to provide health services to its citizenry.

The Transgender Persons (Protection of Rights) Act, 2017: Pakistan is the one of the countries which passed the transgender Act ensuring their health rights, identity, fundamental rights and a full code for their protection. Few important clauses of the act are section 04- Prohibition against discrimination and the denial or discontinuation of or unfair treatment in healthcare Services and sec 12 which is related to *Right to Health of the trans-community*.

Legal, Policy & Constitutional Support: With regards to access to healthcare the existing law(s) neither support no do create any hindrance. Majority of the respondents reported to believe that there is not any single or conjugate policy; legal framework or general health policy which exists to help and benefit the communities and key and vulnerable population directly. Sind provincial government however has law pertaining to key populations access to HIV services but implementation of the law in true letter and spirit has been seen to be always questionable since its inception and enactment. Unlike HIV response in Pakistan having Pakistan AIDS strategy that articulates the human rights based programming

with clear identification of key and vulnerable population and programmatic prioritization, national TB control program does not have any similar strategic framework except national strategic plan.

Ability and competency of **policy makers** to make such policies regarding HIV and TB was regarded as questionable by all key populations alike. Laws which are related to homosexuality and socially forbidden deeds directly influence the access of some of the key populations to both TB and HIV services. Participants of the study doubted over the sincerity of the government by alluding towards governments face saving tactics at international level when it comes to international commitments. They added that the governments continue to show commitment but then they don't do what is required at the implementation level.

Even if there is law the laws are not translated into actions that could ensure the provision of HIV or TB services to KPs in a respectable manner. Laws are also required to ensure access of KPs to services with safety and dignity.

It can be inferred from the responses gathered from IDIs, KIs and FGDs that supportive laws which could impact the access of KPs to TB and HIV services under the emblem of human rights and gender equality are almost non-existent and by design and intent fail to provide fulcrum for protection of human rights in a legal perspective. The policy and strategic direction, although after devolution in Pakistan rests with provinces, and even if there is national strategic plan for TB response in Pakistan, the entirety of national TB response is to realise the need and importance of inclusion of legal and policy support for key and vulnerable population in its strategic plans.

Stigma And Discrimination: Different entities work across the country to counter stigma and discrimination against key and vulnerable populations. There is no formal mechanism in strategic plan of TB response to counter the stigma and discrimination.

APLHIV provides one common platform for all of the key population under HIV response only. Almost all participants confirmed the existence of the intra-family, intra society and healthcare settings related stigma. Key populations included in the study were found unaware of the entities working on prevention of stigma and discrimination.

Participants regarded the healthcare providers at health facilities/ private clinics found to have somewhat discriminatory attitude. Majority of respondents stated that the quality of the care was not good or they encounter problems during their consultations with HCPs, who could not diagnose their disease properly and early.

They shared instances when HCPs didn't hesitate to harass or even abuse the KPs.

Lack Of Legal Support And Stigma Impacting Gender Sensitive Responses:

Stigma and discrimination against all key population is unchecked- Some participants stated that whenever they asked the healthcare providers and allied staff any logical question related to disease and its management, the healthcare providers tend to be irritated. In extreme cases of discrimination, health care providers were reported to indulge in abusing some groups of key populations including the trans-community very often. Denial to services, mockery and harassment were very commonly seen.

Gender (In) Equality And Human Rights Based Programming In TB Response:

A gender-based approach to TB aims at addressing the social, legal, cultural and biological issues that underpin gender inequality and contribute to poor health outcomes. It encourages activities that are gender-responsive investments to prevent new cases of TB, and strengthen the response to fulfil the right to health of women, men and trans-communities. Even the Constitution of Pakistan provides a strong legal framework in terms of many dimensions of women's equality, implementation of many provisions is weak and this legal frameworks does not encapsulate the varied dimensions of the word gender and is found be devoid of the broader definition as it is seen to exclude the trans-community in entirety. A number of studies suggest that barriers to early detection and treatment of TB vary; and are greater for women than for men. Gender differences also exist in rates of compliance with treatment; fear and stigma associated with TB seems to have a greater impact on women than on men, often placing them in an economically or socially precarious position

Awareness And Protection Of Health Rights: Ministry of Human Rights and Human Rights Commission in Pakistan are the two institutions of high prominence in Pakistan when it comes to protection of human rights. The Ministry of Human Rights in Pakistan

is mandated to review human rights situation in the country including implementation of laws, policies and measures in accordance with the human rights standards. It coordinates the activities of Ministries, Divisions and Provincial Governments with respect to human rights. It refers and recommends investigations and inquiries in respect of any incident of violation of human rights. It takes initiatives for harmonization of legislation, regulations and practices with the international human rights covenants and agreements to which Pakistan is a party and monitors their implementation. An Action Plan to improve Human Rights situation in Pakistan was approved on 13th February, 2016, (National Policy Framework) by the Prime Minister of Pakistan, Unfortunately the action plan is devoid of an all-inclusive, multifaceted, multi-sectoral coherent approach that could ensure the protection and promotion of human rights of any of the most marginalised segments including the key populations in Pakistan. Even there is not an entity that by constitution or law could provide a platform for protection of human rights.

When participants were asked about Human and Health rights and the role of government(s) in protecting human rights and its efforts in prevention; control and ending TB and HIV from Pakistan, majority of the participants could not articulate what is meant by health or human rights. When probed only the few could enumerate the following as health rights.

“Access to medicine; Free Tests; Good Nutrition; Advice and counselling; Right to know about the status of the test; Equality in care and access to information- denial in case of disclosure of HIV/TB status”. Only PLHIV Group

Mostly, after probing, expressed their dissatisfaction regarding the role of government(s) including at multiple levels in ensuring the access of KPs to information and showed concerns over the existing initiatives taken by government(s) to curb both chronic diseases.

Since there is not a particular law that guarantees the protection of human and health rights and awareness on various aspect of health and human rights is almost non-existent among the key and vulnerable populations the cases of violations of human rights at healthcare setting as well as outside the healthcare settings are not recognised, reported and followed.

Human Rights & Gender Based Programming In TB Response: TB's national strategic plan does not have ample focus on legal and human rights based programming and key populations are not exclusively defined in National Strategic Plan (NSP). The NSP has priorities but different ones- focusing not exclusively on the key populations like MSMs, TGs and PLHIV or for that matter even miners and prisoners but on disease burden and distribution and provision of diagnostic and treatment services. No mechanisms exist to ensure the awareness raising of both KPs and HCPs on human rights and protection of human rights. No human rights monitoring system exists in healthcare settings. Although there is representations from KPs as well as the national TB association in Pakistan in CCM that undertakes the role of watchdog but when it comes to violation of human rights, the CCM does not have its mandate to countercheck such violations.

Protection Of Health Rights: A human-rights-based approach is to ensure laws establish rights to health, non-discrimination, privacy, freedom of movement, and enjoyment of the benefits of scientific progress, among others. Human rights law also establishes the legal obligations of governments and private actors. The fulfilment of human rights requires governments and states to respect, protect and fulfil the appropriate legislative, administrative, budgetary, judicial and other measures toward the full realisation of rights so that respect and promotion of human rights could be ensured. Majority of the respondents of the study including the service providers and key populations shared their dissatisfaction over the infection control measures at health facilities; responsiveness; safety, trust, privacy, confidentiality and attitude of healthcare providers. They also regarded the schedule of testing and treatment outlets at public sector health facilities and the waiting time for consultation as inconvenient and uncomfortable. Equitable distribution of gender sensitive trained human resource and diagnostic and treatment facilities were demanded during the focus group discussions and in-depth interviews. Some of the participants also shared that they don't trust HCPs but they don't have any other option

An important revelation is non-availability of adequate, safer and comfortable sitting arrangement in waiting areas of the TB clinics in major hospitals of the public sector. Comparatively the respondents regarded such arrangements at private hospitals to be more improved. They believed that human dignity, respect and confidentiality and privacy is most of the times seen to be in jeopardy at majority of the TB clinics in government hospitals. Some healthcare providers were quoted to be

abusive and mostly the affectees included the trans-communities .The respondents also share their concerns on the non-availability of trained human resource who are equipped with refined knowledge and updated information especially guidelines related to IPC skilled required for communication with a TB patient.

There are no known or approved means of legal remedies available to people with TB when their rights are violated, including their rights to free testing and treatment; privacy or any other right. There is no accountability mechanism which exists under law for government or private healthcare providers who violate the rights of people with TB, including their rights to free testing and treatment, privacy and compromised quality of care.

Gender Sensitivity & The Gender Based TB Response: There isn't any single policy/law specifically ensuring the protection against discrimination against any group of the key population on the basis of gender. Ensuring gender perspective in health interventions has historically remained an issue in Pakistan. Programs providing health care do not use evidence from research for planning and they fail to ensure pre-service training of healthcare providers and planner on gender and gender related sensitivities. Mechanisms by which the planners and program implementers of the national TB response and partners could remain continuously informed of the human rights and gender dynamics impacting the effectiveness of the intervention do not exist.

One of the important pillars of gender based programming is equality in access to economic opportunities. It is a very huge issue not only at individual level but also at household level as well as country level as additional resources are required to cope with the challenges of disease burden. For Public health sector this has implications as we cannot eradicate a communicable disease due to poverty resulting from the lack of economic opportunities and poor social and economic conditions. The responses gathered from the qualitative data are indicative of the lack of adequate measures which could ensure the existence of mechanisms by which the planners and program implementers of the national TB response could remain recognizant of human rights and gender dynamics impacting the effectiveness of the intervention.

Inclusion Of Key and Vulnerable Populations (In Planning, Decision Making

And Participatory M&E): Almost all KPs accepted that at some stage they have been approached to listen to and include their needs and expectations in national TB response but there is a difference in what is gathered (inputs) from KPs and what is provided (Services). Majority of the key populations added-not aware of the formal mechanisms which are required to ensure the inclusion of the communities in planning for national TB response in Pakistan. The national TB program conducts the participatory planning in some cities, followed by the provincial level and then national level consultations by including the representation from TB patients association and Civil Society but unfortunately due to competing priorities and lack of funding , the gender specific interventions and actions remain always less prioritised.

There is TB association of Pakistan which is member of the CCM along with the HRCP but these two entities alone cannot influence the decision making when it comes to the allocation of resources as well as prioritization of the gender and human rights based interventions ahead of allocations for medicine and supplies only.

Resource Allocation and Distribution: Government of Pakistan has a national strategic plan covering the period of 2017-20 that would, if implemented in accordance with a rationalized budget, require US\$ 526 million. 65 % of this need remained unfunded. GF has been supporting almost over 90 % of the existing TB intervention and its operational cost but that constitutes only 28% of the actual cost estimated (of 526 million). Only Punjab province has an approved PC-1. At implementation level, the support from provincial government is in the form of human resource only and all medicine and supplies and diagnostic test facilities are being supported by the Global Fund. The GF has already indicated that Pakistan government must gradually increase its resource allocation from its own sources of the existing to 50% in 2018; 70% in 2019 and 80% in 2020.

Priority Actions and Resource Allocations: Actions which may influence the gender equality and equitable distribution of resource in gender and human rights perspective remained untouched so far in national TB response. The national TB coordination mechanism include does not have a dedicated focus on gender equality explicitly narrated in national strategic plan. Most of the respondents also

added that decision-makers and service providers fail to assimilate and demonstrate awareness and knowledge of the consequences of gender inequality and hence render to compromise on it for medicine and supplies.

Availability of financial resources, mostly GF grant; political priorities; cost of free medicine, tests and supplies and donor requirements were quoted as determinants by the respondents as key factors influencing the resource allocation for different components.

Social Protection and Inclusion: There is no compensation for time lost from work. This has implications on the acceptability and affordability of the service by some key populations including the MSWs, FSWs and even trans-community who remain indulged in commercial sex work. In some areas support for intake of nutritious food is provided by the service providers under TB response. There is no additional compensation for health care workers working in TB in public sector but health care workers working in private sector have incentives. Although there are mechanism of social protection including the Benazir Income Support Program and Zakat but social and identity of some key populations including the MSMS and TGs does not have conducive effect in accessing such resources. In case of MSMS and TGs it is very difficult; many deserving KPs are denied access to such entitlements and safety nets just because systematic errors as well as politicization of the program.

Protection, Privacy and Confidentiality: There is no formal and approved written policy for disclosure of the information related to one's status as TB patient. There are no specific pre-service sensitivity trainings in gender, human rights, stigma and discrimination in Pakistan. However medical and nursing graduates are taught about ethics and behaviours, but it doesn't gender and human rights. The service delivery sites do not have appropriate arrangements for the safety, privacy and confidentiality of information. This becomes more severe and less acceptable in cases of transgender and women.

Access To Service Delivery and Acceptability Of TB Services: On average a KP has to visit 3 to 4 times to have a clear and final diagnosis. There are cases when HCP failed to make a clear diagnosis. At private clinics the KPs were reported to have been treated better. One average a TB patient had to spend 15 to 20

thousands initially on tests and travel costs. Most of the KPs are reported to have free medication. Majority had received the information on drug regimens but a significant proportion of the respondents added that information on follow-up was only provided when asked. The two stage sputum collection method was regarded as cumbersome by all KPs. Factors hindering access to TB services by KPs include the non-availability of 24 hours service delivery; common counters for TB patients; delays in OPD (waiting time) and diagnostic tests; transportation of feeble patients; and non-availability of male family members to accompany female staff.

Services and Information: which are currently being provided include the diagnostic procedures including the microscopy; chest X-ray; gene Expert; tuberculin skin test and LED microscopy with varying degree of availability and acceptability. The information being provided to individuals who come for TB testing include the nature of TB; the test procedure and rationale; prevention measures; information on free treatment and care for TB and duration of TB treatment and side effects and mitigation

Recommendations were made by the respondents as well as the lead consultant in consultation with the stakeholders at validation workshop. Important recommendations included the establishment of across the stakeholders accountability framework; participation and inclusion of communities to reach every key population and evidence based planning besides establishment of an advocacy initiative to influence policy change for gender and human rights based programming in national TB response. Evidence gathered from quantitative and qualitative assessments must be used for evidence based planning.

The establishment of Multi-sectoral approach in planning for END TB PROGRAM is essential. Similarly establishment of a task force on TB covering gender, law, economy, education service provision, trade, industry and tourism as well as transport is important. The same task force must have a sub- task force on Gender that works to ensure Gender and Human Rights Based programming and that advocates for the adequate and equitable resource allocation. The task force should also, in coalition and networking act as a watch dog to track the progress of government in attaining outcomes of the international commitments in Pakistan. Evidence with regards to disease burden entails the reshaping of data collection

mechanisms keeping in view the internationally recognised nomenclature associated with categorization of both key and vulnerable populations as well as categorization of disease. Introduction of Human Rights and Gender related competency based knowledge in medical schools and colleges as well as mandatory pre-service training in gender sensitivity and human rights. Provision of economic opportunities or at least equal access to safety nets including the Zakat, Baitulmal, Benazir Income Support Program and health insurance scheme and social protection Use of cellular technology for consultative process for planning of the national TB response with more coherent and cohesive approach of reaching out to both key and vulnerable populations and awareness raising as well. Stringent policies must be enacted at healthcare settings to avoid discrimination and reward and punishment method must be included in hospital policies.

INTRODUCTION

Access to healthcare and effective utilization of healthcare services is impacted by a larger number of determinants including the individual's health seeking behaviour as well as the availability, quality and affordability of the services. The societies which have realised the linkage between health and economic productivity have invested immensely in health sector to enable the population live healthy and productive. .

Disease Burden of TB and Prioritization: TB is the 10th leading cause of death worldwide with a 16% Case Fatality Rate and is the 5th leading cause of death in Low and Middle Income countries. TB is also the leading killer of HIV-positive people. In 2017, 10 million people fell ill with TB, and 1.6 million died from the disease (including 0.3 million among people with HIV i.e.18.75%). **Eight (08)** countries account for two thirds of the total disease burden globally, with India leading the count, followed by, China, Indonesia, the Philippines, **Pakistan**, Nigeria, Bangladesh and South Africa. Pakistan is among the five leading countries of TB disease burden globally and contributes 2/3rd of the TB related disease burden in EMRO region.¹ Despite meticulous efforts a huge number of cases remained missed and/or could not access the TB related health services globally and also in Pakistan. In Pakistan, the incidence rate of tuberculosis is 267 per 100000 population while the mortality rate is 27 per 100000 population. Unfortunately the data related to disease burden and its distribution with age and sex as well as category of the key population is not available in Pakistan. The standard reporting format fails to capture this type of information. The following table provides the maximum segregation for incidence of TB cases.

