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Joint evaluation of the UN Joint Programme on AIDS's work with key populations (2018–2021)

Country case studies

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Abbreviations and acronyms

ACMS	Association Camerounaise pour le Marketing Social
AIDS	Acquired immunodeficiency syndrome
ART	Anti-retroviral therapy
ARV	Anti-retroviral drugs
ATS	Amphetamine type stimulant
BCC	Behaviour change communication
BUF	Business Unusual Fund
C4D	Communication for Development
CBM	Community-based monitoring
CBO	Community based organisation
CCDAGs	Centres de conseil et de dépistage anonyme et gratuit (Centres for free counselling and testing)
CCM	Country Coordinating Mechanism
CDC	Centres for Disease Control
CE	Country envelope
CHW	Community health worker
COP	Country Operating Plan
CRS	Crisis Response System
CSO	Civil Society Organization
CSW	Commercial sex worker
DAS	Division of AIDS and STI, Department of Disease Control
DDC	Department of Disease Control, Ministry of Public Health
DOC	Department of Corrections
DoL	Division of Labour
DSSB	Division des Soins de santé de Base, Ministry of Health
EMG	Evaluation Management Group
eMTCT	Elimination of HIV mother to child transmission
(e/P) MTCT	(elimination/prevention of) Mother-to-child HIV transmission
EQ	Evaluation question
ERG	Evaluation Reference Group
FSW	Female sex worker
GAM	Global AIDS Monitoring
GBV	Gender based violence
GFATM	Global Fund for AIDS, TB, and Malaria
GE	Gender equality
Global Fund (GF)	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOU	The Government of Ukraine
GPC	Global (HIV) Prevention Coalition
HCW	Health care worker
HF	Health Facilities
HIV	Human immunodeficiency virus
HIVST	HIV self-testing
HD	HD: Health District
HMIS	Health Monitoring Information System
HSS	Health Sector Strategy
IBBS	Integrated bio-behavioural survey
IUD	Injectable drug user
ILO	International Labour Organisation

JP	Joint Programme
JPMS	Joint Programme Monitoring System
JT	United Nations Joint Team on AIDS
JUNTA	Joint United Nations Team on HIV/ AIDS
KASF	Kenya AIDS Strategic Framework
KCM	Kenya Coordinating Mechanism
KI	Key informant
KII	Key Informant Interview
KNASP	Kenya National AIDS Strategic Plan
KP	Key population
KPLHS	Key population-led health services
LGBTIQ+	Lesbian, Gay, Bisexual, Transexual, Intersex, Queer and other non-binary persons
LMIC	Lower middle-income country
LOE	Level of effort
MAT	Medically assisted treatment
M&E	Monitoring and Evaluation
MOJ	Ministry of Justice
MOH	Ministry of Health
MOPH	Ministry of Public Health
MSM	Men who have sex with men
MSW	Male sex worker
NACC	National Aids Control Committee
NAP	National AIDS Programme
NASCOP	National AIDS and STI Control Programme
NGCA	Non-Government controlled areas
NGO	Non-government organisation
NHSO	National Health Security Office
NSP	National Strategic Plan
ONCB	Office of the Narcotics Control Board
ONFP	Office de la Famille et de la Population
OST	Opioid substitution therapy
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	Person living with HIV
PMTCT	Prevention of mother to child transmission
PPB	Pharmacy and Poisons Board
PPE	Personal protective equipment
PR	Principal Recipient
PrEP	Pre-exposure prophylaxis
PSE	Population size estimate
PWID	People who inject drugs
PWUD	People who use drugs
RRTTPR	Reach, recruit, test, treat, prevent and retain cascade
S&D	Stigma and Discrimination
SDG	Sustainable Development Goals
SGBV	Sexual and gender-based violence
SI	Strategic information
SOGIE	Sexual orientation, gender identity and expression
SOP	Standard operating procedure
SRA	Strategic results area

SRH	Sexual and reproductive health
SRH(R)	Sexual and reproductive health (and rights)
STI	Sexually transmitted infection
SW	Sex worker
TA	Technical assistance
TB	Tuberculosis
TG	Transgender
TGW	Transgender Women
TNP+	Thai Network of Positive People
TOC	Theory of change
TOR	Terms of reference
TRA	Transition readiness assessment
TRP	Technical Review Panel
TSM	Technical Support Mechanism
TWG	Technical working group
UBRAF	Unified Budget, Results and Accountability Framework
UCO	UNAIDS Country Office - Perú
UHC	Universal Health Care
UN	United Nations
UNAIDS	Joint United Nations Program on HIV and AIDS
UNAIDS CO	UNAIDS Country Office - Thailand
UNCT	United Nations' Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UN WOMEN	United Nations' Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
VMMC	Voluntary medical male circumcision
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization
YAC	Youth Advisory Council
YKP	Young key population

1. Republic of Cameroon country study

26 January 2022

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Introduction

Purpose and scope of the case study

This case study is part of a larger evaluation to assess the relevance, coherence, equity, efficiency, effectiveness and sustainability of the UNAIDS[1] Joint Programme on AIDS (JP) support for key population (KP) programming at country level over the years 2018-2021, with a view to improving UNAIDS programming with and for key populations under the new UNAIDS United Budget, Results and Accountability Framework (UBRAF) 2022-2026. The primary unit of analysis for the evaluation is how the JP has supported KP programming at the country level. Six countries were chosen for the case studies, covering all UNAIDS regions and a variety of epidemics. The six countries are Cameroon, Kenya, Peru, Thailand, Tunisia, and Ukraine. The case studies have been supplemented by document review and key informant interviews (KII) at the global and regional levels.

The KPs, as defined by UNAIDS, are sex workers (SW), gay men and other men who have sex with men (MSM), transgender persons (TG), people who inject drugs (PWID), and prisoners, including young people who are part of these KPs.

Method and approach

The evaluation draws on direct and indirect collection, observation and triangulation of facts and data for all phases (planning, implementation, reporting) of the UNAIDS JP's support for KP groups. The methods were largely qualitative and data sources included Key Informant Interviews (KIIs) both individual and group (52 interviews); Documentary Review (DR) (50 documents) and Direct Observation (DO) of service delivery sites (3 sites). Digital recording was included to complement the note taking. Recordings were destroyed once analyzed and anonymized in paper form. 60 percent of the interviews were virtual, both because of the COVID-19 context and the restricted logistics budget of the evaluation.

A key feature of the evaluation's methodology was the inclusion of KP representatives in the evaluation team. Three KP representatives were team members (from PWID, SW and prisoners' milieus and the last from the MSM and TG environment). As evaluation team members, they facilitated outreach interviews of KP members in their gathering points some of which were the premises of the services delivery associations that they manage. Their participation to preparatory and review meetings with EHG, UNAIDS and cosponsors provided genuine insights on how to render the evaluation feasible among KPs, what progress was achieved by the JP vis-à-vis concerns of the KPs and what are the appropriate next steps to better address KP realities. They learnt some interviews techniques by doing initial interviews together with the Team Leader. Then they went on individually to conduct interviews. They specialized in community interviews (providing notes to the Team Leader) while the Team Leader worked at both community and institutional levels.

Target groups

A total of six institutional groups where targeted by the evaluation including (1) the UNAIDS Secretariat; (2) the cosponsor agencies; (3) the KP NGOs, CSOs, CBOs, networks; (4) the Government-led bodies (MOH, NAP, NACC, CCM, prisons, other sectors); (5) the Multilateral/bilateral donor and other funders and (6) the HR, gender, legal advocates, and other. Concerning the above strategic level, eight (8) institutional interviews, were held with groups of professionals or individuals in the CCM; UNAIDS; WHO; UNDP; GIZ; ACMS, CARE and CAMNAFAW. At community level, 24 KP members were interviewed and 20 group or individual interviews were held with the community level institutions (CSOs/CBOs: "Operational Stakeholders") as shown in Table 1 below. A total of

[1] References to UNAIDS in this report refer to the Joint United Nations Programme on HIV and AIDS, consisting of the UNAIDS Secretariat and UN agency Cosponors. The UNAIDS Secretariat in Cameroon is referred to as the UNAIDS Country Office (UNAIDS CO).

52 interviews were conducted. 60 percent of the interviews were virtual, both because of the COVID-19 context and the restricted logistics budget of the evaluation.

Table 1: Sample of Key population groups and stakeholders interviewed

Category	Strategic Stakeholders	Operational Stakeholders	Beneficiaries (5 KP Groups)	TOTAL
Sample size	8	20	24	52
Description	**UN:** UNAIDS, WHO, UNDP **GOV:** CCM **BILATERALS:** GIZ **NGOs:** CAMNAFAW, CARE, ACMS	CSO & CBOs Providing services to the 5 Groups of KPs	MSM/TG: 12 SWs: 4 PWID: 6 Prisoners: 2	
Strategic level	8			
Community Level		44		44

National HIV Context and Response

Overview of the HIV epidemic

Cameroon is implementing its 2016-2027 Health Sector Strategy.[2] The priority programmes include HIV/AIDS, Malaria, Tuberculosis (TB), reproductive health, mother, neonatal, child and adolescent care and prevention transmission from mother to child (RHMNCA/PTMCT), the Expanded Programme on Immunization (EPI) and non-communicable diseases. The Strategy aims at achieving universal access to health services, relying on the empowerment of beneficiaries, the strengthening of the six pillars of the health system[3], multisectoral participation, decentralization of the management and inclusive delivery of services. The strategic infrastructure to achieve these ambitions include ten Health Regions, 200 Health Districts[4], 1,815 Health Areas and 5,434[5] Health Facilities (HF) across the country.

Many challenges need to be addressed to achieve the goals and targets in the Strategy, including an uneven geographic distribution of health facilities; demotivated staff/poor working conditions; a low proportion (40%) of population within the manageable reach (5 km) of a HF; a low rate of health personnel per inhabitants (0.9/1000 inhabitants[6] below WHO's norm: 2.3/1000[7]); a high occurrence (94%) of HFs with stock-outs[8]; a low proportion (8%) of the national budget for health;[9] a general weakness of the six pillars of the Health Sector Strategy (HSS); and a significant proportion (39%) poverty within the population.

In terms of HIV prevalence, Cameroon faces both a generalized epidemic (2.7%)[10] among its population aged 15-49 years and a high concentration of transmission in highly at-risk groups including sex workers (24.3%) and men who have sex with men (20.6%)[11].

The significant efforts of the Cameroon Government, the UNAIDS Joint Programme, multi- and bi-lateral partners, CSOs and different actors appear to yield good results. Pending confirmation by specific investigations, such results including significant progress on the three 90's as is shown in table 2 below.

[2] Stratégie sectorielle de santé 2016-2027 (SSS 2016-2027)
[3] Monitoring the building blocks of health systems: A handbook of indicators and their measurement strategies, WHO, 2010
[4] Plan Stratégique National de Lutte contre Paludisme 2019-2023 (PSNLP 2019-2023)
[5] DHIS2, 2020
[6] Plan Stratégique National de Prévention et de Lutte contre le Cancer (PSNPLCa) 2020 - 2024.
[7] The World Health Report 2006, WHO
[8] SSS 2016-2027, p109
[9] SSS, p109
[10] Cameroon Demographic and Health Survey 2018 (DHS2018)
[11] Integrated Biological and Behavioral Survey assessment reports (IBBS), 2016,

Table 2: Key indicators of progress in the HIV response in Cameroon[12]

Output and Outcome indicators	Reference	Base-line	Achieved	Achieved	Target	Achieved
	2010	2017	2018	2019	2020	2020
HIV prevalence in the general population 15-49 years	4.3%	3.4%	2.7%	NA	NA	2.7%
HIV prevalence among pregnant women		5.7%		5.7%		5.7%
% PLHIV who have access to ARV treatment (tested positive and treated)	100%	100%	NA	83%	90%	74.7%
% PLHIV on treatment with viral load suppression	NA	NA	NA	77,8%	90%	88.1%

The documentation of KP group demographics is still unreliable because of the gap in systematic country-wise investigations. The table below presents KP size estimates from official sources.

Table 3: Estimated size of key populations in Cameroon[13]

KP Group	2017	2018	2019	2020	2021
Sex workers[11]	-	70,000	-	-	-
Men who have sex with men[11]	-	7,500	-	-	-
People who inject drugs[11]	-	1,250	-	-	-
Prisoners[14]		30,000	-	-	-
Transgender*	-	1,250	-	-	-
TOTAL	-	110,000	-	-	-

*NSP2018-2022: figure of known similar group used for the unknown (PWID are newly integrated group, highly stigmatized, likewise the transgender people)

HIV prevalence has decreased in the general population from 15 to 49 years (4.3% in 2011[15] to 2.7% in 2020[16]) and among sex workers from 36.7% (2010) to 24.3% (2020); MSM from 44.5% (2017) to 20.7% (2020); prisoners from 11.5% in men and 12.1% in women (2010) to 4.1 in men and 1.6% in women. Data is missing for transgender people and people who inject drugs. The prevalence of HIV among pregnant women has been constant between 2017 (5.7%)[17] and 2020 (5.7%)[18].

[12] Country report Cameroon 2020
[13] Country Reports Cameroon 2019
[14] http//fiacat.org/presse/communique-de-presse/2871-communique-desengorgement-des-prisons-au-cameroun (2017)
[15] Cameroon Demographic and Health Survey 2011 (DHS2011)
[16] Cameroon Demographic and Health Survey 2018 (DHS2018)
[17] Country report Cameroon 2017
[18] Country report Cameroon 2020

Table 4: Progress in the HIV response among the general population and key populations[19]

Output and Outcome indicators	Reference	Baseline	Achieved	Achieved	Target [20]	Real
	2010	**2017**	**2018**	**2019**	**2020**	**2020**
HIV prevalence – general population 15-49 years	4.3%	3.4%	2.7%	NA	2.45	2.7%
HIV prevalence – pregnant women	NA	5.7%	NA	5.7%	5.18	5.7%
HIV prevalence – sex workers	36.7%	36.7%	14.0%	NA	33.4	24.3% [21]
HIV prevalence – men who have sex with men (Dla:24%; Ydé:44%)	NA	44.5%	14,8%	44.5%	40.5	20.7%
HIV prevalence – transgender	NA	NA	NA	NA	NA	NA
HIV prevalence – people who inject drugs	NA	NA	NA	NA	NA	NA
HIV prevalence - prisoners (male)	11.5%	11.5%	2.0%	NA	1.82	4.1%
HIV prevalence - prisoners (women)	12.1%	12.1%	NA	NA	11	11.6%

Overall context for Key Population groups

The enabling environment is challenging due to the criminalization of the sex work (article 343 of the penal code), homosexuality (article 347 of the penal code) and the use of drugs (article 74 of the penal Code, article 102 of Law No 97/19 of 07 August 1997 on the control of narcotics). Criminalisation is associated with frequent prosecutions against MSM and PWID in particular and TG people as reported by key populations and human rights advocates including the UNITY platform of KPs[22] and Human Rights Watch (HRW)[23]. Tolerance prevails concerning sex workers. Given the freedom of association[24] KP groups can organise themselves as associations (and do so) provided they do not claim their sexual identity. However, the adverse sociocultural perception of some KP groups as threats to social equilibrium and norms stigmatizes and discriminates all five categories of key population with frequent social exclusion, harassment, and violence.

Gender equality is part of the political agenda in Cameroon and has a specific ministry in charge of the promotion and the respect of women rights and family protection (Le Ministère de la Promotion de la Femme et de la Famille - MINPROFF). The country participates in all the major international frameworks and agendas on gender equality including the UN Women's Strategic Plan 2018–2021; the 2030 Agenda for Sustainable Development with a view to gender equality; The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Optional Protocol; The "Women's Bill of Rights"; the Beijing Declaration and Platform for Action (PFA), United Nations Security Council Resolution 1325 on Women, Peace and Security (2000) and the further seven related resolutions). Much progress needs to be made as shown by the following statistics:

From OCHA, Oct.2019[25], it is reported that: poverty in women is higher (51.5%) than national level (39%); only 4.6% of women own a land/house; scolarisation rate is lower among girls (110%) vs boys (125%); parliamentarians record a low rate of women (27.1% in 2017); 105.8/1000 girls aged 15-19 years give birth to a child; HIV prevalence is higher in women (5%) compared to men (2.3%); GBVs is common (56,4%) among women in marital union.

[19] Country report Cameroon 2020
[20] NSP2018-2022: estimates assuming AIDS elimination by 2030, computing from most recent data available
[21] Integrated biological and behavioral assessment reports (IBBS), 2016,
[22] Rapport annuel 2020 des violences et violations faites aux MSG au Cameroun, UNITY Platform/ONUSIDA
[23] https://www.hrw.org/fr/news/2021/11/20/au-cameroun-une-personne-intersexe-ete-victime-dune-attaque-brutale
[24] Law n ° 2020/009 of July 20, 2020 modifying and supplementing certain provisions of law n ° 90/053 of December 19, 1990 relating to freedom of association
[25] https://reliefweb.int/report/cameroon/donn-es-sur-l-galit-des-sexes-au-cameroun

UNAIDS Secretariat supports the UNITY platform of LGBTI for an enabling environment, including the production of critical statistics on related GBV. In 2020, The UNITY platform[26] reported more than 2,000 cases of violence and rights violations against 930 members of the sexual and gender minorities, compared to 1,400 cases in 2019. More than 50% of the cases involved psychological violence, the rest being physical, sexual, economic, or legal violence and hate speech. Gay men are the first victims of violence (552), followed by lesbians (214) and transgender people (64).

UN Women has supported the promotion of gender equality in broad terms, with a budget of 3.2 million USD/year for 2018-2020. This provided for Women's Economic Empowerment: 45.1%; Governance, Leadership and Political Participation: 32.1%; Humanitarian Action, Peace and Security: 22.3% and End Violence Against Women: 0.5%. The efforts of the JP, in collaboration with stakeholders is establishing increasing tolerance, better respect of human dignity in trials; increased access to services, despite the status quo of the law and oppressive social norms.

Policy and programmatic response and financing

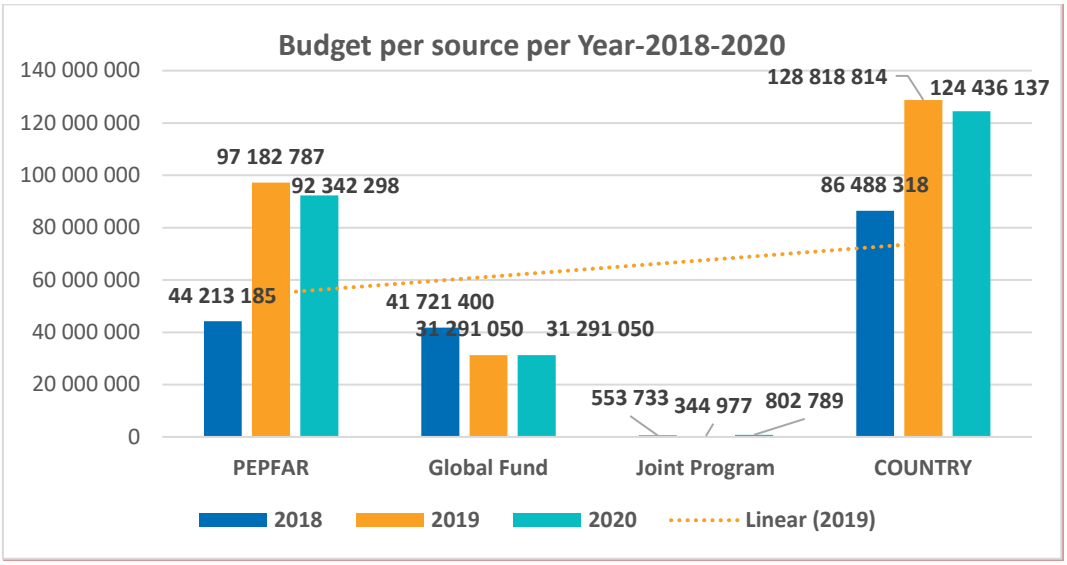
Despite the criminalization of sexual or drug use identity, the National Policy (which is the inclusive pack of regulatory and legal documents including the NSP) involves the inclusion of KPs (SWs; MSM; TG; PWID; Prisoners) in national strategic planning[27] (consideration as priority groups towards the elimination of HIV/AIDS). The ratification of the Universal Declaration Human Rights by Cameroon and its Constitution provides for equal access to health and social services for all. The penal code prohibits violence, stigma and discrimination against any person. The national programmatic response for KPs includes subventions (NFM2 2018-2020, NFM3 2021-2023 Global Fund), collaborative programmes (USAID/PEPFAR/CDC: COP2018; 2019; 2020; 2021) and technical assistance ventures (JP UNAIDS 2018-2021) providing for an inclusive package of services to control HIV/AIDS and to establish an enabling environment for health interventions and socio-judiciary protection vis-à-vis key populations.

The domestic contribution of funds to the control of HIV/AIDS remains insignificant (less than 0.001% of national health spending). The state relies on its contribution in-kind (Infrastructure, Human Resources, Governance & Enabling environment). The external sources (mainly Global Fund and PEPFAR) provide for gaps of the local funding; prevention, treatment, and care; reduction of abuse (human rights, gender, stigma and discrimination (S&D)); empowerment of KP communities and reduction of socioeconomic vulnerability of beneficiaries. The budget distribution is reflected by Figure 1 below.

[26] Annual report 2020 on violence against sexual and gender minorities in Cameroon, UNITY Platform

[27] PLAN STRATEGIQUE NATIONAL VIH 2018-2022_FINAL; PLAN STRATEGIQUE NATIONAL VIH 2011-2015; PLAN STRATEGIQUE NATIONAL DE LUTTE CONTRE LE VIH, LE SIDA ET LES IST 2014-2017; Décision n0: 1106/D/MINSANTE … du 15 Juin 2015 Portant création du Groupe travail Ad Hoc sur lutte contre le VIH/SIDA chez les HSH, Travailleuses du Sexe et leurs Clients au Cameroun, Health Sector Strategy 2016- 2027, Constitution, Penal Code etc.

Figure 1: Budget for HIV by year and source - 2018 to 2020 (US$)



Between 2018 and 2020[28], the budget for HIV control in Cameroon has accrued from USD 86,488 318 USD in 2018 to USD 124, 436, 137 in 2019 and USD 124 226 208in 2020. The main source of funds is PEPFAR providing 51%; 75%; 74% of external funding for 2018, 2019, 2020 respectively. The Global Fund has contributed 48%, 24% and 25% in 2018, 2019, 2020. The JP contribution is much smaller, in line with their mandate, at 1%, 0.46% and 0.48%.

The Joint Programme Response

Partnerships, orientation and approaches of the Joint Programme

In Cameroon, the Joint Programme relies on 11 agencies of the United Nations that are active within the Joint Team on HIV (UNDP, UNICEF, UNFPA, WHO, UNHCR, WFP, ILO, UNESCO, OCHA, UN Women and UNAIDS Secretariat). The JP's main partners by sector include NACC; CCM; ministries and high government bodies in charge of Health, Police, Gender, Human Rights, Social Protection in the Public Sector; International and National NGO/CSOs (CARE, CHP, YDF, Horizons Femmes, PSI/ACMS); Key Population organizations (Alternative Cameroon, Affirmative Action Cameroon, Humanity First, Empower Cameroon, Ladies' Wake-Up, JAPSO, Colibri…) and networks (such as the UNITY Platform, and RITA).

In Cameroon, the JP implements strategic results areas (SRA) with a focus on combination prevention for youth (SRA3), screening and treatment for PLHIV (SRA1); and activities to strengthen the enabling environment (SRA6) as shown in column 2 of Table 5 able below. Column 3 indicates the specific activities for key populations under each of the SRAs.

[28] 1 Global Funds' subventions' budget: NFM2 2018-2020, NFM3 2021-2023; 2. USAID/PEPFAR/CDC: COP2018; 2019; 2020; 2021); 3. Budgets of the UNJPA annual plans 2018, 2019, 2020, 2021.

Table 5: Joint Programme orientation, approaches and key population specific responses

Strategic orientation	Approaches in Cameroon	Key population specific responses in Cameroon
HIV prevention for displaced people in targeted locations	ARS 3: Access to combination prevention and the ability to protect oneself from HIV among young people and adolescents	**Combination HIV prevention in 95% of mapped hot spots as needed:** ▪ SW, MSM, PWID. ▪ Adolescents and young people
HIV testing and treatment for displaced people in targeted locations (Littoral and West)	SRA1: Access to screening, knowledge of the status, immediate, quality, continuous, affordable treatment for PLWHIV children & adults.	**Differentiated HIV services by the community:** ▪ Individual & family screening, active case finding, ARVs, sensitization of the lost to follow-up, mentoring, liaison, retention, etc. ▪ Availability of complete disaggregated data (place, age, sex) demonstrating the achievement of 95-90-90 in the target populations. ▪ Improved data on HIV-related S&D (in communities; in health facilities) and in all locations will be available and demonstrate significant progress towards the zero S&D goal.
Human rights, stigma and discrimination	SRA 6: Removal of punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV.	**Normalization of HIV:** ▪ Fast Track Cities and the HIV Prevention Coalition, ▪ Interventions on the creation of a legal and human rights framework more conducive to a wider participation of civil society.

(Source: PLAN CONJOINT 2021 JUNTA 29062021[29])

[29] Equipe conjointe du système des Nations Unies sur le VIH/SIDA, Plan Conjoint 2021

Case Study Findings

Relevance of Joint Programme activities

In Cameroon, 11 cosponsor agencies have contributed to the JP's work targeting the five key population groups, to varying degrees. The evaluation team designed a scale to determine the level of relevance of the JP activities. Table 6 below summarizes the analysis.

Table 6: Relevance of activities to the needs and priorities of key populations

Interventions	UNAIDS Cosponsors	Focus			Number of regions covered	KP groups included in activities (no of groups in brackets)
		Rather specific to KP (designed specifically for one or more KP groups)	KP & others (not designed for KP groups but may benefit them)	Rather specific to general population		
Education	UNESCO, UNWOMEN, UNFPA	-	1	2	10/10 regions	MSM; PWID (2)
Training	UNICEF, WHO, UNAIDS	1	2	-	2/10	SW (1)
Prevention-Treatment-Care	WHO, UNFPA, UNICEF, ILO, UNHCR, WFP, UNWOMEN, UNESCO, UNAIDS, WB	1	2	1	6/10	SW; MSM; TG; PWID; Prisoners (4)
Human Rights: Legal services & Literacy; S&D; GE; Actors Awareness	UNAIDS, ILO; UNDP, UNWOMEN, UNESCO, UNICEF, UNFPA	1	2	-	6/10	SW; MSM; PWID; TG; Prisoners (5)
Financial Support	UNICEF, UNAIDS, WB	1	3	-	5/10	SW; MSM (2)
Networking & community Development	UNAIDS, ILO, WHO, UNICEF, WFP, UNFPA, UNDP, UNWOMEN	1	1		10/10	SW; MSM; IDU; TG; Prisoners (5)
Alternative Subsistence	WFP, UNAIDS		2	-	2/10	SW (1)
Enabling Milieu / Advocacy	UNAIDS, UNFPA, UNICEF, WHO, ILO, UNDP, UNWOMEN, UNESCO	1			4/10	MSM; PWID; SW; TG; P (5)
Total/Average	10	6	12	2	5, 6/10	25/40
Proportions	10	6/20	12/20	2/20	5/10	
%		30%	60%	10%	51,25%	62.5%

The table above shows that most activities (90%) target KPs but of these only 30% specifically target KPs, whilst the majority (60%) benefit KPs as well as other populations. A minority (10%) of the activities focus on the general population. It also appears that the coverage of the country was partial, depending on the specific activities, ranging from 2/10 (Alternative Subsistence) of the country regions to 10/10 (Education). Per key action, the average inclusion of specific groups of KPs was 62.5% (3 out of 5).

The above activities of the cosponsor agencies are aligned with UNAIDS seven key activities for stigma and discrimination response[30] namely: Stigma and discrimination reduction; HIV-related legal services; monitoring and reforming laws, regulations and policies relating to HIV; Legal literacy ("know your rights"); sensitization of lawmakers and law enforcement agents; training for health-care providers on human rights and medical ethics related to HIV; and reducing discrimination against women in the context of HIV. The various forms of execution included workshops, Behaviour Change and Communications, and advocacy sessions, school lessons.

Prevention-Treatment-Care related activities to key populations especially through the involvement of CSO/CBO representatives in service delivery. The latter locate KPs, raise awareness and distribute inputs (lubricants, condoms) to them including through drop-in centers set up by UNFPA with the support of WHO. KP representatives also provide testing (community level and self-testing) and link positive cases with HFs and monitor key populations compliance with treatment. Training sessions to address the specific needs of KPs have been held at health facility level to equip the health staff with competences for relevant care and treatment. Training and technical support for health staff to strengthen health facility capacities regarding mental health as well as specific health issues for certain key populations such as those related to anal sex (MSM, prisoners) have been undertaken.

Ongoing gaps identified include (a) inputs to care for injuries resulting from the violence suffered; (b) tests and liaison with health centers for other pathologies associated with HIV (Tuberculosis, Hepatitis, etc.) that affect KPs due to their lifestyle (e.g., sharing syringes and pipes for PWIDs), and (c) hormones for TG people. The respondents in this evaluation also reported the lack of health service training focused on TG people, PWID and failure to address prisoners in activities. Support by the Joint Programme to key population communities, CSO/CBOs, drop-in center to strengthen institutional capacity and increase geo-demographic coverage and networking is also limited.

Financial Support was implemented through a Cash Transfer Initiative with an amount of 72,352,000 XAF[31] (about 130,400 USD), i.e. 76,000 XAF (about 140 USD) per beneficiary). This enabled 952 PLHIV, SW, MSM and TG people to meet their most emergent needs, such as food, transport, including for the collection of medicines and the payment of school fees. For KPs the lack of money is a barrier to the continuity of activities (beneficiaries and CBO agents included) such as travel from CBOs to PWIDs and vice versa. Alternative livelihoods required training and technical support for 355 PLHIV (83% women), beneficiaries of income-generating activities on the related management.

Human rights and gender equality were supported by most cosponsor agencies (cf. see Table 6 above). **Legal services** were provided by KP organizations (Empower Cameroon, Alternative Cameroon, Camfaids, etc.) assisting victims via advice, mediation or denunciation in the advent of police abuses, arrest and unfair trial. Hence, in some cases dignity and the safeguard of KPs' rights were protected resulting in return to freedom when the claimed offences could not be substantiated in custody. The CSOs were receiving assistance from a law firm supported by the JP. The legal services are a critical added value of the JP from the standpoint of KPs members (as reported in KIIs) despite the limited geographical coverage of the intervention. Many of the cosponsor agencies have been involved in advocacy sessions aiming to improve the legal environment in favor of KPs. Thus, workshops were organized to recall the relevant ministries (in charge of justice, gender, etc.) of the signing by the Government of different international agreements on human rights, gender and equality.

[30] Updates on actions to reduce stigma and discrimination in all its forms, UNAIDS, 2017 (p20/33)
[31] https://www.exchangerates.org.uk › Average exchange rate in 2021: 1USD = **554.8235 XAF**

Stigma & Discrimination was addressed alongside human rights related activities. In this context, awareness-raising activities addressing discrimination against PLHIV were carried out within the framework of the "Global Partnership of Action for the Elimination of All Forms of Stigma and Discrimination Related to HIV". Trainings and workshops were organized by UNAIDS in health facilities for security forces and Magistrates in Yaoundé and Douala to foster tolerance and respect concerning the right to health and justice of the KP groups. Furthermore, 11 panel discussions on the extent of stigma, its causes, and relevant responses, were attended by 340 participants in health facilities, communities, and workplaces. Support was provided by ILO, UNAIDS, UNICEF, and UN Women. Awareness-raising against stigma and discrimination has been carried out for community leaders (chiefdoms; clergy), government and judicial bodies. Sensitization workshops for health workers against S&D and KPs against self-stigma were held. The programme is reported to have contributed to a less hostile environment for KPs, catalyzing their access to HIV care.

Capacity, resources and coherence of the Joint Programme

The cosponsor agencies work on the following 3 High Priority Areas with an emphasis on KPs and humanitarian zones in Cameroon: High Priority Area I**:** Prevention of HIV for IDPs in specific sites; High Priority Area 2: Testing and treatment of HIV for IDP in target sites of Littoral and West region; High Priority Area 3: human rights, stigma and discrimination.

The competence of the agencies is respected by civil society and government stakeholders and the work of different agencies serves as a thematic reference and setting of standards e.g. WHO treatment and care guidance for key population groups, or UNFPA's strategies in SRH programming. Each of the cosponsor agencies contribute specific thematic and technical knowledge across the above three strategic domains of the JP based on their expertise, and across nine[32] approaches of the programme. In Cameroon, the Division of Labour (DoL) stands as follows: UNDP: Human Rights; WHO: treatment of HIV/AIDS and associated pathologies among key populations; UNAIDS Secretariat: leadership/coordination; UNICEF: PTMCT; UNHCR: HIV among the refugees and Internally Displaced Populations (IDPs); UNFPA: condoms and Reproductive Health; WFP: nutrition and nutritional support against ARV side effects; ILO: S&D in the workplace (abuse, dismissal of employees who are PLHIVs). According to KP and different stakeholders' interviews, this represents an exceptional added value to the programme.

However, The JP is confronted with insufficient leadership and advocacy for KPs, which limits progress in generating KP domestic funding and in developing the KP agenda further. The UNAIDS Secretariat is yet to upgrade the KP response to a priority/integral agenda item of the UNCT & UNDAF coordination mechanisms. The Secretariat is yet to generate sufficient commitment by cosponsor agency country representatives to bridging programmatic gaps necessary to deliver an effective, coordinated, KP agenda in the country. According to stakeholders, the inability of agencies to concretize some of the specific assignments of the JP is related to lack of leadership from the Secretariat. For example, the JP entrusted UNDP and the World Bank to mobilize the needed non-core funds from non-UN sources but this was not undertaken and prompted the cosponsor agencies to draw from their core budgets, the share of which was not sufficient or effective enough in relation to need.

The human resources are available among the cosponsor agencies to carry the Technical Assistance (TA) work of the JP and to participate in existing interagency coordination platforms (UNCT, Thematic groups, etc.) country team and the regular meetings to take the KP agenda forward. Nevertheless, the funds available to the JP are reported insufficient by all stakeholders and beneficiaries. The different small-scale projects or initiatives supported by the JP do not support a sufficient portion of KP needs (e.g., provision of health products, support to income generating activities, testing) neither do they go far enough (e.g.: support to the normalization of the police custody and the judiciary

[32] (1)-Advocacy ; (2)-Education ; (3)-Training ; (4)-Health care services (including testing and treatment) ; (5)-Counselling, legal services; (6)-Human rights; (7)-Financial support; (8)-Networking and community development; (9)-Alternative livelihoods.

processes not bridged through the institutionalization stage) and KP-led organizations report gaps in addressing their needs, particularly PWID and TG needs

The internal coordination mechanisms of the UNCT and UNDAF is expected to ensure that there is neither duplication nor discordance between UN agencies interventions including those involved in the JP. However, there is evidence of gaps between cosponsor agencies including failure by some agencies to play their assigned role, for example, an insufficient supply of condoms by UNFPA; lack of mobilization of funds by UNDP and the World bank despite the assignment agreed with the JP.

There are also shortcomings in the coordination of efforts and lengthy processes affecting progress. An example thereof is the creation of a key populations' working group that has been in process since 2015[33].

There is a platform promoted by the US Embassy that brings together UN partners, bilateral actors and civil society organizations involved with the KP response. The JP are consulted by stakeholders of other programmes (USAID; EU; GIZ; CARE) regarding TA and the JP participates in these platforms. The Government, the UN and other actors (USAID etc.) have collaborated on elaborating the Health Sector Strategy[34] and the National Health Development Plan[35] to include KPs. However, there is evidence of poor coordination during implementation which can lead to duplication of services funded by multiple partners. Within the same health district/area different initiatives (JP; Global Fund; USAID/PEPFAR/CHAMP; UE; GIZ) are delivering the same services (condoms, lubricants, testing, counselling, treatment, etc.) often for the same KPs group(s).

Overall, and according to Key Informants the main challenges and bottlenecks to progressing KP responses include the presence of punitive laws, the high dependence of the HIV response on external funding; the weak coordination of the national HIV response by the government body in charge (NACC); gaps in mapping stakeholders and interventions together with the insufficient focus of the JP on the relevant critical strategic challenges.

Efficiency and effectiveness of Joint Programme activities

The following section presents finding regarding the level of achievement of the JP planned targets and whether the implementation was suitable to ensure the attainment of performance targets.

Implementation of activities and coverage of KP groups

The JP has implemented activities concerning the three priority areas of intervention and the five KP groups have been reached through a pack of activities. However, the implementation of these activities has not always met expectations (completeness) with a late launch of some activities due to the scattered provision of financial resource and the coverage of KPs has not been proportional across activities and target areas. Furthermore, material resources were insufficient or not available (e.g: condoms, lubricants, hormones).

Geographically, as a result of the security situation and HIV prevalence in the country, the coverage of activities ranged from 2 to 10 regions. Most activities focused on five regions, namely: Centre, Littoral, West, South, and East. Only exceptionally the JP extended some activities to all the 10 regions of Cameroon, namely communications campaigns to fight against stigma and discrimination and promote the rights of PLHIV (education); training of 166 labor inspectors and social litigation magistrates on human rights (Training) and the use of available legal instruments to defend the rights nation-wide of workers who are victims of AIDS-related discrimination (HR).

Support in mobilizing and empowering key population led organizations

The JP has supported the mobilization of 100 CSOs/CBOs to contribute to the HIV response for KPs. These CSOs/CBOs are networking with national organizations like Alternative Cameroon, Humanity First Cameroon (for MSM), Horizons Femmes (HF) for SWs; Empower Cameroon for (PWID),

[33] Décision N0 : 1106/D/MINSANTE/CAB/SG/STBP/CNLS/SP/SPSE/of 15June 2015 creating an Ad hoc Taskforce on HIV control among MSM, Sex workers and their clients in Cameroon.
[34] Health Sector Strategy2016-2027 (HSS2016-2027)
[35] National Health Development Plan 2016-2020 (NHDP2016-2020)

Affirmative Action Cameroon (for prisoners and sex workers). The different projects going on in the country have established a rapport between KP related organizations from national to community level, including the support of WHO to community delivery of HIV services among key populations in the West of the country.

Owing to UNAIDS Secretariat support, the MSM (Alternative Cameroon), PWID (Empower Cameroon), sex workers (Horizons Femmes) groups are members of the monitoring and oversight commission of the Country Coordination Mechanism (CCM) of the Global Fund programme. They are also involved in UHC discussions. Additionally, owing to UNAIDS' support, associations working for all five KP participated in the elaboration of the NSP2018-2022, as well as to the development of the Global Fund New Funding Model 3 (NFM3) Request. UNAIDS Secretariat equally mobilized consultants during those two processes to ensure adequate inclusion and programming of KP orientated strategies and interventions. The UNAIDS cosponsors also associated different KP groups.

The JP has supported the putting in place of the UNITY platform, a national network of KPs-led associations, that operates at the strategic level to influence policies and strategies and coordinate the implementation of services at grass-root level by local CSOs/CBOs. The JP has offered different advocacy trainings and tools. It also supports the collection of data that backs the solicitations presented to the authorities and stakeholders on the ground of evidence. Some capacities were supported like developing communication for service intake, reduction of stigma and discrimination (S&D) and human right abuse, with CSO and individuals trained on their rights and possible recourses to protection. Thousands of people from key population groups were covered. Capacities of community leaders and those of health facility managers and SWs were strengthened to overcome societal obstacles and support community systems and community-led surveillance, particularly in West and Littoral regions with the support of ILO and WHO.

However, notable limitations affect the effectiveness of the JP in ensuring that KP-led CSOs can significantly monitor and insure accountability of policies and programmes and the implementation of services***.*** Among these are: (a) the very low number (100) of CSOs/CBOs mobilized. The 100 of organizations is insignificant, with a ratio of 0.5 per Health District (100 vs 200 HDs) and 1/18.5[36] Health Areas (HAs). The support of the JP to CSOs also restricts to 3, 6 or 12 months with limited budget (inferior or equal to 10 000USD). Most of the support is absorbed by services development and delivery to the detriment of institutional strengthening and significant effort towards an enabling environment. This applies to the non-institutionalization of novelties taught to decision makers of the legal/judiciary sector that are yielding respect of human dignity towards KPs, during security forces & legal procedures.

Humanitarian settings

The JP has responded to the needs of KPs in humanitarian settings by supporting the establishment of comprehensive and specific tailored interventions with the contribution of WHO, UNFPA, UNAIDS, UNHCR, UNDP, UNESCO and WFP. Among such interventions were communication for change of behaviour (radio, tv, posters at health facilities & public venues), awareness raising on covid-related risks and access to services vs HIV, associated diseases, and Sexual & Reproductive Health (SRH) and family planning (FP), advocacy, provision of shelters, maintaining children at school with adapted education, provision of food and nutritional advising.

The JP also responded to needs of KP Internally Displaced Populations who were covered by an inclusive pack of services. About 603 PLHIV have received COVID-19 personal protection kits.

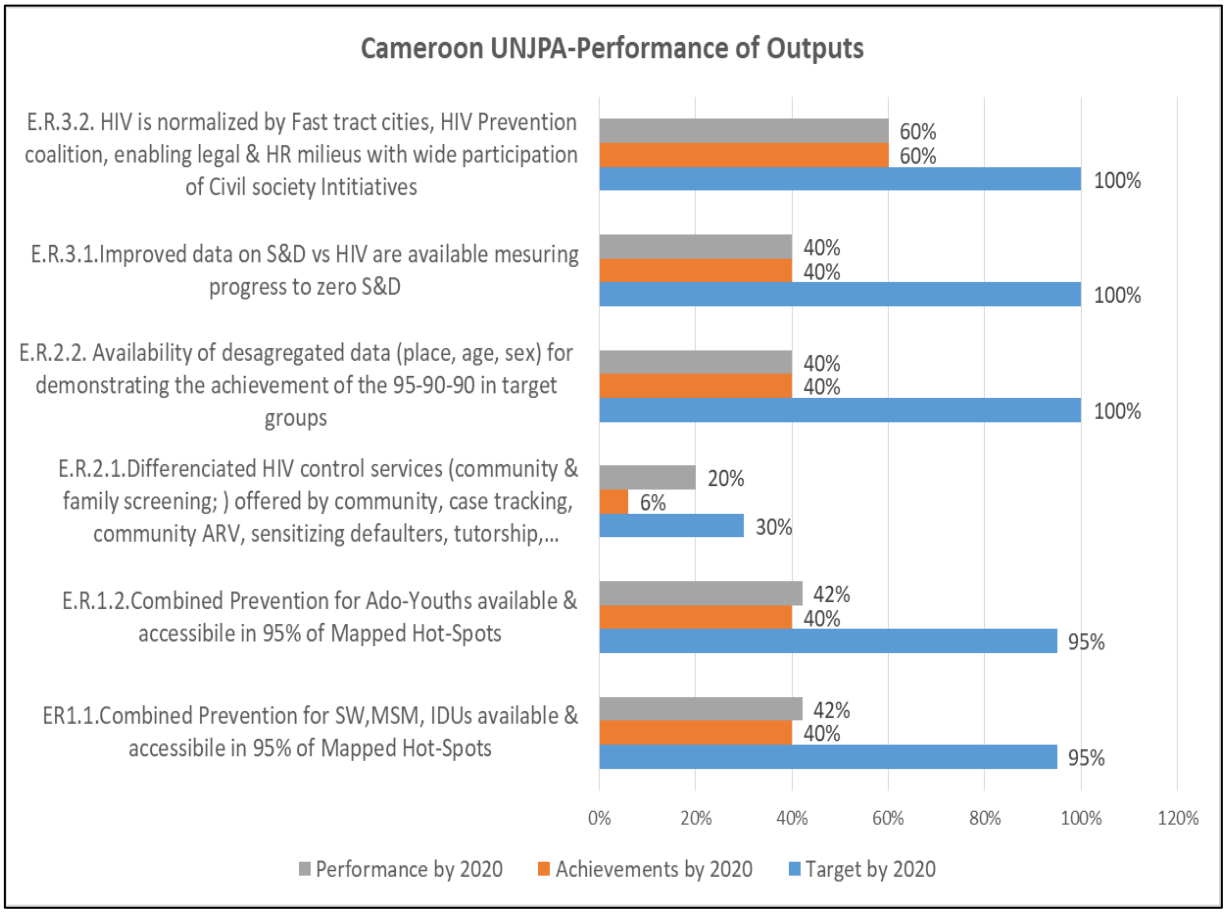
Nevertheless, some shortcomings were noted including the insufficient coverage and the discontinuity of the provision. The support to the service delivery capacity of institutions was poor. The condoms were insufficient and only one supply recorded. The provision for needs in subsistence was quite low. The funds covered a few with many others left with barriers to access to services.

Contribution of the Joint Programme to outputs and intermediate outcomes

[36] DHIS2 : 1810 Health Areas in Cameroon.

In Cameroon, the JP pursues six outputs, the achievement of which is expected to contribute to the achievement by the country of its targets within the "fast track" commitments to end HIV by 2030[37]. Figure 2 below shows the progress of the JP in achieving its six outputs (that are aligned to the national strategy for AIDS control 2018-2021 in Cameroon).

Figure 2: Performance of the Joint Programme against expected results

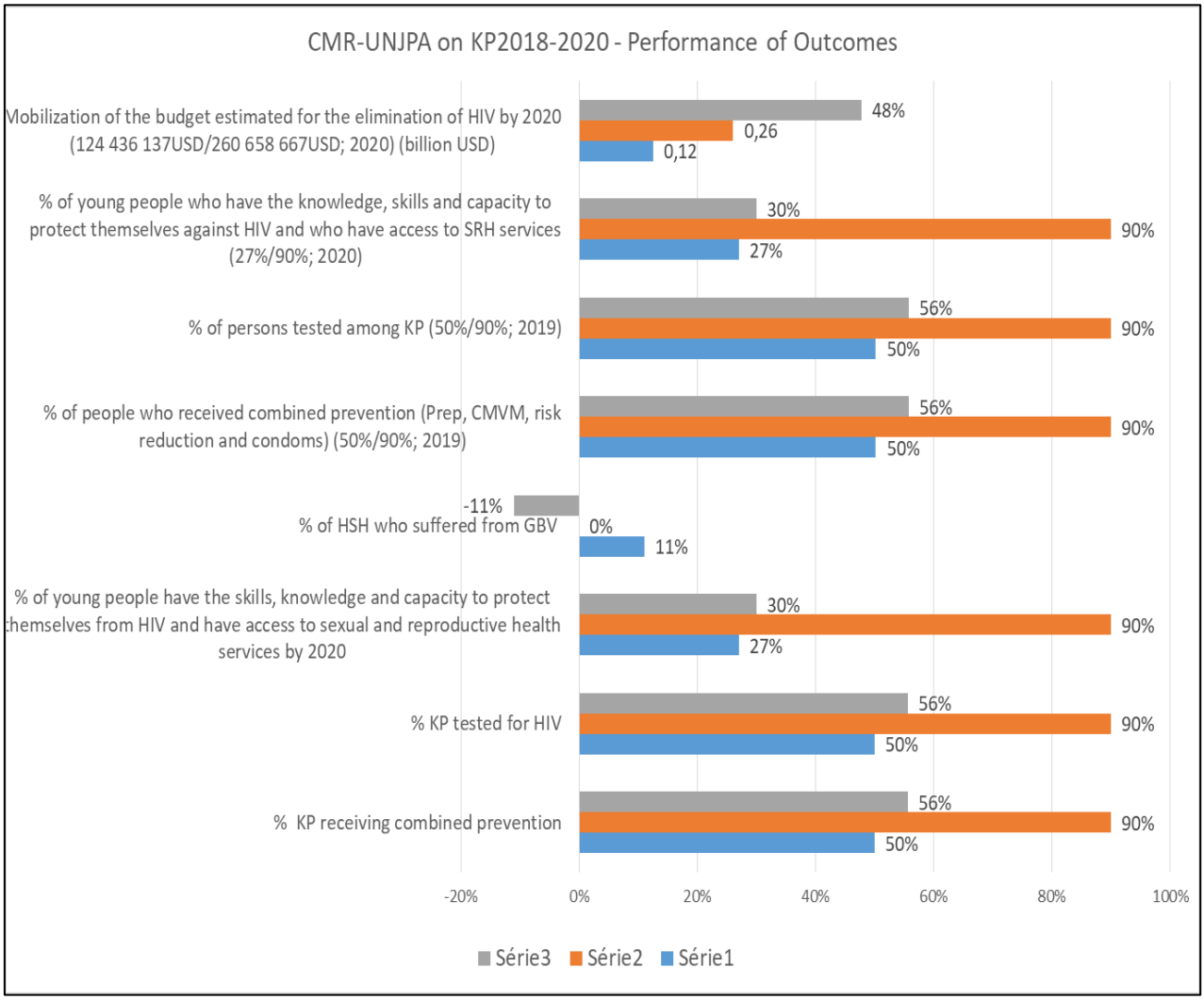


The performance on the expected results at the output level of the JP on KPs ranges from 20% to 60%. The output E.R.3.2. On the "normalisation of HIV" records 60% achievement. While the delivery of differentiated service by the community is significantly lower at 6%. All other outputs stand within the interval 40%-42%; indicating that notable efforts have been invested, though much is still to be done in order take results to a significant scale.

Contribution of the Joint Programme to expected outcomes: Since 2018[38,39] the JP has implemented interventions in its three high priority domains and progress has been recorded against six outputs. The performance on country outcomes ranged from -11% to 56% (Prevalence of GBV in MSM to % of KPs covered with combination prevention services). The negative evolution (-11%) concerns the percentage of MSM who suffered GBV, where an increase was recorded instead of the planned reduction.

[37] https://www.unaids.org/sites/default/files/media_asset/fast-track-commitments_en.pdf
[38] Country Report_ CMR_2018
[39] Country Report_ CMR_2019 ; Country Report_ CMR_2020

Figure 3: Progress in the response to HIV against key indicators



Combination prevention services

Priority Area 1 of the Joint Programme covers HIV prevention for displaced people in targeted locations, young people, especially young women and adolescent girls included combination prevention services and empowerment support so the beneficiaries would protect themselves from HIV. The combination HIV prevention services focused on the specific identified needs of SWs, MSM, PWID and were provided in hot spots. All combination HIV prevention services focused on the specific identified needs of adolescents and young people were provided in hot spots. Through its support, the JP has contributed to the coverage of combination prevention services for KPs, specifically, SWs (14, 507 in 2018 and 24,958 in 2019), MSM (11,922 in 2018 and 7,944 in 2019) and prisoners (15,364 in 2018 and 21,418 in 2019)[40]. However, the data does not give an indication of the service packages or quality of services actually delivered. As indicated in the overview of the HIV epidemic, in 2019 the total number of key populations in Cameroon was estimated to be 110,700. The breakdown is 70,000 SW; 7,500 MSM; 30,700 prisoners; 1,250 PWID and 1,250 for TG people (estimated figure in the absence specific data).

HIV testing and treatment

Under High Priority Area 2 of the Joint Programme HIV testing and treatment for displaced people in targeted locations, differentiated HIV services (community HIV testing, active case finding, family testing, community distribution of ARV, outreach to those lost to follow-up, mentoring, liaison, and retention, etc) were provided within the community by KP members. Data collection and analysis

[40] CMR reports 2019 and 2020

activities were conducted to ensure the availability of comprehensive data, disaggregated by location, age and sex. This served as the basis to assess achievement of the 90-90-90 goals in the targeted population groups.

Stigma and discrimination

As part of High Priority Area 3 human rights, stigma and discrimination, the Joint Programme undertook advocacy, training and supported data dissemination, towards the removal of punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV. Support was provided to all key populations with special emphasis on women's empowerment centers for the generation of improved data on HIV-related stigma and discrimination (both at community and health facility level across the 200 Health districts in Cameroon) and to the KP CSOs. Surveys and reports on stigma and discrimination, gender-based violence and harassment including by police and gendarmerie forces are critical contributions of the Joint Programme in all settings (family, community, workplace, schools, markets and other publics spots). Such data is used by the Joint Programme to develop advocacy activities targeting the security forces, the judges and legislators. The support was provided UN Women; UNAIDS; UNICEF; UNDP; ILO; OCHA and UNESCO. This information has been used to demonstrate significant progress towards the goal of zero stigma and discrimination.

Human rights and gender equality

The promotion of human rights, gender equality and reduction of criminal/discriminatory laws, stigma and discrimination shows substantial advancement. This includes (a) advocacy with and training of legislators and legal actors to conform arrests and judicial process to human dignity requirements and contribute to the decriminalization the KP practices; (b) the increased acceptance of key populations in society following communication for development and advocacy to reduce stigma and discrimination; (c) the increase in the number of organizations providing services and support to key populations; (d) the co-implementation by many UN agencies of human rights and gender equality GE promotion (UNFPA, UNAIDS, UNDP UN Women , UNHCR, ILO).

Concerning data collection, the JP has supported the country generation and use of disaggregated KP-data (including use of KP-generated data) for strategic planning and resource allocation processes. The support of the UNITY platform to produce annual reports on GBV against the LGBTI community in Cameroon is a success story.

The initiatives of the Fast Track Cities and the HIV Prevention Coalition, as well as interventions to create a legal and human rights framework more conducive to broader civil society participation, were conducted. The aim was to contribute to the normalization of HIV through a reduction of stigma and discrimination. Broadly, the administrative environment is sufficiently tolerant though insufficiently decriminalised.

HIV data for tracking of the 90-90-90 targets

Efforts to strengthen the data system through an integrated data collection mechanism (ASRH/ HIV/ GBV/ COVID-19 data) are in the pipeline of the government. Health Facilities, CSOs/CBOs and community health workers have been trained and supplied with data system tools to record services including data on the sex, age and place. Nevertheless, the support of the JP fails to provide comprehensive and reliable data on the size and HIV prevalence of the different key population groups. HIV prevalence data are only available for MSM, SWs and PWID. Mapping (beyond indicative size estimates) is not available for any of the group. Hence, the needs of the KP groups cannot be determined, to the detriment of rationalized strategic planning and resources allocation. Data on the service delivery for KPs are also limited. While support to include GBV in national transversal studies (DHS; MICS) is a positive achievement, the including KPs specific data, biosocial-wise and epidemiologic-wise remains challenging.

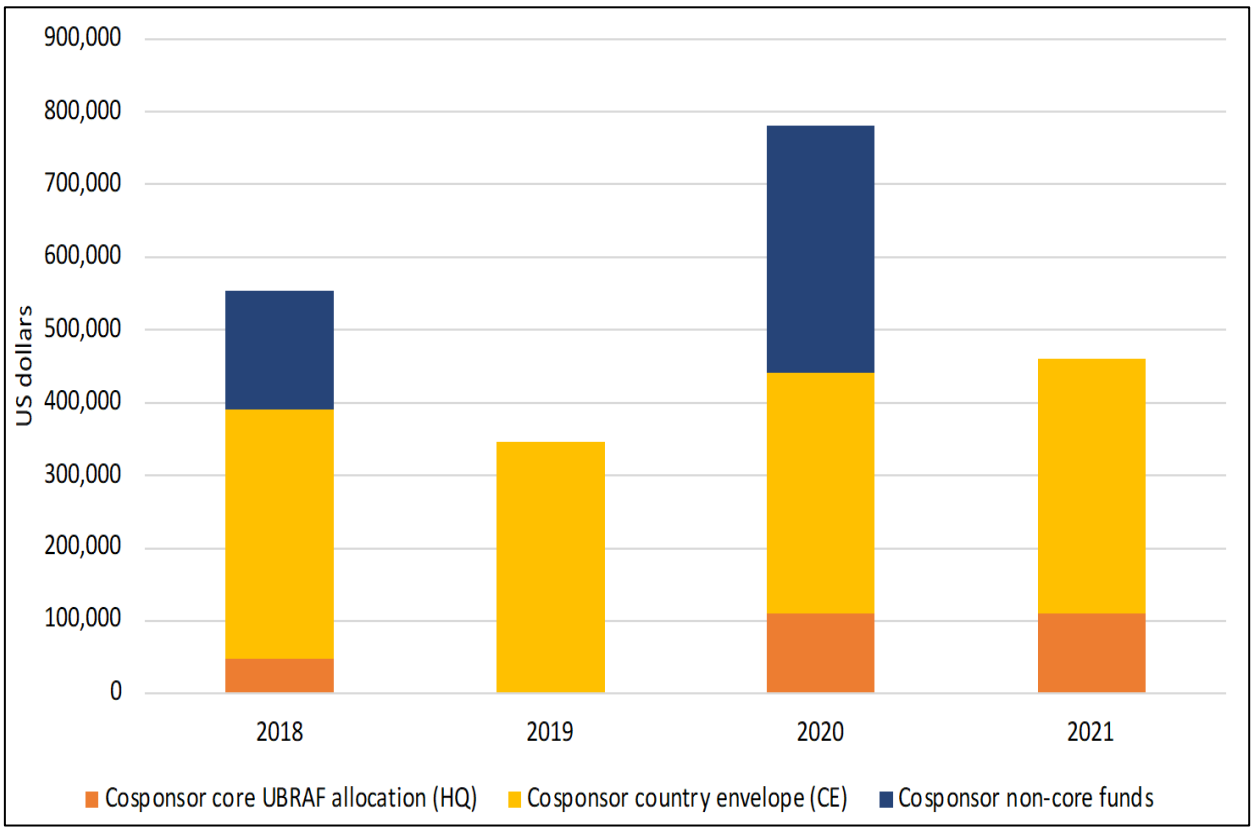
In a nutshell, there are significant achievements concerning the availability of strategic information on the key population response. However, fragmentation, the lack of a performance framework, national reference denominators, gaps in mapping and standardization and quality assurance are limiting the usefulness and the quality of the data.

Resource mobilization

Cosponsors consider that the resources mobilised during the evaluation period are insufficient to achieve the national plan and JP objectives. The mobilization of funds has increased between 2018 and 2020[41], with the budget for HIV control in Cameroon growing from US$ 86,488,318 in 2018 to US$ 124,436,137 in 2019 and US$124,226,208 in 2020. The main source of funds is PEPFAR with 74% of the funds in 2020. The Global Fund is the second provider with a contribution of 25%.

Figure 4 presents the total budget by funding source across the UBRAF 2016-2021 Strategic Results Areas (SRAs) and agencies/cosponsors between 2018 and 2021. As shown, the cosponsor agency country envelopes have remained largely consistent over time, although the significant variation in the budget for cosponsor agencies non-core funds by year suggests that the data is incomplete for some years.

Figure 4: Joint Programme funding by source – 2018 to 2021 (US$)

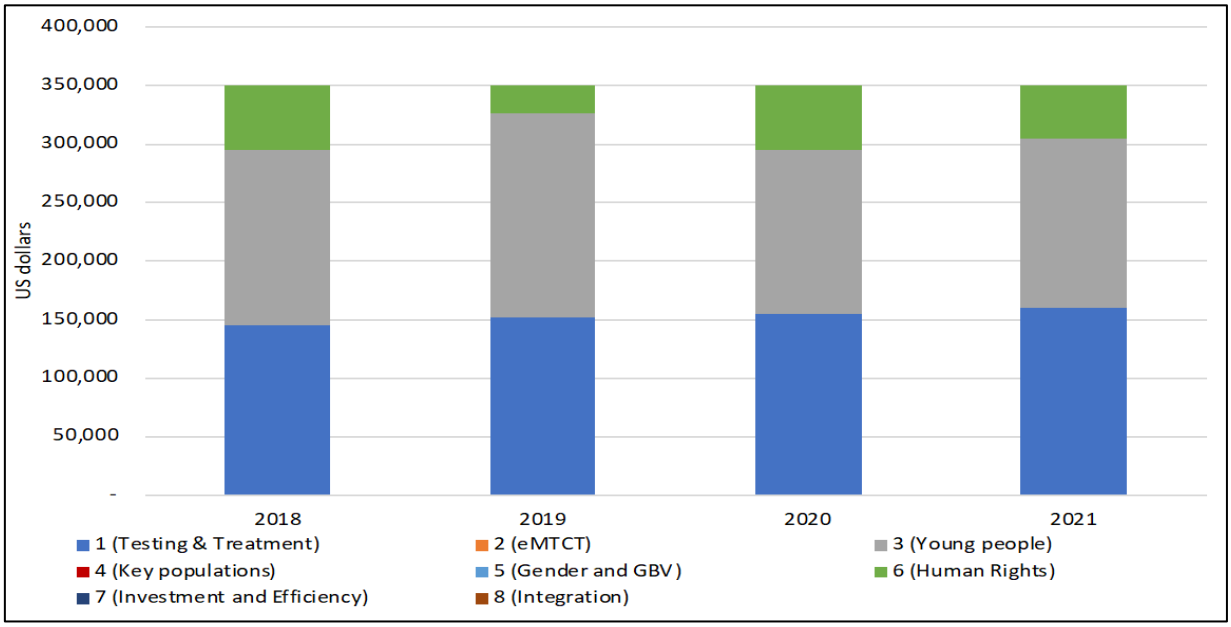


Source: Download from JPMS

Figure 5 shows that most of the country envelope budget is for SRAs 1 (Testing and treatment) and SRA3 (Young People), with some budget for SRA 6 (Human Rights). There is no specific budget for SRA 4 (Key Populations).