END TB Strategy To urgently improve detection, diagnosis and treatment rates, WHO, the Stop TB Partnership and the Global Fund launched the new initiative in 2018, [Find. Treat. All. #End TB](#), which set the target of providing quality care to 40 million people with TB from 2018 to 2022. One of the targets of the Sustainable Development Goals for 2030 is to end the global TB epidemic.² Ending the TB epidemic is part of achieving the Sustainable Developmental Goals (SDGs), but eliminating TB requires a well-coordinated and innovative response. Now more than ever, however, we have the opportunity to end this disease once and for all. The endemic issues of poverty and illiteracy in less developed and developing countries

¹WHO- fact sheet, STOP TB Partnership country profile Pakistan

² United Nations' Sustainable Development Goals: 17 goals to transform our world. 20th January 2016

which have failed to create an impact by halting the disease burden especially the communicable diseases have impacted the access and utilization of services in health sector. These societies in these countries have overt causes of causes including the lack of all-inclusive and implementable health policies; insufficient financial and human resource allocations and sub-optimal utilization; lack of prioritization of preventive care; inequitable service distribution and dependency on donor funds resulting in lack of systematic approach in planning and implementation as well as consistency of responsiveness and sustainability in change.

SDGs, Tuberculosis and Gender Equality in Pakistan: The United Nations' Sustainable Development Goals which were earlier set as Millennium Development Goals has continuously prioritized the goal for promoting gender equality and women empowerment but targets remained far from its reach so far continually during the period 2000 to 2015. In 2014, Pakistan approved Vision 2025, which outlined its medium-term development priorities and strategies. With support from some external support the government of Pakistan had agreed to conduct the country gender assessment to inform and buttress the strategic development plans to improve gender equality and economic empowerment in line with Vision 2025. The gender preferences even in provision of healthcare was overtly seen and equality in access to healthcare was seen to prevail at households level with boys more likely to receive full immunization coverage, seek treatment, and provision of antibiotics for acute respiratory infections, and receive oral rehydration therapy for boys.

Pakistan is challenged with gender inequalities, and despite efforts there is a wide gap and gender based inequality between males and females in terms of employment opportunities, paid work, access to health services and health outcomes in Pakistan. ***In such scenario non-inclusion of trans-communities in development sphere and developmental mechanisms leave them deprived of economic opportunities by default.*** The gender inequality has deep roots in Pakistani society. Culturally, women are at a disadvantage from birth and are subject to discrimination during their entire life course in Pakistan, while men are perceived economic and social utility and Transgenders are seen to be even the cult and punishment of God in some societies. The neglect of girls and these trans-communities continues in their childhood and adolescence, with only 25% of women able to complete their primary education as compared to 49% of men in Pakistan. Female literacy is only two thirds that for men in urban Punjab, the biggest province

of Pakistan and is beyond doubt much worst in rural areas of Pakistan. ³According to WHO, people living with HIV are around 29 times more likely to develop TB than persons without HIV. TB is the most common presenting illness among people living with HIV, including those taking antiretroviral treatment and is the major cause of HIV-related death. Most TB cases and deaths occur among men, but TB remains among the top three causes of death of women worldwide. There were an estimated 510 000 TB deaths among women in 2013, more than one third of whom were HIV-positive women. In a study done to assess the gender variations in delay from symptom onset to help seeking, diagnosis and treatment of TB it is evident that compared with men, women experienced longer delays at various stages of the clinical process of help seeking for TB which warrants appropriate measures to improve the situation. Gender dynamics in TB enrolment, treatment and cure rates are not uniform. In most low and middle-income countries about two-thirds of reported TB cases are men and only one third women, and it is not well known whether this is due to a higher risk of developing TB among men or under-notification of TB among women with the evidence that women are less likely to be diagnosed with tuberculosis and successfully treated. It is evident that the health seeking and treatment behaviour of men and women living with HIV, TB-HIV co-infection or suffering from TB, requires a systematic assessment from a gender perspective to inform national planning and budgeting for gender-responsive and gender-transformative. ⁴

Health and Human Rights: The premises of health rights is often confined in the right to the enjoyment of the highest attainable standard of physical and mental health, often referred to as "the right to health" The right to "the highest attainable standard of physical and mental health" is not confined to the right to health care along but systems and organelles of the healthcare systems must ensure respect, confidentiality, responsiveness and trust along with beneficence. The right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment. WHO led Commission on Social Determinants of Health has put emphasis on reducing inequalities in healthcare by ensuring health services, goods and facilities be made to be Available, Accessible, Acceptable and of good

³ M. Nasrullah and J A. Bhatti Gender inequalities and poor health outcomes in Pakistan

⁴- UNAIDS, MoNHSR&C, Govt of Pakistan, TB and HIB through Gender Lens

Quality (AAAQ).⁵ A human rights-based approach and gender mainstreaming add value to health sector strategies and actions by contributing to the reduction of gender-based (and other) health inequities.

All human rights are interdependent and interrelated. Human rights, and in particular the human right to development, provide the values, principles and standards essential to safeguard that most precious of all rights — the right to be human, (of which the right to be woman, men and trans persons is an integral component). **A human-rights-based approach is to ensure laws establish rights to health, nondiscrimination, privacy, freedom of movement, and enjoyment of the benefits of scientific progress, among others. Human rights law also establishes the legal obligations of governments and private actors.** The fulfilment of human rights requires governments and states to respect, protect and fulfil the appropriate legislative, administrative, budgetary, judicial and other measures toward the full realisation of rights so that respect and promotion of human rights could be ensured.

National Health Vision and Investment in health sector: National Health Vision 2016-25, the most hailed strategic guideline is meant to provide an overarching national vision, an agreed upon common direction, harmonizing provincial & federal efforts, inter-provincial efforts and inter-sectoral efforts for achieving the desired health outcomes and to create an impact. It provides a jointly developed account of strategic directions to achieve the common vision, and which gives a guideline of best practices for the provinces/ areas to carve their respective policies and initiatives within their domains. The word 'national' depicts common political aspirations of the provincial and the federal governments. It has consonance with provincial & federal health policy frameworks, post devolution health sector strategies, and with international health treaties, commitments and regulations to which Pakistan is a signatory.⁶ The national health vision regarded the equity as one of the pillars of programming but does not make an account of the social determinants and social and political as well as legal barriers which impede the

⁵ Committee on Economic Social and Cultural Rights (CESCR)- The Right to the Highest Attainable Standard of Health, General Comment 14. E/C.12/2000/4, available at [http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En), accessed Oct 10, 2018

⁶- National Health Vision – 2016-25, Government of Pakistan

access to and utilization of health services. The influence of gender inequality in healthcare with a focus on key and vulnerable populations is mission.⁷

Espoused by the conventional social lens of myopic sightedness, the development interventions have failed to recognize and include the trans-communities and key and vulnerable population in various development interventions and scope of this intervention is limited to the inclusion of women in different development interventions in gender perspective. In Pakistan, the National Health Accounts (NHA) is a framework established under the Federal Bureau of Statistics (FBS) that continues to work in estimating the total healthcare expenditures (both public and private) in Pakistan. NHA methodology actually tracks the flow of funds through the healthcare sector by compiling the four selected dimensions, i-e (i) Financing sources (ii) Financing agents (iii) Health care providers & (iv) Healthcare functions. ⁸ Historically both health and education sector in Pakistan remained less prioritised from policy perspective as well as allocation of resources and service delivery and distribution patterns which in return allowed private sector to exploit the situation by inflicting a huge out of pocket expenditure. Inter-sectoral coordination in an important component of health services but unfortunately it does not exist in true letter and spirit. Out of the pocket expenditure is generally proportionately very high in overall expenditure on health.

Gender Equality: GENDER Refers to social attributes and opportunities associated with being male and female, socially constructed expectations on roles of women and men and their relationship with each other, which are learned through socialization processes. Concepts of gender may vary across race, culture, class, age, and time, and are therefore changeable. The nomenclature used in gender based development programs in Pakistan fails to recognise the others in addition to men and women, thus when programs are engendered, the trans-communities which are less likely to avail economic opportunities and social inclusion remain left out of the central focus. Gender equality is the preferred and desired situation wherein women, men and trans-communities enjoy the same rights, opportunities, and have equal value and respect for whatever the biological identity and sexual

⁷National Health Vision 2016-25, Government of Pakistan; Public Health Account Committee

⁸NHA- FBS, Government of Pakistan

orientation one has. From process perspective it is one essential approach that recognizes the different needs and interests of women, men, and all other genders and thus allows a redistribution and adjustment of power and resources whereas gender mainstreaming is a gender and development strategy that entails gender analysis to assess the implications for women and men of any planned action, legislation, policy, or program so that women and men may equally benefit, and gender inequalities are not perpetuated. Gender mainstreaming is a long-term process and strategy that aims to reflect women's and men's concerns and experiences as an integral part of the design, implementation, monitoring and evaluation of all sectoral policies and programmes, including health. The ultimate goal is to achieve gender equality it incorporates concerns and experiences of women as well as of men into the design, implementation, monitoring, and evaluation of policies, programs, and projects.

INTERNATIONAL COMMITMENTS OF PAKISTAN

Pakistan is signatory of various International Conventions pursuant to which Pakistan is bound to ensure that the provisions of such International Conventions and agreements are duly implemented and reflected in the laws of the country. Importantly these declarations include the acceptance and respect of the state of Pakistan to these commitments. Important international commitments to which Pakistan is a signatory includes the Universal Declaration of Human Rights; International Covenants on Civil and Political Rights; International Covenant on Economic, Social and Cultural Rights and Convention on Elimination of all forms of Discrimination Against Women.

UNIVERSAL DECLARATION OF HUMAN RIGHTS

"The Human Rights Declaration" is the first declaration stating the human rights to which all human being are inherently entitled and subsequently its provisions have been reflected in various international treaties and covenants.

Article 2 of the Human Rights Declaration provides that "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status".

The Human Rights Declaration, along with the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political

Rights and its two Optional Protocols together constitute the “International Bill of Human Rights”.

INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS

Article 6 of the International Covenant on Civil and Political Rights (“**ICCPR**”) provides that every human being has an inherent right and this right shall be protected by law and no one shall be arbitrarily deprived of his life.

Article 7 of the ICCPR states that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment and in particular no one shall be subject without his free consent to medical or scientific experimentation.

In terms of Article 10 of the ICCPR all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

3.1.4 Article 16 provides that everyone shall have the right to recognition everywhere as a person before the law.

Article 17 states that no one shall be subjected to arbitrary or unlawful interference neither with his privacy, family or correspondence nor to unlawful attacks on his honour or reputation and everyone shall have the right to protection of law against such interference and attacks.

Article 26 states that all persons are equal before the law and are entitled without discrimination to the equal protection of the law. In this respect the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Pakistan is a signatory to the ICCPR and has ratified the ICCPR with the reservation that Article 3 shall be applied in conformity with the personal law of the citizens of Pakistan and the Qanoon-e-Shahadat; and with regard to Article 25 has made the reservation that the same shall be subject to Article 41(2) and Article 91(3) of the Constitution.

International Covenant on Economic, Social and Cultural Rights

Article 2 of the International Covenant on Economic, Social and Cultural Rights (“**ICESR**”) reflects the provisions of Article 2 of the Human Rights Declaration and provides that the State Parties to the ICESR undertake to guarantee the rights

contained therein without discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Rights with regard to health are recognized in Article 12 of ICESR and include,

(a) Reduction of the stillbirth-rate and infant mortality and for the health development of the child;

(b) Improvement of all aspects of environmental and industrial hygiene;

(c) Prevention and treatment and control of epidemic, endemic, occupational and other diseases; and

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Pakistan is a signatory to ICESR and has ratified the ICESR with a reservation which reads "Pakistan with a view to achieving progressively the full realization of the rights recognized in the present Covenant shall use all appropriate means to the maximum of its available resources."

Convention On The Elimination Of All Forms Of Discrimination Against Women

Pakistan is also signatory to the Convention on the Elimination of All Forms of Discrimination against Women ("CEDAW") with a general declaration with regard to the accession to CEDAW being subject to the provisions of the Constitution of Pakistan and a reservation on Article 29(1) of CEDAW.

In terms of Article 12 of CEDAW, State Parties are obligated to take appropriate measures to eliminate discrimination against women with TB in the field of health care on the basis of equality with men; which include access to health care services, including those related to family planning. State Parties to CEDAW are further required to ensure appropriate services for women in relation to pregnancy; post natal care, nutrition during pregnancy and lactation and to provide free services where necessary. In terms of Article 14(2) (b), State Parties are required to ensure adequate health care facilities for women in the rural areas on a non-discriminatory basis; which include information, counselling and services for TB specifically.

Constitution of Pakistan and Health Rights

That Health related rights are not included in the Fundamental Rights provided in constitution. The word social economic is provided in Preamble and principle of policy of the Constitution but that part of constitution is not enforceable through Court of Law.

"Therein shall be guaranteed fundamental rights, including equality of status, of opportunity and before law, social, economic and political justice, and freedom of thought, expression, belief, faith, worship and association, subject to law and public morality" It is pertinent to mention here that nothing is mentioned about TB, treatment and safeguard as a right in Constitution. **Treatment and protection from TB should be provided.**

COMMUNITY, RIGHTS AND GENDER (CRG) TOOLS ROLL-OUT IN PAKISTAN

Socio-cultural, legal and religious barriers as well as lack of respect for human rights in different countries invariably impact the lives of some groups in entirety and sub groups disproportionately with stigma and discrimination often overlooked and poorly mitigated by state organelles. Most often the data which is required to substantiate the momentum of advocacy is not available and hence these most marginalized, underserved and vulnerable population remains languishing with same apathy and lack of prioritization.

The Stop TB Partnership, the World Health Organization (WHO) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) are collaborating on projects to find and treat an additional 1.5 million people with tuberculosis (TB) who are currently missed by the country specific health systems by the end of 2019(base line 2015). Under the GF-TB Strategic Initiative (SI), the Stop TB Partnership works with national TB programmes and partners in 14 countries, providing technical support through a combination of innovative approaches, tools and best practices to identify and remove gender and human rights related barriers in the context of TB with a particular focus on key populations and vulnerable groups. These 14 countries include: Bangladesh, Cambodia, Kenya, Tanzania, India, Nigeria, Ukraine, The Democratic Republic of Congo, Indonesia, Mozambique, Myanmar, Pakistan, Philippines, and South Africa.⁹ STOP- TB Partnership is an international entity with the expertise and mandate to align synergies all over the world to fight against tuberculosis. It has been working in many countries across the globe to make this world free from tuberculosis. The mission of the partnership is to ensure interruption in TB transmission by ensuring equitable access of patients suffering from tuberculosis to safe and effective diagnostic and treatment services by enabling them to be empowered not only in participation for planning and implementation of national TB control programs but also undertake significant roles in influencing policy shifts. The participation of a wide range of constituencies gives the STOP TB partnership the credibility and the broad range of medical, social and financial competencies needed to defeat TB.

⁹ <http://stoptb-strategicinitiative.org/>

The Stop TB Partnership was established in 2000 as a global movement to accelerate social and political action to stop the spread of TB. In 2014, the World Health Assembly unanimously approved the End TB Strategy, a 20-year strategy (2016-2035) to “end the global TB epidemic”, with the vision of a world with “zero deaths, disease and suffering due to TB” After 15 years of its establishment, the fourth edition - the Global Plan to End TB 2016-2020 was launched at the end of 2015 to expedite the greatest possible speed to reach the End TB targets endorsed by the world’s Ministers of Health in 2014.

Following slide presents a summary of the End TB Strategy 2016-35.