[41] 1 Global Funds' subventions' budget: NFM2 2018-2020, NFM3 2021-2023; 2. USAID/PEPFAR/CDC: COP2018; 2019; 2020; 2021); 3. Budgets of the UNJPA annual plans 2018, 2019, 2020, 2021.

Figure 5: Country envelopes by Strategic Result Area – 2018 to 2021 (US$)



Source: Country envelope databases shared by UNAIDS.

Response to contextual factors

The Joint Programme has demonstrated flexibility and adjusted actions to respond to the changing context/landscape and emerging issues of different KP groups through changes in advocacy, partnerships with the critical administration (security forces, ministries of health, justice, women's affairs). Specific issues of TG people and PWIDs have been tabled by UN organizations under the agenda "leaving no one behind" and the principles of human rights and access to health services. However, the ministry of health in Cameroon has assimilated two KP groups (TG; Lesbians) with the MSM in order not to upset the public opinion and the established legal order. The JP is adopting a step-by-step approach towards changing the enabling environment. The JP's actions have established traction and impact in changing the human rights and health landscape affecting KP groups.

Sustainability of the results of the Joint Programme activities

The sustainability of the results of the Joint Programme's work, particularly for key population-led organisations and responses is grounded on the following critical steps led by the Joint Programme:

(a) The reinforcement of acceptance vis-à-vis the KPs: the JP, under UNAIDS Secretariat leadership has supported the transformation of the legal and behavioral environment through capacity strengthening of health and legal providers to effect and promote abstention from abuse, S&D during services delivery or administrative processes regarding KP groups. The JP's support to Human Rights protection included judicial assistance from lawyers to ensure fair legal/judicial for processes for KP members. KPs CSO's including Empower CMR, Camfaids, Alternative etc. are sustaining this work by providing support to different KP individuals in need and perpetuating advocacy by the JP. The work to increase acceptance and judicial assistance are yielding some results, which stimulate the connection of KP members and reduces their auto-stigmatization across the five prioritized regions of the country (Centre, Littoral, West, East, South).

(b) The boosting of community participation and stakeholders' commitment: the JP has supported the decentralization, the improvement and the accessibility of HIV services including the intensification of the delivery within communities. With the leadership of WHO, the de-medicalization of testing (both community level test and auto-test) removed the transport/cost barrier. The strengthening of service delivery capacity at community level is facilitating autonomy and boosting coverage. The JP has supported the rise of drop-in centers, service providing

association, community cascade and synergy of care with reference Health Facilities, including tracing and returning more than 80%[42] of defaulting KP PLHIV to treatment.

The actions listed above and the explicit positioning of the JP cosponsor agencies as champions of the investment on KPs towards HIV elimination, has further boosted the open commitment of KPs' CSOs/CBOs and the support from different stakeholders (Multi/bilateral agencies, Global Fund, International and national NGOs).

Increasing political will. The current constitution of Cameroon[43] (1996) states the equality of all citizens including the right to health for all. There is no discriminatory policy or law vis-à-vis the access to health services. Owing to UNAIDS and WHO advocacy, provision of consultants, and their support to the participation of KP groups, the two recent national strategic plans (NSP 2014-2017 and 2018-2022) have made provisions for the delivery of health services to KPs specifically. JP support has contributed to some level of elaboration in the programming of services to KPs. The state grants authorization to KP-led or targeted associations based on the freedom of association[44]. Following advocacy from the JP, led by UNAIDS, the MOH created a Taskforce for the KP response in Cameroon which has been in place since 2015. The JP is supporting the NACC towards the operationalization of the Taskforce for an effective HIV response for KPs. The Government collaborates with stakeholders in the provision of services to KPs as priority groups for HIV elimination. The different actions taken by JP cosponsor agencies receive collaboration from the government. The JP succeeded in having KP representatives sit with government representatives in decision making platforms (CCM, Strategic planning, proposals development). According to people interviewed for this evaluation, the political will has resulted in a more inclusive environment.

Limited country health systems capacity. The health system operates continuously at three pyramidal levels. Though the mechanisms for a KP targeted HIV response were not in place until the JP-led the MOH and NACC to realize the need for a specific programming at the start of the last decade (2010s). Since then, at the central level, in terms of guidance, planning and coordination, the State engages with national partners (Alternative, Affirmative Action, Humanity first, Empower, Horizons Femmes, Femmes Santé et Développement, ACMS etc.) cosponsor agencies of the UN, PEPFAR, GIZ, CARE to achieve impact and outcome results including the creation of an enabling environment. At the regional level, regional delegations through the regional AIDS technical group (RTG) and regional hospitals coordinate partners and stakeholders of the health system in providing technical support to the operational (or Health District (HD)) level of the HIV response. The HD level of the programme supervises HIV services delivery by certified treatment centers (CTC[45]), HIV management units (HMU[46]) CSOs and communities (CBOs, Community Health Workers, social animators, and leaders).

However, the functionality of Cameroon's health system is not optimal despite progress made in HIV (reduction in the rate of new infections; improvement of the quality of life of those infected or affected, access to services, inclusion of KPs). The different challenges or bottlenecks include: an ineffective supply chain; the inequitable distribution of health facilities; the insufficient quantity and quality of human resources technologies and infrastructures; gaps affecting community participation and the mastery of the sociocultural obstacles to HIV elimination; the negative administrative and legal framework that jeopardizes access for KPs. Some KP groups are further marginalized (omission of TGs and PWID in the creation of the KP taskforce; mobilized technical assistance consultancies are rather equipped for MSM and SWs programming than for other KPs).

[42] Plan Conjoint 2021_JUNTA, p7

[43] Loi N°96/06 du 18 janvier 1996 portant révision de la Constitution du 02 juin 1972. https://www.prc.cm/fr/le-cameroun/constitution

[44] Law n° 2020/009 of 20/07/ 2020 revising law n° 90/053 of 19/12/1990

[45] Mbanya D. et al.; Current Status of HIV/AIDS in Cameroon: How Effective are Control Strategies? https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3699997/

[46] Zeh Meka A. F. et al. ; Challenges and barriers to HIV service uptake and delivery along the HIV care cascade in Cameroon in Research ; Volume 36, Article 37, 27 May 2020 ; 10.11604/pamj.2020.36.37.19046

Insufficient domestic resources
As mentioned previously, insufficient domestic resource allocations for HIV and high dependence on external funds for the HIV and KP response, threatens financial and programmatic sustainability. Also, the availability of funds tends to be punctual. National stakeholders lack the ability to mobilize significant funds. Only 1.3% of the total funds estimated for the elimination of AIDs in Cameroun by 2020 were mobilized.

Broadly, limitations to sustainability include the followings: The discontinuity of the supply of inputs for health services; the dependence on UN support or other external partners'; the vulnerability of CSOs/CBOs because of an insufficient institutional capacity; the negative effects of the harassment of staff and beneficiaries of programmes by security forces and the general population and the low institutionalization or formalization of progress achieved via advocacy. For instance, the respect of dignity in arrest and trials induced by trainings, workshops were not consolidated by SOPs, regulations, acts or other mechanisms forming integral process elements within the ministry of justice; police department etc.). Moreover, insufficient financial resources are expected to severely limit the progress made, once external support ends. Also, the very low number of target CSOs/CBOs mobilized is likely to impact on the sustainability of the KP programme.

Conclusions

Summary conclusions

Status of the key populations response and contribution of the Joint Programme
The HIV response environment is ambiguous with a mix of political will, increasing acceptance, growing participation of KP CSOs, and the rising commitment of stakeholders on the one hand, but with persistent repressive laws, significant stigma and discrimination, neglect of some KP groups (PWIDs and TG people) on the other hand. The coordination of actors is limited. The synergy is high during the strategic phase (development of NSP2018-2022) and Global Fund Funding Request but notably lower during the fundraising process of other funders and during the implementation and follow-up phases. The JP has championed the introduction of KP interventions in the national strategy, the increase of acceptance and access to KP services and participation and synergy of KPs' CSOs among achievements.

Joint Programme efforts involve impactful interventions/strategies in three strategic response areas. Among these are: (a) like testing-treating-tracking, combine and differentiated services, and integration of other pathologies (TB, hepatitis, STIs, SRH.) within an increased community participation; (b) human right and tolerance reinforcement for the reduction of barriers (official, financial, cultural, and physical) to HIV control services via transformative advocacy, training and awareness raising, financial support and the control of S&D. The mobilization of resources is insufficient due to the low contribution of the Government and failure from the community of stakeholders to attract the estimated funding that would bridge the KP response to HIV elimination.

Status of key populations programming and contribution
The JP has provided the toolkits for KP programming and offered trainings. This has helped to shape strategic KP programming, but it remains non-inclusive. There is a shortage of evidence for rational programming in the absence of a thorough mapping and reliable count of key populations' groups. The poor-involvement of certain KP groups such as TG people and PWID and resulting programmatic gaps means associated interventions are omitted (like hormonotherapy, minor surgery, anal care). The limited resources available restricts the geographic, demographic, and logistic coverage of JP and the other partners as well. The prioritization of the JP to supporting services is at the detriment of boosting the institutional strength of actors, especially CSOs/CBOs and mitigating the weakness of the pillars of the health system with a stress on resources raising.

Positioning of the Joint Programme in relation to other partners in the country
The JP is perceived by the local stakeholders as the champion and leader of the specific response to HIV among KPs because of its efforts in orienting and prioritizing this new direction. Most stakeholders (contractors of USAID; of Global Fund, Bilateral agencies) resort to UN cosponsor agencies technical support to improve the implementation of programme. However, this can have sociocultural implications with perceptions that ''*… the JP is striving to impose deviant sexual practices and drug use on the local culture and administration*."

The role played by the Joint Programme in brokering space for key population-led groups in decision making processes
The JP leads the brokering of space for KP networks in decision making processes through the support to (a) the introduction of KPs matters in national policies and strategies (NASP2018-22); (b) the operationalization of the national task-force for KPs entities, where UNAIDS is a nominated member of the steering committee created in 2015' and (c) the participation of KPs in the national dialogue processes, which is key to successful Global Fund support. .

However, the JP has failed to focus equal attention to KPs other than MSM and SWs/Clients and the JP's activities have yet to impact the law-based, social, economic, and inter-communities barriers that hamper the KP influence in decision making and access to services.

Gaps, challenges and proposed actions for the Joint Programme

Major gaps and challenges to be addressed are summarized in the table below together with proposed actions for the Joint Programme.

Table 7: Gaps, challenges and proposed actions for the Joint Programme

Gaps and challenges	Key population groups					Proposed actions
	SW	MSM	IUD	TG	Pr*	
Insufficient knowledge of population size and location		x	X	x		Mapping & enumeration study
Insufficient technologies and medicines for care in particular hormonal and anal care		x		x	x	Contribute to & support capacity building in resources mobilization
				x		Programming of hormones for transgender people
Economic barriers to service for poor/vulnerable key populations	X	x	x	x	x	Support the scaling up of income generating activities
Insufficient coverage in one-stop-shop for services	X	x	x	x	x	Mainstream the distribution of inputs around the one-stop-points
Persisting stigma and discrimination still to be reduced	X	x	x	x	x	Investigate & implement best options for S&D reduction
Quantification of inputs not grounded in evidence		x	x	X		Coach data driven planning
Weak programmatic and financial reporting	X	x	x	x	x	Reinforce the M&E system

Pr*: Prisoners

Considerations for the Joint Programme

Technical considerations

The Joint Programme should consider continuing with:

- One-stop-point to address all 5 key population groups
- Establishment of developed and supported drop-in centers; with a specialist doctor e.g. proctology /MSM; Specific services for drug users.
- Growing (but still weak) involvement of CSOs / CBOs in the design and implementation of activities
- Income generating activities financed for the relief of the most disadvantaged beneficiaries
- Distribution of self-tests for confidentiality
- Enhancement of functioning of existing (Embassies-UN-CSOs) and forthcoming (KPs Stakeholders Workgroup) coordination mechanisms.

The following actions should be phased out:

- Supporting extra-community health facilities with packs of inputs destined for key populations; that can be managed by community health facilities (e.g. proctology for MSM, hormones for TGs).

Cross-cutting considerations

1: Optimizing the contribution of the Joint Programme
The JP should concentrate on technical assistance, influence on the enabling environment, system and stakeholders strengthening to optimize the impact on HIV outcomes while avoiding unnecessary dispersion of its limited resources. The inclusion of operational interventions should be for the purpose of learning, namely the piloting of strategies/actions to assess/test their added value.

2: Mobilization of sufficient resources
The JP should embark on a thinking and design process to lead to an effective and lasting strategy for resources mobilization that matches the ambition of HIV elimination in the medium term.

3: Creating an enabling environment
The persistence of repressive laws, stigma and discrimination and legal and social abuses should undergo a systemic analysis looking at psychological, cultural, societal aspects and dynamics. This would enable the JP to generate evidence and implement actions that are based on evidence . Operational research should be the corner stone of the innovation process towards the reduction of legal coercion and societal rejection.

Considerations by evaluation criteria

1: Relevance
The JP should enhance the relevance of its interventions by including the following:

(a) Conduct the mapping and an integrated biological and behavior survey to generate the knowledge needed for an adequate programming of an HIV response with and for key populations

(b) Conduct needs assessment by KP community and involve community members in the planning phase to avoid the omission of specific needs like hormonotherapy for TGs, injury management Kits for PWID, SOPs for a reliable HIV testing process of PWID.

2: Coherence
To reduce shortcomings such as the duplication of services, the JP should consider reducing and omitting less effective interventions while strengthening best practices or knowledge where

available, and with other stakeholders; the JP should support the implementation of the stakeholder coordination committee on KPs response created in 2015 by the Minister of HIV.

3: Efficiency

The JP should rationalize approach towards efficiency including: (a) mobilizing an adequate expertise to readjusting the estimate of the total funding amount needed for the elimination of HIV, (b) proposing a reliable tool/or reinforcing the related competence in assessing costs by programme component/activity/needs /beneficiaries; (c) timely fund disbursement to stakeholders through the operationalization of electronic financing opportunities; (d) institutionalization of mechanisms (such as change of regulation, SOPs) should be built-into the support process delivered to stakeholders (security force, media, justice, women affairs, social protection) for transformation of practices concerning human rights and stigma an discrimination.

4: Effectiveness 1 – enhancing response monitoring by CSOs

In order to enhance the effectiveness its support to ensuring monitoring and accountability of policies and programmes and implementation of services by KP led organization, the JP would need implement a relevant capacity building of the CSOs including:

(a) The provision of critical tools, knowledge and programming processes concerning the monitoring of decision makers' commitments or responsibilities towards the awaited steps to an enabling environment. (b) Develop an advocacy vision, a related strategy, and a plan to keep the CSO's network on a constant work and track through the final goal « zero » barriers to the success of HIV response for KPs.

5: Effectiveness 2 – programming CSOs

The JP could support the NACC to overcome the shortcomings of HIV response effectiveness that tie with the inadequacy of programming and the insufficiency of the implementation of community level activities; both fuelled by the insufficient number of mobilized CSOs and the low proportion of services delivered by the CSOs. This will involve determining the total number of CSOs to mobilize, setting up an operationalization and coordination mechanism.

6: Effectiveness 3 – enhancing data system for KP

The JP needs to support the NACC with an enhancement process towards a structured data system on the KP response. This implies putting in place and/or improvement of the related sectors' data systems (security forces, Family & Women's Affairs, Justice, Human Right Commission), networking and centralization by the National Institute of Statistics (INS). In addition, the JP should reinforce the M&E system in place to improve reporting at all levels.

7: Sustainability

The JP should support the Government in optimizing the sustainability of interventions through: (a) Putting in place a sustainable financing strategy supported by all stakeholders, based on adequate building of skills ; (b) Strengthening the health system (functionality of the supply chain, adequacy of workforce; (c) Adjusting the programming of human and material resources (equipment, infrastructure) to match the universal access to HIV services; (d) Determine the necessary minimum number of CSO/CBOs for an effective coverage and take the CSO / OBC coverage and networking to that level; and (e) Institutionalize the best practices other lessons learnt improving services for key populations.

Annex 1: People interviewed – Cameroon

Name	Position	Organization
Strategic Stakeholders		
Donato Koyalta Steave Nemande	Strategic Information Adviser - Interim Country Director UNAIDS Strategic Intervention Officer	UNAIDS/CO UNAIDS/CO
Mbala Ebenguè Madeleine Julie Ep. Eloundou	National Gender and Human Rights Specialist	UNDP (co-sponsor)
Dr Etienne Kembou		WHO (co-sponsor)
Arsène Beng	Technical Secretary	CCM, Government/Global Fund.
Arouna Ngounga Tena		CAMNAFAW, CSO/Global Fund
Florent Ngueguim Ngnintedem	MEAL Technical Coordinator	CARE, CSO/USAID-Pepfar
Louise Bamba Mme Manga	Health-Program staff Communication-Program Staff	GIZ (Bilateral stakeholder) GIZ (Bilateral stakeholder)
Lilly Claire Ekobika Ngom Priso	Senior Coordinator in charge of special projects (STAR, Jeune S3)	ACMS (Association Camerounaise pour le Marketing Social), USAID-Pepfar/ CSO, for MSM & SW
Operational Stakeholders		
Representative		AFFIRMATIVE ACTION, CSO
Representatives		CHP, CSO/Global Fund, SW
Representative	Programs Director	HORIZONS FEMMES, CSO, SW
Representative	PCA	PLATEFORME UNITY, CSO
Representative	Executive Director	YDF, CSO, (PWID)
Representative	Programme Director	HUMANITY FIRST, CSO
Representative	ATDH	HUMANTY FIRST (MSM& prisoner)
Representative	Coordonateur de Site	ALTERNATIVE CAMEROUN, CSO,
Representative	Directeur exécutif	CAMFAIDS (MSM), CSO
Representative	Program director	EMPOWER CAMEROON (PWID)
Representative	Executive Director	TRANSAMICAL (Transgender)
Representative	Executive Director	AVAF (FSF)
Representative	Président Superviseur	ASEPT, CSO, (SW)
Representative	CDSSR	CAMFAIDS (MSM), CSO
Representative	Coordinatrice Exécutive	LADYIES WAKE-UP (FSF)
Representative	Beneficiary (Executive Director of a CBO))	POSITIVE VISION (TG)
Representative	Superviseur	EVICAM, (SW)
Representative	Accountant	EVICAM, (SW)
Representative	Service provider	EVICAM, (SW)
Representative	Executif Director	ALUCOSIS, (SW)
Beneficiaries		
Beneficiaries (MSM/TG)		
Representative		Asceaupev (MSM)
Representative		Humanity First Cameroon, (MSM)
Representative		TRANSAMICAL, (TG)

Name	Position	Organization
Representative		POSITIVE VISION (TG)
Representative		TRANSIGENCE, (TG)
Representative		RITA, (TG)
Representative		AVAF, (FSF)
Representative		JETRAM OUEST, (FSF)
Representative		Lady's wake up, (FSF)
Representative		(HSH)
Representative		(HSH)
Representative		TG
Beneficiaries SWs		
Representative		Mobilised by ASEPT, (SW)
Representative		Mobilised by ASEPT, (SW)
Representative		Mobilised by ASEPT, (SW)
Representative		Mobilised by ASEPT, (SW)
Beneficiaries PWID		
Representative		EMPOWER CAMEROON, (PWID)
Representative		EMPOWER CAMEROON, (PWID)
Representative		EMPOWER CAMEROON, (PWID)
Representative		EMPOWER CAMEROON, (PWID)
Representative		EMPOWER CAMEROON, (PWID)
Representative		EMPOWER CAMEROON, (PWID)
Beneficiaries Prisoners		
Representative		EMPOWER CAMEROON, (Ex-prisoners)
Representative		EMPOWER CAMEROON, (Ex-prisoners)

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Annex 3: Joint Programme activities by priority area and focus – Cameroon

Table 1: Mapping of JP cosponsors and interventions

CO-SPONSORS INVOLVED	BUDGET USD	RESULTS EXPECTED	HPA/SRA	TARGET GROUPS	ZONE REGIONS	INTERVENTIONS (fill using the yearly plans 2018-2021)							
						Education	Training	Prévention traitement et soins	Human Rights: Legal services & literacy; S&D; GE; Actors Awareness	Financial Support	Networking & commu-nity Dev.	Alternative Subsistence	Enabling milieu / advocacy
ILO	25000	Résultats attendus 1.1. : Des services de prévention combinée du VIH axés sur les besoins spécifiques identifiés des populations clés (travailleurs du sexe, hommes ayant des rapports sexuels avec des hommes, consommateurs de drogues injectables) sont disponibles et accessibles dans 95 % des points chauds cartographiés.	**DOMAINE DE HAUTE PRIORITE I : Prévention du VIH pour les personnes déplacées dans des endroits ciblés**		West; Littoral, Center, East, South	**X** Sensitization campaigns on HIV prevention, stigma and discrimination, and prevention of GBV helped reach over 14 100 IDPs and members of the host	**X** 47 staff from six CBOs and PSAs	**X** Sensitization campaigns on HIV prevention, stigma and discrimination, and prevention of GBV helped reach over 14,100 IDPs and members of the host populations. A total of 69 tested HIV positive and 68 were put on antiretroviral treatment (ART)		EGPAF/ PEPFAR **WHO-PAHO**			

UNICEF (2), UNHCR (1), PAM (1), UNHCR (1), UNFPA (1), UN WOMEN (1), UNESCO (3)	230860	Résultats attendus 1.1. : Des services de prévention combinée du VIH axés sur les besoins spécifiques identifiés des populations clés (travailleurs du sexe, hommes ayant des rapports sexuels avec des hommes, consommateurs de drogues injectables) sont disponibles et accessibles dans 95 % des points chauds cartographiés.			East, West, Littoral	**X** La sensibilisation continue sur le VIH (126 sessions au total)	**x** 50 peer educators and 8 peer counsellors were trained on CSE and provided psycho-social support to 326 displaced adolescents/youth in the new user-friendly spaces.	**X** 4,306 pregnant/breastfeeding women were sensitized, 3,866 (90%) were tested for HIV, and 33 (0.85%) were HIV+ and put on treatment. 58 adolescents were tested HIV-, 54 children living with an index HIV+ adult were tested and one child was HIV+ and link to care.	35 community health workers have a better knowledge of the rights-based approach to fighting discrimination and GBV among people living with HIV and AIDS		**X** Mise en place et redynamisation de 6 groupes de soutien de jeunes et de pairs éducateurs dans les sites des réfugiés		
Lead Agency	**Budget**	**Résultats**	**Service area**										
PAM (1) OMS (2) UNICEF (2) UNFPA (1) UNDP (1) UN WOMEN (1)	**123000**	Résultats attendus 2.1. : Les services différenciés de lutte contre le VIH (dépistage communautaire du VIH, recherche active de cas, dépistage familial, distribution communautaire d'ARV, sensibilisation des	DOMAINE DE HAUTE PRIORITE II : Dépistage et traitement du VIH pour les personnes déplacées dans des endroits ciblés (Littoral et Ouest)		West, Littoral		**X** 30 regional trainers and 330 health care providers from 10 health districts were trained in the West Region on PMTCT and HIV care and treatment for children and adolescents in the context of COVID-19.	91 of the 433 PLHIV identified were put on ARV treatment. Over 80% of ART patients lost to follow up were brought back into care (variation from 90.8% in January to 80.1% in May 2020, rising to 85.3% in October 2020.)				Advocacy and support have enabled the implementation of a mechanism for transporting samples (CVs and EIDs) between non-PEPFAR health facilities supported by WHO and PEPFAR-supported sites

		personnes perdues de vue, mentorat, liaison et rétention, etc.) sont fournis par la communauté											
OMS (3); UNICEF (1)	**32 000**	Résultats attendus 2.2. : Des données complètes, ventilées par lieu, âge et sexe, sont disponibles pour démontrer la réalisation des objectifs 95-90-90 dans les groupes de population ciblés.	Domaines de résultats de la stratégie (SRA 1) : Les enfants et les adultes vivant avec le VIH ont accès au dépistage, connaissent leur statut et se voient immédiatement proposer et maintenir un traitement de qualité à un prix abordable.		Center, East, Littoral, South								
Lead Agency	**Budget**	**Résultats**	**Service area**										
UN WOMEN, UNFPA	27000	Résultats attendus 3.1. : Des données améliorées sur la stigmatisation et la discrimination liées au VIH (tant au niveau des communautés que des établissements de santé) et dans tous les lieux seront disponibles et démontreront des progrès significatifs vers	Domaines de résultats de la stratégie (SRA 3) : Les jeunes, en particulier les jeunes femmes et les adolescentes, ont accès à des services de prévention combinée et sont habilités à se protéger du VIH.		Center, South, East		An average of 60 health workers are been trained to be aware of how to tackle/not perpetuate stigma and discrimination in specific health districts						

		l'objectif zéro stigmatisation et discrimination.											
UNDP; UN WOMEN ILO; UNESCO	**55 000**	Résultats attendus 3.2. : Les initiatives des villes Fast Track et de la Coalition pour la prévention du VIH, ainsi que les interventions visant à créer un cadre juridique et des droits de l'homme plus propice à une plus large participation de la société civile, ont contribué à normaliser le VIH.	Services de prévention combinée et sont habilités à se protéger du VIH.		10 regions	communications campaigns to fight against stigma and discrimination and promote the rights of PLHA	166 labor inspectors and social litigation magistrates were trained on human rights		use of available legal instruments to defend the rights nation-wide of workers who are victims of AIDS-related discrimination				
TOTAL BUDGET	**492 860**												

2. Kenya country study

24 January 2022

Kenya Consultants: Lawrence Gelmon and Parinita Bhattacharjee
Key population team members: Doreen Moraa, Jeffrey Walimbwa, John Mathenge

Global level team leader: Lawrence Gelmon
Global level deputy team leader: Clare Dickinson

Introduction and context

Purpose and scope of the Kenya country study

This case study is part of a larger evaluation to assess the relevance, coherence, equity, efficiency, effectiveness and sustainability of the UNAIDS[47] Joint Programme on AIDS (JP) support for key population (KP) programming at country level over the years 2018-2021, with a view to improving UNAIDS programming with and for key populations under the new UNAIDS United Budget, Results and Accountability Framework (UBRAF) 2022-2026. The primary unit of analysis for the evaluation is how the Joint Programme has supported KP programming at the country level. Six countries were chosen for the case studies, covering all UNAIDS regions and a variety of epidemics. The six countries are Cameroon, Kenya, Peru, Thailand, Tunisia, and Ukraine. The case studies have been supplemented by document review and key informant interviews (KII) at the global and regional levels.

The KPs, as defined by UNAIDS, are sex workers (SW), gay men and other men who have sex with men (MSM), transgender persons (TG), people who inject drugs (PWID), and prisoners, including young people who are part of these KPs.

Methods

The country case studies focused on a qualitative analysis of Joint Programme activities in relation to capacity and country needs, examining progress made in key populations programming, to gain a comprehensive and nuanced understanding of UNAIDS support and contribution to key populations at the country level. Additionally, the case studies focused on eliciting lessons learned, good practices, and examples of factors helping or hindering the JP work with and for key populations. This case study was conducted through document review and key informant interviews (KIIs) with staff of the UNAIDS secretariat and cosponsors, Ministry of Health, PEPFAR and other funders of key populations programme in the country, key populations-led networks and key populations representatives in the Global Fund Kenya Coordination Mechanism (KCM) and NGOs working with and providing services to key populations. A total of 18 interviews, involving 26 individuals were conducted in October 2021, all interviews being virtual due to the COVID-19 situation in Kenya. Non-response by some of the co-sponsors (e.g., WHO, UN Women, ILO) was a limitation. A list of all KIIs is in Annex as well as a bibliography of documents reviewed.

National HIV context and programme response

Kenya's HIV epidemic

Kenya jointly has the third-largest HIV epidemic in the world (alongside Tanzania) with 1.5 million people living with HIV in 2019.[48] In the same year, reports from the health management information system (HMIS) indicate that 20,897 people died from AIDS-related illnesses. While this is still high, the death rate has declined steadily from 58,446 in 2013.[1]

The first case of HIV in Kenya was detected in 1984. By the mid-1990s, HIV was one of the major causes of illness in the country, putting huge demands on the healthcare system as well as the economy. In 1996, 10.5% of Kenyans were living with HIV, although prevalence has more than halved since then, standing at 4.5% by 2019.[1] This progress is mainly due to the scaling up of HIV treatment,

[47] References to UNAIDS in this report refer to the Joint United Nations Programme on HIV and AIDS, consisting of the UNAIDS Secretariat and UN agency cosponsors. The UNAIDS Secretariat in Kenya is referred to as the UNAIDS Country Office (UNAIDS CO).

[48] National AIDS Control Council (NACC), Kenya AIDS Strategic Framework II 2020/21-2024/25, 2020

care and prevention programmes over the past fifteen years. In 2019, 72% of people living with HIV were on treatment.

The analysis[49] of the HIV epidemic shows geographical diversity, with HIV prevalence ranging from 20.1% in Homa Bay County (in Western Kenya on the shores of Lake Victoria) to a low of 0.2% in Mandera and Wajir counties (in the Northeast). The analysis of new infections in 2020 shows that thirteen counties with more than 1,000 new infections accounted for 72% of new infections. Of these thirteen counties, eight high burden counties (Kisumu, Nairobi, Siaya, Homa Bay, Migori, Nakuru, Mombasa, and Kisii) with more than 1,500 new infections contributed to 57% of all new infections, while the remaining five counties (Kakamega, Kiambu, Usain Gishu, Kajiado, and Machakos) with more than 1000 new infections, contributed an additional 15% of all new infections in the country.

The diversity in HIV prevalence among Kenyan subpopulations is high. As in most countries in the region, HIV prevalence is higher among females (5.8%) compared to men (3.1%)[50]. HIV prevalence is higher among key populations such as female sex workers (FSWs) 29%, men who have sex with men (MSM) 18.9%, and people who inject drugs (PWID) 18% and about 5-6 times higher than in the general population[51]. The HIV epidemic among key populations shows geographical and gender diversity with self-reported HIV prevalence among FSWs ranging from 49% in Homabay to 16% in Mombasa and 36% among female PWID to 17% among male PWID[52]. In an HIV prevalence study conducted among fisher folk in the Nyanza region, HIV prevalence was 31%; higher among females (41%) than males (25%)[53]. There are also age-related differences in HIV prevalence. For both sexes combined, HIV prevalence peaks among adults aged 40-54 years. Prevalence among women peaks at 11.9% at ages 40-44 years and 11.7% in the 50–54-year age group. While the gender difference is not very stark until age 0-14 years, girls' and women's prevalence increases multiple fold after 15 years. Women aged 20-34 years have an HIV prevalence more than three times higher than men of the same age group[54].