VISION	A world free of tuberculosis-zero deaths, disease and suffering due to tuberculosis			
GOAL	End the global tuberculosis epidemic			
<hr/>				
INDICATORS	MILESTONES		TARGETS	
	2020	2025	SDG 2030	End TB 2035
Reduction in number of TB deaths compared with 2015 (%)	35%	75%	90%	95%
Reduction in TB incidence rate compared with 2015 (%)	20% (<85/100 000)	50% (<55/100 000)	80% (<20/100 000)	90% (<10/100 000)
TB-affected families facing catastrophic costs due to TB (%)	zero	zero	zero	zero

Table 1- End TB Strategy 2016-35 at a glance

With Technical Assistance (TA) from STOP-TB Partnership the Association of People Living with HIV (APLHIV) in Pakistan facilitated an initial assessment of existing situation of gender sensitivity and human rights programming in planning, implementation and monitoring and evaluation of TB programs at national and sub-national levels. The AIM of the assessment is to see how legal environment has been impacting the access of the key populations to clinical, diagnostic and preventive services as well as their rights to healthy living. Another important milestone, the partners would contribute to signify involves an assessment of the gaps in data related to key population and the findings of which will be used for advocacy for evidence-based planning in near future. The use of these tools in Kenya, Tanzania , Ukraine and Cambodia have shown impactful results in supporting these countries at the level of assessment, planning, implementation with a greater involvement of

Roll-out of Community Rights and Gender Tools in Pakistan By The APLHIV-Pakistan

key and vulnerable populations in programming and reshaping the interventions in gender transformative approach.

CRG Tools

Community, Rights and Gender Tools are a set of tools for strategic planning in ensuring to reach each and every key and vulnerable population in national level TB and HIV responses. One essential approach in HIV /TB programs is to ensure the interventions have gender equality and human rights programming (assessment in a human rights and gender perspective).

The Global Plan to end TB 2016-20 recommended to developing country level framework for key, underserved and vulnerable populations in order to identify them, plan actions to understand their characteristics and estimate their size and then include them and enable them to access quality TB specific preventive, diagnostic and curative health services. In alignment with the strategic plan of Global Fund for ending TB 2016-20, the Stop TB Partnership envisaged to involve the communities at the centre of program execution. To understand the existing situation of gender barriers, stigma, lack of protection of health and human rights and denial of services to clinical and preventive services which result into lack of prioritization of the sub groups of key populations for programmatic interventions in TB and HIV programs in developing countries. To enable the stakeholders to assess the situation, the TB Partnership developed three assessment tools; TB/HIV Gender Assessment tool; Legal Environment Assessment Tool and Data for Action Framework. The tools will be used with adoption/adaptation for generating discussions aimed at inferring the conclusion and recommendations required for prioritization of key populations at the country level.

During the initial phase of this assessment following important documents were assessed and reviewed to ascertain the legal aspect of the CRG roll-out in Pakistan

During the literature review following documents were studied

- Constitution of Pakistan 1973
- International Conventions and commitments of Pakistan
- Code of Civil Procedure 1908
- Criminal Procedure Code 1898
- Pakistan Penal Code 1860
- The Transgender Persons (Protection of Rights) Act, 2017
- THE PUBLIC HEALTH (EMERGENCY PROVISIONS) ORDINANCE, 1944
- The Epidemic Disease Act 1958

- The Pakistan Family Courts Act 1964
- **THE PUBLIC HEALTH (EMERGENCY PROVISIONS) ORDINANCE, 1944**
- **THE SINDH HIV AND AIDS CONTROL TREATMENT AND PROTECTION ACT, 2013**
- Global TB Report – WHO – 2017, 2018
- Annual Report – Stop TB Partnership – 2016
- Annual Report NTP 2013 Pakistan
- National Health Vision 2016 to 2025
- National Health Policy 2001 Pakistan
- World TB day Report 2018
- Pakistan Prison Rules 1978
- Pakistan The Prison Act 1894
- Guardians and Wards Act 1890
- Precedents Judgments of Supreme Court
- Health and the 18th amendment in Constitution of Pakistan by Dr. Sania Nishtar
- State of Human Rights in 2017, Pakistan by HRCP

The TA support from the STOP-TB covered the following activities in chronological order.

Establishment of core group
 Establishment of multi-stakeholder forum
 Prioritization Workshop (key population group's prioritization)
 Adaptation of the CRG tools and finalization of geographical locations
 Roll-out of CRG tool
 FGDs
 KIs
 IDIs
 Analysis of data and consolidation
 Validation Workshop
 Finalization of report and dissemination
 Development of advocacy framework

The country level process was led with establishment of a collaborative approach between national TB program and APLHIV-Pakistan primarily. The core group was established to provide oversight and administrative assistance in accessing the essentially important data pertaining to programs. The core group for the three components of the assessment was jointly established comprising of like-minded professionals who have already been working in gender, human rights and legal

support for marginalized communities in general and key populations in particular in Pakistan. The core committee leveraged their expertise and acquaintance in mobilizing the willingness of the larger multi-stakeholders' meeting during the prioritization workshop. The consultants working in three groups managed to supervise the dialogue during the prioritization workshop.

While the core group provided guidance and support in ensuring the effective coordination and also in ensuring the technical accuracy of the proposed assessment, the multi-stakeholders forum acted as a fulcrum for identification and endorsement of the prioritization of key populations. The core group meetings held twice before the prioritization workshop was held on September 28, 2018 at hotel envoy continental. The 1st official meeting of the core group was held on July 30th at CCM conference room followed by 2nd one at conference room in National AIDS Control Program Pakistan office. The proposed methodology and way forward was discussed and agreed upon.

There are 09 major and 33 sub-types of key populations who are, for various reasons, vulnerable to TB and to HIV as interfaces exist. During the prioritization process in a multi-stakeholders which was attended by, besides members of the core group, the ministry of health; human rights; judiciary; UN agencies and representative of the key population along with one member of the parliament.

Prioritization Workshop

With the concurrence of the core group which was established to provide oversight and strengthen the inclusiveness, diversity and ownership of the planned intervention of CRG roll-out in Pakistan, through a consultative process, the prioritization workshop was held at Envoy Continental Hotel on 28th October 2018. 65 participants including one member of the parliament; Country Coordination Mechanism; Human Rights Commission of Pakistan; community representatives from MSMs, TGs as well APLHIV communities as well as focal persons from UN agencies including WHO, UNODC and UNAIDS besides focal persons from National TB Control Program; National AIDS Control Program; president of the national TB association as well as the members of the bar council and honourable civil judge from Islamabad High Court enabled the organisers in attainment of the consensus in prioritizing the key population for the detailed assessment.



Figure 1- MNA Nafeesa Khattak addressing the audience at Prioritization Workshop

The lead consultant along with the consultant working on Data for Action briefed the participant about the importance of prioritization workshop and the contribution from each one of them. With the help of consultant currently working on “DATA FOR ACTION”, the lead consultant then engaged in individual assignment by requesting them to read the list of key populations and then assess how legal environment and gender has been impacting in general on health status and access to TB services in particular.

The workshop provided an opportunity to communities as well as both policy makers and the civil society representatives to critically think and prioritize those groups of key populations which are deemed to be affected by the legal barriers and gender inequities in program planning and implementation. The responses were measured in frequencies to reach the inference. It is evident from the table given below that majority of the participants prioritised the PLHIV as the most prioritised KP followed by the trans communities and then people who are co-infected with HIV/TB and MSMS as 2nd and 3rd important KP respectively.

KPs	Frequencies for ranking position			Cumulative Frequency	Ranking
	1	2	3		
PLHIV	19	19	12	50	1st
HIV/TB Co-infected	10	10	26	46	3rd
Transgender	10	28	10	48	2nd
MSMs	11	18	17	46	3rd
PWID	2	19	17	38	
Prisoners	3	10	10	23	
Urban poor	0	4	18	22	
Health workers	0	9	13	22	

Table 2- Frequency table - Prioritization of the Key Populations

The three (HIV/TB co-infected will be under PLHIV) KPs most prioritised in terms of importance through ranking scores are given below.

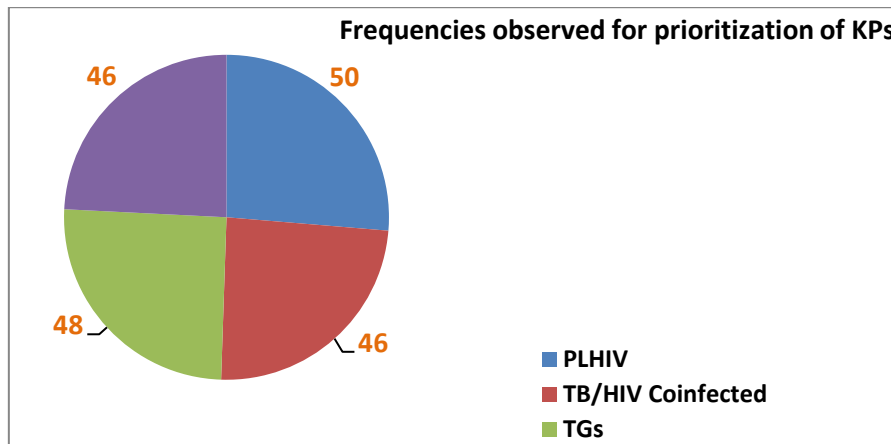


Table 3- Most Prioritized KPs in Prioritization Workshop for CRG roll-out in Pakistan



Figure 2- Civil Judge Mr. Saeed Khursheed delivering concluding remarks

He then gave examples to enrich their understanding on how to prioritise and rank the two to three most marginalised they have identified and prioritised. A slide highlighting the scoring criterion and scoring was displayed and then discussed to enable the participants to prioritize the key population with an informed level of logical understanding.

The participants were then requested to fill the printed sheets of the prioritization scoring and hand over to facilitators. The components of the criterion were following.

- Exposure to Environment Risks
- Exposure to Biology Risks
- Exposure to Behavior Risks
- Legal, social & economic Barriers to Accessing Services
- Human Rights & Gender Barriers to Accessing Services
- Estimated (and/or official data, if available) Contribution to the Country's TB Disease Burden

While the individual responses related to prioritization of KPs on the printed templates were being analysed, the group work was assigned to the participants. The participants were divided into three groups led by moderators and team leads. The facilitator supervised the group work to ensure that the participants have understood the purpose of the group work. The three groups worked on

- 1- Availability of Data related to KP
- 2- Legal barriers and human rights perspective in national TB response
- 3- Gender identities and equitable access to health services in national TB response

Participants of the workshop were engaged in a participatory manner to assimilate the importance of the workshop. After initial brainstorming on epidemiological and contextual background and disease burden of TB in Pakistan, the participants were then actively engaged to prioritise the key population and then rank them on a predefined set of criteria laid down by STOP TB Partnership in CRG tools.

The three important key populations identified include, in chronological order by the frequency index, the PLHIV, Transgenders, MSMs and HIVTB co-infected. These groups will be focussed in qualitative research study in order to understand the impact of legal and gender related barriers and human rights perspective with regards to access to health service in TB response.

Purpose of the CRG Tools roll-out in Pakistan

The main objective of the qualitative part of the assessment was to identify gaps in availability and accessibility of services being provided to target key populations and to assess the strategic direction and country level mechanisms which ensure the access of these populations considering the human rights perspective as well as gender related factors. The ultimate purpose is to strengthen the national TB response in Pakistan by ensuring the inclusion of human rights in program activities and engendering the national TB response. It is hoped that this study will help the TB programs at national and sub-national levels to assess the TB epidemic context and

response from gender and human perspectives in order to attain all three 90s of global TB strategic milestones. The broader objectives of the qualitative study under the roll-out of the CRG tools in Pakistan as was to understand;

The level of human rights and gender consideration in planning and implementation of existing programs in TB and HIV/AIDS and how it has been impacting the access of key population to TB and HIV services.

What are the legislative and legal provisions in country context to support the health and human rights protection as well as access to quality healthcare for key populations?

Do the programs have ample and accurate information on the key populations to develop plans to tackle disease burden of TB.

The goal of this scoping study is also to contribute in community empowerment so that in future they could play a significant role in

- Advocacy for the formulation of community centered policies or policy shifts and resource allocation encompassing gender diversities, health and human rights challenges.
- Planning and implementation of the TB programs in Pakistan
- Monitoring and evaluation of TB programs in Pakistan

The specific objectives included the assessment of

- Gender (in) sensitivity & (in) equality and human rights programming in planning, implementation and monitoring and evaluation of TB programs at national and/or sub-national levels.
- The legal environment and its impact on the access of the key populations to clinical, diagnostic and preventive services as well as their rights to healthy living.
- The gaps in data for evidence based planning related to key population.
- Policy advocacy, strengthening of the TB and HIV program planning and evidence for investment

Development/Adaptation of The CRG Tools

UNAIDS had developed HIV gender assessment tool which was modified by UNAIDS and WHO for gender and human rights assessment in national HIV and TB responses. The tool is a compendium of three sub-tools - a structured set of guidelines and questions that can be used to guide and support the process of analyzing

- the extent to which national responses to TB (and HIV) take into account the critical aspect of gender equality and human rights; evidence based planning; inclusion of KVPs in decision making and legal support for marginalized.
- the extent to which the national response recognizes gender (in)equality as a key determinant of HIV and TB burden and then acts upon that recognition

The adaptation process at the country level was led by the lead consultant with concurrence from the core-group. The country team led by the lead consultant ensured the contextualization of the assessment tools and then pre-tested them before the training workshop for the teams of data collectors.

The detailed assessment of the existing situation in terms of epidemiology, determinants of the diseases burden and impact of gender and legal barriers was completed through administration of a qualitative study tools including focus group discussions and key informant interviews with a wide range of stakeholders including the key populations; service providers and advocates of health and human rights as well as program planners and managers. The roll-out process was preceded by extensive desk work of reviews of the policies, strategic documents and similar studies and the core group was kept abreast. The tools developed included

1- FGD Guide to be used for focus groups discussions with PLHIV (including the co-infected), MSMs, and TGs

2- Key Informant Interview Questionnaire to be used for the specific responses from program managers, planners, service providers, funding agencies, ministries, human rights entities and civil society organizations working in health interventions; gender and human rights.

3- In-depth Interviews with individuals affected /remained affected with TB, TB/HIV

METHODOLOGY

Although the data collection from the respondents was collected through qualitative research methods of data collection including the Focus Group Discussions, Key Informant Interviews and In-depth Interviews, the study in entirety was mixed having qualitative and quantitative components as information on epidemiology and disease burden as well as resources was collected and analysed through quantitative methods. The team based findings and conclusions by utilizing (i) quantitative data on sex-disaggregated indicators as well as disease burden collected through questionnaires as well as analysis of the programmatic data

provided by the NTP and the NACP in Pakistan (ii) qualitative information provided from key interviewees, participants in focus group discussions, key informant interviews and In-depth interviews and s; and (iii) Desk review of the quantitative data and qualitative information and analysis available in documents on human rights, gender and development in Pakistan.

The tools for data collection capturing the three components of the CRG including the following were jointly developed in order to create convenience for data collection.

TB Gender Assessment Tool

The level of human rights and gender considerations in planning and implementation of existing programs in TB (and HIV/AIDS) and how it has been impacting the access of key population to TB and HIV services and (health) rights.

TB Legal Assessment

Helps in assessing the legal environment, laws, policies and regulatory frameworks which impact the TB response by influencing the access of Key and Vulnerable population to services and information as well as protection of rights.

Data for action – Key population

Help identify, prioritize, include and reach to the key and vulnerable populations in TB response as well as evidence on ample and accurate information on the key populations to develop plans to tackle disease burden of TB

Relevant questions were added keeping in view the existing situation of the national TB response mixed methods approach; involving both quantitative and qualitative data collection. The assessment provides benchmarking for output and outcome indicators and explores influencing and predictive factors related to gender aspects of TB and HIV care services, general health seeking attitudes and behaviours/practices.

Comprehensive literature review was carried out by the team of consultant working under the three sub-themes. They explored the existing situation regarding TB and HIV services in Pakistan. The online resource repositories including Google, Google Scholar, Pub Med, Elsevier, Journals of Public Health were used to explore the relevant information. Besides this with the help of the core group several meetings were held with the focal persons working in national and provincial TB responses.

For information gathering, the websites of department, ministries as well as national and international organizations i.e. UNAIDS, UN-Women, UNFPA, UNICEF, Rutgers WPF, USAID, DFID, Pathfinder, Population Council, and Rahnuma FPAP were also searched. Initially the coordinator APLHIV wrote to potential professionals to become part of the core-group and with consent the members the core group was formed followed by the agreement on terms of reference for the core group and endorsement of CN and agreement on CN proposed plan of action for the CRG roll-out in Pakistan. It was decided that all the data would be retrieved from program offices of NACP and NTP in Islamabad and also information will be retrieved from UN Women and UNAIDS. Focal persons from all the concerned departments and development partners were identified and approached for data collection.

Training of Data Collectors

A team of 04 data collectors was trained at APLHOV office covering the conceptual understanding; research methods with a particular focus on questionnaires of IDIs, KIIs and FGDs. They were then sent out to conduct the FGDs, KIIs and IDIs. The lead consultant conducted the KIIs, IDIs as well as FGDs in some critical areas of high importance.

Data Collection and Analysis

Data was collected from respondents on printed questionnaires used by the data collectors. The FGD guide was used to gather data from the participants of the focus group discussion and responses were recorded first on hard copy of the guide and then data entered manually. Same process was followed for the data collection of Key Informants and IDIs both at national and provincial level. The data collectors along with lead consultants visited Karachi, Lahore, Rawalpindi and Peshawar. The qualitative aspect was achieved through in depth interviews of key informants, government officials, civil society representatives, representatives of relevant donor and development partners, communities representing the key and vulnerable populations and relevant public health officials. Following is the summary of the data collected. UN colleagues and some of the members of the core –groups were approached through

Locations	FGDs	KIIs	IDI
Rawalpindi	1- MSMs	1- representative of the TG community CBO 2- Legal AID expert	TB/HIV Co-infected - 04

Islamabad	1- PLHIV	1- NTP Manager 2- CCM M&E officer 3- NGO working for TG rights 4- Law officer-Human rights wing	TB/HIV Co-infected – 02
Lahore	1- PLHIV Trans community (TB/HIV Co-infected) 2- Trans-community	1- Civil Society 2- Provincial TB Program 3- Association -TB	TB/HIV Co-infected – 07
Karachi	1- PLHIV (TB/HIV Co-infected) 2- MSMs		TB/HIV Co-infected - 04
Peshawar	1- PLHIV (TB/HIV Co-infected)		TB/HIV Co-infected 03

The data collected on the hard copies of the questionnaire was entered manually into the soft copies and then reviewed by the data collector. The data was triangulated at the level of data entry and then review.

The data after cleaning the error was entered manually into analysis sheet and analysed. Themes and sub themes were generated under the following headings.

1- Disease Burden, Social Environment and Behavioural information

2- Social, Political and Environmental determinants impacting the access to information and services and protection of health rights

3- Legal and Political Factors affecting TB response

4- GENDER (IN) EQUALITY and HUMAN RIGHTS BASED APPROACH IN TB POLICIES AND PROGRAMS

5-Inclusion and Participation in Planning for Decision making for equitable service provision under national TB response.

6-Resources Mobilization and Equitable Resource Distribution

Roll-out of Community Rights and Gender Tools in Pakistan By The APLHIV-Pakistan

7- Social protection and material assistance

8- Protection, privacy and confidentiality

9- Delivery and Acceptability of TB related services

FINDINGS OF THE ASSESSMENT

National level gender desegregated data on all key population in Pakistan is not available at country level. The proportion of various key populations under TB response at national level, therefore, cannot be ascertained. The monitoring and evaluation (M&E) system of NACP is trying to capture gender desegregated data as well as other demographics information related to risk, such as place to work, pregnancy status etc. for HIV/AIDS but no such information on TB is available at national level. Although the details assessment of the legal and gender determinants involved the three major key populations prioritised during the prioritization workshop; the literature review indicates that in Pakistan no organised efforts were made to enable any of the key population to access the TB services in an enabling environment with dignity, respect and affordable manner. During the literature review, prior to prioritization workshop, it was learnt that there are 3.4 million migrants in Pakistan¹⁰

Owing to deteriorating law and security situations and repeated military operations which led to huge displacement in tribal belts of Khyber Pakhtunkhwa in recent years, another 3 million people have been found to live as refugees and internally displaced population in Pakistan. ¹¹ These populations have huge vulnerability to tuberculosis from both economic as well as environmental reasons.

The situation with regards to prisoners and the detainees is no different. In 12 out of the 32 prisons of Punjab the biggest province of Pakistan, 161,021 prisoners for TB were screened and out of which 430 were confirmed to have tuberculosis and were getting free treatment. ¹²

Under Punjab TB Control Program, the diagnostic services are being freely provided in all jails. There were total 1448 presumptive cases of Pulmonary Tuberculosis among jail inmates during Q1 to Q3 in 2018 and in comparison only 244 cases were registered.

¹⁰ UN's International Migration Report 2017

¹¹ UNHCR, Population Statistics 2017

¹² Review of Health System in Prisons of Punjab - 2012

In order to assess the current HIV situation in Jails of Punjab and to ensure provision of treatment services, Punjab AIDS control Programme, Government of the Punjab Primary and secondary Healthcare Department in collaboration with the office of Inspector General Prisons, has conducted two complete rounds of screening of the entire jail Population of Punjab (First round 43032 screened and second round 40411 screened). The following table provides the findings of the screening in all including the Borstal institutions and juvenile jails as well as women jail in Punjab province.

Prevalence of HIV, HCV, HBV and Syphilis in Punjab Prisons	
HIV	2.34 %
HCV	14.30 %
HBV	2.85 %
Syphilis	3.16 %

Table 2- Prevalence of HIV, HCV and Syphilis in Punjab Prisons

The observations made during the desk review as well as the responses gathered from the FGDs, KIs and IDIs were categorised under the following subsets of information.

1- Disease Burden, Social Environment and Behavioural Information

Epidemiology of Tuberculosis in Pakistan

Globally of the estimated 10.4 million new cases, only 6.3 million were detected and notified in 2016, leading to a gap of 4.1 million cases. The global rate of TB case reduction remained at less than 2% and needs to accelerate to 4–5% by 2020 to reach the first of the "End TB Strategy" milestones.

Pakistan shares 62% of the disease burden of Eastern Mediterranean region of WHO. The disease kills almost 44000 Pakistanis every year and causes considerable economic loss. Pakistan with estimated disease case load of 525,000 new sensitive TB cases annually ranks 5th and with caseload of 27000 drug resistant TB cases ranks 6 among 30 high-burden countries. NTP along with PTP's notify, diagnose and treat about 366,061. Whereas the missing drug sensitive cases remain at about 166,000.¹³

¹³World TB Day 2018– Information Brochure National TB Control Program Govt of Pakistan

The data on TB disease burden was gathered through both assessments as well as the discussions with relevant M&E sections of both NTP and NACP and assessment of the data provided by the M&E sections. Estimated TB Incidence in Pakistan is 525,000 (44% in females and 56% in males). Majority, 89% of the patients are above the age of 14, in which around 207,000 are female and 261,000 are males. Only 11% of the patients are below the age of 14, in which 27,000 are girls and 30,000 are boys. ¹⁴

Estimates of Disease Burden	Number (000), Range		Rate (100K)	
Mortality (excludes HIV+TB)	54	(42-67)	27	(21-34)
Mortality (HIV+TB only)	2.2	(1.1-3.8)	1.1	(0.56-1.9)
Incidence (includes HIV+TB)	525	(373-704)	267	(189-357)
Incidence (HIV+TB only)	7.3	(3.6-12)	3.7	(1.8-6.2)
Incidence (MDR/RR-TB)	27	(17-39)	14	(8.8-20)

Unfortunately the data related to disease burden and its distribution with age and sex as well as category of the key population is not available in Pakistan. The standard reporting format fails to capture this type of information. The following table provides the maximum segregation for incidence of TB cases.

Gender	0 To 14 years	> 14 years	Total
Females	27 (25-29)-(48%)	207 (166-248)-(44%)	235 (185-284) - (44%)
Males	30 (28-32)-(52%)	261 (203-319) - (56%)	291 (223-359) - (56%)
Total	57 (61-63) (11%)	468 (329-607) (89%)	525 (373-704) - (100%)

TB Case Notifications – 2017

According to Global TB Report of 2018, there are 267 patients of TB in the population of 100,000, which is 525,000 in total population. Total number of mortality only from TB is 27 in the population of 100,000 which is 54,000 in total population. As far as the mortality in co-infection (HIV + TB) is concerned, the number is 2200 patients in total population in 2018. Estimated incidence of MDR TB cases is 27000.

Indicators	Number in thousands	Per 100,000
Mortality (excludes HIV+TB)	54 (42-67)	27 (21-34)
Mortality (HIV+TB only)	2.2 (1.1-3.8)	1.1 (0.56-1.9)

¹⁴Global TB Report 2018, WHO

Incidence (includes HIV + TB)	525 (373-704)	267 (189-375)
Incidence (HIV + TB only)	7.3 (3.6-12)	3.7 (1.8-6.2)
Incidence (MDR-RR/TB)	27 (17-39)	14 (8.8-20)

Source: (Global TB Report, 2018) page 198, World Health Organization

Health Facilities by Province

Free TB diagnostic and treatment services are available in more than 1700 public and private sector facilities across Pakistan. In 2016, around 69% of the estimated incident TB cases were notified and put on treatment. More than 90% of the TB patients notified are successfully treated. More than 120 advanced diagnostic facilities and 32 specialized treatment facilities have been established across the country for free of cost early diagnosis and treatment for MDR TB patients. In 2016 alone, 366,000 TB cases were notified and enrolled on treatment. We have a strong cooperation and partnership with the private sector. Today more than 3500 General Practitioners, 125 NGO health centres, 2,000 Pharmacies, 35 private hospitals and 45 Para-state hospitals in 88 districts are engaged in TB control. It is noteworthy that private sector is contributing towards 28 percent of total TB case notification in the country. There are total of 987 hospital working all over Pakistan along with 4962 dispensaries, 1135 MCH centres, 607 Rural Health Care, 4897 Basis health units. As for as the clinic for TB is concerned, they are 376 in numbers; 54 in Punjab, 186 in Sindh, 28 in KPK, 22 in Baluchistan, 67 in Azad Jammu and Kashmir, 17 in Gilgit Baltistan and 2 in Islamabad Capital Territory. Also 21 Art centres providing the services in HIV response are operational in Pakistan.¹⁵

Province	Hosp.	Disp.	MCH Centre	RHC	BHU	TB Clinic	ART Centre	Total
Punjab	304	1504	515	296	2455	54	11	5139
Sindh	334	2093	151	103	768	186	5	3640
KPK	202	562	141	100	942	28	2	1977
Balochistan	98	555	92	70	506	22	2	1345
AJK	17	100	177	33	194	67	0	588
GB	25	107	55	2	18	17	0	224

¹⁵- NHIRC Pakistan

ICT	7	41	4	3	14	2	1	72
Total	987	4962	1135	607	4897	376	21	12985

Table 3- Health facilities in Pakistan

The treatment outcomes of the intervention are provided below.

Quarter of your 2017	Cure %	Completed %	Lost to follow up %
Q1	28	65	3
Q2	26	67	3
Q3	26	67	3
Q4	26	67	3

Table 4- Treatment outcomes of incident TB cases – 2017

As per the data of National TB Control Program in 2017, a total of 368,979 cases were notified as confirmed TB with 26,150 (7%) screened for HIV. These number were 366,061 and 13092 (4%) in 2016, 331,780 and 12,162 (8%) in 2015, 316,577 and 10,715 (3%) in 2014, 298,980 and 8,306 (3%) in 2013, 285,396 and 10,423 (4%) in 2012.

Years	All Notified	Screened for HIV		Reactive Cases
2012	285396	10423	4%	17
2013	298980	8306	3%	49
2014	316577	10715	3%	90
2015	331780	12162	8%	59
2016	366061	13092	4%	71
2017	368979	26150	7%	127

Table 5- Screening of HIV in Notified TB Cases

Trends Regarding Incidence of TB In Pakistan

Data source of World Bank shows that from 2000 to 2017, TB incidence rate is a bit decrease from 275 to 267. Interesting in 10 years from 2003 to 2012, the incidence rate is same as of 276.¹⁶

¹⁶- Worldbank.org/indicator/SH.TBS.INCD

When respondents were asked about the trend in knowledge and access to TB services and HIV/TB co-infection; the respondents of the in-depth interviews added that there has been an overall improvement.

"I think knowledge in urban setting has improved and so had access to care but importantly the free medication is an important determinant of success but a lot has to be done in order to reach and include everyone" A co-infected added. Another one shared "Slightly better now. Counselling is given at the start of treatment. Free treatment and medicine."

TB patients who are PLHIV

Figure shows in 'UNAIDS Data 2018' that estimated 150,000 people are suffering from HIV/AIDS (all ages) across the Pakistan. That figure was 66,000 and 12,000 in 2010 and 2005, respectively. The HIV/AIDS prevalence is more than twice as high in males compared to females (ratio 70% to 30%); consistent with notification data from routine surveillance (NACP).

No. of PLHIVs suffering from TB (Pulmonary, extra pulmonary) and currently on ARVs i.e. have received ARVs in past six months						
Provinces	Male	Female	TG	Children		Total
				Male	Female	
Federal	3	0	0	0	0	3
Punjab	440	77	4	5	2	528
Sindh	211	40	6	8	4	269
KPK	32	5	0	0	1	38
Balochistan	17	2	0	0	0	19
Total	703	124	10	13	7	857

Table 6- TB patients on ARVs

HIV/AIDS Awareness and Knowledge

Pakistan Demographic and Health Survey 2017-18, shows a series of questions asked of both women and men that addressed respondents' knowledge of HIV prevention; their awareness of modes of HIV transmission; and behaviours that can prevent the spread of HIV.

67% of men and 32% of women have heard of AIDS (data not shown). 46% of men and 18% of women age 15-49 know that consistent use of condoms is a means of preventing the spread of HIV. Limiting sexual intercourse to one faithful, uninfected partner can reduce the chance of contracting HIV, 58% men and 25% of women go with this statement. The proportions of men and women who know that limiting sexual intercourse to one uninfected partner and both using condoms are means of preventing HIV are 42% and 16%, respectively.

Awareness on TB Sign and Symptoms, Factors, Disease Distribution and Health Seeking Behaviour

It has been found in most of surveys in Pakistan that people have some knowledge regarding identification of TB symptoms, place of treatment and about transmission/spread but no accurate information has been identified previously. In this study, among the participants different responses were recorded and varied depending on their medical condition, sexual characteristics and geographical locations. Participants shared different perspectives with regards to knowledge and skills related to signs and symptoms and prevention of Tuberculosis and HIV. In their opinion 20% TB/HIV co-infected knew about symptoms; transmission and place of treatment when asked. They viewed that some 10-20% HIV positive had knowledge about the disease and the associated factors which contributes to acquisition of tuberculosis. They enumerated the following factors as leading contributing factors (with maximum frequencies quoted by the respondents) for acquisition of Tuberculosis.

S.No	Contributing factors of Tuberculosis reported by the respondents
1	Unemployment
2	Health Seeking Behaviour
3	Malnutrition
4	Air pollution
5	Sharing work place/ home
6	Weak immunity
7	Stress

Table 7- List of contributing factors of TB

Among the respondents in cities like Islamabad, Lahore, Karachi, Peshawar and Karachi the respondents added that 70% of literate MSMs are found to be aware of TB and its symptoms, transmission, spreading through (addiction) and risk factors through awareness sessions conducted by NGOs and community based organizations. Amongst the key populations included in the study the respondents of

both FGDs and IDI added that only 5% Transgenders had any adequate awareness of the accurate information (symptoms, spread, risk factors and right place of treatment) regarding the disease (TB). Almost all respondents added that awareness level of the PLHIV especially the co-infected is seen to be higher with regards to tuberculosis sign and symptoms; mode of transmission as well as information related to treatment. They participants of the KIIs which included service providers and program planners as well as civil society activists guessed that more than 50 % of the PLHIV are reportedly aware of sign and symptoms of tuberculosis however the respondents of the in-depth interviews which comprised of the key populations especially the co-infected individuals indicated that less than 10% of the trans-community and as much as 40 to 70 % of the MSMs depending upon the literacy level and opportunities and access to information are aware of the signs and symptoms of tuberculosis.