Kenya's HIV response

Kenya AIDS Strategic Framework

The HIV response in Kenya is led by the National AIDS Control Council (NACC) and the National AIDS and STI Control Programme (NASCOP) within the Ministry of Health. While NASCOP is responsible for the health sector response, NACC is accountable for multi-sectoral collaboration and resource mobilization. Historically the key population programme in Kenya has been led by NASCOP with the Key Populations Manager providing management and technical guidance to the programme.

Kenya has made substantial progress in its HIV response, as evidenced by the progressive decline in HIV incidence, as seen in table 1. Mother-to-child-HIV transmission has declined from 13.9% in 2010 to 10.8% in 2019[55].

[49] NASCOP, NACC and UoM, Evidence brief- Epidemic Analysis, November 2021

[50] National AIDS Control Council (NACC), Kenya AIDS Strategic Framework II 2020/21-2024/25, 2020

[51] Integrated bio-behavioural survey report, NASCOP 2010/2011.

[52] National AIDS and STI Control Programme (NASCOP). Third national behavioural assessment of Key Populations in Kenya: polling booth survey report. Nairobi: Government of Kenya. 2018. [Accessed on 2nd March 2021]. Available from: https://hivpreventioncoalition.unaids.org/wp-content/uploads/2020/02/Third-national-behavioural-assessment-of-key-populations-in-Kenya-polling-booth-survey-report-October-2018-1.pdf

[53] Integrated bio-behavioural survey of fisher folk communities along the Lakeshore of Lake Victoria, Kenya, draft report, CDC, UMB, KEMRI, NASCOP, 2019.

[54] Preliminary KENPHIA report, NASCOP, 2018

[55] HIV new estimates report, NACC, 2020

Table 8: Declining HIV incidence in Kenya

Estimates	2010	2019	% reduction
Total annual cases	75,000	42,000	41%
Children new cases	12,826	6,800	53%
Adolescents 10-19	18,004	6,186	34%
Young people 15-24	35,776	14,410	40%
Adults	88,622	34,610	39%

Source: HIV new estimates report, NACC, 2020

Kenya has also scored well in the latest scorecard by the Global Prevention Coalition (GPC) in 2020: scoring "very good" (10/10) for voluntary male medical circumcision (VMMC), "good" (8/10) for MSM, SWs, adolescent girls and young women (AGYW) and pre-exposure prophylaxis (PrEP) and "medium" 7/10 for PWID and condoms but noting that structural barriers of criminalisation of sex work, drug use and same-sex relationships still exist[56].

However, Kenya fell short of meeting the global 2020 targets of reduction of new HIV incidence by 75% and has prioritized HIV prevention in the Kenya AIDS Strategic Framework II - 2020/21–2024/25 (KASF)[57]. The KASF II notes that "despite the tremendous progress made in more than three decades, HIV continues to be a significant contributor to national disease burden. The Kenya AIDS Strategic Framework II will focus on bridging the gaps in programme coverage through differentiated approaches that meet the needs of citizens within their geographical locations". The goal of the KASF is "to contribute to the attainment of Universal Health Coverage (UHC) through comprehensive HIV prevention, treatment, care and support for all people in Kenya" across five objectives:

1. Reduce new HIV infections by 75%
2. Reduce AIDS-related mortality by 50%
3. Micro-eliminate viral hepatitis and reduce the incidence of sexually transmitted infections (STIs)
4. Reduce HIV-related stigma and discrimination to less than 25%
5. Increase domestic financing of HIV response to 50%

Notably, the strategy is in line with Kenya's devolution and decentralisation to 47 county governments, with an evidence-based approach, focussing on "high priority geographies based on epidemic analysis, prioritising populations for comprehensive preventive interventions based on epidemic typology in the geographies". Key populations in the KASF II include MSM, FSWs, PWID/PWUD) and TG people, but also includes "those left behind like women who inject or use drugs, young KP and KPs in migrant settings and prisons"[58].

Key Population programmes in Kenya

Kenya's journey with key population programming began in the 1990s with ground-breaking work by local and international researchers and implementers that built up a substantial body of evidence that demonstrated that key populations are critical to the HIV response[59]. Key populations-led groups started forming and organizing by the early 2000s and by the latter part of the decade, there was a groundswell of MSM and FSW-led groups delivering prevention and treatment services and influencing policy, becoming equal partners in the HIV response.

[56] Global Prevention Coalition; Kenya scorecard 2020; accessed at https://hivpreventioncoalition.unaids.org/wp-content/uploads/2020/12/Kenya-Scorecard-HIV-prevention-2020-Final-v1m-002.pdf
[57] Kenya Ministry of Health, NACC; The Second Kenya AIDS Strategic Framework 2020/21-2024/25; 2020
[58] ibid
[59] For more details on these groundbreaking research efforts with KPs in Kenya see Krotz L; Piecing the Puzzle: The Genesis of AIDS Research in Africa; University of Manitoba Press; 2012.

In 2009, using evidence from the Modes of Transmission (MOT) study[60], consistent advocacy led to the inclusion of FSW, MSM and PWID defined as key populations as a priority group in the Kenya National AIDS Strategic Plan (KNASP III 2009-2014), marking the beginning of government-led programming, developed jointly with key populations[61]. In 2020, transgender people and people in prisons and closed settings were also added as priority populations in the national strategic framework[62]. Recent size estimation exercises, which included virtual mapping for MSM estimated 190,000 FSW, 61,000 MSM, 20,000 PWID, and 5,000 transgender people in Kenya[63] [64].

The Government of Kenya and international donors (mainly PEPFAR and the Global Fund) fund the Key Populations programme. More than 100 partners (NGOs and CBOs) implement the programme in 36 of 47 counties using a standard HIV combination prevention package[65]. Almost 25% of the partners implementing key populations programme in Kenya are key populations-led organisations. The prevention programmes provide much emphasis on delivering education, information and commodities such as condoms, lubricants and HIV self-test kits through a peer led model. Clinical services are provided by standalone clinics established by the implementing partners in their drop-in centres, outreach clinics in the sex work/cruising[66] or drug use venues by the implementing partners, as well as integrated clinics which have been established within public health facilities in partnership with county governments. Violence prevention and response systems have been established by the implementing partners and are led by the key populations.

Kenya has made considerable progress towards achieving the global targets, but large gaps and associated challenges remain. By March 2020, Kenya had expanded programme reach for FSW, MSM, PWID, and transgender (TG) people to 36, 33, 16 and 3 out of 47 counties, respectively. Several counties still need to initiate key populations programmes, and the recent Global Fund country application plans for expansion to all 47 counties.

In the first quarter of 2020, against the current official population size estimates, **programme coverage** (defined as reached with 2 services in past 3 months) was 73% for FSWs, 82% for MSM, 71% for PWID (one service being a needle and syringe programme) and 5% for transgender people. Kenya scaled up opioid substitution therapy (OST) services in the last five years by initiating nine Medically Assisted Treatment (MAT) clinics and had enrolled 5,208 PWID (26% of estimated PWID). Enrolment in the OST programme fell short of the 40% target, suggesting that the programme needs further expansion. There is no data available for people in prison settings at the national level, even though programmes for people in prison settings are funded by PEPFAR.[67]

The **behavioural programme outcomes**, measured by a 2017 population-based survey, show condom use at last sex with a client for FSW was 92% and at last sex for MSM was 79%. The key populations programmes need to prioritise access and utilization of prevention services (condoms and PrEP) among MSM. Eighty-eight percent of PWID reported using safe injecting equipment during the last injection; unfortunately, 40% also reported experiencing a drug overdose[12.]

Treatment programme outcomes showed that 46% of FSW living with HIV knew their HIV status, 73% of all FSW living with HIV were receiving ART, and 79% of all FSW receiving ART demonstrated

[60] World Bank. 2009. Kenya - HIV Prevention Response and Modes of Transmission Analysis. World Bank. © World Bank. https://openknowledge.worldbank.org/handle/10986/3044 License: CC BY 3.0 IGO."
[61] National AIDS and STI Control Programme (NASCOP). Reaching the unreached: the evolution of Kenya's HIV/AIDS Prevention Programme for Key Populations. Nairobi: Government of Kenya. 2016
[62] National AIDS Control Council (NACC), Kenya AIDS Strategic Framework II 2020/21-2024/25, 2020
[63] National AIDS and STI Control Programme (NASCOP). Key Population mapping and size estimation in selected counties in Kenya – Phase 1 report. Nairobi: Government of Kenya, 2019
[64] Emmanuel F, Kioko J, Musyoki H, Kaosa S, Ongaro MK, Kuria S *et al.* Mapping virtual platforms to estimate the population size of men who have sex with men (MSM) who use internet to find sexual partners: implications to enhance HIV prevention among MSM in Kenya. Gates Open Research 2020,
[65] National AIDS & STI Control Programme (NASCOP). National Guidelines for HIV/STI Programming with Key Populations. Nairobi: Government of Kenya, 2014.
[66] Areas where MSM go to make connections, either for paid or unpaid transactions
[67] Musyoki H, Bhattacharjee P, Sabin K, Ngoskin E, Wheeler T, Dallabetta G; A decade and beyond: learnings from HIV programming with underserved and marginalized key populations in Kenya; JIAS 24:53; 30 June 2021; accessed at https://doi.org/10.1002/jia2.25729

viral suppression; similar outcomes for MSM were 52% - 80% - 74% and for PWID were 43% - 68% - 64%. It is of concern that achievement of care continuum targets among key populations, especially the first 90, is much lower than Kenya's general population (80%-96%-91%).[68] There are assumptions that considering the country's geographic diversity, there are at-risk key populations subpopulations who are being missed by the testing and treatment programmes such as adolescent and young key populations (who constitute 9-12% of the estimated key populations numbers). Kenya also needs to develop key populations differentiated care models linking community outreach and clinical efforts and scaling up community ART initiation and dispensation for key populations to address the gaps related to the second 90 target. These can only be accomplished with the strengthening of key populations-led community-based networks and CBOs, making the goal of community-based monitoring (CBM) possible.

In terms of **structural programme outcomes**, a high proportion of key populations reported experiencing police violence in the last 6 months: FSW (48%), MSM (20%), and PWID (44%) in the population-based survey. Though reporting of violence and support provided in response to the reports by implementing partners has increased in the last decade, police violence against key populations remains high[69]. In the recent stigma index study (2021) sex workers reported high levels of stigma and discrimination including violence, 30% reported emotional violence, 25% reported physical violence and 19% reported blackmail, while 23% reported discriminatory remarks and gossip. 18% of the sex workers also reported avoiding health care services due to fear of being identified as sex workers. Similarly, 20% of the transgender community reported experiencing physical violence and another 20% reported avoiding accessing health care to avoid disclosing their gender identity. 18% of people who use or inject drugs also avoided seeking health services due to fear of someone finding out that they use drugs[70].

Despite existing gaps, there are several learnings that emerge from the Kenya key populations programme. Some of the successful strategies that provided confidence to donors, implementers, and researchers to participate in the Kenyan scale-up plan for key populations include[71]:

- Formation of the Key Populations Technical Working Group (TWG)
- Early development of policy guidance and programme standards
- Decentralization of the response at county level
- Setting up a robust monitoring system with defined targets from grassroots to national level that included key populations data
- Continuous advocacy and sensitization of service providers, stakeholders, and decision-makers
- Development of a Technical Support Unit within NASCOP to support the scale-up of the key populations programme, initiate collection of key populations indicators at the county level, and provide guidance
- Establishment of diverse models of services provision including “one-stop shop’’ and integrated models
- Strategic partnership with a variety of stakeholders including key populations-led organisations and key populations research advisory groups such as the G1072
- Active promotion of KP led service delivery models with support to more than 25 key populations-led organisations

[68] National AIDS and STI Control Programme (NASCOP). Third national behavioural assessment of Key Populations in Kenya: polling booth survey report. Nairobi: Government of Kenya. 2018. [Accessed on 2nd March 2021]. Available from: https://hivpreventioncoalition.unaids.org/wp-content/uploads/2020/02/Third-national-behavioural-assessment-of-key-populations-in-Kenya-polling-booth-survey-report-October-2018-1.pdf

[69] Kenya Ministry of Health, NACC; The Second Kenya AIDS Strategic Framework 2020/21-2024/25; 2020

[70] PLHIV Stigma Index 2.0 Kenya Country Assessment, NEPHAK, 2021

[71] Musyoki H, Bhattacharjee P, Sabin K, Ngoskin E, Wheeler T, Dallabetta G; A decade and beyond: learnings from HIV programming with underserved and marginalized key populations in Kenya; JIAS 24:53; 30 June 2021; accessed at https://doi.org/10.1002/jia2.25729

[72] The G10 is the MSM research coordination committee in Kenya, led by GALK, the Gay and Lesbian Coalition of Kenya

- Proactive documentation to create visibility for the programme and the populations.

The following achievements of the key populations programming were highlighted by KIs:

- Key populations are meaningfully involved and participate in decision making. Key populations-led organisations are leading the implementation of interventions.
- Population size estimates have been conducted and these estimates guide programming and allocation of resources. There is confidence in these estimates among stakeholders.
- The key populations programme is peer-led, and this model ensures that key populations have a role in programme design and implementation. Peer conventions are organised by the national programme annually to seek feedback from peer educators.
- The coordination mechanisms are robust and ensure that the programme is coordinated and managed at national, county, and implementation levels.
- Young key populations have been identified as key populations with availability of programming guidelines and pilot interventions
- Expansion of programmes to include TG populations, prisons, and vulnerable populations
- Adaptation of the key populations programme to address COVID-19 issues
- Innovations like inclusion of mapping of MSM and outreach to virtual platforms to reach MSM who seek partners and services in virtual platforms
- M&E frameworks and systems have strengthened within the key populations programme moving to the Kenya Health Information System (KHIS) platform and using electronic reporting through the electronic medical records (EMR) system
- The leadership of the Ministry of Health, especially NASCOP and NACC, in addressing the structural barriers and creating an enabling environment
- Increased funding to key population programmes especially to key populations-led organisations

Enabling environment

Despite governmental support for the HIV prevention programmes, Kenyan national and county laws continue to criminalize selling sex, same-sex relationships, drug use, and drug possession, raising structural barriers for key populations to access health services. Sodomy is a felony per Section 162 of the Kenyan Penal Code, punishable by 14 years' imprisonment, and any sexual practices between males (termed "gross indecency") are a felony under section 165 of the same statute, punishable by 5 years' imprisonment. While female same sex-sexual activity is not explicitly prohibited by law, lesbians, bisexual women and transgender persons are not recognised in the Kenyan Constitution. On 24 May 2019, the High Court of Kenya refused an order to declare sections 162 and 165 unconstitutional.[73] The state does not recognise any relationships between persons of the same sex and same-sex marriage is banned under the Kenyan Constitution of 2010. There are no explicit protections against discrimination on the basis of sexual orientation and gender identity.

In an environment where behaviours of key populations are criminalized and judged based on prevailing norms around gender, identity, sexuality, and drug use, it can be an uphill task to scale up key populations programmes and maintain their fidelity and quality. During the past decade, key populations programming has experienced several setbacks, including an attack on MSM clinics in Kilifi, community agitation against the needle and syringe programme and the death of PWIDs due to heroin overdose crisis caused by methadone supply shortages.

Protection of human rights and creating an enabling environment for programming with people living with HIV, key populations and adolescent and young people has been prioritised in the KASF II. The strategic framework is becoming bolder in putting forward the intention of working with KPs. The policy environment in Kenya has improved. Several policies have been developed that have created an enabling environment and have reinforced the government and other partners'

[73] NASCOP, NACC and UoM, Evidence brief- Epidemic Analysis, November 2021

commitment to KP programming. The law enforcement environment has improved and there is more acceptance by law enforcement about the existence of key populations. There have been a series of court rulings in favour of transgender rights, such as the right to change the names appearing on legal documents. Improved media coverage of key populations i.e., reduction of sensational reporting and increased empowering stories can be seen. The recently published Kenya PLHIV Stigma Index 2.0[74] reports a reduced level of stigma felt by PLHIV and KPs since the previous Stigma Index measurement in 2014[75] and various organisations are working to protect and improve LGBT rights.

Financing of the HIV response

As can be seen in table 2 and table 3[76], expenditure in Kenya for HIV prevention has increased over the past four years, while reported expenditure for treatment has declined.[77] What is notable however, is the increasing percentage of the HIV budget that is being funded domestically – prevention rising from a negligible domestic contribution in 2017 to 9.3% in 2020, and a 62.9% contribution to the treatment and care budget.

Table 9: Reported HIV expenditure – Prevention - Kenya

YEAR	Total Domestic	Total international	Overall total	% Domestic funded
2017	$39,237	$32,927,491	$32,966,727	0.12%
2019	$877,295	$39,364,116	$40,241,411	2.18%
2020	$4,402,418	$42,773,945	$47,176,363	9.3%

Table 10: Reported HIV expenditure – Treatment Kenya

YEAR	Total Domestic	Total international	Overall total	% Domestic funded
2017	$357,238,668	$355,720,426	$712,959,094	50.1%
2019	$145,440,448	$264,666,678	$410,107,126	35.5%
2020	$345,709,776	$204,305,184	$550,014,960	62.9%

However, table 4 demonstrates the total expenditure for key populations in 2020.[78] As can be seen, while the bulk of sex worker programming (72.6%) is being funded domestically, there are no funds allocated for PWID, and the categories of KP in the budget does not include specific transgender programming. This may change in 2021 as TGs have been added to the list of key populations in the current National Strategic Plan (NSP).

If one assumes that the bulk of key populations funding would be classified as "prevention-related", it could be seen that the key populations programming budget of USD 10.25 million is approximately 22% of the total prevention budget of USD 47.1 million.

Table 11: Expenditure on key populations – Kenya 2020

YEAR	Total Domestic	Total International	Overall Total	Program Group	% Domestic funded
2020	$976,130	$1,831,582	$2,807,712	MSM	34.8%
2020	$0	$2,756,462	$2,756,462	PWID	0%
2020	$3,408,853	$1,285,491	$4,694,344	SW	72.6%
TOTAL	$4,384,983	$5,873,535	$10,258,518		42.7%

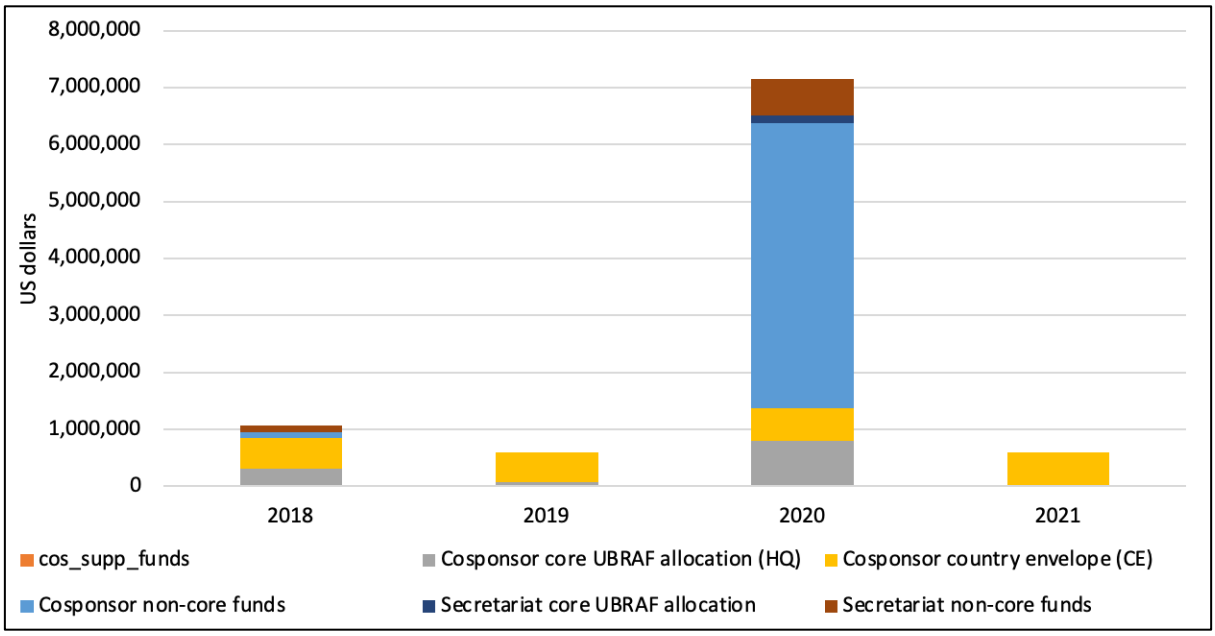
[74] NEPHAK; PLHIV Stigma Index 2.0 Kenya Country Assessment; 2021
[75] Kenya Ministry of Health; The National HIV and AIDS Stigma and Discrimination Index Summary Report; 2014
[76] Data from the Country Reports, Global AIDS Monitoring; accessed at https://hivfinancial.unaids.org/hivfinancialdashboards.html#
[77] The number of PLHIV on ART has increased significantly in recent years, with more than 1.2 million people now on treatment. Total treatment expenditure should not have declined, unless the cost has reduced and /or the data has not been captured. As there have been other issues found with reporting in this review, the latter may be the case here.
[78] ibid

UNAIDS Joint Programme key population response

Joint Programme funding in Kenya 2018–2021

Figure 1 presents the total budget by funding source across all UBRAF 2016-2021 Strategic Results Areas (SRAs) and agencies/cosponsors between 2018 and 2021. The spike in budget in 2020, notably through the inclusion of almost USD 5 million in co-sponsor non-core funds in 2020, suggests that the data is incomplete for all years.

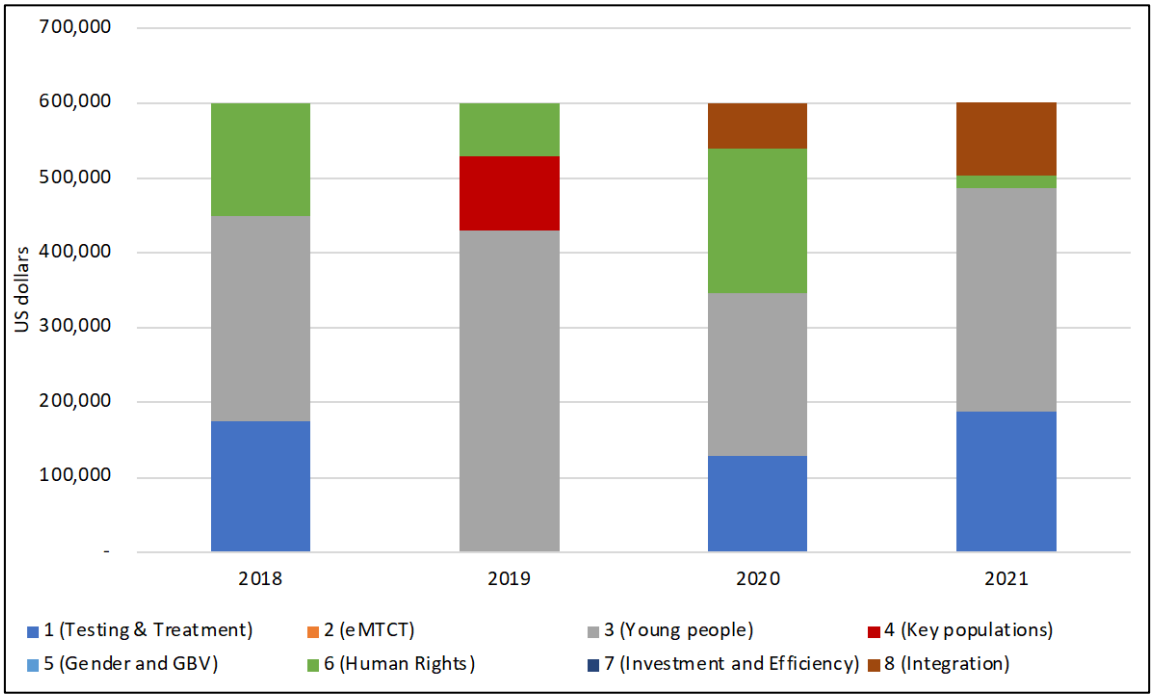
Figure 6: Total budget by funding source (2018-2021)



Source: Download from JPMS.

Figure 2 shows that while the total Joint Programme country envelope budget has remained consistent at USD 600,000 per year, the funding by Strategy Result Area (SRA) has varied. The budget for SRA 4 (Key Populations) was USD 0 in all years except for 2019 with a budget of USD 98,000. The co-sponsors with budget for SRA4 in 2019 were UNHCR and UNODC.

Figure 7: Country envelope budget by SRA[79]



Source: Country envelope databases shared by UNAIDS.

Deeper review of the budgets casts some doubt as to the reliability of figures presented above. In particular, the targets associated with budgeted activities for UNHCR in 2019 relate to ensuring the availability of HIV services for refugees and migrants, not defined by UNAIDS as a key population group, yet these budgets are still included in SRA4.

Strategic orientation and programmatic approaches

The UN Joint Programme in Kenya has representation from all eleven agencies, and totals 45 persons. As seen in table 5, 26 of these people are on the JP management committee. The committee meets monthly, chaired by the UNAIDS Country Director.

Table 12: Joint Programme Membership in Kenya

Agency	Number of representatives on the JP team
UNAIDS	7
UNICEF	3
IOM	3
UNODC	2
WFP	2
UN Women	2
ILO	1
WHO	1
UNDP	1
World Bank	1
UNFPA	1
UNHCR	1
UNESCO	1

[79] Includes Business Unusual Fund (BUF) budget in 2020 and 2021.

Joint Programme Planning for Key Populations

The Kenya Joint Programme Planning Document for 2018-2021[80] lists five high priority areas on which the various members agencies would focus, with the goals to achieve by 2022 being:

- All children, women and men living with HIV know their status, are linked to and sustained on treatment
- Young people, key and priority populations are empowered to protect themselves from HIV and all children, women and men have access to combination prevention services
- Women and men have equal access to HIV and SRHR services to mitigate gender inequality in the risk and impact of HIV infection
- The rights of children, women and men living with, at risk of and affected by HIV, including key and priority populations, are promoted, protected and fulfilled, for zero HIV-related stigma, discrimination and GBV
- The HIV response is fully funded and efficiently implemented based on reliable strategic information and leveraging strategic partnerships

Key populations are named directly in two of the priority areas: **area 2** which encompasses combination prevention interventions against key and vulnerable populations; and **area 4** which encompasses human rights, stigma and discrimination issues aimed at the entire population but with inclusion of key populations.

Within the many activities and sub-activities listed under each priority area, "key populations" are rarely mentioned by name – not at all under priority area 1, and are mentioned in priority area 5 only in activity 5.2.2 – "Capacitate counties to use cascade data (e.g. key populations, eMTCT and general population) to address gaps and monitor progress towards the achievement of the prevention and 90-90-90 targets at county level".

Priority area 2 is where the key populations-related programming initiatives are found. However, for most of the activities listed, there is more mention of adolescents, AGYW, and other vulnerable populations without key populations being named or highlighted, for example:

1. 2.1 – Prioritisation for high impact prevention combination interventions – mainly about condom promotion, but the populations mentioned are:

   2.1.2 – **Youth led** development and dissemination of integrated combination prevention video graphic materials

   2.1.4 – **Strengthen the capacity of AYP including the boy child** through Youth Advisory Councils (YACs) (UNICEF)

2. 2.2 – Integrated gender-sensitive HIV/SRHR/GBV interventions for HIV prevention – including preventing adolescent pregnancies, addressing school curricula, etc. **Key populations not named**
3. 2.3 – HIV Combination Prevention in Humanitarian Settings – Activity 2.3.4 is "Integrated SRH/HIV services provided to **key populations in the refugee communities"** (UNHCR – Cosponsor country envelope USD 26,750)
4. 2.4 – Capacity of **adolescents and young people's networks** to advocate for youth friendly services and rights – **young key populations not named**
5. 2.5 – Social protection and economic empowerment including mitigating the effects of COVID-19**, key populations not named**

The two deliverable areas covering KPs are 2.6 and 2.7:

6. **2.6 Standard package for combination prevention for** key **populations**

[80] All data in this section accessed through the JPMS portal

2.6.1 – Priority counties supported to implement the standard package for combination prevention for key populations: MSM, FSW, MSW, PWUD/PWIDs (incl. Needle and Syringe exchange [NSP] and Opioid substitution therapy [OST])

UNFPA	Cosponsor non-core funds	$90,000
UNICEF	Cosponsor non-core funds	$190,000
UNODC	Cosponsor non-core funds	$220,000

7. **2.7 Rights-based and targeted high** impact combination **prevention interventions for key populations**

2.7.1 – Rights-based and targeted high impact combination prevention interventions for key populations

UNICEF	Cosponsor non-core funds	$190,000

2.7.2 – Support the operationalisation of the Lamu County Medically Assisted Therapy (MAT) programme

UNODC	Cosponsor country envelope (CE)	$57,780

2.7.3 – Support Kenya Prison Services with PPE for COVID-19 mitigation and printing of health facility tools

UNODC	Cosponsor country envelope (CE)	$6,313

2.7.4 Advocacy and technical support for implementation and monitoring of the prevention revolution roadmap – a diverse set of activities all funded by UNODC, including:

- Ongoing TA to Kenya's OST/MAT programme
- Advocacy and TA for a rights-based, targeted, KP-led response for HIV prevention among key populations
- Increase access to OST/MAT to people in prisons in Kenya by installing an OST dispensing site within a prison facility in Nairobi Kenya (proposed-Kamiti Maximum Security)
- Facilitate quality of routine data in DHIS 2 and annual progress reporting for Global AIDS Monitoring (GAM), county HIV profiles and estimates and Kenya AIDS Response Progress (KARP)
- Generation of strategic information and key publications in the area of HIV and drug use in Kenya and the African Region

UNODC	Cosponsor country envelope (CE)	$64,200

Key populations, or at least MSM, are considered under **priority area 3**, where deliverable 3.1 (supported by UNWomen and UNHCR – USD 100,000 each from non-core funds) addresses issues facing MSM and perhaps TGs. There is only one activity listed under this deliverable: "support communities to address harmful gender norms, negative stereotypes and concepts of masculinity, contributing to a gender-sensitive response". The other two deliverables and four activities in priority area 3 address gender equity and GBV.

Key populations are also mentioned in **priority area 4,** which deals with human rights and stigma/discrimination. Activity 4.1 addresses the capacity of state and non-state human rights institutions and duty bearers, but Activity 4.2 has the objective of strengthening networks of PLHIV and key populations:

4.2.1 – Strengthen networks of people living with HIV, key populations and vulnerable populations to know and claim their rights

UNHCR	Cosponsor core UBRAF allocation (HQ)	$15,975

UNICEF	Cosponsor non-core funds	$96,000
UNDP	Cosponsor non-core funds	$89,000

4.2.2 – Enhanced partnership with the national CSO mechanism to enhance advocacy on national accountability and rights-based programming on HIV

UNDP	Cosponsor country envelope	$22,140

4.2.3 – Networks of PLHIV, key populations and other non-state actors know and claim their rights

UNDP	Cosponsor country envelope	$16,200

Activity 4.3 addresses stigma reduction and will support activities addressing stigma in the workplace (ILO CE USD 31,030) while Activity 4.4. focused on supporting the HIV Stigma Index survey (UNAIDS Secretariat UBRAF Core allocation USD 10,000).