With regard to correct information of preventing HIV through sexual transmission and rejection of misconceptions about HIV, the cumulative data from KIIs, IDIs as well as FGDs is suggestive of a significantly important awareness prevailing among literate and trained MSMs and PLHIV. when asked 80-100% of the TB HIV co-infected, PLHIVs, MSMs were reportedly found to be aware of the fact that it can be prevented through condoms and by avoiding sharing of syringes/injections and razors of infected people. Misconceptions were reported to be widespread in all key populations of TB response across Pakistan. The respondents added that although they are personally aware of the mode ad means of transmission yet the larger proportion of the communities they represent living with HIV and TB who were aware of prevention methods believed in misconceptions like sharing meals and using cooking utensils of those infected with HIV can transmit disease to the other person.

“The main reason of not maintaining safe sex behaviour in “sex work” is that majority (95%) of customers/clients demand sex service without using condom, they even offer more money if we reject to have sex without condom use. Safe sex behaviour may be practiced by 6 to 7 % people of the community’’. (TGs)

When asked about condom role in reducing risk of getting HIV while having sex, respondents of FGDs, KIIs and IDIs added that almost majority (ranging between 40% to 90% of the all key populations are aware of the fact that condom contributes in reducing risk of HIV transmission.

The health seeking behaviours was quoted to be influenced by the literacy, awareness level, and the personal preferences. Despite knowing the fact and

reality, hardly anyone uses it while having sex because of sexual pleasure. A group of Transgenders in Lahore shared some additional information and reason about refraining condom usage and linked it to sexual pleasure and client satisfaction. They said 95% customer demands to have sex without using condom for both personal sexual pleasure of client and it also benefits us in monetary terms-client offers more money.

During discussion and interviews with participants' responses were recorded and they shared their views regarding relationship between TB and HIV. 30-40% of the key populations especially the MSMs and PLHIV were reported to have known about the relationship of TB with HIV but these are the ones who were informed about this relationship during any training /orientation conducted by a CBO or NGO. While responding to the question related to this relationship, some presumably shared that HIV positive persons' immunity weakens so any infection or disease can easily attack a person. Moreover less than 40% of PLHIV co-infected group shared same point of view that there is a relationship but unable to explain it.

When the opinion on locations of higher prevalence/incidence of TB and HIV/TB was sought from the respondents majority of the respondents added that TB prevalence was found to be higher in rural areas because of lack of access to both knowledge and services, other argues that in urban setting where people live in congested localities are more vulnerable to acquire TB therefore prevalence may be higher in urban and peri-urban settings.

2- Social, Political and Environmental Determinants Impacting The Access To Information And Services And Protection Of Health Rights

Different perspectives were recorded regarding social determinants that put an impact on access to information and health services as well as protection of health rights. Participants were given some factors (economic vulnerability, incarceration, malnutrition, smoking, indoor air pollution, drug and alcohol use, poor housing, and unemployment) which they believe are detrimental in putting an impact on access to information and health services as a result increases vulnerability to TB. Apart from the aforementioned factors, different perspective and experiences were shared by different groups. Some-TBHIV co-infected believed people working in industries, exposed to environmental pollution and professional shepherds are more likely to have TB. Second group of participants-PLHIV, regarded Economic vulnerability/financial issues, attitude of healthcare providers, poor housing, sharing places and joint family system as contributing factor for spreading of TB especially in rural and poor areas. While Transgenders in Lahore considered self-stigma as main

reason which hinders accessibility to health services. They further added that if a community member is diagnosed with HIV or TB, the stigma and discrimination person faces in community make situation tough for the diseased and often leads to isolation in their closed groups. Similarly, PLHIV pointed out smoking, kitchen sharing (common usage of utensils) and people who eat from hotels as social determinant which impacts access to information and health services.

“Care of the affected persons and concealment of one status due to stigma carries a risk and vice versa when the affected person is stigmatized. Joint family system-Poor Health Seeking Behaviour. Smoking; Sharing of utensils; Unemployment... In aghish most of the key populations like MSWs as well as TGs would leave the home which is a double jeopardy. Concealing the status is also a double jeopardy among these populations. 30 to 35 % people leave house just because of stigma. Malnutrition is another factor”

“Self-stigma is the main reason of not accessing health services as the patients already perceive the stigma attach to TB and HIV patients within the community. If a community member is diagnosed HIV or TB the stigma and discrimination he/she faces within the community is of the worst extent; ignored and rejected either isolated by their close group”.

(TGs Lahore)

PLHIV co-infected held all the social determinants/factors (economic vulnerability, incarceration, malnutrition, smoking, indoor air pollution, drug and alcohol use, poor housing, and unemployment) mentioned at the start of discussion are responsible which puts impact on access to information and health services as well as protection of health rights. There was also suggestion that discrimination of TB patients persisted even after cure, which could be due to inadequate knowledge on the curability of TB.

According to MSMs Poor Health seeking behaviour; Smoking; Sharing of utensils with affected person congested localities with poor ventilation; Unemployment; Malnutrition, physical disability to access test and medication were regarded as social determinant impacts access to information and health services.

;

“The govt has setup mobile clinics and different health centres are in place in different cities to prevent and end both TB and HIV”. MSMs group Lahore

Most interestingly one of the respondents working in a key position also indicated towards the need of reliable data coming from accurately undertaken scientific research in this regard. He stated" **We don't have sufficient data to reach any inference yet I believe malnutrition and economic vulnerabilities are most important. Although, they affect the individual mostly but ultimately the family as well. With inflation increasing day by day, the economic vulnerability affects the already malnourished disproportionately; at individual level productivity is reduced hence health is endangered. At household level, household economy is affected as number of working members is reduced in order to take care of the sick. Ultimately government has to spend more resources on the health which it does not.**"

In terms of most quoted responses regarding the social determinants which impact the access to information and services as well as risks and vulnerability to tuberculosis, the following table represents the social determinants.

S.No	Social and Environmental Determinants
1	Economic Vulnerability / lack of economic opportunities /Poverty/unemployment
2	Illiteracy resulting in stigma and discrimination
3	Joint family system sharing kitchen, utensils and common living areas
4	Poor housing; water and sanitation and transport
5	Poorly ventilation; crowded spaces; poor transport
6	Lack of nutritious food
8	Household and environmental smoke, smog and fog in winter

Table 8- Social determinants contributing in spread of TB in Pakistan

When asked about what personal, family or societal factors contribute in acquisition of tuberculosis, following factors were enumerated.

S.No	Behavioural Determinants
1	Poor health Seeking behaviour
2	Smoking
3	Lack of prioritization of personal health
4	Poor dietary habits

5	Lack of prioritization of health at household level
6	Poor environmental and personal hygiene

Table 9- Behavioural Determinants

3- Legal and Political Factors Affecting TB Response

There are instances when legal environment-laws/policies and frameworks either support or hinder in accessing and utilization of preventive and curative services as well as continuum of care with regard to TB response in many countries. Different insights were explored from pertinent groups (PLHIV, TB HIV Co-infected, TGs, and MSMs) as well as services providers, civil society organizations and key informants including the judiciary and focal person in ministries dealing with human rights about legal frameworks and policies, basic health policies, and other general government policies in relation to HIV, TB, HIV/TB, or DR-TB. Majority of the groups at different locations shared identical responses like there are no specific policies included in the health sector which are meant to empower and enable the different groups of key populations/communities in planning through implementation and observation of enactment of legal apparatus and laws in this country with a particular and explicit focus on access to healthcare.

Given the diversity in both prioritization and planning for health interventions among all four provinces as well as the Islamabad Capital Territory, it is imperative to have a common but contextualized understanding of the nomenclature used to ensure right based approach as well as gender sensitivity in initiation through planning and implementation as well as participatory monitoring involving communities under national TB response. An understanding of the legal frameworks in the four provinces would be necessary to develop convergence in developing a uniform, palatable but proper understanding of the state of a “rights-based” approach to TB. This is especially important because the after the 18th Amendment to the Constitution of Pakistan with devolution, the state of Pakistan constitutionally committed to delegate the decision making with regards to a number of health-related issues from concurrent national and provincial legislative power, thus bringing them under the exclusive power of provincial assemblies.

The Epidemic Diseases Act of 1958 and the Epidemic Diseases (Amendment) Act of 2011 seem to grant broad authority to provincial authorities to take measures and prescribe regulations to address epidemic diseases if “ordinary provisions of the law for the time being in force are insufficient.” What those “ordinary provisions of law” are remained unclear during this course of assessment. The use of phrase **Epidemic** is conspicuously misfit is used in association with national TB response as the inclusion

of TB in epidemic diseases cannot be justified keeping in view the control measures as well as perceived risks to social mobilization for improved uptake of TB services.

Articles Of Constitution/Laws Related To Human And Health Rights In Pakistan

The following table presents the summary of all articles of the constitution and different laws which are directly or indirectly related to protection of human rights and legal aspect of healthcare in Pakistan.

Summary of article of the constitution/laws related to human and health rights			
No	Article No and description	Summary	TB and this Article
1	(8) Laws inconsistent with or in derogation of fundamental rights to be void.	Any law against inconsistent with the fundamental rights provided in Constitution is void	This will help to deal with laws that violate the Basic fundamental rights of people with TB. PLD 2007 S.C 642
2	(9)Security of person	No person shall be deprived of life or liberty save in accordance with law	This will help to people with TB not to be treated as arbitrary or not to be detain and isolated and not to be deprive from life. Word life is very significant as it covers all facts of human existence. Life includes all such amenities and facilities which a person born in free

			<p>country is entitled to enjoy with dignity, legally and constitutionally</p> <p>(PLD 2002 Lah 55)</p> <p>Duty of the state is to see that the life of a person is protected as to enable him to enjoy it within the prescribed limits of law. Pollution, environmental, degradation and impure food items also fall in the category of deprivation of life (2005 SCMR 1)</p>
3	(10) Safeguards as to arrest and detention	No person who is arrested shall be detained in custody without being informed, as soon as may be, of the grounds for such arrest, nor shall he be denied the right to consult and be defended by a legal practitioner of his	<p>This is relevant if people with TB are arrested or detained for treatment or criminalized and gives right to consult with legal practitioner.</p> <p>(PLD 1965 LAH 112DB)</p> <p>(PLD 2003 S.C 442)</p>

		choice.	
4	(10A). Right to fair trial	This article provided right of fair trial for every citizen without any discrimination or bar	If TB patients are arrested are detained for treatment or criminalized then this article is available for their fair trial and remedy
5	(14) Inviolability of dignity of man, etc	(1) The dignity of man and, subject to law, the privacy of home, shall be inviolable. (2) No person shall be subjected to torture for the purpose of extracting evidence.	This right is available also for TB patients he could not be forced for treatment
6	(15) Freedom of movement, etc.	Every citizen shall have the right to assemble peacefully and without arms, subject to any reasonable restrictions imposed by law in the interest of public order.	This right is also available to people with TB, there is no restriction on movement and assembly
7	(17). Freedom of association:	(1) Every citizen shall have the right to form associations or unions, subject to any reasonable restrictions imposed by law in the interest of sovereignty or integrity of Pakistan,	Every citizen having TB also have the right to form associations or unions, subject to any reasonable restrictions imposed by law in the interest of sovereignty or integrity of Pakistan, public order or morality.

		<p>public order or morality.</p> <p>(2) Every citizen, not being in the service of Pakistan, shall have the right to form or be a member of a political party, subject to any reasonable restrictions imposed by law in the interest of the sovereignty or integrity of Pakistan and such law shall provide that where the Federal Government declares that any political party has been formed or is operating in a manner prejudicial to the sovereignty or integrity of Pakistan, the Federal Government shall, within fifteen days of such declaration, refer the matter to the Supreme Court whose decision on such reference shall be final.</p>	
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		(3) Every political party shall account for the source of its funds in accordance with law.	
8	(18) Freedom of trade, business or profession.	Subject to such qualifications, if any, as may be prescribed by law, every citizen shall have the right to enter upon any lawful profession or occupation, and to conduct any lawful trade or business	This will help to people with TB to join any profession or trade, however there is stigma and discrimination towards join and professions
9	(19) Freedom of speech, etc.	Every citizen shall have the right to freedom of speech and expression, and there shall be freedom of the press, subject to any reasonable restrictions imposed by law in the interest of the glory of Islam or the integrity, security or defence of Pakistan	This right will help the people with TB to share their views and freedom of speech
10	(19A). Right to information:	Every citizen shall have the right to have access to information in all matters of public importance subject to regulation and reasonable restrictions imposed by law.	This is a useful provision that allows or dissemination of correct information relating to matters of TB

11	(25) Equality of citizens.	All citizens are equal before law and are entitled to equal protection of law.	There shall be no discrimination on the basis of TB
12	(25A). Right to education:	The State shall provide free and compulsory education to all children of the age of five to sixteen years in such manner as may be determined by law.	There should be no discrimination with TB people, every person has right of education
13	(26). Non-discrimination in respect of access to public places.	In respect of access to places of public entertainment or resort not intended for religious purposes only, there shall be no discrimination against any citizen on the ground only of race, religion, caste, sex, residence or place of birth.	At national level there is no discrimination for people with TB however at International level there are restrictions for people having TB
14	(27)Safeguard against discrimination in services.	No citizen otherwise qualified for appointment in the service of Pakistan shall be discriminated against in respect of any such appointment on the ground only of race, religion, caste, sex, residence or place of birth:	There is discrimination at Jobs in Pakistan for people having TB; there are many official jobs in which medical are mandatory. (2000 SCMR 1956)

Table 10- Articles of the constitution/laws related to human and health rights

Principles Of Policy

It is pertinent to mention here, that an obligation has been cast on the state with regard to health care in the form of Principles of Policy, in Chapter 2 of the Constitution.

Article 29 of the Constitution provides that it is the responsibility of each organ and authority of the State and each person performing such functions on behalf of such organ or authority to act in accordance with the Principles of Policy in so far as they relate to the functions of such organ or authority. Article 29 also casts an obligation on the President in relation to the affairs of the Federation to procure the preparation and provision to the Parliament each year, a report on the observance and implementation of the Principles of Policy. A similar duty is also cast on the Governor of each Province to provide a similar report on a yearly basis to the Provincial Assembly, in relation to the affairs of his respective province.

1.3.3 The Principles of Policy are provided in Article 31 to 40 of the Constitution and are as follows:

- (a) Islamic Way of Life; which may impact mobility of KPs in accessing health services
- (b) Parochial and other similar prejudices to be discouraged;
- (c) Full participation of women in national life;
- (d) Protection of Family etc.
- (e) Protection of Minorities; excluding sexual minorities
- (f) Promotion of Social justice and eradication of social evils;
- (g) Promotion of Social and economic well-being of the people;
- (h) Participation of people in Armed Forces; and
- (i) Strengthening bonds with Muslim world and promoting international peace.

The rights in Part II Chapter 1 are justifiable by the expressed terms of Articles 8 and 199. Pakistani courts have read the rights to life and dignity, as

entrenched in articles 9 and 14, expansively. The Supreme Court in *Zia v. WAPDA* said “The word ‘life’ in the Constitution has not been used in a limited manner. A wide meaning should be given to enable a man not only to sustain life but to enjoy it.”

The Court continued:

“The Constitution guarantees dignity of man and also right to life under Article 9 and if both are read together, question will arise whether a person can be said to have dignity of man if his right to life is below bare necessity like without proper food, clothing, shelter, education, health care, clean atmosphere and unpolluted environment. Such questions will arise for consideration which can be dilated upon in more detail in a proper proceeding involving such specific questions.”

However it is important to note that fluidity and implicit interpretations as well as generalizability of such legal phrases as well as verdicts when it comes to acquirement of legal support for protection of human rights in issues like TB response by insinuation to such precedence of judgments.

True to the Court’s prediction, subsequent cases have since expanded on the importance of the rights to life and dignity for health. Justice Nasir Aslam Zahid has argued that broad interpretation of the right to life has meant that “all the socioeconomic rights contained in the Principles of Policy have become part of the right to life under Article 9 (a fundamental right) and, therefore, enforceable through the Courts.” A succinct canvas of case law enforcing the right to health by way of the rights to life and dignity would provide an understanding of the potential for the vindication of health rights (or health-related rights) in Pakistani courts.

Article 38 of the Constitution provides that “The State shall” promote the social and economic well-being of people including by “secur[ing] the well-being of the people ... by raising the standard of living” and “provid[ing]

basic necessities of life, such as food, clothing, housing, education and medical relief for all such citizens, irrespective of sex, caste, creed or race, as are permanently or temporarily unable to earn their livelihood on account of infirmity, sickness or unemployment."

That the Health related rights are not included in the Fundamental Rights provided in constitution. "Therein shall be guaranteed fundamental rights, including equality of status, of opportunity and before law, social, economic and political justice, and freedom of thought, expression, belief, faith, worship and association, subject to law and public morality"

In Article 9 of the Constitution of Pakistan word Life is provided which is explained by the Supreme Court of Pakistan in case laws which includes Health Rights for every Citizen of Pakistan.

Amendment in Constitution of Pakistan is required to provide and confirm Health Rights as Fundamental Rights for every citizen of the State.

It is pertinent to mention here that nothing is mentioned about TB, treatment and safeguard as a right in Constitution.

Treatment and protection from TB should be provided in Constitution and be protected as Fundamental Rights.

[The Transgender Persons \(Protection of Rights\) Act, 2018](#)

Pakistan is the only country which passed the transgender Act ensuring their health rights, identity, fundamental rights and a full code for their protection. Main Section relevant to health and other issue with remedied are given below.

Sec. 2(1) (a).The Transgender Persons (Protection of Rights) Act, 2017.

Sec. 2 (1) (d): "**complainant**" means a Transgender person who has made a complaint on being aggrieved by an act of harassment; or any offence against his rights;

Sec. 2 (1) (e). "**Gender identity**" means a person's innermost and individual sense of self as male, female or a blend of both or neither; that can correspond or not to the sex assigned at birth.

Sec. 2 (1)(f). "**Gender expression**" refers to a person's presentation of their gender identity, and/or the one that is perceived by others,

Sec. 2 (1)(h). "**Harassment**" includes sexual, physical, mental and psychological harassment which means any aggressive pressure or intimidation intended to coerce, unwelcome sexual advance, request for sexual favours or other verbal or written communication or physical conduct of a sexual nature or sexually demeaning attitudes causing interference with living, mobility or work performance or creating an intimidating, hostile or offensive work or living environment including the attempt to punish the complainant for refusal to comply with such requests or to bring forth the complaint

Sec. 2 (1)(n). "**Transgender Person**" is a person who is:-

Intersex (khusra) with mixture of male and female genital features or congenital ambiguities; or

(ii) Eunuch assigned male at birth, but undergoes genital excision or castration;
or

(iii) A transgender man, transgender woman, Khawja Sira or any gender identity or gender expression differs from the social norms and cultural expectations based on the sex they were assigned at the time of their birth.

RECOGNITION OF IDENTITY OF TRANSGENDER PERSON

Sec. 3. Recognition of identity of transgender person.-

(1) A transgender person shall have a right to be recognized as per his or her self-perceived gender identity, as such, in accordance with the provisions of this Act.

(2) A person recognized as transgender under sub-section (1) shall have a right to get himself or herself registered as per self-perceived gender identity with all government departments including, but not limited to, NADRA.

(3) Every transgender person, being the citizen of Pakistan, who has attained the age of eighteen years shall have the right to let himself or herself registered according to self-perceived gender identity with NADRA on the CNIC, CRC, driving license and passport in accordance with the provisions of the NADRA Ordinance, 2000 (VIII of 2000) or any other relevant laws'

(4) A transgender person to whom CNIC has already been issued by NADRA shall be allowed to change the name and gender according to his or herself-perceived identity on the CNIC, CRC, driving licence and passport in accordance with the provisions of the NADRA Ordinance, 2000 (VIII of 2000).

4. Prohibition against discrimination,-No person shall discriminate against a transgender person on any of the following grounds, namely:-

(a) The denial or discontinuation of or unfair treatment in, educational

Institutions and services thereof;

(b) The unfair treatment in, or in relation to, employment. Trade or occupation

(c) The denial of, or termination from, employment or occupation;

(d) The denial or discontinuation of or unfair treatment in healthcare Services;

(e) The denial or discontinuation of unfair treatment with regard to, access to, or provision or enjoyment of use of any goods, accommodation, service, facility,

benefit, privilege or opportunity dedicated to the use of general public or customarily available to the public;

(f) The denial or discontinuation of, or unfair treatment with regard to, right to movement, safe travel and use of public facilities of transportation;

(g) The denial or discontinuation of, or unfair treatment with regard to, the right to reside; sale, purchase, rent or otherwise occupy or inherit an., movable and immovable property;

(h) The denial or discontinuation of or unfair treatment in, the opportunity to stand for or hold public or private office; or

(i) The denial of access to, removal from, or unfair treatment in, government or private establishment, organizations, institutions, departments, centres in whose care, custody or employment a transgender person may be.

5. **Prohibition against harassment.**-Harassment of transgender persons, as defined in this Act, both within and outside the home, based on their sex, gender identity and gender expression is prohibited.

6. **Obligations of the Government.**-The Government shall take following steps to secure full and effective participation of transgender persons and their inclusion in society, namely:-

(a) Establish protection centres and safe houses to ensure the rescue, protection and rehabilitation of transgender persons in addition to providing medical facilities, psychological care, counselling and adult education to the transgender persons;

(b) Establish Separate prisons, jails, confinement cells, etc for the transgender persons involved in any kind of offence or offences;

(c) Institute mechanisms for the periodic sensitization and awareness of the public servants, in particular, but not limited to, law enforcement agencies and medical institutions, relating to the issues involving the transgender persons and the requirement of protection and relief of such persons;

(d) Formulate special vocational training programmes to facilitate, promote and support livelihood for transgender persons:

(e) Encourage transgender persons to start small business by providing Incentives, easy loan schemes and grants; and

(f) Take any other necessary measures to accomplish the objective of this Act.

Sec.12. Right to Health.-The Government shall take the following measures to ensure non-discrimination in relation to transgender persons, namely:-

(a) To review medical curriculum and improve research for doctors and nursing staff to address specific health issues of transgender persons in cooperation with PMDC;

(b) To facilitate access by providing an enabling and safe environment for transgender persons in hospitals and other healthcare institutions and centres;

(c) To ensure transgender persons access to all necessary medical and psychological gender corrective treatment.

Sec.16. Guarantee Of Fundamental Rights

(1). In addition to rights mentioned in this Chapter, fundamental rights mentioned in Part II of Chapter I of the Constitution of the Islamic Republic of Pakistan shall be available unequivocally for every transgender Person.

(2) It shall be the duty of the Government to ensure that the fundamental rights mentioned in sub-section (1) are protected and there shall be no discrimination for any person on the basis of sex, gender identity or gender expression.

Sec.17. Offences and penalties

(l) Whoever employs compels or uses any transgender person for begging shall be punishable with imprisonment which may extend to six months or with fine which may extend to fifty thousand rupees or with both.

Sec.18. Enforcement Mechanism

In addition to the remedies available under the Constitution or The Pakistan Penal Code 1860 (Act XLV of 1860), the Code of Criminal Procedure, 1898 (Act V of 1898) or the Code of Civil Procedure 1908 (Act V of 1908), the aggrieved transgender person shall have a right to move a complaint to the Federal Ombudsman, National Commission for Status of Women and National Commission of Human Rights (NCHR) if any of the rights guaranteed herein are denied to him or her.

Majority of the respondents reported to believe that there is not any policy. Legal frameworks or general health policy which exists to help and benefit the

communities and key and vulnerable population against the preventable diseases including the tuberculosis with legal and policy support. Participants even doubted ability and competency of policy maker to make such policies regarding HIV and TB. Participants rather shared recommendations which could benefit them in future. The only group aware about a framework/policy was TGs quoted to have TG bill passed; although majority of the respondents even shared that TG itself does not protect the rights of TGs to healthcare or prevention against any infection including tuberculosis. However it is pertinent to note that laws which are related to homosexuality and socially forbidden deeds directly influence the access of some of the key populations to both TB and HIV services.

Recommendations:

- That Transgender Persons (Protection of Rights) Act, 2017 nothing is mentioned about TB specifically. There should be an amendment regarding TB treatments, diagnoses and protocols. As per discussions although the act has been passed but it is not implemented in its true sense.
- There should be separate Medical Receipts mentioning TGs category
- Separate WARDS
- Doctors for TGs
- Free medication
- Awareness sessions for TB and Legal rights
- Awareness about TG Act 2018

For state and provincial policy makers

- Acknowledge transgender community affected with TB, in developing policies, systems protocol and service delivery with 0 discrimination.
- Public and private insurance programs should be initiated by the Govt. for TGs having TB.
- The health Sector Strategy 2010-2017 has not mentioned about TGs , the strategy must reviewed for inclusion of transgender health and TB treatment during revision.
- Non Govt Organizations should have programs in partnership with the Govt. organizations to empower and educate the TG people about TB, treatment, care and symptoms.
- There is discrimination and harassment in treatment centers.
- People with TB or their representatives should be provided with legal aid to be able to use existing legal mechanisms to hold the private sector accountable in cases of negligence
- Treatment literacy programs related to TB should be implemented through methods of mass communication to empower current and future patients with sufficient knowledge to understand their own

treatment and care and safeguard themselves from misdiagnosis and incorrect treatment

That TGs community is uneducated and badly neglected by society. Although TG Act ensuring their Health and fundamental rights but 90% of TG people are not aware about existing laws. They are not aware about provisions of Transgender Act, their rights and forums for the enforcement of provisions.

“The laws which discriminate our gender identity and sexual behaviour affect the access of the KPs to access health services” One advocate from among the TG shared during the key informant interview.

“Even if there is law the laws are not translated into actions that could ensure the provision of HIV or TB services to us in a respectable manner. Laws are also required to ensure access of KPs to services with safety and dignity. Social Media can be a good platform to improve the awareness of the KPs on laws and strategies developed for them. Non existence of law that could take care of every human being is a biggest challenge for us as it prevents the equity and equality in health”.

“The laws of our country are very punitive against trans genders as we are not being given equal opportunities as compared to the general populations. The govt must introduce special laws to protect our community which ensure equal opportunities in the country for TGs”. **(TGs)**

It can be inferred from the responses gathered from IDIs, KIs and FGDs that supportive laws which could impact the access of KPs to TB and HIV services under the emblem of human rights and gender equality are almost non-existent and by design and intent fail to provide fulcrum for protection of human rights in a legal perspective. The policy and strategic direction, although after devolution in Pakistan rests with provinces, and even if there is national strategic plan for TB response in Pakistan, the entirety of national TB response is to realise the need and importance of inclusion of legal and policy support for key and vulnerable population in its strategic plans.

“No idea about law but lack/non existence of these laws aggravates our tension. Had there been any law and judicial activism we would have at least expected something from this state.”

By legal means involuntary isolation, quarantine or detention of people with TB is not practiced in Pakistan but self stigma and intra family pressures may force the patients from key populations to remain isolated. This is more evidently seen even in case of trans-communities.

The key populations felt less hopeful with the law enforcement agencies as well with regards to protection of their civic rights and access to health services.

“Police attitude is not good with us .They abuse, beat and snatch all our stuff without any reason whenever wherever they want .e.g. (personal experience) We around 4 friends were roaming on road suddenly police came they stopped us behaved rudely, asked irrelevant questions, in a mean while they started abusing and beating us and took our all money which we had earned on that day” One TG respondent added

With regards to access to healthcare the law(s) neither exist nor we can conclude what would it have been had it been there. It is silent and does not take into account of the care most of the KPS require.

With regards to the government's commitment in working towards implementing the international treaties and declarations; the key informants as well as the participants of the FGDs doubted over the sincerity of the government by alluding towards governments face saving tactics at international level. In true letter and spirit the government continue to show commitment but then they don't do what is required at the implementation level.

Although there is not a single national human rights monitoring system in healthcare related cases but there is representations from KPs as well as the national TB association in Pakistan in CCM that undertakes the role of watchdog. It also conducts the patients exit interviews in field monitoring (undocumented) to see the cases of violations. In case of violations of health rights, harassment and discriminatory attitude, the MSMs and PLHIV usually report to APLHIV but this is limited to those who have at least minimal understanding of the issues.

“We don't know, if there are no specific laws. How come we can argue about its supportive or punitive in nature”. **(PLHIV Islamabad)**

“Every one of us has been subjected to imprisonment and police punishment more than once. Even the police take all the money from us. The laws are not supportive for our community in all matters other than access to HIV and TB services even”. **(TGs)**

Stigma & Discrimination and impact on TB response

Different bodies work across the country to counter stigma and discrimination against key vulnerable populations. There is no formal mechanism in strategic plan of TB response to counter the stigma and discrimination but APLHIV provides one common platform for all of the key population under HIV response. During the study most the groups were unaware of the entities working on prevention of stigma and discrimination.

“No platform as such till yet working for us”.**(PLHIV)**

“We don't know; even if there are entities, the law is less helpful as it remains vague in many aspects” **(PLHIV)**

“We report every issue and problem we face in the society to Khajasara society (KSS) who support us against every issue we face in society”. **(TGs)**

“Naz male health alliance & APLHIV”. **(MSMs)**

TGs and MSMs mentioned *Khawja Sira society* as platform where they report such issues and *Naz male health alliance and PLHIV* respectively.

Stigma and discrimination in general population against PLHIV is shown in various surveys. The Demographics and Health Survey (PDHS) 2012-13 reported overall, 17% of women and 15% of men expressed accepting attitudes of PLHIV. The Stigma Index assessment was carried out in 2010 by APLHIV. In this assessment, a sample of

833 PLHIV was interviewed. Results of stigma index assessment showed that majority of patients were poor, without any employment opportunities resulting due to discrimination against their HIV status. The APN+ regional study undertaken in 2013 was also done by APLHIV. It looked at the access, initiation and adherence of ART. Results showed that 49.2% of respondents (n=525) reported to have denied medical services due to their HIV status; another 40% experienced some type of housing instability (forced to change place of residence or unable to rent accommodation because of their HIV status) and 25% reported their children were prevented, dismissed, or suspended from attending school in last 12 months. ¹⁷

Perceptions of the patients about care provided by the health care providers at health facilities/ private clinics were generally found unsatisfactory and somewhat discriminatory. Majority of respondents stated that the care was not good or they encounter problems during their consultations with doctors or who could not diagnose their disease properly and early. They shared instances when HCPs didn't hesitate to harass or even abuse us.

“Yes. They abuse even in some cases”. **(MSMs)**

“Create awareness and sensitize them all specially to Health care providers treat us like human beings and take care of our Human Rights. Use media for awareness and sensitization”. **(PLHIV)**

Participants also stressed on creating awareness especially to health care providers to treat them as human beings. Moreover, suggested to use media for awareness/sensitization. In addition to the aforementioned suggestions they added that HCPs must be trained on health and human rights and rights of patients and ethical parameters. They should ensure the completeness of information being provided to patients, preventive care, and information on drug regimens and care and use of medicine.

¹⁷- HIV and TB response through gender lens- UNAIDS Document

“Many HCP themselves don't know how do TB and HIV spread and how it does not. They must be trained. They should ensure the completeness of information, preventive care, and information on drug regimens and care and use if medicine. Counselling” **(PLHIV co-infected)**

Participants shared their experiences when asked about victimization in any healthcare setting for being HIV, TB/HIV co-infected or for any general health problem on the basis of gender. Participant from PLHIV FGD explained that once HIV positive patient went to doctor for ENT check-up, after getting history and came to know about the patient's HIV+ status doctor prescribed medicine without a proper physical examination and check-up. Some participants stated that whenever they ask a healthcare provider and allied staff any logical question, the doctors feel irritated and do not respond. In extreme cases of discrimination, health care providers are reported to indulge in abusing some groups of key populations including the transgender community. However denial to services, mockery and harassment are very common.

“Their attitude is normally not good with us. They don't think us human even. They sometimes deny giving us service. E.g. one HIV+ patient went to ENT surgeon after knowing his HIV status Dr was not willing to look his ear and prescribed him the medicine without proper check-up.”**(PLHIV)**

4- Gender (In) Equality And Human Rights Based Approach In TB Policies And Programs

Promoting gender equality and reducing gender-based discrimination are at the heart of a HRBA. If health-care systems are to respond adequately to problems caused by gender inequality, it is not enough to simply "add in" a gender component late in the implementation phase. The system must be designed to address gender norms, roles and relations from the outset. This is the basis of gender mainstreaming.