It should be noted, that with few exceptions, where key populations are mentioned, they are not disaggregated in the plans. The exceptions are the activities that are dealing with OST and MAT programmes which are obviously targeted at PWUD. While SWs or MSM are mentioned in a few planning activities, transgender persons are not listed as a distinct key populations community in any of the planning documents.

Planning versus reporting

The above detail of the planning for 2020-2021 demonstrates not only the current levels of activity of the JP but also the levels of funding being allocated for key populations programming. The JP partners active in the current year plans are UNODC (4 activities), UNICEF (3 activities), UNHCR (3 activities), UNDP (3 activities), UNFPA, UNWomen, ILO and the UNAIDS Secretariat (1 activity each). It is notable that in the division of labour, UNFPA is responsible for the majority of key populations activities, but in the current annual plan, UNFPA is represented by only one activity (2.6.1 Implementing combination prevention for KPs in priority counties) where their contribution is USD 90,000 out of a total USD 500,000, the remainder coming from UNICEF and UNODC.

Reviewing the planning and reported results for the previous three years 2018-2020, there is an issue with the JPMS reporting in terms of inconsistencies between what was planned and what is reported. For example, many activities in the annual reports are not attributed to any one agency and there are several instances where the planned activity does not appear in the subsequent annual report and conversely, activities are reported that were not included in the previous year annual plan.

The 2019 JPMS report for Kenya describes 35 separate activities carried out or supported by the Joint Team, of which only six are explicitly dealing with key populations. The bold print indicates cosponsor activities and level of funding in the 2018-2019 plan:

- Over 250 LGBTIQ+ refugees from neighbouring countries were tested and linked to existing support systems in Kenya and Kakuma. A total of 587 refugees are currently receiving care through the national health system. **UNHCR Cosponsor country envelope (CE) USD 15,301**
- The JT supported the development of standard operating procedures (SOPs) for HIV testing services (HTS) in prison settings and Kenya Prison Services, support was also provided to the Kenya Pharmacy and Poisons Board to develop the national guidelines and minimum standards for Methadone dispensing pharmacies. **UNODC Cosponsor country envelope (CE) USD 70,000**
- In partnership, the Federation of Kenya Employers (FKE), NACC and the Confederation of Trade Unions (COTU(K)) collaborated with the Kenya Long Distance Truck Drivers Union/Highway Community Health Resource Centre to support establishment of HIV/wellness workplace programmes in ten companies. In addition, with the County Government of Makueni support was provided to sensitize Male Champions on HIV and SGBV and an outreach programme for sex workers in Mlolongo (a weigh bridge for trucks and a hotspot for sex workers) was supported.

This resulted in 2,349 truckers and 897 female sex workers knowing their status. **ILO Cosponsor core UBRAF allocation (HQ) USD 26,750**

- Access to HIV and STI prevention was scaled up through procurement and distribution of male condom dispensers for key populations and FSW integrated services which reached 2,785 female sex workers with SRH/HIV/GBV services. There were also several activities in the previous plan, including **"Coordination of the National Condom TWG strengthened" UNFPA Cosponsor country envelope (CE) USD 18,792; "Demand creation for condom use through condom rebranding among AYP in Makueni and Kilifi counties" UNFPA Cosponsor country envelope (CE) USD 52,920. Notable is that FSWs are not mentioned in the activities themselves and that the planned activity was to be in a specific location, but this is not mentioned in the reporting.**
- To improve service delivery and generate evidence to inform programming, a costing study of FSW Drop-in-centres/ one stop shop for integrated HIVSRH/TB services was conducted in Mtwapa and Kilifi sites (on the Kenyan coast). **Not listed in 2018-19 planned activities**
- HIV testing and counselling was also conducted at MHAC Nairobi as part of migration health assessments, an assessment of "Risk and Protection Factors Exposing Migrants to Vulnerability in Eastleigh" (a township in Nairobi) was also conducted showing that girls and women in Eastleigh experience higher rates of modern slavery in domestic work, the sex industry and forced marriage. Training curricula on "Caring for Trafficked Persons: Guidance for Health Providers" designed for the Kenya context to increase awareness of HIV risk and vulnerabilities among Victims of Trafficking (VoT) and GBV was developed, and training of trainers conducted. **Not mentioned in the 2018-2019 workplan**

Three other activities in the 2019 report could be related to key populations programming:

- The JT provided financial and technical support in the reinvigoration and capacity building of the National Technical Working Group on HIV, Human Rights and the Law.
- Capacity building for the new membership of the HIV and AIDS Tribunal (HAT) and preliminary evaluation of their previous Strategic Plan were conducted.
- Capacity development of all 47 counties in use of Spectrum and GOALS models to facilitate interpretation and use at the decentralized levels

The infrequent referencing or mentioning of key populations in the 2019 annual report was even more pronounced in the 2020 report including little attribution as to which agency sponsored the activity. Only 23 activities were reported (key informants attributed this to a combination of reduced budget and the COVID-19 pandemic) with **only one directly mentioning key populations:**

1. In partnership with COTU(K), Kenya Long Distance Truck Drivers Union/Highway Community Health Resource Centre, Kenya Pipeline Company, Directorate of Occupational Safety and Health Services provided support to truck drivers and sex worker hotspots reaching 1,743 truckers and sex workers (1,019 men and 724 women), distributing 2000 masks and hand sanitizers, 30,000 condoms and 345 HIV self-testing kits. **ILO Cosponsor country envelope (CE) USD 44,913**

However, five other activities, two dealing with human rights and three with the development of strategic information (including the support of the modes of transmission study) held implications for key populations:

1. Support for the development of a Draft Strategic Plan (2021-2025) for the HIV and AIDS Tribunal. A final validation meeting for the strategic plan is planned for 26 February 2021
2. Development of an online tool for use by partners and communities to document health related human rights violations
3. Kenya Modes of Transmission study implementation at national and each of the 47 counties to guide prevention efforts
4. Generation of HIV estimates at national level and for each of the 47 counties to guide target setting for KASF II, the Global Fund proposal and COP20

5. Generation of 47 HIV epidemiological and financial profiles to understand county progress towards achievement of Fast Track Targets with concrete recommendations on what needs to be done differently

Main partnerships of the Joint Programme

The Joint Programme have partnered with a broad range of entities during implementation including:

1. **Government partners:** the key partner has been the Ministry of Health especially the NASCOP and the NACC. UNODC also works with Pharmacy and Poison Board (PPB), the drug regulatory authority under MoH. In addition, UNAIDS and other JP partners work with county governments.
2. **Civil society:** the JP has worked closely with a broad range of CSOs, PLHIV organizations, and key populations organizations and networks. In the last few years, UNAIDS has strengthened its partnership with Network of People Living with AIDS in Kenya (NEPHAK) and Women Fighting AIDS in Kenya (WOFAK) especially during the COVID 19 period, supporting the organizations with information and other personal protection kits. Key populations-led networks were supported to participate in development of the Global Fund proposal. UNODC also worked with county facilities and CSOs working with PWID, to strengthen their capacities related to harm reduction especially OST/ MAT
3. **Donors:** The evidence of this collaboration was not very strong but donors (during KIIs for this evaluation) confirmed UN agencies' participation in the PEPFAR country operation plan process and the Global Fund country application writing process. What appears to be the case is that meetings are held with senior personnel in the donor agencies, but lower-level programme officers (such as those assigned to key populations) are not included in these meetings. Donors like the Open Society Initiative for East Africa (OSIEA) reported co-funding a few civil society partners including working with UNODC on developing a policy for the National Authority for the Campaign Against Drugs and Alcohol (NACADA) or legal reform related to the amendment of narcotic, drug and psychotropic substance (control) amendment bill.

Case study findings

Relevance and coherence of Joint Programme activities

SUMMARY - The planned activities prioritizing key populations access to combination prevention services and promotion and protection of their rights are relevant as they align with the priorities of the county (as stated in KASF I) and the key populations community. However, as the accomplished activities do not always match the planned activities, relevance and coherence is partially lost.

- The overall role of the JP to "convene, catalyse and bring parties together" is appreciated by the government.
- The most relevant activities were related to UNODC's contribution in initiating and strengthening the MAT clinics in the coastal region and initiating HIV testing and MAT within prisons.
- Most of the JP work with FSWs is focused largely on the Coast through one local NGO, although the HIV burden in FSWs is higher in Nairobi or Nakuru. There was dissemination of studies conducted like the costing study of FSW in Kilifi county for use by national programmes.
- There were limited activities conducted to protect the rights of the key populations. While there were two specific wins related to data privacy policy and illegality of subjecting people suspected of being homosexual to undergo anal examination, the role of the JP in these wins is not very clear.
- Coherence of the JP activities with other key populations funder activities and even within the JP cosponsors is low, other donors were not aware of JP activities with key populations, and some JP partner agencies did not collaborate on any key populations -focused interventions.
- Resources within the JP for key populations programming have reduced over time with increased dependence on donors for funding large-scale programming work.
  (Strength of evidence: Strong - supported by JPMS reporting, documentation and KIIs)

Relevance of activities to key population needs and priorities

The JP has a good relationship with the government and in relation to the key populations programme is seen as a neutral organisation, with technical expertise, access to combination HIV prevention services and protection of human rights as a mandate. Historically, the JP has played an important role in the creation of an enabling policy environment for key populations by directly working with NASCOP and key populations -led organisations. The UNAIDS Country Office and the World Bank were the driving forces and funders of the first 2009 Modes of Transmission Study[81], which provided the key evidence and justification for including key populations in the national strategy from 2009. UNAIDS have supported development of a more recent study (2019/20) with dissemination of the final report pending.

The 2018-2020 programme plans of the JP members were aligned to the priorities of the key populations programme as stated in KASF I. The priority towards ensuring that key populations have access to combination prevention services has been actualised by UNODC supporting the scale up of the MAT Programme. As noted earlier, UNODC has been the most active of the JP agencies working with key populations, having received funding from USAID during this period to support the scale-up of the MAT clinics especially in the coastal counties. UNODC played a key role in setting up more than six clinics including a MAT clinic within the Shimo La Tewa prison in partnership with county government and CSOs. The Lamu MAT clinic was set up using UBRAF funds while another MAT clinic is being set up in Nairobi in partnership with Kenya Prisons Service.

[81] World Bank. 2009. Kenya - HIV Prevention Response and Modes of Transmission Analysis. World Bank. © World Bank. https://openknowledge.worldbank.org/handle/10986/3044 License: CC BY 3.0 IGO."

UNODC has also guided the country through the development of policies, SOPs and training packages for the MAT service providers in the clinics and among NGOs implementing harm reduction programmes in the counties. They have been involved in sensitisation of law enforcement personnel, especially for PWIDs, and have some good examples to demonstrate impact. UNODC has been sensitising county and national government officials to consider alternatives to imprisonment for people who inject and use drugs. Recently the Judge in Shanzu Court, Mombasa County, announced that PWID will be sent to rehabilitation rather than prison. Sensitisation has also targeted the religious and community leaders in the coastal counties to ensure acceptance of PWID. UNODC has also provided technical support to NASCOP, NACC and the PPB especially in relation to managing and scaling up the MAT programme. Technical support to PPB was important in ensuring that a regulation system for methadone was established and the national drug control system is strengthened. UNODC also advocated for the inclusion of buprenorphine as an alternative to methadone with the initiation of pilot projects. Finally, UNODC also supports the Kenya Prisons in development of SOPs for HTS.

The limited UNFPA projects for key populations are notable, given that in the JP division of labour, UNFPA was given the primary responsibility for the response to key population programming. Although it does not appear in the current workplan, UNFPA has been providing some support to the International Centre for Reproductive Health (ICRH) for FSWs and TGs which operates on the coast in Kilifi County. During the evaluation period a costing study for FSW Drop-in-centres/ one stop shop for integrated HIVSRH/TB services was conducted in Mtwapa and Kilifi sites. This study aimed to help the country in scaling up integrated services for key populations. In addition, UNFPA supported procurement and distribution of male condoms for the country. Condom dispensers for key populations and FSW integrated services were procured and distributed during this period. UNFPA is mainly interested in FSWs, leaving MSM issues to UNDP. UNFPA is currently focussed on providing "upstream policy and advocacy and conference support" and less so on "community engagement" (UN key informant). It was noted that KPs have a low priority in UNFPA's recently revised global strategy, and while country offices do have autonomy in the development of their HIV programme, they cannot stray too far outside of the global strategy.

IOM in collaboration with the Kamukunji Sub-County Health Management Team (SCHMT) operates a Community Wellness Centre (CWC) in Eastleigh, a migrant dense urban settlement in Nairobi. IOM's Eastleigh Clinic offers free, non-discriminatory, migrant-friendly and comprehensive HIV/AIDS care services to urban migrants and community members including MSM, PWID and FSW. Traditionally the HIV/AIDS program has been co-funded by IOM and CDC (through Amref). Unfortunately, the CDC funding through AMREF ended in 2021 leading to funding gaps mainly around effective HIV/AIDS care and treatment service delivery.

UNHCR has been involved in testing and linking up LGBTIQ+ refugees to existing support system in Kenya and Kakuma. Their focus has been on refugees with special focus on the LGBTIQ+ community.

In addition, the JP also supported provision of testing services for truckers and FSWs in Mlolongo, Machakos and Mariakani, Kilifi county.

Though UNICEF supports the national government by providing technical support to the national PMTCT programme and the adolescent girls and young women programming focusing on those who are highly vulnerable and at risk, their role in key populations programming has been limited. Despite that Kenya has national guidelines allowing implementing partners to work with young key populations, UNICEF's commitment to ensuring access to services for young key populations has been sub-optimal.

The World Food Programme (WFP) focuses on PLHIV especially those who are malnourished. They support NASCOP to improve the nutritional status of PLHIV, especially assessment in HIV and nutrition, nutrition status and food security status; development of guidelines and policies; training of health care workers on nutrition and HIV; and development of a surveillance system especially doing a longitudinal survey to assess nutrition status (PLHIV clients were complaining that they were gaining weight because of the *HIV* drug dolutegravir (DTG)). WFP also implements HIV and nutrition

programme in the refugee camps to provide food security and social protections. They are also working with the Ministry of Labour to link with the national social protection system. However, WFP does not work with key populations or does not necessarily prioritise PLHIV based on their status as A key population, even though key populations living with HIV are some of the most vulnerable people and experience multiple stresses if they are also malnourished.

UNESCO is not working with key populations in Kenya. Their main activities with HIV are in the Education Sector, where they have been working on development of a comprehensive sexuality curriculum. This has not made much progress in recent years, as continuing resistance by the Ministry of Education to include aspects of sexual diversity, family planning and comprehensive HIV prevention have limited the effectiveness of programme delivery. UNESCO has resisted applying more lobbying or advocacy pressure to the MoE, citing fears of offending the government (UN Key informant).

UNDP has also been active in the area of human rights, supporting the HIV Tribunal and working with civil society in rights-based programming (see below).

The role of UNWomen in the HIV response has been limited to providing support to women PLHIV. There are no activities listed for the past three years in the JPMS that are directly with the involvement of key populations.

The geographic diversity of the epidemic in Kenya, as noted in section 2.1, has been reflected for key populations only in the activity supported by UNFPA, UNODC and UNICEF to support comprehensive services for KPs in 11 priority counties, as defined by the KASF.

The JP activities for key populations show no geographical focus or prioritisation with the exception of one activity - support to comprehensive services for key populations in 11 priority counties (UNFPA, UNODC and UNICEF).

Despite the fact that the JP has been working with key populations organisations, especially in supporting their participation in COP planning, Global Fund proposal writing, participating in the KCM and other capacity development activities, key population key informants felt that during the past three years the activities and visibility of JP members have reduced in the key population arena. This may be due to a number of factors, including reduced resources, both human and financial, sub-optimal involvement of key populations groups in the activity planning process or non-completion of some planned activities.

Human rights and gender equality

Summary - The role of JP in protecting and promoting human rights and gender equality in the context of key populations programming has been limited in the last three years (JP activities and KII).

- Some planned activities were not implemented
- UNODC has been active in trying to involve female PWIDs in their programmes, with little success
- UNDP has assisted in the reorganization of the HIV Tribunal
- Little advocacy or work by the JP on decriminalization or reducing penalties for key populations activities (Strength of evidence: strong, supported by JP plans, JPMS reports and KIIs)

Protection of human rights of key populations is a priority area in KASF I and has been prioritised by the key populations. The Kenya key populations programme also has been progressive in developing guidance to address intersectional vulnerability related to age or gender by generating guidance to work with young key populations and female drug users. Some of the activities planned by the JP during 2018-2020 also focused on human rights but many of those activities were not implemented.

UNODC has played an effective role in addressing the human rights of people who inject drugs by conducting intensive work in partnership with the civil society organisations, with law enforcement including the judiciary; community leaders, clerics, chiefs to create an enabling environment for PWID and protect their human rights. Though the Kenya key populations programme has estimated the presence of women who inject drugs, their participation in the HIV prevention programme has been poor. UNODC helped the harm reduction programme and the MAT clinics to develop a walk-in system for women to facilitate access. In addition, a specific day for women in the MAT clinics is being discussed to provide safe and exclusive space for them. UNODC and MAT are considering offering special timings for sex workers in the clinics, especially in the evening when they are available. UNODC also supports MEWA, a CSO working with women who inject drugs to start a female shelter to ensure safety for FSW who use drugs and experience high violence.

As noted, UNDP has been active in the human rights arena, supporting the reorganisation of the HIV Tribunal, holding consultations with civil society to improve rights-based programming, and conducting studies on policy issues.

There has been little evidence of activities by the JP members to advocate more strongly for changes in the criminalisation of key populations, or to support CSOs that are campaigning for legal reform. In 2018, Kenya had two big wins in the context of human rights with the passage of a ruling that resulted in the development of a data privacy policy, to protect key populations and made it illegal to subject people suspected of being homosexual to anal examinations. However, it is not clear whether the JP played a role securing these wins as the advocacy towards these changes was led by the National Gay and Lesbian Human Rights Commission.

Internal and external alignment and coherence of activities

As noted in section 3.1 the JP in Kenya has representation from almost all partner agencies, with the exception of the World Bank, who no longer have an HIV Department or individuals with responsibility for HIV issues[82]. The JP members meet monthly to follow up on their activities. These meetings are well-attended, and in theory the various JP agencies in the country should be well-acquainted with all programmes and activities. However, some KIs did not seem to be well-versed in the work of the JP for key populations outside of their own agency programme.

The UNAIDS Secretariat and the key agencies working with key populations and vulnerable populations (UNODC, UNICEF, UNDP) have good relations with both NASCOP and NACC. They sit on national technical working groups and on the Global Fund Country Coordinating Mechanism (CCM) where they support the attendance of key populations representatives and the committees that draft the Global Fund applications.

Both NASCOP and NACC review their joint planning with the JP partners. The UNAIDS country team also engages regularly with PEPFAR (as appropriate and needed) and brings on board the relevant cosponsors to discuss overall programmes and specific issues such as the key populations programmes. PEPFAR funds UNODC to implement programmes with PWID in the coast and has regular interaction with UNODC as a grantee. OSIEA is a funds human rights work, however they have no interaction with the JT.

Some Joint Team members felt that the division of labour with the JP is important as different member institutions have different expertise and skills and it is easy to leverage this expertise to address specific needs of the programme. However, it was also agreed that there needs to be more visibility and engagement with other institutions. Various members of the joint team were not aware of their roles and were sceptical of the division of labour being effective. The role of the regional JP in supporting the country programme was not mentioned by KIs, with the exception of UNODC-led activities with PWU/ID in Kenya which are also supported by the regional office.

[82] The World Bank was one of the cosponsors who benefited from the 2019-2020 biennium Kenya UBRAF allocation though the JT member is based in HQ in Washington DC and was a key informant. The WB did some work in Kenya last year on allocative efficiency issues

Concern was raised that when programming with key populations becomes the responsibility of everyone, it ends up being the responsibility of no one and that the division of labour would benefit from sharper leadership and targeted key population programming with the JP. Additionally, changes in staff within the agencies necessitates time to sensitize people and to ensure they gain an understanding of the cross-cutting issues and coordination mechanisms within the JP.

The key populations networks and leaders who were interviewed were not aware of the division of labour within the JP and were not sure how each member agency could support them. They felt that only a few agencies have been visible in the last few years (UNODC, UNAIDS, UNHCR and UNDP) and the interaction of the JT members with grassroots organisations and key populations networks was limited.

Capacity and resources of the Joint Programme

The diminished resources available for JP activities is a recurring theme (although not mentioned by KIs outside of the JP) and a level of disagreement exists concerning optimum allocation of the limited resources. The various agencies are responsible for fund-raising outside of their UBRAF allocation, with some expressing that the division of available funds should be divided *a priori* between agencies while others expressed that funding should go directly to the UNAIDS Secretariat for allocation.

All agencies, with the exception of WB, have designated staff assigned to working on HIV and AIDS programming. However, they often work alone, and not full time on HIV and AIDS programming, and are responsible for overseeing the full range of activities, including key populations. Furthermore, some agencies use most of the UBRAF allocation for staff costs, leaving minimal funds for activity[83].

It is also apparent from the activities listed in Section 3 that AGYW and young men are a priority for the JP. The only key population that seems to be a priority is PWUD/ PWID, under the wing of UNODC, despite the high prevalence and HIV risks documented for sex workers, MSM and transgender persons.

Efficiency and effectiveness of Joint Programme activities

SUMMARY – There are mixed messages on the effectiveness of the JP activities over the past four years:

- UNODC has helped the country to establish and implement activities in five of nine MAT clinics and enrol 60% of the overall MAT clients in these clinics
- Other programmes had sub-optimal reach (e.g., testing only 2,785 FSW or 250 LGBTIQ+ people) making the programmes partially effective
- Programmes implemented with LGBTIQ+ and truck drivers focused solely on HIV testing, thus making them inefficient in addressing other needs of the population
- The costing study conducted by UNFPA in Kilifi has not yet been disseminated limiting its use in programming for key populations
- Capacity strengthening of the key populations networks has been *ad hoc* and needs-based without any apparent long-term plan or vision.

(Strength of evidence: strong: supported by national reports, JPMS reports and KIIs)

Implementation of activities

UBRAF's Strategic Result Area 4 calls for "HIV prevention among key populations" with output 4.1 being "HIV services for key populations" and output 4.2 being the availability of harm reduction services for PWUD[84]. It is evident that these activities are being successfully implemented in Kenya by UNODC through support to harm reduction for PWID as well as drug-users who do not inject, reaching the majority of the PWID in the Coast County. The enrolment of MAT clients in the Coast is high (60% of the national MAT clients). UNODC is now supporting the government to scale up the

[83] UCO Key informant

[84] UNAIDS; Unified Budget, Results and Accountability Framework (UBRAF) Workplan and Budget 2020-2021; UNAIDS/PCB (44)/19.17; accessed at https://www.unaids.org/sites/default/files/media_asset/UNAIDS_PBC44_Workplan-Budget_EN.pdf

MAT programme in other counties through development of policy guidance and training of MAT providers and mobilizers. UNODC contributions in the last three years have been effective in strengthening capacity of the national and county governments as measured through establishment of MAT clinics and enrolment and retainment of MAT clients in these clinics.

UNFPA supports supporting key populations programming through its ICRH implementing partner. ICRH has reached 2,785 sex workers (1.55% of total sex workers in Kenya). The programme has been effective in reaching the FSW population in Kilifi county with comprehensive services (though it is not clear why Kilifi county was selected as there are other counties with higher prevalence of HIV among FSW and other gaps in reach). In addition, UNFPA continues to procure condoms for both HIV prevention and contraception, through which the key populations programming has also benefitted. A costing study in Kilifi for the provision of integrated services for FSW was conducted by UNFPA. However, the findings of the study have yet to be shared with the key populations national programme, limiting its use and replication.

JT agencies have reached LGBTIQ+ refugees and trucker drivers however the number reached too low to prove the intervention effective. In addition, these programmes have focused largely on HIV testing, making these programme inefficient as the other risks and needs of the populations were not addressed.

UNDP and other agencies are receiving funding for advocacy, policy change and addressing human rights issues. These activities are by definition long-term endeavours, and while the number of activities supported by JP members are well-listed, one does question how "progress" is being measured. **Conducting workshops, consultations and conferences are examples of activities carried out in the name of advocacy and fostering policy change, but it is difficult to ascertain impact, given the lack of progress over the past ten years towards decriminalising drug use or sex work, or recognising same-sex relationships.**

Strengthening and empowering KP-led organisations

The JP demonstrates examples in recent years of supporting key populations-led organisations and civil society in key populations-related initiatives, both in-country, as well as supporting key population and civil society leaders to attend and present in international conferences and high-level consultations with PEPFAR or other global agencies.

UNODC has involved PWID and harm reduction networks in the design of interventions especially in relation to the MAT clinics. UNODC made efforts to collectivise the MAT clients forming PWID groups in each clinic and supported them to register although this has not been very successful, in part (according to KIs) as unlike other key populations communities the PWID community is not very united. **That said, PWID leaders have emerged, yet there is a clear need for mentoring to ensure their leadership roles.**

UNICEF also supports young people as champions to sit in committees (Youth Advisory Councils - YACS) at county level and share their perspective and defend their interests. While some of the champions could be KPs, the programme does not use this criterion to select the champions. WFP has not engaged with KPs directly but through implementing partners and NASCOP. There is some direct involvement in the refugee camps, yet the focus is on facilities and not specific populations.

While there has been support for key populations organisations, with the exception of UNODC, key populations do not feel they are adequately involved in the processes/programming initiated by the JP. The support by UNAIDS was ad hoc, without a plan or a long-term vision and geared more towards PLHIV networks than key populations networks. It was also noted that the government and donors were doing more to mobilise key populations and strengthen key populations-led organisations through the KPIF funding and other sources than the JP. This could be a visibility issue (the UN JP being only one representative at the larger nationally convened committees and TWGs), rather than an understanding of the "behind-the-scenes" work of the JP agencies and the UNAIDS Secretariat. While most of the JP engagement is at national level (policy, strategy), KIs agreed that the communication with the wider KP community has not been effective.

Response to COVID-19 pandemic

Summary:

- The JP has been involved in providing information on COVID-19 which is available in the virtual spaces
- UNAIDS supported KP groups by procuring sanitisers, bleach solution and soap to facilitate compliance to MoH guidelines
- UNODC provided support to assist PWID with access to methadone through mobile van services (Strength of evidence: moderate, supported by KIIs)
- The JP has recently partnered with the German Government in contributing USD 500,000 to support efforts of the Kenya Government in alleviating the impact of the COVID-19 pandemic among people living with, at risk of and affected by HIV, including key populations.

Joint programme partners have individually and collectively responded to the COVID-19 pandemic in Kenya, targeting several of their interventions and assistance towards key and vulnerable populations, such as providing information on COVID-19 to websites and social media spaces used by key populations. UNAIDS supported the key populations leadership to come together to discuss the impact of COVID-19 among KPs, and UNICEF is working on developing IEC materials on HIV and COVID. The Key Populations Consortium was provided with personal protective equipment by UNAIDS through NEPHAK and WOFAK, that are PLHIV-led organisations.

UNAIDS and UNICEF mobilised the JT to undertake emergency procurement based on a direct request from NASCOP to buy paediatric ARV (DTG 50 mg) when there was a shortage in early 2021. UNAIDS, UNICEF, UN Women and UNFPA procured and donated to NSACOP/MOH 47,000 doses of DTG 50 mg. This emergency procurement also helped key populations living with HIV.

Support was also provided by UNODC to the MAT clinic to ensure continuity of care and mitigating risk for key populations who attend the clinics. UNODC supported the MAT clinic staff, and clients with PPE (reusable masks to make it more sustainable), sanitizers, information on social distancing etc. In partnership with NASCOP, CSOs and Kenya Red Cross a mobile van service to dispense methadone to MAT clients close to their home during curfew and other COVID-19 related restrictions on mobility was initiated. UNODC also advocated for take home doses and helped in developing an SOP (5 days' medicine in pre-packed containers) to guide provision of doses. Based on this work UNDOC is also advocating, with the PPB, to consider scale-up of the mobile service to address barriers related to distance to the clinic and daily dosing. Some of the advocacy by UNODC and CSOs has not been successful due to lack of resources or other policy issues.

The COVID-19 pandemic produced added stress among the key populations (especially sex workers) including loss of livelihood, loss of shelter, food insecurity, loss of social support system and increased experience of violence. However, other than UNODC, the support from the JP to address these consequences in key populations was very limited,

In December 2021, the JP announced a joint project with the German Government, valued at USD 500,000. The project aims to improve food security and menstrual hygiene as well as provision of personal protective equipment among people living with HIV, adolescent girls and young women, key populations and people living with disability. Working through networks such as National Empowerment Network of People Living with HIV in Kenya (NEPHAK), International Community of Women living with HIV - Kenya Chapter (ICW-Kenya) and Bar Hostess Empowerment and Support Programme, the initiative will target more than 18,000 households with food baskets, sanitary pads, reusable face masks and hand sanitizers in seven counties (Nairobi, Mombasa, Homabay, Kisumu, Siaya, Migori and Busia).

Contribution of the Joint Programme to outputs and intermediate outcomes

As noted above the JP in Kenya has mixed results in terms of contributing to defined outputs and intermediate outcomes:

- Scaled up provision of comprehensive services for key populations groups including the most vulnerable key populations groups – the JP made a significant contribution fifteen years ago in supporting the Modes of Transmission Study and lobbying for integration of the result in the HIV strategy prioritising key populations KPs. Since the government has taken on key populations KP programming with the support of PEPFAR and the Global Fund, the role of the JP in scale-up of key populations services has been minimal, other than UNODC's support to PWUD/PWID interventions.
- Promotion of human rights, gender equality and removal or reduction of criminal and discriminatory laws and stigma and discrimination – the recent Kenya Stigma Index 2.0 study demonstrated a reduction in the overall index, from 45% in 2014 to 23.28% in 2021[85], although higher degrees of stigma and discrimination still exist against certain populations. The JT, especially UNDP, have been working in this area for several years and continue to allocate funds for activities to address stigma and gender inequality. Their overall contribution to the reduction in stigma and discrimination is difficult to determine as many different agencies and interest groups in both government and civil society, locally and internationally funded, are working in the domain, and the monitoring and reporting of activities in the JPMS is not optimal.
- Sustainable financing and programming mechanisms for key populations groups (the intermediate outcomes) – the reduction in JP funding casts doubt on the sustainability of JP activities in Kenya, much less a national sustainable mechanism for funding key populations interventions. The goal of the current KASF is to increase domestic funding of the HIV response to 50% (currently at 40% with no funding to PWID to over 70% of the sex worker programme domestically funded). Whether this high level of key populations funding can be maintained is questionable. There is no evidence that the JP lobbying efforts with the government are addressing the funding of the key populations programme, especially in the context of the country's adoption of the Universal Health Coverage (UHC) agenda, or whether there have been discussions about ensuring that key populations, especially young key populations, are included in the social protection programme plans.