A gender-based approach to TB aims at addressing the social, legal, cultural and biological issues that underpin gender inequality and contribute to poor health outcomes. It encourages activities that are gender-responsive investments to prevent new cases of TB, and strengthen the response to fulfill the right to health of women, men and trans-communities. Even the Constitution of Pakistan provides a

strong legal framework in terms of many dimensions of women's equality, implementation of many provisions is weak and this legal frameworks does not encapsulate the varied dimensions of the word gender and is found be devoid of the broader definition as it is seen to exclude the trans-community in entirety. Since 2002, the proportion of seats in the national and provincial assemblies reserved for women has increased to about 20%, and varies at local government levels from 10% to 33%. The presence and activity of female representatives have contributed to the passage of 10 and 6 new laws at the national and provincial levels, respectively, which promote or increase the protection of women's rights and empowerment. Although trans community was provided an opportunity to contest election in 2018 yet their absence in parliament along with people who endorse a diverse gender identity and sexual orientation in society leave the key and vulnerable population including MSMs, Trans-community and Female Sex Workers far less prioritised in development sphere. Pakistan is one of the developing South Asian countries with generalized form of wide gender inequality in society. Credible research sources and anecdotal evidence is suggestive of the prevailing gender gaps in gender preference of sons at birth, access to health and education facilities; nutrition and access to economic opportunities.

Being signatory to international treaties such as Convention to Eliminate All form of Discrimination against Women, International Conference on Population and Development and Millennium Development Goals; the Pakistan government is obliged to achieve gender equality. Government's efforts to fulfil its commitments are reflected to a certain extent in its policies on Health, Population and Women's development, and programmes including Primary Health Care and Family Planning, and Maternal, New-born and Child Health.

Pakistan's score on the Gender Gap Index has not shown consistent improvement from 2008 to 2014 compared with Bangladesh and India. In 2014, Pakistan ranked second poorest on the index (141 out of 142 countries), with Bangladesh and India achieving better ranks of 68 and 114, respectively. Similarly, Pakistan ranked 108 out of 133 countries in 2010 for the Woman's Economic Opportunity Index, worse than Bangladesh (104) and India (84). Conversely, Pakistan's score on the Gender Inequality Index improved from 0.573 to 0.536 between 2011 and 2014. Pakistan ranked 121st in 2014, ahead of than India (130th) but was behind Bangladesh (111th). In gender-based discrimination experienced, the Social Institutions and Gender Index classified Pakistan as "high" overall, and alarming "very high" for sub indicators revealing son bias and women's lack of protection from legal mandates (family code). The different gender index scores illustrate that Pakistan's accomplishments with respect to gender equality and women's empowerment are

dependent upon the dimensions being measured. The Gender Inequality Index (GII) was introduced in 2011 as a composite index to measure the percentage loss of human development in a country due to gender inequality Pakistan ranked 121 out of 155 countries in 2014 on the GI, improving to 0.54 from 0.573 in 2012. 18

Conventionally such measures are of significant relevance when it come to make a sense of empowerment of sexual minorities as well as socially excluded key and vulnerable populations in Pakistan with regards to policy and programmatic priorities in development emblem.

A number of studies suggest that barriers to early detection and treatment of TB vary; and are greater for women than for men. Gender differences also exist in rates of compliance with treatment; fear and stigma associated with TB seems to have a greater impact on women than on men, often placing them in an economically or socially precarious position. Because health and welfare of children is closely linked with their mothers, TB in women can have serious repercussions for families and households. Women have less access to health services due to cultural, social and economic reasons. Sometimes they are stigmatized by discriminatory behaviours of health care providers. Most of the public sector health facilities also lack proper places of examination for privacy purposes and consultation room lack of confidentiality of communications.

Awareness and Protection Of Health Rights

The Ministry of Human Rights in Pakistan is mandated to review human rights situation in the country including implementation of laws, policies and measures in accordance with the human rights standards. It coordinates the activities of Ministries, Divisions and Provincial Governments with respect to human rights. It refers and recommends investigations and inquiries in respect of any incident of violation of human rights. It takes initiatives for harmonization of legislation, regulations and practices with the international human rights covenants and agreements to which Pakistan is a party and monitors their implementation. The Prime Minister of Pakistan approved Action Plan to improve Human Rights situation in Pakistan on 13th February, 2016. The Action Plan includes formulation of National Policy Framework and provincial strategies on promotion and protection of human rights, legal reforms, proposal to improve forensic sciences, upgrade physical facilities and

¹⁸Asian Development Bank. Pakistan country gender assessment—Volume 1 of 2: Overall gender analysis 2016

equipment's to investigate human rights violation on scientific grounds. The Action Plan sets four key human rights priority areas concerning vulnerable segments of the society i.e. Protection of Women Rights, Child Rights, Rights of Minorities and the Rights of Persons with Disabilities (PWDs).¹⁹***Unfortunately the action plans is devoid of an all inclusive, multifaceted, multi-sectoral coherent approach that could ensure the protection and promotion of human rights of any of the most marginalised segments including the key populations in Pakistan.***

A Human rights based approach (HRBA) applies a conceptual framework to understand the causes of (non-)fulfilment of human rights. It is based on international human rights standards and principles and it develops the capacities of rights-holders to claim their rights and duty-bearers to fulfil their commitments. A HRBA also aims to support better and more sustainable health outcomes by analysing and addressing the inequalities, discriminatory practices (intentional and non-intentional) and unequal power relations that are often at the heart of development challenges.

The goal of the HRBA is to ensure all programmes of development cooperation, policies and technical assistance should further the realization of human rights as laid down in the Universal Declaration of Human Rights (UDHR) and other international human rights instruments.

In this study when respondents were asked if they knew about the their human and health rights and the role of government(s) in protecting human rights and its efforts in prevention, control and ending TB and HIV from Pakistan, majority of the participants could not articulate what is meant by health or human right. Mostly, after probing, expressed their dissatisfaction regarding the role of government including at multiple levels in ensuring the access to information and showed concerns over the existing initiatives taken by government to curb both chronic diseases. However PLHIV groups in Lahore praised government role to end TB in Pakistan. The participants however, in IDIs and FGDs enumerated the following as their health rights.

¹⁹Ministry of Human Rights, Government of Pakistan

“Access to medicine, Free Tests, Good Nutrition, Advice and counselling, Right to know about the status of the test; Equality in care and access to information-denial in case of disclosure of HIV/TB status”.

(TB HIV co-infected Peshawar)

However except the participants from the trans-communities who participated in Lahore, other participants were found to have at least minimal understanding of the health rights pertaining to tests and access to medicine, free tests, good nutrition, advice and counselling, equality in care. One of the participants from among the MSMs added.

“Our health rights are as equal as anyone in this world. Right to access the health services, Right to have good health”. [PLHIV Islamabad]

Since there is not a particular law that guarantees the protection of human and health rights and awareness on various aspect of health and human rights is almost non-existent among the key and vulnerable populations the cases of violations of human rights at healthcare setting as well as outside the healthcare settings are not recognised, reported and followed. Even there is not an entity that by constitution or law could provide a platform. Human rights commission of Pakistan documents the cases of violations of human rights but in a particular it doesn't make an account of violations of health rights with a particular focus on general population even.

HIV strategic plan includes the key population focusing the equity as well as protection for human rights but TB's national strategic plan does not have ample focus on legal and human rights based programming and key populations are not exclusively defined in NSP. NSP has priorities but different ones- focusing not exclusively on the key populations like MSMs, TGs and PLHIV or for that matter even miners and prisoners. An Act for Transgender communities is passed for their welfare and protection but protection of their health rights is not explicitly defined.

Majority of the respondents of the study including the service providers and key populations shared their dissatisfaction over the infection control measures' responsiveness; attitude of healthcare providers; schedule of testing and treatment outlets at public sector health facilities as well as duration of the time for consultation. They also showed their dissatisfaction on the number of healthcare

providers and demanded for equitable distribution of human resource and diagnostic and treatment facilities. And secondly some suggested that overall behaviour and conduct of hospital staff should not be discriminatory and talking in general said that law should facilitate each individual and provide treatment free of cost in hospital.

An important revelation is non-availability of adequate, safer and comfortable sitting arrangement in waiting areas of the TB clinics in major hospitals of the public sector. Comparatively the respondents regarded such arrangements at private hospitals to be more improved. They believed that human dignity, respect and confidentiality and privacy is most of the times seen to be in jeopardy at majority of the TB clinics in government hospitals. Some healthcare providers were quoted to be abusive and mostly the affectees included the trans-communities. The respondents also share their concerns on the non-availability of trained human resource who are equipped with refined knowledge and updated information especially guidelines related to IPC skilled required for communication with a TB patient.

One patient of active tuberculosis shared "The ward that used to accommodate only TB patients has been abolished and patients are kept in general ward that itself is a stigma. Doctors are good but few in numbers and hence can't pay attention and automatically patients and their relatives are stigmatized."

"They have discriminatory attitude yes.... Even if not discriminatory, the human resource is not enough and hence we need to wait for a longer time in waiting areas which are often congested. They tend to have derogatory remarks about the male family members who accompany us".

Similarly as per human rights standard the TB services must be accessible both physically as well as financially but the opportunity cost lost is not compensated and KPs are reported to miss the tests and consultations.

I am a poor man and have been requesting several hospital staff for transfer of my record to Korangi Hospital but the main officer (Shah Sb) demanded money from me even before signing. I had to pay him but now my travel to this hospital for one hour would not be needed. A member of PLHIV in Karachi

"Equality is there but not equity; for example TB services are not available in an equitable manner everywhere. In every town we don't have such facilities"

The protection of human rights and its promotion entails the states and government to take into account the non-clinical needs of the patients and their families as well.

They must provide support to cater to the needs keeping in view the equity. *I am co-infected and my wife (she was present among the participants) is also HIV Positive but not co-infected. She required admission for delivery. The doctor demanded for money in addition to the cost that I had to pay for the medicine and disposable instruments. Our case was dealt by the doctor in the last after literally begging them. I hope you know the case of the transgender. Not a single religious person was ready to attend and pay the funeral prayers- the simple reason was she was a transgender and people believed that she was someone who had a bad profession (sex work).*

There are no known or approved means and way of legal remedies available to people with TB when their rights are violated, including their rights to free testing and treatment, privacy or any other right. There is no accountability mechanism which exists under law for government or private actors that violate the rights of people with TB, including their rights to free testing and treatment, privacy and compromised quality of care. The national human rights monitoring and enforcement mechanisms do not exist except the human rights commission of Pakistan but as shared earlier the combination of two things i.e. lack of formal mechanism for mitigation of violations as well as lack of awareness on human rights has led to a situation where violations are not formally documented or reported even.

In mayo hospital Lahore we are being discriminated and stigmatize by doctors specially doctor Hina and doctor Arshad have always shown rude behaviour they usually start loose talking's and taunting our community clients".(PLHIV Lahore)

There are no formal and approved measures in place to educate people affected by TB and key populations about their legal rights especially focussing on health rights. The promotion of human rights and awareness rising on human rights undertaken by some NGOs in this regard has added a little but significantly important improvement in knowledge of MSMs, PLHIV and Trans-communities in Pakistan but this work has to be up-scaled with a policy and programmatic support instead of its confinement in bits and pieces. KPs avoid filing suit or complaining of their rights violation because of complex judicial system; vague legal support; stigma and risks associated with self-esteem as well financial burden and delays in judicial proceedings.

When explored through discussion about policy perspective related to gender sensitization, equality and gender transformative approaches, the participants of

the FGD could not provide input owing to limited understanding of the broader perspective of gender and associated nomenclature. We can conclude to say that there isn't any single policy specifically regarding protection or discrimination against any group of the key population on the basis of gender. Engendering the health interventions has historically remained an issue in Pakistan

"They do but most of the time what we require from them is found to be missing when it comes to provision of the required services".

(TB HIV co-infected Peshawar)

Different perspectives were explored about use of research based evidence in programs providing health care especially in TB response. Almost all respondents tend to assert that evidence is not used for the planning of intervention. Programs providing health care do not use evidence from research for planning and they fail to ensure pre service training of healthcare providers and planner on gender and gender related sensitivities in planning and implementation of the interventions. They justified their argument by saying that if they had used evidence in programs they would have become aware of problems ranging from poor conditions to clinical issues the respondents were facing.

"No, if they had done so; they would have become aware of our problems ranging from poor conditions to the clinical issue which we have; some doctors even do not see towards us while talking to us."**(TB HIV co-infected)**

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"Health Care Providers in some cases have harassed our people. They abuse us even and don't shy off. Now with support from APLHIV we have been able to sensitize them to at least talk to us in a respectable way but a lot has to be done. Some of the religious leaders also reportedly tortured our fellows mentally by making remarks about our character".

[Economic Opportunities and Tuberculosis](#)

Deprivation of economic opportunities and employment of Key vulnerable population is a major issue because poor financial status puts vulnerable population in catastrophic situations. Upon discussing the matter with participants all groups as

well as the key informants confirmed the fact that poverty and lack of economic opportunity have huge impact in both access to information and services as well as affordability of the healthcare. One of the participants shared his experience that he is a driver and government needs to provide loans so that he can own a car and become independent to solve his issues as no one is ready to give a permanent job to any person with an illness that is transmittable. Trans-community stated that money and resources are the only source to overcome all problems for them.

“Yes, the economic deprivation and poverty are the major issue of our society the all social behaviour and identity shape in our society is determined by the economic conditions of and individual”.(PLHIV)

It is a very huge issue not only at individual level but also at household level as well as country level as additional resources are required to cope with the challenges of disease burden. For Public health sector this has implications as we cannot eradicate a communicable disease due to poverty resulting from the lack of economic opportunities and poor social and economic conditions.

5- Inclusion and Participation In Planning For Decision Making For Equitable Service Provision Under National TB Response

Community participation is vital for achieving objectives and successful completion of any program. To explore community's perspective they were asked to share their experiences at what level and how frequently they are taken into confidence regarding the programs that are meant for them. All the groups were somehow cognizant and admitted that at some stage they have been approached to listen and express their aspirations. But at the same time they complained about the services/facilities which are sometimes overlooked during planning and implementation.

“Yes, sometimes they listen our voices but they do nothing to address issues and needs. They must take our voices/suggestions serious to end TB. (PLHIV)Yes they use to consult us and get view point of the community and collect evidences from the field”(TGs)

Majority of the key populations added that they are not aware of the formal mechanisms which are required to ensure the inclusion of the communities in

planning for national TB response in Pakistan. However some admitted that if not them their representatives were invited by CCM and APLHIV sometime back in this year. The national TB program conducts the participatory planning in some cities, followed by the provincial level and then national level consultation by including the representation from TB patients association and Civil Society but unfortunately due to competing priorities, the gender specific interventions and actions remain always less prioritised when it comes to funding. TB is not on the agenda of the advisory committee or senate committee for health. **One of the female participant complaint discriminatory attitudes by NGOs, and CBOs she said that the NGOs and CBOs who are working for us also discriminate us. They initially make promises to give treatment along social support packages and other incentives. After registering us in their respective NGO initially they provide some of the said incentives but after some time they start to make excuses and gradually cut off all social support packages and other incentives.**

The responses gathered from the qualitative data are indicative of the lack of adequate measures which could ensure the existence of mechanisms by which the planners and program implementers of the national TB response could remain cognizant of human rights and gender dynamics impacting the effectiveness of the intervention.

Although planners as well as government also recognise the importance of the inclusion of the organizations representing TB affected populations meaningfully in decision-making at different stages, levels and sectors of the country TB response but financial resource are not enough to do it in each and every level. There is TB association of Pakistan which is member of the CCM along with the HRCF but these two entities alone cannot influence the decision making when it comes to the allocation of resources as well as prioritization of the gender and human rights based intervention ahead of allocations for medicine and supplies There is no legal and policy restriction on any of the (key) populations to access domestic and/or international funding to support the national TB response but limited financial resources are not enough to fulfil the cost of commodities including medicine and testing even. None of the key affected population is excluded by laws or regulations or policies from engaging in the national HIV/TB response but sexual orientation, professional sex work as well as social and cultural barriers including the stigma prevent these key population from actively pursuing the access to these resources and economic vulnerability and lack of economic opportunities preventing them from networking.