It is recognised that the UN Joint Programme has made a contribution over the past five years in each of these key result areas. However, the extent of that contribution is unknown as the Kenya government has taken on a large proportion of the KP response along with various programmes and interventions supported by other funders with budgets that dwarf the JP contributions.

Response to contextual factors

In the last three years, certain contextual factors have impacted on the key population programme:

- Mobilizing resources to scale up the key population programme to cover 47 counties in Kenya. The JT supported the Global Fund proposal application process in 2020 through provision of national and international TA. The JT was also proactive in ensuring that consultations took place with various constituencies during the proposal writing phase which took place during the first wave of COVID-19, with very limited face-to-face meetings. The agencies supported NACC and NASCOP to organize the virtual meetings and intensive consultations were conducted with all constituencies to ensure that needs and priorities of the constituencies including key populations were included. Key populations were supported to participate in these national meetings and to organise specific meetings with their constituencies as and when needed. This process culminated the country receiving around USD 23 million to support the key populations programme.

[85] PLHIV Stigma Index 2.0 Kenya Country Assessment, NEPHAK, 2021

- Decriminalization of same sex relationships. In the last five years, using a combination of public advocacy and public interest litigation, rights activists in Kenya managed to drive discourse on issues facing LGBTIQ+ populations. A series of progressive legal wins have been secured expanding the recognition and protection of the community. These have included: defending the rights of transgender individuals to change their names on official documents, allowing the registration of LGBT rights organisations and banning the use of anal examinations and STI testing on men suspected of being gay. While it is not illegal to identify as lesbian, gay or transgender in Kenya, many in the community continue to face high rates of harassment, discrimination, violence and social exclusion.[86]

The High Court of Kenya refused an order in May 2019 to declare sections 162 and 165 (which outlaw "carnal knowledge against the order of nature and indecent acts between males whether in public or private" as well as "acts of gross indecency") unconstitutional. JP support to this decriminalisation process has been found to be "lukewarm" by the key populations community and activists; rather the JP should focus more on ensuring that behaviours, work and practices that put key populations at risk of HIV and other diseases are decriminalised.

- Lack of commodities in Kenya for prevention and treatment over the past year. In April 2021, Kenya experienced a shortage of anti-retroviral drugs due to a dispute between USAID and the Kenyan government. During the year similar shortages related to condoms, lubricants, rapid test kits and methadone has been experienced. As noted, UNFPA supplied some condoms, but not enough to meet the national need. NACC and NASCOP advocated with the national government to allocate domestic resources towards commodities and succeeded to some extent. If the resources are used to address the commodity gap it will in turn benefit key populations. The role of the JP in working with the government to address the commodity issues is unclear. However, there could be a role for the JP in supplying technical assistance for forecasting and supply management to the government and county procurement offices to ensure that these shortages are minimised.

Sustainability of the results of the Joint Programme's activities

As noted above, the earlier work in Kenya by the JP has resulted in key populations programming becoming an integral component of the HIV response both in the Ministry of Health and in the National Strategies. KIs resoundingly stated that key populations programming has been "institutionalised" in Kenya and is unlikely to be removed from the national plan for the foreseeable future.

With decreased JP resources and the government taking over the majority of key populations programming with the support of PEPFAR and the Global Fund, the JP has focused on providing financial and technical support to networks of communities including key populations organisations, to meaningfully engage in the Global Fund application process to prioritise key populations programming. It was noted that JP advocacy for key populations programming, in coordination with PEPFAR, resulted in an increased allocation of funds in the most recent Global Fund grant application.

Furthermore, the JP members provide TA support to all government Technical Working Groups (TWGs). The JP under the coordination mandate of UNAIDS has been working closely and proactively with PEPFAR and other stakeholders to influence KP programme prioritization and release of the KP Investment Fund as well as the resources allocated for community-led monitoring (CLM) in the PEPFAR Country Operating Plans (COPs) for 2020 and 2021.

Despite prioritisation of key populations in the national response and a commitment to funding (e.g., KASF goal to increase domestic funding of the HIV response to 50%) key populations programming is still heavily supported from donor funds. Therefore, concerted efforts are needed to ensure prioritisation of key populations programming within the 50% contribution. Even more vulnerable

[86] Network of People Living With AIDS in Kenya (NEPHAK); PLHIV Stigma Index 2.0 Kenya Country Assessment; 2021

are the key populations -led organisations and networks, which are also dependent on external funding, as domestic funding potentially allocated to key populations programming is likely to fund service provision over community support.

Conclusions and considerations regarding future priorities

Summary conclusions: status of Kenya's key population response

The JP in Kenya has improved the policy environment for key populations and has played a very strong advocacy role by supporting NACC and NASCOP with technical guidance. This advocacy also increased the profile and visibility of key populations in the HIV response of the country. In the past the JP strategically placed or seconded staff within NACC and NASCOP which increased the influence of JP in the key populations response. The JP has also been instrumental in mobilizing political support in the key populations programme brining government, CSOs and key populations-led organisations to the same table for discussions and decision-making.

However, during the period of this evaluation the role and visibility of the JP in key populations programming has diminished, with two exceptions (UNODC work with PWUD/PWID and to a lesser extent UNDP work on human rights and policy). UNAIDS did play a role during the outbreak of COVID-19 pandemic in 2020, when it reprogrammed its core funding to support PLHIV and key populations groups with food basket and hygiene packs. The funding of the non-UBRAF core funds has not increased significantly. Resource mobilization to scale up programming has been challenged and the limited available resources are typically channelled through NASCOP and NACC, making the actual contribution of the JP less visible to the key populations community.

UNODC seems to have had the highest visibility within the key populations programme in the last few years. UNODC received funding from PEPFAR and played a critical role in initiating and scaling up the OST programme in Kenya with 26% of PWID enrolled in the programme to date. UNODC not only played a key role by supporting the national government in developing policies and guidance but also worked with county governments and CSOs in creating an enabling environment and establishing and running the MAT clinics. Capacity strengthening and advocacy with the PPB also provided support to the MAT clinics and facilitated scale up across the country. IOM also plays a role by providing HIV/AIDS treatment and care to key populations among the migrant populations in urban settlements.

Besides the activities supported mainly by UNODC, IOM and the UNAIDS Secretariat itself (through its attendance at meetings and seat on the TWGs and CCM), other JP members had a limited role in the key population programme. UNDP, UNFPA, UNAIDS and WHO had some visibility through supporting or co-sponsoring a handful of activities, but other JT members are either not up to date/aware of the key population programme in Kenya or did not think of integrating or considering the needs of key populations within their mandate. For example, even though key populations would have benefitted from the WFP food programme or UNICEF AGYW programming, they were not consciously considered. UNFPA's increasingly minor role in key populations programming in the country belies their position in the division of labour as the agency most responsible for key populations initiatives.

In addition, a strong connection between the key populations groups and the JP in the past three years has not been fostered and key populations groups are often unaware of the roles of the JP and note a general level of disconnect from the JP programming. Other actors actively funding the HIV and key populations response, while acknowledging the presence of the JP as one of the national stakeholders at the planning table (mainly the UNAIDS Secretariat) did not see the JT as a strategic partner resulting in limited coordination and partnership which is a missed opportunity.

There is a place for the JT in the key populations response given their prestige, high-profile and good relations with the government. More powerful advocacy and lobbying to change the illegality of key populations communities, more pressure on the Ministry of Education to provide more factual and realistic comprehensive sexuality training in the school systems, and more work with young key populations, especially underage sex workers and MSM are all areas where the UNJP agencies could play an important role.

Lobbying and advocating with government to increase funding to the key populations programme, combined with technical assistance to the key populations community on organisational and network development, management, and sustainability skills are potential roles for the JP in Kenya.

Considerations for the Joint Programme in Kenya

The key priorities of the JP should continue to be informed by an analysis of key opportunities and challenges facing key populations programming. In Kenya the JP played a key role in ensuring that key populations were included in the national HIV response and an enabling environment was built to scale up programming in the country. They also played a key role in ensuring the response is evidence based (the modes of transmission and other studies), commodities were available to prevent HIV (mainly condoms until recently) and capacity was strengthened (policy makers, elected representatives and KP leaders) to manage and implement the programme. The Kenya key populations programme is now more than a decade old and has matured with strong leadership from the government (NASCOP and NACC), adequate resources from funders (PEPFAR and Global Fund) and strong leadership and visibility of the key populations groups and networks. In this scenario with limited resources available, the role of JP needs to be more strategic, and consideration should be given to the following areas:

- The role of the JP in support of key populations programming needs to be re-evaluated and responsibility clearly assigned to those agencies that place a high priority on key populations components of the HIV response.
- A greater proportion of the limited available resources in the JP workplan should be targeted and allocated to specific key population groups and related activities, rather than designating activities for “key populations” in general.
- The JP should support the national government through management-level technical assistance and mentoring to ensure that commodity security is achieved in relation to testing, prevention and treatment commodities.
- The JP should work more directly with key populations led organisations and focus on strengthening their capacity to take leadership roles and implement key populations programmes in pursuit of the global target of 80% of the programmes being implemented by KP-led organisations in the country.
- The JP needs to push for political commitment for key populations programming in Kenya to comply with the targets of the Global AIDS Strategy to ensure global targets are realised; most critically for domestic financing and accountability and participation of the affected communities in decision-making.
- Criminalisation of key populations is still a structural barrier to access HIV services. The JP has a role to play to strengthen the decriminalisation movement in Kenya by supporting key populations groups with evidence and strategies to advocate for change.
- The JP has access to global technical support and expertise. There are critical programming issues in Kenya that would benefit from technical inputs from the JP including: introducing new HIV prevention technology (such as injectable PrEP and ART), including mental health issues in key populations programming, improving the database for key populations (including population size estimates and mapping exercises), and ensuring greater inclusion of TG and young K key populations communities in the county level response. The JP should support the national programme to develop technical strategies using global and national guidance available on these topics.

- The JP should further engage in advocacy around young key populations with donors like PEPFAR to ensure relevant guidelines are implemented and young key populations are reached with effective services.
- In an effort to strengthen the community-led monitoring process, first and foremost by including key populations and PLHIV, the JP should proactively support the methods and processes for implementing Community Led Monitoring (CLM) in key populations programmes.
- To address violence and stigma against key populations, which continues to be high, the JP should work more actively with both the government and NGO institutions that work in the field to strengthen and empower the key populations-led response to violence and stigma.
- Recognising the diversity of the key populations communities in Kenya, the JP should create fora with key populations sub-populations and engage with them proactively to understand their needs and gaps in programming and influence national and county policy and programmes funded by PEPFAR and Global Fund to address the needs. The JP should continue to participate in the COP process and influence the process to ensure that key populations priorities are included in the plans.

Annex 1: Key informants – Kenya

The table below lists the names and organizational affiliations of the key informants who were interviewed as part of the Kenya country study. Due to the COVID-19 situation, all interviews were conducted remotely, using Zoom.

Name	Organization
Janet Musimbi	NASCOP TSU
Reuben Musundi	NACC
Obwiri Kenyatta	CDC
Julius Oliech	CDC
Representative	KESWA
Representative	KENPUD
Representative	GHPN
Representative	KP consortium
Representative	KCM Representative
Representative	KCM Representative
Representative	KCM Representative
Representative	Osiea
Helgar Musyoki	Global Fund
Representative	Health Gap
Representative	Kenya NGO AIDS Consortium
Faizal Sullieman	UNODC
Fauz Ibrahim	UNODC
Lilian Langat	UNFPA
Aggrey Achola	IOM
Gloria Billie	UNAIDS
Medhin Tsehaiu	UNAIDS
Jane Kamau	UNESCO
Joyce Owigar	WPF
Pierre Robert	UNICEF
Zara Shubber	World Bank
Edwin Odhialo	UNAIDS

Annex 2: Bibliography/Background documents – Kenya

1. CDC, UMB, KEMRI, NASCOP; Integrated bio-behavioural survey of fisher folk communities along the Lakeshore of Lake Victoria, Kenya, draft report; 2019.
2. Emmanuel F, Kioko J, Musyoki H, Kaosa S, Ongaro MK, Kuria S *et al.* Mapping virtual platforms to estimate the population size of men who have sex with men (MSM) who use internet to find sexual partners: implications to enhance HIV prevention among MSM in Kenya. Gates Open Research 2020,
3. Global Prevention Coalition; Kenya scorecard 2020; accessed at https://hivpreventioncoalition.unaids.org/wp-content/uploads/2020/12/Kenya-Scorecard-HIV-prevention-2020-Final-v1m-002.pdf
4. Kenya Ministry of Health; National AIDS Control Council (NACC); Kenya AIDS Strategic Framework II 2020/21-2024/25; 2020
5. Kenya Ministry of Health; The National HIV and AIDS Stigma and Discrimination Index Summary Report; 2014
6. Krotz L; Piecing the Puzzle: The Genesis of AIDS Research in Africa; University of Manitoba Press; 2012.
7. Musyoki H, Bhattacharjee P, Sabin K, Ngoskin E, Wheeler T, Dallabetta G; A decade and beyond: learnings from HIV programming with underserved and marginalized key populations in Kenya; JIAS 24:53; 30 June 2021; accessed at https://doi.org/10.1002/jia2.25729
8. NACC; HIV new estimates report; 2020
9. NASCOP, NACC and Univ. Manitoba; Evidence brief- Epidemic Analysis; November 2021
10. NASCOP; Integrated bio-behavioural survey report; 2010/2011.
11. NASCOP; Key Population mapping and size estimation in selected counties in Kenya – Phase 1 report; Nairobi: Government of Kenya, 2019
12. NASCOP; National Guidelines for HIV/STI Programming with Key Populations; Nairobi: Government of Kenya, 2014.
13. NASCOP; Preliminary KENPHIA report; 2018
14. NASCOP; Reaching the unreached: the evolution of Kenya's HIV/AIDS Prevention Programme for Key Populations; Nairobi: Government of Kenya; 2016
15. NASCOP; Third national behavioural assessment of Key Populations in Kenya: polling booth survey report; Nairobi: Government of Kenya. 2018. Accessed at: https://hivpreventioncoalition.unaids.org/wp-content/uploads/2020/02/Third-national-behavioural-assessment-of-key-populations-in-Kenya-polling-booth-survey-report-October-2018-1.pdf
16. NEPHAK; PLHIV Stigma Index 2.0 Kenya Country Assessment; 2021
17. UNAIDS; Unified Budget, Results and Accountability Framework (UBRAF) Workplan and Budget 2020-2021; UNAIDS/PCB (44)/19.17; accessed at https://www.unaids.org/sites/default/files/media_asset/UNAIDS_PBC44_Workplan-Budget_EN.pdf
18. World Bank; Kenya - HIV Prevention Response and Modes of Transmission Analysis; World Bank; 2009 accessed at: https://openknowledge.worldbank.org/handle/10986/3044 License: CC BY 3.0 IGO."

Annex 3: Supplementary Interview Guide used in Kenya

1. Over the past five years, what do you think are the most significant changes that have occurred in KP programming and how has the work of the Joint Programme contributed to these changes?
2. How is WHO supporting the Joint Programme at country level to address the needs of different KP groups? (examples, best practice?)
3. What do you consider are the main results or outcomes of Joint Programme support to KPs at country level? (evidence/examples?)
4. How is the Joint Programme supporting the meaningful engagement of different KP groups in HIV and health governance, strategic planning, programming/implementation, and monitoring processes (at global and country levels)?
5. How is the Joint Programme supporting the country-level response to address the needs of different KP groups in humanitarian emergencies and COVID-19?
6. How well does the Division of Labour 'work' for KPs? E.g. leverages agency roles and expertise in support of different of KP groups? Ensures support is coherent and harmonised/does not fragment KP responses?
7. What are some of the human rights, gender and equity issues in KP programming that have been (or are being) addressed by Joint Programme activities?
8. What do you consider to be main lessons learned from the strategic period that is ending?
9. For the JP to contribute to achieving the new Global Strategy's Strategic Priority Outcomes, what gaps need addressing and what needs to change?

3. Peru country study

Consultants:
Country team leaders: Carlos Caceres and Ximena Salazar
Key population team members: Jana Villayzan and Azucena Rodriguez

Global level team leader: Lawrence Gelmon
Global deputy team leader: Clare Dickinson

Introduction and context

Purpose and scope of the Peru country study

This case study is part of a larger evaluation to assess the relevance, coherence, equity, efficiency, effectiveness and sustainability of the UNAIDS[87] Joint Programme on AIDS (JP) support for key population (KP) programming at country level over the years 2018-2021, with a view to improving UNAIDS programming with and for key populations under the new UNAIDS United Budget, Results and Accountability Framework (UBRAF) 2022-2026. The primary unit of analysis for the evaluation is how the JP has supported KP programming at the country level. Six countries were chosen for the case studies, covering all UNAIDS regions and a variety of epidemics. The six countries are Cameroon, Kenya, Peru, Thailand, Tunisia, and Ukraine. The case studies have been supplemented by document review and key informant interviews (KII) at the global and regional levels.

The KPs, as defined by UNAIDS, are sex workers (SW), gay men and other men who have sex with men (MSM), transgender persons (TG) (specifically in Peru transgender women (TGW)), people who inject drugs (PWID), and prisoners, including young people who are part of these KPs. In Peru the Ministry of Health also defines People living with HIV (PLWHIV) (including Venezuelan migrants) as a key population[88].

Methods

Team

The team was composed of 4 people:

- 2 researchers in charge of conducting the interviews, the analysis, report preparation, participation in the KP country team leads updates, and in the country analysis workshops
- 2 KP representatives collaborating with KP organization leaders, members, and other constituencies; accompanying some interviews, and reviewing the presentation of findings (PPT and reports)

Methodological approach

The evaluation is theory-based and involved the development of a Theory of Change (TOC) which has served as an overall analytical framework for the evaluation. The TOC outlines the relationships between the JP activities and interventions and how these are expected to bring about change and results for KP responses. The TOC also includes a forward-looking component through use of the Strategic Priority Outcomes (SPOs) of the new Strategy 2021-2026, the intention being to help identify existing gaps for the achievement of the new strategy and to inform future KP programming recommendations. Ten evaluation questions, based on OECD DAC Evaluation Criteria[89] were identified refined and mapped to the TOC.

The country case studies focused on a qualitative analysis of the JP activities in relation to capacity and country needs, examining progress made in KP programming, to gain a comprehensive and nuanced understanding of UNAIDS support and contribution to KPs at the country level. Additionally, the case studies focused on eliciting lessons learned, good practices, and examples of factors helping or hindering UNAIDS work with and for KPs. This case study – in Peru - was conducted through document review and KIIs with staff of the UNAIDS Country Office and Cosponsors, Peruvian government ministries, KP-led networks (leaders, activists and members), NGOs working with and providing community services to KPs and other NGOs, and the Global Fund Country Coordinating Mechanism (CCM). A total of 29 interviews were conducted along with 3 discussion groups with

[87] References to UNAIDS in this report refer to the Joint United Nations Programme on HIV and AIDS, consisting of the UNAIDS Secretariat and UN agency Cosponors. The UNAIDS Secretariat in Thailand is referred to as the UNAIDS Country Office (UNAIDS CO).

[88] The evaluation did not consider people living with HIV; however, in the Political Declaration, PLH are part of KPs (see art. 25 in PD 2021)

[89] https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

members of a PLWHIV youth organization (3 persons), members of FSW organizations (4 persons), and Local UNAIDS secretariat members (5 persons) in September and October 2021. A list of all KIs is in Annex as well as a bibliography of documents reviewed.

National HIV context and programme response

Peru's HIV epidemic

Since 1983, when the first AIDS case was reported in the country, the notification of HIV and AIDS cases and deaths showed an increasing trend until 2004-2006, when antiretroviral treatment (ART) was implemented in health facilities. After that, AIDS deaths receded, and have continued to decline until today. A new estimate of PLWHIV for 2020 indicates a total of 91,000 people living with the virus[90] in Peru.

The HIV epidemic in Peru continues to be concentrated, specifically among MSM and TGW. The latest epidemiological surveillance[91] shows an average prevalence of 10% for MSM, with the city of Lima having the highest prevalence (18%); furthermore, in the last five years, there has been an increase in cases of HIV infection diagnosed among young people between 20 and 24 years old, most of them men. In TGW, the average prevalence was 31.8% (the Loreto region in the Amazon and Lima representing the areas with the highest concentration, i.e., 40% and 36% respectively) [92].

Given Venezuela's economic and health crisis, millions of Venezuelans left the country, and Peru is one of the countries that has received the most Venezuelan migrants (1,286,464 in November 2021)[93] including PLWHIV. Until June 2021, the Ministry of Health (MoH) reported 3,409 Venezuelans living with HIV on ART. Most of them are concentrated in the cities of Lima and Callao, representing 4.5% of the total number of people receiving treatment from the MoH in the whole country[94].

Recent estimations of HIV prevalence among FSW and people in prisons are not available[95]. The previous studies were carried out in 2002[96] and 2003[97] respectively. In recent years there has been an increase in cases in the indigenous populations of the Amazon, especially those located in the Northern Amazon area near Ecuador; in some communities, HIV prevalence has reached up to 7%[98].

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[90] National Centre for Epidemiology. Prevention and control of diseases. Ministry of Health of Peru. Note: The HIV infection case curve includes all stages of infection, including the AIDS stage. Report as of September 1, 2021.
[91] National Centre for Epidemiology, Prevention and Control of Diseases. Epidemiological Surveillance (2017)
[92] Op.Cit.
[93] Plataforma de Coordinación Interagencial para Refugiados&Migrantes de Venezuela. 4.12.21. https://www.r4v.info/es/refugiadosymigrantes
[94] Dirección de Prevención y Control de VIH, ETS y Hepatitis (MINSA), 2021
[95] Cfr. with section 1: introduction and Context. About prisoners, there are very few epidemiological studies. A study in the prisons of Arequipa, Moquegua, and Tacna (South of Peru) carried out in 2017 shows that 25.9% of the inmates who practice anal sex in prison are carriers of an STI and that 57.9% of the inmates who have relationships in prison do not use a condom (Cf. Pino Chávez W, Jiménez Bengoa M, Fernández Cárdenas L. Associated Factors and Seroprevalence of HIV, Syphilis, Heptitis B and C in the Prison Population of Arequipa, Moquegua and Tacna, Peru, 2017. Revista Postgrado Scientiarvm P. 31 - 40 January 2018 Volume 4 - Number 1 DOI: 10.26696 / sci.epg.0069. Another study concludes that the estimated prevalence of infectious diseases in the population deprived of liberty is higher than that of Peruvians (Cf. Hernández-Vásquez A, Rojas-Roque C. Diseases and access to treatment of the Peruvian prison population: an analysis according to sex. Rev Esp Sanid Penit. 2020; 22 (1): 9-15. Concerning sex workers, a 2012 study concludes that this group only represents 0.8% of estimated new HIV cases. This result is consistent with the low prevalence of HIV and high condom use (Cfr Alarcón J. Et al. Estimation and analysis of HIV incidence in the adult population of Peru: results of the application of the mathematical model MoT. Revista Peruana de Medicina Experimental 2012 Vol 29 (4). Unfortunately, no more current studies have been found.
[96] Oficina General de Epidemiología, Dirección General de Salud de las Personas – Componente CETSS e Instituto Nacional de Salud del Ministerio de Salud del Perú. Protocolo de Vigilancia de Segunda Generación de ETS e infección por VIH en Trabajadoras Sexuales PERÚ – 2002. Ministerio de Salud
[97] Cárcamo C, et al. Estudio basal de prevalencia de sífilis y VIH y comportamientos asociados en población privada de libertad, Perú 1999. Rev Peru Med Exp Salud Pública, 2003, vol20 (1): 9-14.
[98] Centro Nacional de Epidemiología, Prevención y Control de Enfermedades (MINSA) Análisis de Situación de Salud de los Pueblos Indigenas de la Amazonía Viviendo en el Ámbito de las Cuatro Cuencas y el Rio Chambira, 2020

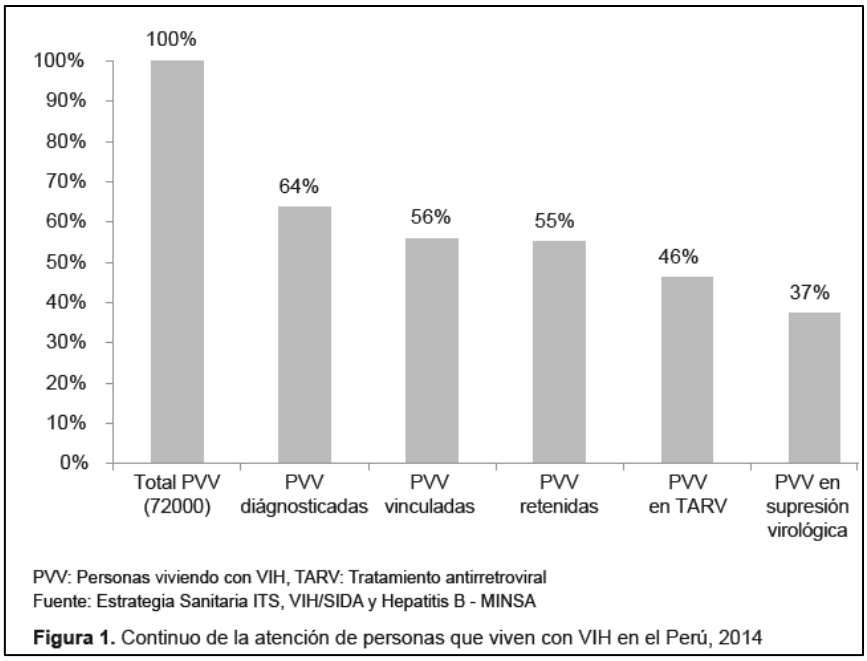
Finally, it is important to add that between 2018 and 2019, an IBBS on HIV, syphilis and hepatitis was carried out among indigenous people of the Amazonas and Loreto regions. HIV prevalence was 1.8% in the Awajún community and 0.55% in the Wampis community. Additionally, prevalences of syphilis and viral hepatitis were 1.6% and 1.5%, respectively. According to this evidence, the Amazonian indigenous communities experience a higher vulnerability to the epidemic[99].

Peru's HIV response

Global commitment has been driving the acceleration of the response to the HIV epidemic, so that by 2030, AIDS will be eliminated as a public health problem. To achieve this commitment, it was proposed that, by 2020, 90% of PLWHIV should know their HIV status, 90% of those diagnosed should be receiving ART, and 90% of those on ART should achieve viral suppression. In 2013 the Continuum of Care indicators were proposed by WHO and accepted by all Latin American countries to monitor the epidemic. This year, 2021, those Continuum of Care targets were upgraded to 95-95-95, to be accomplished by 2026.

Unfortunately, efforts to improve the Continuum of Care indicators in Peru were plagued by a series of structural and programmatic barriers to diagnosis, linkage to health facilities, and retention in care, including the provision of ART[100] as seen in Figure 1. Thus, in 2014 the Continuum of Care was expressed as follows:

Figure 8: Estimates of the Cascade of Care for PLWHIV (2014)



PVV: Personas viviendo con VIH, TARV: Tratamiento antirretroviral
Fuente: Estrategia Sanitaria ITS, VIH/SIDA y Hepatitis B - MINSA

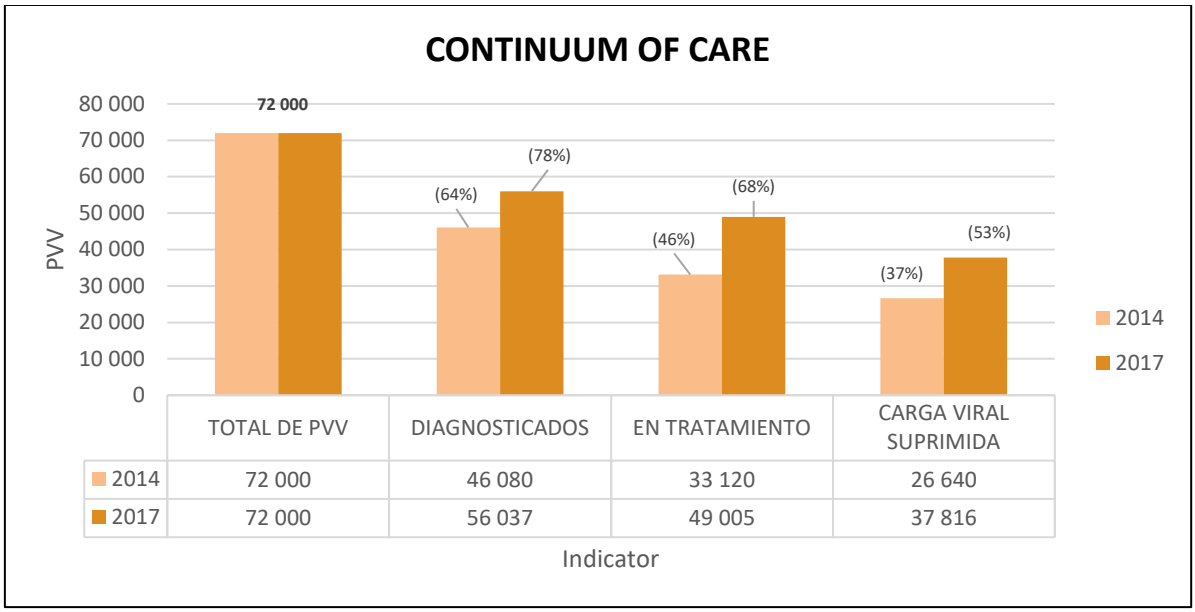
Figura 1. Continuo de la atención de personas que viven con VIH en el Perú, 2014

[99] Carcamo, C. et al (2019) Estudio Epidemiológico para determinar la prevalencia y comportamientos de riesgo asociados al VIH, en comunidades indígenas en Condorcanqui y Datem del Marañón. Lima: Ministry of Health.

[100] Garcia-Fernandez L., Novoa R., Huaman B., Benites C. (2018) Continuo de la atención de personas que viven con VIH y brechas para el logro de las metas 90-90-90 en Perú. *Rev Peru Med Exp Salud Publica*. 35(3): 491-6. doi:10.17843/rpmesp.2018.353.3853.

The latest study of the HIV Continuum of Care (2017)[101] considered the same population estimate (72,000)[102], and showed progress compared to 2014 (Figure 1), as shown in the following figure:

Figure 9: Estimates of the Cascade of Care for PLWHIV (2014 versus 2017)



It should be noted that, by 2020, the gaps to reach the 90-90-90 targets were 12% for people diagnosed with HIV, 13% for linkage to care, and 20% for the achievement of viral suppression. With the new commitment (95-95-95 targets) the gaps have increased[103].

In 2019, services focused on PLWHIV were on track to achieve those goals. Unfortunately, according to the UNAIDS report (2020)[104], the COVID-19 crisis derailed efforts. Both the identification and the notification of cases fell substantially: as of November 2020, only 1,905 new HIV infections had been reported compared to the entire decade's annual average (6,968)[105]. Thus, according to the MoH of Peru, until the end of 2020, ART coverage reached only 80% of those in need. During the lockdown due to COVID-19, from 16 March to 30 June 2020, primary care facilities were closed. COVID-19 became the focus of heath care provision, leaving many other health problems almost unattended. In this context, an HIV test confirmation was not sufficiently accessible, and those diagnosed before could not start treatment. Services resumed only after the lockdown was terminated by the end of June 2020 but at a gradual pace witnessed by HIV screening coverage reduction of 36% until August 2020, and the proportion of those discontinuing ART increased 15% compared to 2019[106].

Both the Political Constitution of Peru (1993) and the General Health Law (1997) establish the right to health and equitable access to services, as well as the responsibility of the Government to promote conditions that guarantee health coverage[107]. That said, in Peru this provision is treated as

[101] Centro Nacional de Epidemiología. Prevención y Control de Enfermedades (CDC), Instituto Nacional de Salud (INS)y Dirección de Prevención y Control de VIH-SIDA, Enfermedades de Transmisión Sexual y Hepatitis (DPVIH), MINSA, 2017.
[102] UNAIDS SPECTRUM. https://www.unaids.org/es/dataanalysis/datatools/spectrum-epp. It remained the same as the parameters were not updated, as has occurred more recently. The graphs are for 2014 and 2017, and they are graphs of HIV+ people. The screening coverage is about all people without a previous HIV+ diagnosis.
[103] Centro Nacional de Epidemiología. Prevención y Control de Enfermedades (CDC), Instituto Nacional de Salud (INS)y Dirección de Prevención y Control de VIH-SIDA, Enfermedades de Transmisión Sexual y Hepatitis (DPVIH), MINSA, 2017.
[104] UNAIDS (2020). *Seizing the moment: Tackling entrenched inequalities to end epidemics. Global AIDS Update 2020.* Disponible en: https://www.unaids.org/en/resources/documents/2020/global-aids-report
[105] Arana Conde R. (2020). Perú apenas llega al 27% de diagnósticos de VIH en el 2020. *Concexión Vida.* Disponible en: https://conexionvida.net.pe/2020/11/07/peru-apenas-llega-al-27-de-diagnosticos-de-vih-en-el-2020/
[106] Chávez Amaya C. (2020). El abandono de tratamientos para VIH y Sida creció un 17% en pandemia. *Ojo Público.* Disponible en: https://ojo-publico.com/2287/el-abandono-de-tratamientos-para-vih-y-sida-crecio-un-17-en-pandemia.
[107] Salazar Araujo, J. F. (2014). La gestión de abastecimiento de medicamentos en el sector público peruano. Nuevos modelos de gestión. *Sinergia e Innovación*, 2(1), 156-225.

an aspirational right, one that the state is not accountable for at the present time[108]. Through the Regional Divisions of Health, the MoH and the Regional Governments manage a network of public facilities throughout the country, based on a subsidized model of comprehensive health insurance (SIS in Spanish). Establishments play a role in geographically distributed care networks, according to their level of complexity: Hospitals, Health Centres, and Medical facilities; the Social Security System (EsSalud in Spanish) aimed at formally employed workers and their families; and finally, the health services of the Police and Armed Forces.

On the other hand, the private sector assists those who can pay for services directly or through private insurance. It is a fragmented and segmented system, with insufficient funding and limited community participation[109].

One hundred ninety-three establishments distribute ART, primarily hospitals and Health Centers. Almost 25 years ago, the Periodic Medical Care Program (AMP in Spanish) was implemented in Peru aimed at KPs, specifically TGW, MSM, and FSW. The AMP is still being offered by 130 facilities across all regions of the country, and involves community promoters (primarily MSM and FSW, much less TGW) to link KPs to HIV prevention and care services. However, these services still present significant barriers in terms of infrastructure, human resources, and stigma and discrimination. In addition, since 2016, new modalities for population screening have been incorporated (mobile services in KPs interaction spaces, rural mobile brigades, etc.), also including community services through KP organizations[110]. During 2020, 17,976 MSM (7% of the estimated population), 1,678 TGW (5% of the estimated population), and 9,242 FSW (12% of the estimated population) were screened for HIV.

The essential HIV guidelines and reference documents in Peru include:

1. The National Multisectoral Health Plan for 2030: *"Peru, a Healthy Country."*
2. The Technical Standard for Comprehensive Care for Adults with Human Immunodeficiency Virus (HIV) Infection (NTS N ° 097- MINSA / 2018 / DGIESP - V.03)
3. The affiliation of the vulnerable population affected by HIV-AIDS and tuberculosis and people with disabilities to the Comprehensive Health Insurance for broad coverage of free health care (DS 02-2020).
4. The Technical Standard for the Comprehensive Care of Children and Adolescents with Human Immunodeficiency Virus Infection (RM 882/2020)
5. The Technical Standard for Prevention and Control of STIs and HIV/AIDS for the Trans Feminine Population[111] (NT 126/2016)
6. RM N° 649-2020/MINSA approves NTS 164-MINSA/2020/DGIESP (norm for the integral care of women affected by sexual violence)
7. Health Directive N° 131- MINSA/2021/DGIESP, (related to the SRH care services during the COVID-19 pandemic)

[108] In Peru it is common-sense knowledge that there is no universal health care. The government, while not accountable for it at present, is expected to achieve it at some point. According to the World Bank (2021): With the Covid 19 epidemic, the weaknesses of the health sector became more evident: Limited coverage of services, poor availability of human resources (14 doctors per 10,000 inhabitants), and infrastructure (96% of health facilities have inadequate installed capacity). There is a gap between the offer, focused on diseases, and a greater need for care at the first level of care. Cf. World Bank Group. Financing for Universal Health Coverage in Peru after COVID-19. September 2021. Available at: https://documents1.worldbank.org/curated/en/272151632979757783/pdf/Financiamiento-para-la-Cobertura-Universal-de-Salud-en-el-Peru-Despues-de-la-COVID-19.pdf

[109] Op.Cit

[110] Which is unequal concerning TGW, who participate to a much lesser extent in this community offer

[111] In addition to the Technical Standard for the Indigenous population, this is another Technical Standard specific to a key population (trans women) complemented by the provision of technologies for body modification and other specific needs. The other KP are contained in the Technical Standard for the Comprehensive Care of Adults with Human Immunodeficiency Virus (HIV) Infection.

Guidelines currently under preparation include:

1. Decentralization of ART services in the first level of care
2. Incorporation of Assisted Partner Notification
3. Incorporation of PrEP / Combination HIV Prevention
4. Implementation of specialized care facilities for trans women[112] (hormone provision)

Enabling Environment

Stigma, discrimination, and violence are due to the social and historical invisibility of TGW, MSM, FSW and PLWHIV; as well as the context of generalized and even institutionalized discrimination. These factors remain despite the efforts made by the Ministry of Justice and Human Rights in the National Human Rights Plan 2018-2021 and the incorporation of specific Indicators for KPs in the new National Human Rights Policy currently under preparation.

Although the Peruvian Political Constitution has not expressly recognized sexual orientation and gender identity, the Constitutional Court has recognized the existence of the right to gender identity[113]. Likewise, discrimination due to sexual orientation or gender identity is criminally sanctioned. However, hate crimes are still not recognized by the law.

In 2017, the Legislative Decree 1323 was approved, which sanctions discrimination and incitement to discrimination, based on *"(…) sexual orientation and gender identity, (…)"*. In recent years, plans and policies[114] have been approved that consider various forms of discrimination, including those based on people's sexual orientation and identity, providing a series of actions to counteract this situation. However, there is still a need for a comprehensive and specialized system to adequately record, prevent, investigate, and punish stigma, discrimination, and violence.

Civil society has presented several bills to Congress: i.e., the Gender Identity Bill - 26743 (2012) and the Equal Marriage Bill - 525 (2021), which have persistently failed to be approved, given the conservative spirit of Congress. Likewise, the Ministry of Education cannot fully implement Comprehensive Sex Education due to the influence of conservative groups that have become relevant in the country in recent years.

In Peruvian society, deeply rooted prejudice against sexual diversity and sex work is, in some cases, manifested through violence[115]. In a survey carried out by the National Institute of Statistics and Informatics in 2017, 56.5% of the LGBTI people surveyed reported fear of expressing their sexual orientation and gender identity, indicating the fear of being discriminated against and attacked (72%)[116]. Furthermore, 71% and 70% of Peruvians consider that LTGBI people and PLH, respectively, are the most discriminated groups in the country (Ministry of Justice and IPSOS, 2020)[117]. Therefore, HIV/AIDS stigma and discrimination persists, both in society and in health services, which violates the rights of the KPs and PLWHIV, hinders their access to health, and the amelioration of their quality of life.

[112] It should be noted that there is a long delay in the implementation of the technical standard for transgender women throughout the country, although it was promulgated five years ago.
[113] Constitutional Court. Sentence File N° 6040-2015-PA/TC., f.j.14
[114] The following should be noted: the National Plan against Gender Violence 2016-2021, the National Plan against Trafficking in Persons 2017-2021, the National Human Rights Plan 2018-2021, the National Youth Policy, and the Policy National of Gender Equality.
[115] Human Rights International Court. Excerpt 48
[116] National Institute of Statistics and Informatics, First Virtual Survey for LGBTI people, 2017, p. 20. Available at: https://www.inei.gob.pe/media/MenuRecursivo/boletines/lgbti.pdf
[117] MOJ and IPSOS (2020). II Encuesta Nacional de Derechos Humanos. II ENCUESTA NACIONAL DE DERECHOS HUMANOS (www.gob.pe)

Financing of the HIV response

For the allocation of the health budget, Peru uses a results-based budgeting[118] methodology. According to the Ministry of Economy and Finance, as of November 2021[119], Peru budgeted 285.8 million soles (approximately USD 74 million exchange rate: 1USD = 3.9 soles) for the TB / HIV, of which 63% has been executed (a suboptimal level of budget execution). As can be seen in the table, the budget is shared between TB and HIV. There is a difference concerning 2020 of 45%, given a reorientation of health priorities, where for HIV, only coverage of ART was prioritized[120]. It should be noted that, within the public budget, there is no budget item specifically referring to KPs.

Table 13: Evolution of the HIV budget in Peru[121]

Year	Government Budget TB/VIH	Government Budget only HIV
2019	275.8 Million (soles)	90.97 million (soles)
2020	320.2 million (soles)	94.11 million (soles)
2021	285.8 million (soles)	97.32 million (soles)
2022	157.6 million (soles)	

Evaluators own elaboration; Sources: Ministry of Economy and Finance and Ministry of Health

The decreasing budget has been explained as necessary given the new budgeting requirements of the COVID-19 response, and also the fact that Peru is still receiving relatively small grants from the Global Fund, mostly focused on KPs[122].

The KP and the community responses to HIV have been the primary beneficiaries of external donors in the last decade, who carry out actions focusing mainly on HIV prevention, advocacy, community strengthening, and promotion of human rights.

Peru has been classified as an Upper Middle-Income country by international financial organizations[123]. Based on this classification, there has been a rapid withdrawal of international funding for any social programmes, including the HIV response. Peru entered into the transition phase with regard to Global Fund programming[124], which means that resources should move towards domestic financing and a gradual withdrawal of all Global Fund contributions in the next few years. For the period 2018 - 2021, Peru received transition financing of USD 12,000,000, a figure that increased to USD 18,000,000[125] to accommodate COVID-related funding. This grant is nearing completion, and new funding of approximately USD 20,000,000 is being requested for the next three years (2022-2025), also including a COVID-19 component[126].

[118] https://www.gob.pe/843-presupuesto-por-resultados

[119] Ministerio de Economía y Finanzas. Consulta Amigable 2021. Disponible en: https://www.mef.gob.pe/es/?option=com_content&language=es-ES&Itemid=100944&lang=es-ES&view=article&id=504

[120] Ministerio de Salud. Proyecto Presupuesto 2022. SECTOR SALUD. Hernando Cevallos Flores. Ministro de Salud. Octubre 2021. PPT

[121] The reduction on 45% of the HIV/TB budget has become a serious issue in the last quarter of 2021, when the budget was presented and approved by Congress. The main cut was done in ARV. Such level of reduction is unacceptable and puts at risk the most basic rights of PLH. Civil society, UNAIDS, USAID, the CCM, some Congressmen and others mobilized to lobby with MoH and MoF authorities, but the budget was not reinstituted. The impact of this decision is significant, since it involves a cut of 65% in the ARV budget. The MoH offered civil society and the CCM to prepare special projects in the First quarter of the year to restate the budget back to the main lines of activity, but the sustainability of the national HIV response is under threat.

[122] The main question is what will happen with the national commitments (counterparts) with the GFATM and how to build sustainability and resilience concerning HIV prevention in the future.

[123] https://data.worldbank.org/income-level/upper-middle-income

[124] https://www.theglobalfund.org/en/funding-model/throughout-the-cycle/transition/

[125] Interview reference

[126] The investment of the Global Fund in Peru began in 2003. Until 2017, it covered USD 144,453,423 (for TB and HIV), of which USD 67,516,654 has focused on HIV only. Funding from the GF has mainly covered prevention activities implemented by civil society, and the strengthening of community systems and groups, and networks of PLWHA. For the GF, the

Finally, the Envelope funds of the UN JP allocated between 2018 and 2021 (not including staff) reached USD 595,720. Likewise, between 2020 and 2021 the UNAIDS Secretariat has spent USD 856,890 on its activities, including core UBRAF funds, regional funds, other funds, and those transferred by other UN JP cosponsor agencies such as the WFP[127].

Table 14: Budget and expenditure of envelope funds (examples)

2018		
Activities	**BUDGET BY ACTIVITY**	**EXPENDITURES**
PAHO/WHO		
1.1 Technical regulations on comprehensive health care for people living with HIV, transwomen and indigenous populations updated and implemented at national and subnational level		
a. Four workshops in Lima, Callao, San Martín and Tacna cities, for the implementation of technical regulations for transgender people, MSM e indigenous populations at national level, in order to scale up HIV testing, ARV treatment and viral load suppression in these populations	USD 5,700	USD 5,000
b. Capacity building of health workers for proper management of medicines, goods and supplies for HIV testing and ARV treatment	USD 6,700	USD 0
1.2 Updated technical regulations to facilitate inter-programmatic management of key populations and people living with HIV in both prevention and health care settings		
a. Implementation of technical regulations to inter-programmatic and comprehensive management of people living with HIV in five prioritized regions (Lima, Callao, Ucayali, Tumbes and Tacna)	USD 6,700	USD 5,000
b. Five Joint workshops for strengthening competencies of National Aids Program staff and National Sexual and Reproductive Health staff in Lima, Callao, San Martín, La Libertad and Lambayeque.	USD 6,700	USD 19,000
c. Technical support to decentralization of ARV treatment to First level health services in Lima, Callao, Tacna, Ancash and Ica.	USD 6,700	USD 3,000

2019		
Activities	**BUDGET BY ACTIVITY**	**EXPENDITURES**
UNICEF		
2.1 The health sector in Peru has a strengthened information system for the monitoring of cases of mother-to-child transmission of HIV, congenital syphilis and hepatitis B. (Generation, management, dissemination, availability and use), with active participation of the organized civil society		
a. Facilitation of workshops aimed at entities that offer health services for the definition of a single instrument for the analysis of information on cases of transmission maternal HIV, congenital syphilis and hepatitis B.	USD 7,490	N/I

transition is understood as a mechanism by which a country or a component of disease will gradually move towards total domestic financing, and the implementation of the health programs that concern them will cease to depend on the financing contribution of the GF. The GF looks for "successful transitions." One of the conditions is a gradual transition between 5 and 10 years, depending on the country. Peru has already begun its transition with a drastic reduction in financing to only $ 12,000,000 for the period 2018 - 2021; however, the COVID 19 pandemic has changed the conditions increasing this fund to $ 20,000,000.

[127] WFP transferred that money to the Secretariat since it was going to be used for cash transfers to the extent that WFP considered it better for the UNAIDS secretariat to do so, insofar as it dealt with the population vulnerable to HIV and people with HIV, including Venezuelans.

b. Design of a standardised online information system for the timely monitoring of cases of maternal and child transmission of HIV, Syphilis and hepatitis B	USD 18,211	N/I
c. Mobile teams for the monitoring and training supervision of the health teams of Loreto, Ucayali, Lima and Callao on the production and use of information of mother to child transmission of HIV, congenital syphilis and hepatitis B.	USD 16,799	N/I

2020		
Activities	**BUDGET BY ACTIVITY**	**EXPENDITURES**
UNFPA		
3. Human rights, stigma and discrimination		
Campaign: "Micro actions for great rights"	USD 40,000	N/I

2021		
Activities	**BUDGET BY ACTIVITY**	**EXPENDITURES**
UNHCR		
3. Human rights, stigma and discrimination		
Refugees and migrants access to health. Community based organizations and public entities have strengthened capacities to guarantee access to health without stigma or discrimination for people with HIV and key populations refugees and migrants in the country		
3.3.1 Community based mechanism supported. Capacity development conducted to 2 self-supported groups of refugees and migrants living with HIV (one in Lima and one in Tumbes) including psychosocial support	USD 5,325	N/I
3.3.2 Training conducted with key actors. 5 trainings and awareness activities conducted to sensitize public services on the access of refugees and migrants to treatment	USD 5,325	N/I

Evaluators own elaboration; UNAIDS documents: Envelope Funds Work Plans 2018-2021

UNAIDS JP key population response

Strategic orientation and programmatic approaches

The activities established in the Joint Plan 2017-2021 in Peru are guided by the priority areas specified in the Sustainable Development Goals, the UBRAF and the national priorities, which has allowed it to establish four strategic lines[128]:

1. Support for the implementation of a Combination Prevention strategy within the framework of the Multisectoral Strategic Plan (PEM in Spanish) and the Budgeting by Results: **11 activities**

   The activities in this category are focused on KP access to HIV combination prevention in HIV high load areas. The activities consist of support to the Ministry of Health in programming planning and execution of targeted combined prevention in KP at national and sub-national level. Support production of evidence-based combination prevention and KP barriers of access and support in the mobilization of financial resources to complement the plans.

2. Strengthening the Continuum of Care to provide people-centred comprehensive HIV health services to achieve the 90 - 90 - 90 Goals: **5 activities**

   The activities in this category are focused on: Support in integration, organization and management of the information system information on HIV, STIs and Hepatitis; support the Ministry of Health to improve access to medicines, supplies and medical devices through UN administrative and technical instruments; provide technical assistance technical to the Ministry of Health and other actors to close the continuum of care gaps; support to the Ministry of Health and other actors for the design and implementation of HIV care models to KP; and support in the process of strategic HIV planning, monitoring, and evaluation within the framework of the Peruvian health reform.

3. Support to the national effort for the promotion and defence of human rights and the elimination of stigma and discrimination: **3 activities**

   The activities in this category are focused on: Support on the use of information about the Human Rights situation of KP and people living with HIV; favour the participation of organizations and civil society networks in advocacy actions and surveillance based on evidence; support for new public policies and international standards of human rights; youth organizations and their decentralized participation in Andean Regions (Cusco and Junin) and in the Amazon Region (Ucayali).

4. Support for effective and efficient management of human, financial, and programme resources: **1 activity**

   This activity is focused on: Strengthen the workforce capabilities, competencies and diversity to fulfil the mandate of UNAIDS

These strategies have been taken as the basis for implementation of activities with country envelope funds. In addition to these activities there are activities implemented by or through the UNAIDS Secretariat to third parties (NGOs, KP organizations or consultants) (See Annex).

Notably, in 2021, the UNAIDS Secretariat has focused many of its activities on Venezuelan migrants and refugees, especially those living with HIV. The UNAIDS Secretariat is the entity with the most activities related to KPs: for Envelope Funds between 2018 and 2021, 11 of 28 KP activities (9 directly and 2 indirectly) activities out of 28 focused on KPs; for UNAIDS (Local and Regional) funds between 2019 and 2021, 19 of 31 KP activities (14 directly and 3 indirectly). Since 2020 the focus has been specifically on PLWHIV (including migrants from Venezuela), Peruvian MSM and TGW, and indigenous people from the Amazon area.

[128] UNAIDS. New Joint Plan on HIV 2017-2021 of the United Nations System in Peru. 2016

Main partnerships of the JP

In implementing its activities, the UN JP has partnered with:

- **Government:** The key partner for most UN JP cosponsor agencies is the MoH. Likewise, the Ministry of Justice (MoJ) is a partner of the UNAIDS secretariat and UNFPA. For UNHCR/IOM, the main counterpart is the Migration office of the Ministry of Internal Affairs. There is also the CCM (CONAMUSA) within the MoH, which is mainly a partner with the UNAIDS Secretariat and PAHO. In Peru, it is difficult for a UN agency to work without a government counterpart since all UN JP c cosponsor agencies must consider national priorities and base their work on them.
- **NGOs:** AHF[129] Peru, as well as Partners in Health Peru, work closely with some UN JP Cosponsoring agencies, especially with the Secretariat in various projects focused on KPs.
- **Community NGOs and KP organizations**: Small NGOs formed mainly from PLWHIV organizations or by independent leaders such as PROSA, AID for AIDS, Ccefiro, or Illari and a few KP organizations work in coordination with the UNAIDS Secretariat, but also with other UN JP cosponsor agencies such as WFP or IOM.
- **Other donors**: UN JP leading partner (mainly from the UNAIDS Secretariat) is the Global Fund, a donor with whom the Secretariat works through the CCM or by directly supporting activities implemented by the Global Fund. USAID is other main partner in KP-related issues; UNAIDS is working with them in migrant KP-related projects, including health information systems for migrants and refugees under a comprehensive approach, and general strengthening of the health sector. Flora Tristan CSO as implementer partner of the Human Rights Campaign led co lead by UNFPA and UNAIDS.

An important example is the Project **"Emergency Cash Transfers for Migrants with HIV,"** also extended to Peruvian KPs in extreme poverty. This project has been able to bring together UN JP Cosponsoring agencies, NGOs, community NGOs, and leaders of KPs to get the project up and running.

[129] Aids Healthcare Foundation (AHF), is a global non-profit organization that provides HIV care and treatment for KP and PLHIV.

Case study findings

Each of the Items in this case study attempts to answer the questions posed in the context of the Theory of Change. The findings of this case study are directly related to the activities, outputs and Intermediate outcomes aligned to the Strategic Results Areas (SRAs) of the 2016-2021 Strategy and UBRAF. These were related to the new Strategy and draft UBRAF 2022-2026 to link the existing gaps that could influence progress towards the new outcomes and ultimately impact.

Relevance and coherence of JP activities

- The UN JP is not seen as a unified response to HIV. The agencies are referred to independently with “UNAIDS" being the Secretariat.
- UN cosponsor agencies developed a Joint Plan for the period (2017-2021) and met as often as possible to report on progress and discuss activities, changes, and rescheduling.
- The degree of involvement of each cosponsor with KP organisations and networks is variable with some not involved in the response.
- Some of the activities of both cosponsor agencies and the Secretariat could be classified as strategic and catalytic insofar as they have:
  - Contributed to the development of technical standards or policies on a larger scale.
  - Expanded the participation of more actors, the arrival of more beneficiaries, and more significant financing for the activities and introduce essential topics for the KPs.
  - Contributed to the strengthening and empowerment of KP organizations.
- Each cosponsor has concentrated on its activities, which weakens their impact as a JP.
- Not all cosponsor agencies have activities that focus on the needs and strengthening of KP organizations and networks.
- Not all activities correspond, necessarily, to what was presented in the Joint Plan 2017-2021
- Most of the cosponsor agencies have gender experts to ensure mainstreaming in all activities (e.g., WFP, UNICEF, WHO), however the topic is still not an integral part of the thinking of all staff members.
- The human rights (HR) approach constitutes the third strategic line of the Joint Plan 2017 - 2021, which contains three activities directly related to HR.
- Only UNFPA and the UNAIDS Secretariat have realised three activities in the context of HIV and sexual diversity rights and use a non-traditional concept of gender (intersectionality and sexual diversity included).
- The division of labour has not coincided with the responsibilities assumed by the JP cosponsors.
- There is a good alignment and harmonization with external partners (Government, non-UN partners).
- The accelerator resources (Envelope) have been beneficial. However, financial resources remain insufficient to conduct all activities required for KPs.
- There is a disparity in technical human resources, depending on the financial resources that each cosponsoring has.
  (Strength of evidence: Strong, supported by good quality data/documentation and KIIs.)

This section covers evaluation questions 1-4.

Relevance of activities to key population needs and priorities

The question listed above have been to answer as actors do not assume the UN JP as an entity.

- "Technical support has always been provided by PAHO and the UNAIDS office itself. They have been a source of valuable technical support"
- The JP consists of **"**its director for Peru, Ecuador, and Bolivia. It has a part for Monitoring and Evaluation, the technical part, the administrative part, and now the humanitarian part for migrants"
- "Undoubtedly, the two key actors that worked with us in participation spaces were both UNFPA and, without a doubt, UNAIDS, which played a key role"

The UN JP cosponsor agencies developed a Joint Plan for the period (2017-2021) and report meeting as often as possible to report on their progress and discuss activities, changes, and rescheduling. However, as can be seen in the testimony, they do not share a common agenda in practice. At most, two or three agencies coordinate for an activity (based on a commitment) with the UNAIDS Secretariat submitting Joint Annual Reports[130].

However, according to the UNAIDS Secretariat there are different modalities of joint projects and activities: regarding the CE/BUF model, each agency works mainly on a stand-alone basis, while the Secretariat and eventually other agencies can provide technical advice for specific issues. CE/BUF projects probably offer the opportunity of truly joint work throughout project implementation, as was the experience of UNAIDS, OHCHR and UNFPA in the stigma and discrimination campaigns 1 and 2, where they took decisions and endorsed products together, etc. Another model was applied in MFTP for Awajun women's SRH in the indigenous area of Condorcanqui, together with WFP, PAHO and UNFPA; in that experience the UNAIDS Secretariat provided TA in a crosscutting fashion, incorporating HIV intervention lessons in the area. Finally, a UN-to-UN agreement was used to implement the cash transfer project.

Therefore:

- Each UN JP cosponsor (including the UNAIDS Secretariat) builds a particular relationship with the other actors in the country
- The degree of involvement of each cosponsor with KP organizations and networks is quite diverse[131], and some are not involved at all.

[130] The joint reports follow the structure and procedures established by the JPMS, standardized for all the countries. These procedures demand that every agency reports its execution of CE/BUF by itself, while the UNAIDS Secretariat prepares the summary report and the JT validates it before its submission.

[131] It should be noted that UN agencies generally do not work directly with populations – they do so through collaboration with the government and/or third parties. Their mission is to provide technical assistance to the government, and when they intervene it is assumed that they do so in demonstration or pilot projects.

Table 15: JP cosponsor agencies involvement and focus on KP

JP Cosponsors	2018 -2019	2020-2021	Focus on KP
UNAIDS Secretariat (UCO)	Yes	Yes	Yes
UNICEF	Yes	Yes	No
UNFPA	Yes	Yes	Yes
PAHO/WHO	Yes	Yes	Indirectly
UNHCR/IOM	No	Yes	Indirectly (Venezuelans PLWHIV)
WFP	No	Yes	through UN to UN agreement with the UNAIDS Secretariat
UNESCO	Yes	No	Yes (2018-2019)
UNDP	No	No	-
ILO	No	No	-
WORLD BANK	No	No	-
UNDOC	No	No	-
UN WOMEN	No	No	Does not have presence in the country

Consultants' own elaboration; UNAIDS documents: Envelope Work Plans 2018-2021

Each cosponsor intervenes in some geographical regions of interest that may/may not overlap. However, they are not supposed to cover the national territory – that is a duty of the central and regional governments.

Table 16: Geographical areas (example)

Cosponsor	Geographical Area
PAHO/WHO	Lima and Callao (Central coast) San Martín and Ucayali (Central jungle) Chimbote – Ancash (Central coast) Tacna and Ica (South coast) Tumbes (Northern Coast)
UNICEF	Lima and Callao (Central coast) Ucayali (Central jungle) Loreto (North-eastern jungle)
UNAIDS	Lima and Callao (Central coast) Condorcanqui – Amazonas (Northern jungle)
UNHCR	Lima (Central coast) Tumbes (Northern coast)

Consultants' own elaboration; UNAIDS documents: Envelope Work Plans 2018-2021

The above is true despite the fact that:

- All JP members (UNAIDS Secretariat and cosponsors) adhere to the mandates of the United Nations (e.g., Sustainable Development Goals) and the UNAIDS Global Strategy[132].
- All JP members adhere to the Strategic Frameworks of JP (UBRAF, Division of Labour, UNDAF, etc.)[133]
- All JP members should adhere to national priorities, given their close work with the Government[134].
- Further, the UNAIDS secretariat encourages cosponsor agencies to use the Implementation Tools[135]; however, it cannot guarantee that the cosponsor agencies use them.

Some of the activities of both JP cosponsor agencies and the Secretariat[136] could be classified as strategic and catalytic insofar as they have contributed to the development of Technical Standards or Policies on a larger scale:

- Contribution in technical assistance to policies related to the decentralization of health services or introduction of innovations such as assisted notification of contacts (PAHO/WHO, corroborated by the MoH)

  "We have contributed to the decentralization of treatment to the first level of care. The HIV care model in Peru is a second and third-level care model. Unlike tuberculosis… in HIV, there are two hundred second and third level establishments that are those that give ART, and that step of decentralization had to be taken.

  So, what we did and are doing is opening first-level treatment centres so that these centres can on the one hand receive patients from hospitals and start receiving newly diagnosed patients that require treatment. We call this whole process ART decentralization. We have been implementing it since last year with technical assistance from PAHO.

  We have been talking a lot about improving the identification of people living with HIV contacts. A new methodology is the assisted notification; it is the tracing of the already infected person contacts. So that is something innovative; it is something valuable. With that, we cut many transmission chains. Sounds strategic then.

  In that context, we (MoH) will introduce the Assisted Contact Notification which is like a contact tracing but much more accurate. In terms of the reactivity that we can achieve, it is surprising."

- Contribution in technical assistance to policies related to Human Rights: Especially the relationship between civil society and the Ministry of Justice (UNFPA, UNAIDS secretariat, corroborated by the MoJ)

  "We have been accompanying the process of the new Human Rights Policy with indicators that will measure progress for all populations, including key populations.