The Civil society organizations working on TB and HIV, representatives of identified key affected populations, and groups working on gender equality and women's rights issues are officially involved in CCM. Civil Society is significantly represented on CCM Pakistan and there has been four seats allocated for Civil Society. Civil society member inputs to CCM are very frequent. Civil society sector is mostly the part of every CCM sub-committee governing any aspects related to GF grants implementation. Civil society organizations represented on CCM are elected by their constituency.

Other than CCM there are no additional coordination mechanisms in different government sectors (e.g. gender, health or human rights) and levels for joint action on gender equality in the national TB and HIV response.

The participants shared recommendations to improve TB program which included; maintaining privacy, improvement in health care provider's behaviour, assistance for disabled/physically weaker, reduction in waiting time during pathological tests and treatment, and enhance human resource as well as health facilities. They further added that community based testing just like HIV should be introduced; services should be available round the clock and more importantly everyone should be held accountable.

“We should have equitable distribution of human resources for the successful enrolment, Privacy, Behaviour of HCP must be improved and assistance for disabled and physically weaker co-infected must be ensured; Waiting time for both tests and treatment must be reduced with increase in number of healthcare providers as well as health facilities”. **(PLHIV Co-infected)**

“Not directly but our representatives had been invited and one of them is in CCM also”. **(TGs)**

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6- Resources Mobilization and Equitable Resource Distribution

The national TB coordination mechanism include does not have a dedicated focus on gender equality explicitly narrated in national strategic plan. Most of the respondents also added that decision-makers and service providers fail to assimilate and demonstrate awareness and knowledge of the consequences of gender inequality between men and women and KPs in the context of TB. For most of the planners and service providers the medicine and other paraphernalia is more important. Therefore, actions which may influence the gender equality and equitable distribution of resource remain untouched.

Total health expenditure in Pakistan in the FY 2015-16 is estimated as Rs.908 billion. The ratios of total health expenditures to GDP according to NHA 2015-16 is 3.1% while the ratio of general government health expenditures to total general government final consumption expenditure is 9.7%. As analysis of the results of financing sources for FY 2015-16 show that out of total health expenditure in Pakistan, 34% are funded by public sector. Out of total public sector health expenditures, 21.8% are funded by the federal government whereas 58% accrue from its civilian part and 42% from its military setup. Around 64.4% of the health expenditures are funded through private sector out of which 89% is out of pocket (OOP) health expenditures by private households. Further analysis of the OOP health expenditure data reveals that in Pakistan, around 24% of the total OOP expenditure is incurred on in-patient services while OOP spending as outpatient care for their illness is 29%. About 47% are spent on medical products, supplies and equipment & other appliances. Analysis of OOP health expenditure data reflects that in Pakistan 50.0% of the total OOP spending are incurred on “Medicine/Vaccine”, 19.2% and 8% on doctors' fee and diagnostic tests respectively and 7.41% of the total OOP spending are incurred on Cost of Surgery. Further analysis of OOP data with regard to provinces indicates that OOP spending on “Medicine/Vaccine” is highest in Baluchistan (42.28%) followed by KP (40.68%), Punjab (34.62%), while the lowest share is of Sindh (33.49%). Second highest

spending for all the provinces is on doctors' fee and then the diagnostic tests. The reason behind high OOP spending on medicine is that, in private clinics, doctors take the charges including medicine and the value reported in the medicine cost. Third highest spending for all the provinces Cost of Surgery. Development partners/ donors organizations have 1.7% share in total health expenditures.²⁰²¹

Government of Pakistan has a national strategic plan covering the period of 2017-20 that would, if implemented in accordance with a rationalized budget, require US\$ 526 million. 65 % of this need remained unfunded. GF has been supporting almost over 90 % of the existing TB intervention and its operational cost but that constitutes only 28% of the actual cost estimated (of 526 million). Only Punjab province has an approved PC-1. At implementation level, the support from provincial government is in the form of human resource only and all medicine and supplies and diagnostic test facilities are being supported by the Global Fund.

In national HIV response the monitoring mechanism related to spending of allocated amounts of resource has a component that allows the CCM and civil society to gauge the gender equality in spending of the resources but in national TB response it is missing. Moreover the scarcity of financial resources does not allow the NTP management to add components which are related to intervention purely meant to ensure equity and equality in national TB response as it has its own limitations as government of Pakistan did not increase its share of responsibility in terms of financial allocations. The GF has already indicated that Pakistan government must gradually increase its resource allocation from its own sources of the existing to 50% in 2018; 70% in 2019 and 80% in 2020.

Lack of sensitization of decision makers on the importance of gender sensitive and gender transformative programming is an important hindrance in prioritisation of gender sensitive programming and appropriate resource allocation. When inquired about the factors which influence the distribution of resources; following factors were enumerated.

S.No	Factors influencing the resource allocation for different components
01	Availability of financial resources, mostly GF grant
02	Political Priorities

²⁰National Health Accounts 2015-16, Federal Bureau of Statistics, Government of PAKISTAN June 2018

²¹ Household Integrated Economic Survey 2015-16, Federal Bureau of Statistics, Government of PAKISTAN June 2018

03	Cost of Medicine , Tests and Supplies
04	Donor requirements

Table 11- Factors influencing the resource allocation in national TB response

The challenges which hinder the endorsement and roll-out of a gender sensitive equitable distribution of resource for national TB response included the following.

- 18th amendment as provinces does not have sufficient will and autonomy to allocate resources for health
- Lack of ownership of the intervention;
- Lack of national and provincial task forces on TB considering the social determinates;
- Social determinants;
- Huge dependency on GF and Adhocism

7- Social Protection And Material Assistance

There is no compensation for time lost from work. This has implications on the acceptability and affordability of the service by some key populations including the MSWs, FSWs and even trans-community who remain indulged in commercial sex work. In some areas support for intake of nutritious food is provided by the service providers under TB response. There is no additional compensation for health care workers working in TB in public sector but health care workers working in private sector have incentives. Although there are mechanism of social protection including the Benazir Income Support Program and Zakat but social and identity of some key populations including the MSMS and TGs does not have conducive effect in accessing such resources. In case of MSMS and TGs it is very difficult; many deserving KPs are denied access to such entitlements and safety nets just because systematic errors as well as politicization of the program.

8- Protection, Privacy And Confidentiality

There are no specific pre-service sensitivity trainings in gender, human rights, stigma and discrimination in Pakistan. However medical and nursing graduates are taught ethics, which covers part of sensitivity training on gender and human rights.

Key populations do have constitutional or statutory right to privacy and confidentiality in their health status, including their TB status but the lack of awareness on part of healthcare settings does not allow the protection of rights of privacy; Under certain circumstances when an individual has tendency of suicidal

attempt or in mania the health service providers usually disclose the status of a person. The contacts of the TB patients are not tracked as per policy and strategic guideline but health service providers very often ask patients to bring the contact if signs and symptom persist. In case of MSMS and TGs, the tracking of contacts is seemingly difficult. There is no formal and approved written policy for disclosure of the information related to one's status as TB patient.

The service delivery sites do not have appropriate arrangements for the safety, privacy and confidentiality of information. This becomes more severe and less acceptable in cases of transgender and women.

9- Service Delivery and Acceptability of TB services

On average a KP has to visit 3 to 4 times to have a clear and final diagnosis; there are cases when HCP failed to make a clear diagnosis. At private clinics the KPs were reported to have been treated well in comparison to public sector hospitals. The first visit was reportedly not good. On average a TB patient had to spend 15 to 20 thousands initially on tests and travel costs; Most of the KPs are reported to have free medication. Majority had received the information on drug regimens but a significant proportion of the respondents added that information on follow-up was only provided when asked. The two stage sputum collection method was regarded as cumbersome. In general the KPs expressed their sorrow on the difficulties faced by the KPs in comparison to general population. They enlisted the following factors which hinder the access of KPs to TB diagnosis and Treatment.

S.No	Factors which hinder access to testing and treatment
1	Lack of 24 hours service delivery
2	There are no special counters for TB patients
3	Delays in OPD and diagnostic tests
4	Transport
5	Non Availability of male family members to accompany female staff

Table 12- Factors hindering access of KPs to Testing and Treatment Sites

The respondents share that 24/7 services with lesser intervals of waiting time for each patients must be ensured and attitude of the HCPs must be friendly and client centred. There should be mechanisms to register the complaint and access of these services by the poor living in rural areas must be ensured.

"We should have easy access to care; financial support; availability of medicine; Family Support; Nutritional Support and concomitant treatment of other illnesses for improved immunity. We should also have separate information desks and designated wards/OPD. Policy must ensure new doctors are trained and association of KP must be independent"

"There should be TB and HIV (ART) services at every DHQ hospital at least. There must be some initiatives that could help us have some economic productivity at household level and community must be in a position to help the vulnerable and affected population of its own. "

The diagnostic procedures already available include for free are Microscopy; Chest X-ray; Gene Expert; Tuberculin skin test and LED microscopy with varying degree of availability.

The information being provided to individuals who come for TB testing include the nature of TB; the test procedure and rationale; prevention measures; information on free treatment and care for TB and duration of TB treatment and side effects and mitigation.

HIV testing among TB patients is done only at tertiary care clinics and keeping in view the co-infection it has to be made available at all clinics; the written consent for HIV testing is not always taken but verbal is always taken. Other information provided at TB Clinics under National TB response include the importance of completing the full course of treatment and available support only; no information regarding the treatment outcomes and the risks and benefits of the proposed interventions as well as preventive measures are provided. There are no mechanisms to make the KPs aware of their (health) rights. Community based testing and care; family support and travel support along with the access to complete information and trainings of both communities and HCPs targeting behaviour change are some of the areas of improvement

World Health Organization interim guidelines on the use of bedaquiline and delamanid in the treatment of drug-resistant TB may require action by the state to regulate and authorize the use of the drugs. It is important to have an understanding as to whether it is the role of the provinces or the national government to take such action and to direct related recommendations to the proper authority. It appears that the Drug Regulatory Authority of Pakistan continues to operate notwithstanding that the 18th Amendment left in question the role of the national government in

regulation of drugs and medicines, a subject formerly included in the Concurrent Legislative List of the Fourth Schedule to the Constitution. It will also be necessary to study the implementation of the WHO recommendations, which may require involvement of the Council of Common Interests, which is responsible for planning and coordination of scientific research in terms entry 7 to Part II of the Fourth Schedule read with Article 154 of the Constitution. It may benefit the smooth implementation of the WHO guidelines to establish clarity on these issues.

RECOMMENDATIONS

The research team provided recommendations after consolidation and analysis of the findings of the CRG study which was presented at the validation workshop attended by all the participants of the prioritization workshop as well as other important stakeholders including the UN agencies, ministry of health, representatives of the national TB and HIV programs and CCM Pakistan. It was shared with the forum that UN's special session on TB was held in 2018 and the declaration was made which was signed by the foreign minister of Pakistan. The action plan and accountability framework must be developed and implemented with support from the community based organizations as well as public sector entities. The participants not only validated the findings and recommendation but also provided the inputs to add more recommendations in the light of the discussion on findings shared by the lead consultant. Based on the findings of assessment, various suggestions and recommendations were made by the key populations included in the study as well as the service providers and civil society organizations working in TB response in PAKISTAN which were endorsed by the participants of the validation workshop...

Unanimously all participants agreed to add that

- Government should agree to add HEALTH as a right of every citizen and agree to protect health rights through constitutional support through a constitutional amendment. Government at national level must have a strategic framework and an approved plan of action for all communicable diseases and then prioritize the ones with highest burden of diseases. After the 18th constitutional amendment the provinces are required to have a thorough

understanding of the laws and legal frameworks of their own provinces to ensure rights based approach in national TB response.

- The strategic framework must be established to incorporate the social determinants as well a legal and gender related barriers and mitigation of challenges and issues from implementation perspective. Under the strategic framework which must not be influenced by political wish-lists and donor requirements, the implementable actions must be developed for which the evidence should come from country wide detailed assessments covering the rest of factors including the client satisfaction as well as efficiency of intervention.
- Establishment of a task force on TB covering gender, law, economy, education service provision, trade, industry and tourism as well as transport is important. The same task force must have a sub- task force on Gender that works to ensure Gender and Human Rights Based programming and that advocates for the adequate and equitable resource allocation. The task force should also, in coalition and networking act as a watch dog to track the progress of government in attaining outcomes of the international commitments in Pakistan.
- Meaningful collaboration between NACP and NTP at policy and programmatic level as well as synergy at service delivery outlets is essentially required.
- The establishment of Multi-sectoral approach in planning for END TB PROGRAM is essential as social determinants have been seen to impact the effectiveness of intervention. Multi-sectoral approach in planning and implementation and multi-sectoral accountability is equally important. Multi-sectoral Accountability framework would be the guideline for TB Control Program in coming years – High risk groups, vulnerable population, community and civil society should be engaged from the first day of pre-planning and planning stage. The multi-sectoral accountability framework must encompass both public and private sectors as well as community and community based organizations. The ministry of national health services, regulation and coordination (MoNHSR&C) under the patronage of council of common interest may engage provinces and other stakeholders to develop comprehensive treatment guidelines for prevention and management of TB as well as strategic direction for gradual increment in resource allocation.
- The programs are required to capitalize the existence of opportunities including the current institutions and political governments; standing committees on health in senate and national and provincial assemblies as well as all other formal mechanism which could influence the reshaping of health as health right.

- The dearth of evidence with regards to disease burden entails the reshaping of data collection mechanisms keeping in view the internationally recognized nomenclature associated with categorization of both key and vulnerable populations as well as categorization of disease. Gender inclusive and gender sensitive reporting of disease burden is crucial and government must take steps to ensure the establishment of such mechanisms.
- Introduction of Human Rights and Gender related competency based knowledge in medical schools and colleges as well as mandatory pre-service training in gender sensitivity and human rights.
- Shift from resource based planning to disease burden based planning and programming in TB response.
- Up scaling of consultative process for planning of the national TB response with more coherent and cohesive approach of reaching out to both key and vulnerable populations.
- We need 520 million dollars to END TB Strategy, Global Fund is giving us 143 million dollars and nobody talk about the remaining funds. Stakeholders the most importantly the MoNHSR&C and all provincial programs are required to [MITIGATE THE RESOURCE GAPS](#) – PC1 is ready in Punjab with the effort of all stakeholders (cost 34 million dollars) – strategic plan should be revised. Provision of economic opportunities or at least equal access to safety nets including the Zakat, Baitulmal, Benazir Income Support Program and health insurance scheme and social protection.
- Use of cellular technology to enhance awareness on spread of disease as well as reducing the occurrence of misconceptions and myths related to TB and HIV. The accountability framework and National Strategic Plan must ensure the effective use of information technology to reach out the patient/civil society/community for information dissemination as well as to redress of the complaints.
- Establishment of complaint cells, regular review of complaints and establishment of mechanism to improve the responsiveness, efficiency and effectiveness at healthcare settings; stringent policies must be enacted at healthcare settings to avoid discrimination and reward and punishment method must be included in hospital policies. There should be mechanisms to register the complaint and access of these services by the poor living in rural areas must be ensured.
- Private healthcare providers must be regulated to ensure free access of affected populations to medicine and tests.
- Broader advocacy and community mobilization strategy has to be developed in accordance with the evidence available on social, economic and behavioral factors. Global Fund and all bi-literal partners should provide

financial and technical support to the engagement of civil society and communities

- Within the communities peer-networks will help improve the health seeking behavior thus capacity building measures should be developed and undertaken. The help from people who remained patients but recovered successfully can play a significant role in Behavior change.
- Develop a social protection policy and initiate discussion for revision of social protection laws for protection of social well-being of TB patients especially MDR and XDR-TB patients from the catastrophic effects of TB medication.
- The accountability measures have to be in place at all healthcare settings so that not a single active case of TB is missed. The capacity of the LHWs and CHWs has to be significantly improved for an early detection and referral of the suspected cases for laboratory based diagnosis. The networking between community- first level health facility and referral health facilities is essentially required

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