  UNAIDS has played a vital role. It must be recognized that the Government has a relationship with its back to civil society. He has always assumed everything must be led by whoever is in the

[132] UNAIDS. Nuevo Plan Conjunto de VIH 2017-2021 del Sistema de las Naciones Unidas en Perú. 2016
[133] UNAIDS. Nuevo Plan Conjunto de VIH 2017-2021 del Sistema de las Naciones Unidas en Perú. 2016
[134]United Nations Perú. Marco de Cooperación de las Naciones Unidas para el Desarrollo Sostenible PERÚ 2022-2026. September 2021 and United Nations. Marco de Cooperación de las Naciones Unidas para el Desarrollo en Perú. UNDAF 2017-2021.
[135] https://hivpreventioncoalition.unaids.org/resource/practical-guidance-for-comprehensive-hiv-sti-programmes-with-sex-workers/
https://hivpreventioncoalition.unaids.org/resource/practical-guidance-for-comprehensive-hiv-and-sti-programmes-with-men-who-have-sex-with-men/
https://hivpreventioncoalition.unaids.org/resource/practical-guidance-for-implementing-comprehensive-hiv-and-sti-programmes-with-transgender-people/
[136] Take into account that when UNAIDS is mentioned, they are referring only to the Secretariat

Government. What civil society says has been interpreted as a struggle of interests or more emotional than rational requests."

- Advocacy for scaling up the cash transfer programme to a social protection policy assumed by the government (only an account and a declaration of intent from the UNAIDS Secretariat)

  "The cash transfer project is a project that was born, mature and grew. I would say that it is the best practice in management that we are working on together [WFP and UNAIDS Secretariat]. Moreover, it is also formalized. Some resources are transferred to UNAIDS, and we are catalysing it with a partnership with "Partners in Health". It is an exciting work structure that was created and developed independently from the Envelope funds.

  There is an intention to formulate a policy note to the Ministry of Social Inclusion [MIDIS in Spanish] and try to include these populations within the country's social protection system."

<u>They expand the participation of more actors, the arrival of more beneficiaries, and greater financing for the activity, in addition to introducing important topics for the KPs in the activity</u>

- Monetary transfers to alleviate extreme poverty in Venezuelan migrants with HIV, TGW and FSW, including education and information on nutrition and other topics (UNAIDS Secretariat, WFP – account from WFP)

  "We are already at the second implementation phase. It is not only for the Venezuelan migrant population, but also the Peruvian population, which is the LGTBI population, who was completely invisible and was not being addressed by the national social protection system.

  Right now, we are working on essential materials to work on the people living with VIH nutrition issues."

<u>They contribute to the strengthening and empowerment of KP organizations</u>

- Support and technical assistance to situational diagnoses carried out by the KPs[137] (UNAIDS Secretariat, partially corroborated by the community)

  "The funding we received last year was USD 5,000 to survey the impact of COVID-19 on trans women in ten cities in the country and also to do a small health service for trans women community monitoring in each city (…) But although it is a unique study in the country that has seen the impact on one of the populations most affected by the epidemic, UNAIDS has not supported us for its dissemination."

- Support and technical assistance for the institutionalization of KP organizations (UNAIDS Secretariat, corroborated by the community)

  "UNAIDS is supporting us to develop our Strategic Plan."

- Intermediation for dialogue between Civil Society and the Government (UNAIDS Secretariat, corroborated by the community)

  "We have a working table on migrants where many actors are involved. It was deactivated by the pandemic, but it will be reactivated precisely in those days, and UNAIDS is a key actor. Before the pandemic, we also had spaces where UNAIDS convened Civil Society organizations (…). Given the number and diversity of organizations in Peru, it is not easy for us to relate with them. The fact that we can dialogue is something highly valued for us. UNAIDS is an essential and convoking channel, where we as Government realize that we are together in this construction and problems resolution space.

  UNAIDS carries out an essential accompaniment to organizations, generating links with the Government to give an adequate response to HIV issues."

[137] *La COVID19 y las Mujeres Trans en el Perú*. REDTRANS/ONUSIDA and AHF, 2021. Available in: https://issuu.com/dianasolis1/docs/covid19-mujerestrans.

- Intermediation for dialogue between organizations of KPs in conflict (UNAIDS Secretariat, corroborated by the community)

  "UNAIDS has always been open to consultation processes with communities. Consultation and work with community groups… of that, there is no doubt.

  I believe that the pandemic itself has made the dialogue mechanisms not as fluid as they have always been, and it has become challenging. I believe that we must work to restart this work with the community, which can become very complex because now KP organizations are a sum of agendas, personalities, that deserve a solution and the resolution of conflicts in our communities."

Coherence of UN JP activities

Regarding coherence, the JP official discourse is one of harmonization and alignment with the Joint Plan; adhering firstly to national priorities and secondly to the needs (in health and human rights) of KP. However, this occurred differently, since:

- Each Cosponsor has focused on its own activities, which limits the impact of activities.

  "That is a gap, I think. It is a gap that I see pretty strong yet to overcome. Because I think that if we were working together for the same goal better, we would suddenly have more achievements. In other words, the incidence would be more powerful. It would even be excellent for the four agencies to go to the office, to the ministry to speak on the same issue, than to go on their own with their separate agenda, right? I think that, which is one of the main gaps."

  - Not all cosponsor agencies have activities that focus on the needs and strengthening of KPs organizations and networks
  - Not all activities correspond, necessarily, to what was planned in the Joint Plan 2017-2021
  - Meetings do not have the necessary frequency to achieve joint work

  "So, I recognize the capacity of the UNAIDS team to moderate this and make a single Joint Plan. It is a single plan organized by objectives and components. We then meet every six months, generally, to see how we are doing, how progress is going, and what problems there are. Two years later we meet again to work on the next plan. So that is the space in which we avoid "stepping on each other's calluses."

- The JP cosponsors' coordination seems to be limited to reporting what each one has done in a given period in relation to the Envelope Funds. However, according to the UNAIDS Secretariat, the JP has other joint projects beyond CE, such as cash transfers with WFP; MFTP with WFP, PAHO and UNFPA; and technical support to the GFATM programs with UNAIDS and PAHO's participation in the CCM general assembly (strategic monitoring, program design and implementation; including the joint regional project on Data funded by GF; etc.). Finally, together with UNFPA, UNAIDS in Peru also led the Human Rights results group of UNSDCF, which has been another coordination space for the Human Rights National Plan, as well as a S&D national study.

Human rights and gender equality

Gender Equality is considered by the JP cosponsors. However, most of them have Gender Experts to ensure their mainstreaming in all their activities (e.g., WFP, UNICEF, WHO). The fact of having experts, who participate in the meetings, review the activities and documents to confirm that the gender approach "is present" still shows a weakness in this field[138].

"This theme [gender equality] today receives the support of an area of a more cross-sectional unit, which is the area of gender, rights, and interculturality. So we have specialists on that topic. Here in the Peru office, there is an advisor for the entire region who sees these issues, and also

[138] The fact that, after several years, it still needs a specialist to ensure its presence, shows that the topic is still not an integral part of the thinking of all staff members. This reveals that the gender focus has not been advanced to another level within the system.

helps us a lot because she reviews the things contained in our plans, gives them a look, makes suggestions, and usually gives us feedback.

Here we have a gender officer who just started working a few months before me. Then she takes care of it. … The other function is to ensure that all the other officials, including myself, see the gender approach in everything we do: proposals, studies, interventions go through a review and feedback from her to mainstream the gender approach.

Yes, we are trying to give more force to the gender issue. It has not been a subject intensely worked on by us. However, it was put as a critical element that should be mainstreamed in all our interventions."

The Human Rights approach constitutes the third strategic line of the Joint Plan 2017 - 2021, which contains three activities directly related to Human Rights:

- Support for the generation and use of information on the situation of rights of the KPs (corroborated)

  "To point out that the generation of evidence has been a vital part precisely to account for the extent to which Human Rights have impacted different populations´ lives, particularly in adolescents and young people, including indigenous and Afro-Peruvian adolescents. Four hundred adolescents and young people answered this survey. So that gave us a look at how much HR impacted not only on reproductive health issues but on education, employment, protection, etc.

  The key here is the contact with the organizations—the meetings with the civil society, summoning all the sectors and committing. We had drawn up a plan, which we have evaluated, and we have some results with 49% percent progress. The group that has advanced the best is the HIV AIDS group, but then comes the pandemic, and everything stops. The participatory strategy is the richest part of the process. So the conclusion is that this method works[139]."

- Encourage the participation of civil society organizations and networks in advocacy actions and evidence-based surveillance. (corroborated).

  "The new Stigma and Discrimination Index 2.0 is going to start, which has an improved methodology and is conducted by people with HIV, with the support of GNP + and UNAIDS.

  Recently, we have been working with UNAIDS on advocacy and surveillance. We have been addressing the issue of migration and HIV. Collecting information we have been addressing the violation of human rights and the level of recognition of these Rights."

- Support for adapting public policies and regulatory framework to international human rights standards: New Human Rights Plan, Gender Identity Law.

  "The Ministry of Justice called us for two things: a) to support consultation workshops with populations for the third Human Rights Report, and b) to collaborate in designing the National Human Rights Policy. Participating in this process it is possible to influence the policy design. This process is therefore strategic.

  We are accompanying the process of the new Human Rights Policy, where key populations are also included. They are also participating in this process."

Only UNFPA and the UNAIDS Secretariat have clearly assumed these three activities in the context of HIV and sexual diversity rights and a non-traditional concept of Gender.

"We at UNAIDS work with the concepts of Gender and Sexual Diversity.

We work with an intersectional approach; that is, we also include the ethnic-racial issue, the issue of gender inequalities, disability, among other issues. So it is seen as a fairly broad approach, but at the same time, it seeks to respond or strengthen the response to the one that

[139] This process has received technical and financial assistance from UNFPA and UNAIDS Secretariat.

enters the country from this human rights perspective (...) It is the issue of being able to incorporate in the attention of the Ministry of the Woman and Vulnerable Populations (MIMP in Spanish) an intersectional perspective because it is thought, let us say, from a traditional perspective, where many times, even though the norm does not exclude trans women, it has a whole logic that is not designed to address these groups."

Harmonization and alignment of the JP

What we have observed is that the division of labour has not coincided with the responsibilities assumed by the JP cosponsors, both in the activities and the joint work (see example table):

Table 17: pre-specified and actual division of labour within the JP (Example)

Activity	Cosponsor in charge, according to the Division of Labour		Cosponsor actually in charge
	In charge	**Partners**	
Improve social protection for people affected by HIV	UNICEF WORLD BANK	ILO UNDP WFP UNHCR WHO	WFP UNAIDS (Secretariat)
Ensuring that people living with HIV receive treatment	WHO	WHO	WHO/PAHO, UNICEF
Eliminate punitive laws, policies, and practices, as well as stigma and discrimination that hamper effective responses to AIDS	UNDP	ACNUR OIT UNFPA UNESCO UNICEF	UNFPA UNAIDS(Secretariat)
Train youth to protect themselves from HIV infection	UNICEF UNFPA	OMS OIT	UNFPA UNICEF
Addressing HIV in humanitarian emergencies	UNHCR WFP	PNUD	WFP UNAIDS (Secretariat) IOM UNHCR

Evaluators' own elaboration, UNAIDS documents: JP Work Plans

"I think that key populations are transversal. They should concern all agencies, not just one or two agencies. So the Division of Labour must be rethought, in which agencies they are responsible for and who accompanies you.

In reality, each agency has the expertise and a pattern. Furthermore, the main thing is the responsibility that each one has within the project; A specific product that develops then is the logical framework that establishes the controls. Each agency knows precisely what has to be developed, but we established that we had to work it in an articulated way with the four agencies. So one of the issues was trying to make sure that there were issues that crossed, especially in the case of one of the agencies."

On the other hand, there is good alignment and harmonization with external partners (Government and non-UN partners) in activities focused on KPs the Global Fund and with other (non-UN) partners:

Table 18: JP Alignment with Donors and other Non-UN Partners in projects Focused on KPs (Example)

Issue/KP	JP Agencies	Government	Donors	NGOs/ Community NGOs/KP organizations
Venezuelan migrants / refugees (includes living with HIV)	UNAIDS UNHCR	MoH MoFA/ Migration Office	USAID	KP organizations (both Peruvian and Venezuelan)
Humanitarian aid (cash transfer) to the Venezuelan and Peruvian population in extreme poverty (includes TGW and PLWHIV)	UNAIDS WFP		Global Fund USAID	Partners in Health Aid for AIDS PROSA FSWs organizations TGW organizations
Human Rights Policy	UNFPA UNAIDS	Mo Justice		KP organizations NGO
Campaigns against discrimination	UNFPA UNAIDS	Mo Justice		KP leaders

Own elaboration, UNAIDS documents: Envelope Funds Work Plans

Table 6 shows us that the JP Co-Sponsors are aligned with national priorities. Following these priorities, all activities are carried out in harmony with the corresponding government agency, including catalysing funds, as is the case of humanitarian aid activities for which both the Global Fund and USAID allocated funds, seeking their continuity and finally the inclusion of Civil Society (KP and NGOs).

Capacity and resources of the JP

The accelerator resources (Envelope) have been beneficial for a new start, after several years in which the JP had minimal resources. However, according to the people interviewed, financial resources remain insufficient to conduct all activities required for KPs.

> "I believe that UNAIDS does what it can with the scarce resources it has and because there is a problem and it is not technical capacity, nor goodwill, but that of resources to support more populations and to scale.
>
> Let me say, it should be… might be a bit more resourceful than it is.
>
> Speaking from the point of view of my agency, it seems that human resources are lacking, especially."

Table 19: JP Resources – Envelope Funds

Requested budget	2018 allocations	2019 allocations	2020 Allocations	2021 Allocations	KP activities
PAHO/WHO	$32,500	$32,500	$35.000	$35,000	Indirectly
UNICEF	$42,500	$42,500	$35,000	$35,000	No
UNHCR			$40,000	$40,000	Yes
UNESCO	$24,000	$24,000			Yes
UNFPA	$51,000	$51,000	$40,000	$40,000	Yes

Evaluators' own elaboration; Source: Envelope Funds. UNAIDS documents

Table 20: JP Resources – UNAIDS Secretariat and other Funds

UNAIDS Secretariat Funds				
Year	**UNAIDS secretariat funds (USD)**	**Other donors' funds managed by UNAIDS (USD)**		**TOTAL**
2020	481,553	186,488	WFP	668,041
2021	182,318	6,531	AHF Peru	188,849

Evaluators' own elaboration; Source: UNAIDS Funds. UNAIDS documents

As we can see in Table 9, there is no complete information on all JP cosponsors, and those who present information are almost all the cosponsor agencies that between 2018 and 2021 have received Envelope Funds (except UNCHR). Among those that do present information, we see that UNFPA is the one that has the most significant technical human resources with a considerable percentage of the time. In contrast, UNICEF has sufficient human resources but very little time available. UNESCO and PAHO/WHO have little capacity (it is possible that for this reason, UNESCO no longer requested Envelope funds in 2020). Meanwhile, the UNAIDS Secretariat had only two technical human resources until 2020, when it could mobilize resources to hire (temporarily) new specialists due to its workload.

Table 21: JP Technical Resources[140]

Agency	Position	Grade	%Time	Comments
SECRETARIAT	UNAIDS Country Director	P5	40%	Covering three countries: Ecuador, Bolivia and Peru. In addition, the UCD leads the UNDAF Results Group on Human Rights, and there is one staff from RCO / OHCHR supporting directly human rights issues there. An estimated of 10% of this adviser's time will be dedicated to human rights related issues under the framework of this envelope.
	Strategic Information Adviser	NO-C	40%	Covering three countries (Ecuador, Bolivia, Peru), and working in programmatic areas alongside strategic information as well, such as: UNSDCF, technical support to GFATM

[140] This table reflects the technical resources that the JP had during the 2018-2019 period. We cannot assure that the same staff is still in place. We have also included three new specialists hired to work in the Secretariat since 2020, and these contracts are temporary.

Agency	Position	Grade	%Time	Comments
				projects, MFTP, community led monitoring and social protection.
	Specialist in charge of cash transfers program with WFP, HIV and social protection			Temporary contract, ends in April (WFP resources)
	Specialist in Gender and Human Rights			Temporary contract, ends in April (TSM)
	Specialist in Community Mobilization			Temporary contract, ends in April (TSM)
UNHCR	Two officers assigned to the JP on HIV			
UNICEF	Health officer	NO-B	2%	
	Health officer - adolescents and youth	NO-A	5%	
	HIV specialist (LACRO)	P-4	5%	
	HIV specialist (LACRO)	P-4	5%	
WFP	Three officers, two of them leading cash based interventions -plus the CBI team- and one in HIV and nutrition			
UNDP	Programme analyst	LNO-A	5%	
UNFPA	Program Analyst in Adolescents and youth	NO-B	60%	
	Human rights and gender focal point	Service contract	25%	
	Communications officer	G6	20%	
	Program Analyst in Population and development	NO-B	25%	
	Emergencies and humanitarian responses focal point	Service contract	15%	
UNDOC	No information			
UNWOMEN	No presence in Peru			
ILO	No information			
UNESCO	Education Officer	NO-B	10%	
	Health and HIV Education Regional Advisor	P4	5%	Regional staff for Andean countries, based in Chile
PAHO/WHO	National consultant	NO-B	50%	
	Control disease adviser	P4	20%	
	HIV regional adviser for Andean region			30 days / year. Based in Colombia. Covering 5 Andean Countries.
World Bank	No information			

Evaluators own elaboration; Source: UNAIDS document "Peru Joint UN Team on AIDS – Joint Plan 2018-2019"

Hence, we can affirm that there is disparity in human resources, depending on the financial resources that each cosponsoring agency has. For example, UNICEF has a large staff, while the UNAIDS secretariat, given the amount of work despite the new contracts seems overwhelmed.

> "It's a lot of technical assistance. We clearly have very few resources. There are no consultants; it is just us in the meeting."

Efficiency and effectiveness of JP activities

1. Between 2018 and 2021, the JP has implemented approximately 57 activities. Of this total, 40 (70.17%) have been directly or indirectly focused on KPs: 47.5% had an exclusive or significant focus on KPs, while 52.5% were relevant to KPs as well as to other populations.
2. Of the total activities, almost 30% correspond to activities aimed at other populations.
3. Most of the activities were targeted to KPs in general; some were targeted explicitly to PLWHIV and TGW (migrants). No specific activities have been implemented for FSW or Prisoners.
4. Most areas need strengthening, given that the UBRAF outputs are ambitious and depend on the government's political will.
5. For Government actors, the contribution of JP cosponsor agencies is very significant.
6. The only JP members that have intervened in the mobilization and empowerment of KP organizations and networks are the UNAIDS Secretariat and UNFPA
7. The JP has responded to the two contextual factors experienced in Peru between 2018 and 2021: Political instability and the COVID-19 pandemic.
8. Sustainability of the activities is still an enormous challenge for the JP
9. KP organizations and networks are not sufficiently empowered and solid to develop evidence-based advocacy strategies.

(Strength of evidence: Moderate, supported by moderate data/documentation and KII¬s.)

This section covers evaluation questions 5-10

Contribution of the JP to UBRAF outputs and intermediate outcomes

A significant limitation to answering this question is that no annual monitoring of the 2017-2021 Joint Plan has been conducted; only descriptive annual reports have been produced (with no indicator measures).

To analyse the contribution of the Joint Program to UBRAF outputs and intermediate outcomes specifically concerning KPs, we have taken the following Strategic Result Areas (SRA), taking into account the situation in Peru described in the first part of this document:

SRA 1: HIV TESTING AND TREATMENT
SRA 8: HIV INTEGRATION

Situation:
The gaps to reach the 90-90-90 targets by 2020 were 12% for people diagnosed with HIV, 13% for treatment coverage, and 20% for the achievement of viral suppression

Table 22: Activities that primarily focus on other populations, with a lesser KP focus (migrants and refugees living with HIV)

Joint Program Activities	Agency	Joint Program Outputs	JP Contributions (to Intermediate Outcomes)
Project to link Migrants and refugees with HIV to ART and the Health System - Phase II	UNAIDS Secretariat	**Output 1.1: HIV Testing and counselling** **Output 1.2: HIV Treatment cascade** **Output 1.5: Humanitarian contexts and fragile states** - Linking migrants and refugees contributes to improving the Continuum of Care	**Adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment.**
Project to link Migrants and refugees with HIV to ART and the Health System - Phase III	UNAIDS Secretariat		

Table 23: Broader programmatic activities that are directly relevant to KPs but also other populations (PLHIV in General)

Joint Program Activities	Agency	Joint Program Outputs	JP Contributions (to Intermediate Outcomes)
Updating and implementation at the national and subnational level of the technical standard for comprehensive health care for people living with HIV, trans women, and indigenous populations	**PAHO/WHO**	**1. Output 1.1: HIV Testing and counselling** **2. Output 1.2: HIV Treatment cascade** **3. Output 1.5: Humanitarian contexts and fragile states** **4. Output 8.1: HIV services decentralization and Integration**	**Adolescents and adults living with HIV access testing, know their status and are immediately offered and sustained on affordable quality treatment.**
Four workshops in the cities of Lima, Callao, San Martín, and Tacna, to implement technical regulations for trans, MSM, and indigenous people at the national level, to expand HIV testing and ARV treatment, and suppression of viral load in these populations.	**PAHO/WHO**	1. All the activities to improve treatment services and decentralization, strengthening capacities, and updating regulations contribute to improving the indicators of the Continuum of Care. 2. With COVID-19, a humanitarian situation was also generated in which it has been necessary to intervene	It contributes to improving the Continuum of Care with activities to stimulate Testing and Counselling and the decentralization of services.
Strengthening the capacity of health workers to properly manage drugs, goods and supplies for HIV testing and ARV treatment	**PAHO/WHO**		
Updating Technical Regulations to facilitate inter-programmatic management of key populations and people living with HIV in both prevention and health care settings	**PAHO/WHO**		
Five workshops to strengthen the competencies of the National AIDS Program staff and the National Sexual and Reproductive Health staff in Lima, Callao, San Martín, La Libertad, and Lambayeque.	**PAHO/WHO**		
Technical assistance in the strengthening and decentralization of the care services provided by the Ministry of Health, with an emphasis on dispensing for more extended periods (MMD), infection prevention, and	**PAHO/WHO**		

Joint Program Activities	Agency	Joint Program Outputs	JP Contributions (to Intermediate Outcomes)
mental health support, seeking the articulation of these interventions with work at the first level in response to COVID-19 in the country			
HIV services. 24 specialized STI / HIV service points (CERITS and UAMPS) strengthened with an assisted notification strategy, operational procedures, and capacity building to intensify testing and link KP to HIV services	**PAHO/WHO**		
Decentralization of ART in 32 first-level care facilities, with an emphasis on multi monthly dispensing of ARVs (MMD), infection prevention, and mental health, in 5 regions with the highest prevalence of the country	**PAHO/WHO**		
ART in 5 regions	**UNAIDS Secretariat**		

SRA 4: HIV PREVENTION AND KEY POPULATIONS
SRA 8: HIV INTEGRATION

Situation:

- It is a fragmented and segmented system, with insufficient funding and reduced community participation
- Services still have significant barriers in terms of infrastructure, human resources, and stigma and discrimination.
- During 2020, 17,976 MSM (7% coverage about the estimated population), 1,678 TGW (5% of the estimated population), and 9,242 FSW (12% of the estimated population) were screened for HIV.

Table 24: Activities with an exclusive or significant KP focus (mainly PLHIV including migrants and refugees from Venezuela, MSM, Trans Women and Indigenous Population)

Joint Program Activities	Agency	Joint Program Outputs	JP Contributions (to Intermediate Outcomes)
People with HIV, key populations, refugees, and migrants have been included in the Universal Health System (SIS) and can receive STI-HIV services and comprehensive care free of charge.	UNHCR/IOM	**Output 4.1: HIV services for key populations** **Output 8.2: HIV-sensitive social protection** 3. It is essential that key populations have free	**Tailored HIV combination prevention services are accessible to key populations, including sex workers, gay men and other men who have sex with men, people who inject drugs,**

Joint Program Activities	Agency	Joint Program Outputs	JP Contributions (to Intermediate Outcomes)
Access to health for refugees and migrants. Community-based organizations and public entities have strengthened capacities to guarantee access to health without stigma or discrimination for people with HIV and key refugee and migrant populations in the country.	UNHCR/IOM	insurance favouring their access to HIV prevention 4. Extreme poverty can be a limitation for access to prevention, and the Cash Transfer project has been a support in that sense. 5. COVID 19 created a problem for access to prevention, so it has been necessary to develop the capacities of key populations to respond to the epidemic. 6. Specific knowledge of how each KP has dealt with COVID and HIV prevention is beneficial for future interventions. 7. In the same way, the activities of linking the Key population to the prevention services of the Ministry of Health.	**transgender people, prisoners and migrants.** It has been contributed to this outcome by ensuring that all KPs (sex workers, gay men, and other men who have sex with men, transgender people, prisoners migrants, and indigenous people). Have free HIV prevention and care services, especially migrant population living with HIV. It has contributed to starting a social protection system for the poorest KPs, including migrants.
Emergency cash transfers for PLWHIV, KP and migrants and refugees in COVID-19 context	WFP/UNAIDS Secretariat		
Developing capacities to strengthen the community response to COVID-19 from the perspective of migrant and Peruvian people living with HIV / AIDS	UNAIDS Secretariat		
Community appraisal "COVID-19 and trans women in Peru"	UNAIDS Secretariat		
Program for the comprehensive care of Venezuelan migrants and refugees living with HIV / AIDS, whose condition of the vulnerability requires their entry into the integrated health system of PERU	UNAIDS Secretariat		
Peruvian Network of civil society organizations trained in providing support and linking migrants living with HIV to services	UNAIDS Secretariat		
Support for the HIV humanitarian response and key populations.	UNAIDS Secretariat		
Community-Led Responses Project (CLR)	UNAIDS Secretariat		
Strategic Planning Community of trans women of Callao	UNAIDS Secretariat		
Emergency cash transfer for migrants with HIV - Phase II	UNAIDS Secretariat		
Emergency cash transfer for migrants with HIV - Phase III	UNAIDS Secretariat		

Table 25: Broader programmatic activities that are directly relevant to KPs but also other populations

Joint Program Activities	Agency	Joint Program Outputs	JP Contributions (to Intermediate Outcomes)
Updating Technical Regulations to facilitate inter-programmatic management of key populations and people living with HIV in both prevention and health care settings	WHO	**Output 4.1: HIV services for key populations** 8. It is essential to highlight the effort made to update the technical regulations on Prevention to include a wide range of preventive technology to achieve a combined prevention system.	**Tailored HIV combination prevention services are accessible to key populations, including sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people, prisoners and migrants.** It contributes to the extent that work is being done to achieve a combined prevention system.
Use of communication technologies for the prevention of HIV and COVID-19 through the radio program NUESTRAS NOCHES"	UNAIDS/Secretariat		

SRA 6: STIGMA AND DISCRIMINATION AND HUMAN RIGHTS

Situation:

- HIV/AIDS stigma and discrimination persist, both in society and in health services.
- In Peruvian society, deeply rooted prejudice against sexual diversity and sex work are, in some cases, manifested through violence
- Civil society has presented several bills to Congress which have persistently failed to be approved, given the conservative spirit of Congress
- Strong influence of conservative groups

Table 26: Activities with an exclusive or significant KP focus (KPs in general)

Joint Program Activities	Agency	Joint Program Outputs	JP Contributions (to Intermediate Outcomes)
Relevant indicators on the situation of key populations, people living with HIV, adolescents, and young people with HIV are monitored and disseminated to advocate for guaranteeing the human rights of these populations and the accountability of public policies	UNESCO	**Output 6.1: HIV-related legal and policy reforms** **Output 6.2: Legal literacy, access to justice and enforcement of rights** **Output 6.3: HIV-related stigma and discrimination in health care** 1. The Human Rights Plan and the National Human Rights Policy have indicators that it is crucial to monitor. 2. Likewise, continue with the awareness-raising work of companies and unions to include key populations.	**Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed** It has contributed with the activities undertaken with this intermediate outcome
Networks of companies and unions have incorporated the social inclusion of KP into their policies	UNESCO		
A communication strategy is implemented to promote human rights, gender equity and equality, and the inclusion of key populations as crucial social determinants of new HIV infections on the political agenda.	UNFPA		
Formation of self-help groups for migrants living with HIV	UNHCR		

Joint Program Activities	Agency	Joint Program Outputs	JP Contributions (to Intermediate Outcomes)
Peruvian Network of civil society organizations trained in advocacy, use of strategic information and human rights.	UNAIDS Secretariat	3. Training in the empowerment of key populations also contributes to generating changes in the environment.	

Table 27: Broader programmatic activities that are directly relevant to KPs but also other populations

Joint Program Activities	Agency	Joint Program Outputs	JP Contributions (to Intermediate Outcomes)
National policies and regulations have been identified that represent barriers to exercising the rights of people with HIV, key populations, adolescents, and young people in vulnerable situations, emphasizing access to services and development opportunities, and there is a proposal for adaptation.	UNFPA	**Output 6.1: HIV-related legal and policy reforms** **Output 6.2: Legal literacy, access to justice and enforcement of rights** **Output 6.3: HIV-related stigma and discrimination in health care** 4. All the work carried out about human rights laws and regulations has contributed to the results, although more work is still needed. 5. Campaigns also contribute to generating changes in their vision of key populations and reducing stigma and discrimination.	**Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV are removed** It has contributed with the activities undertaken with this intermediate outcome
Civil society has a consensual agenda and advocacy capacities to ensure full compliance with the human rights of people with HIV, key populations, and adolescents and young people in vulnerable situations.	UNFPA		
1.Campaign Against Stigma and Discrimination	UNFPA		
Strengthening the work table on HIV and human mobility	UNHCR		
2.Campaign against discrimination. Community campaign against intersectional discrimination implemented in 5 regions, outside of Lima and Callao	UNFPA		
National Plan of Human Rights implementation	UNAIDS Secretariat		
Implementation of an Evidence-based advocacy strategy on human rights, gender, HIV, and COVID-19	UNAIDS Secretariat		
Strengthening the environment of Human Rights and Gender Equity for those affected by HIV	UNAIDS Secretariat		
Implementation of Andean Observatory of Migrants with HIV	UNAIDS Secretariat		
Elimination of Stigma and Discrimination -Declaration of Paris. Municipality of Lima.	UNAIDS Secretariat		

Between 2018 and 2021, the JP has implemented approximately 57 activities. Of this total, 40 (70.17%) have been directly or indirectly directed at KPs: 47.5% had an exclusive or significant focus on KPs, while 52.5% were relevant to KPs as well as to other populations.

Of the total activities, almost 30% correspond to activities aimed at other populations (see tables 3 and 4): women, adolescents (in general), maternal-perinatal transmission, and internal activities to strengthen the UCO or technical assistance to the Global Fund. In addition, most of the activities are directed at KPs in general; some are directed explicitly at PLWHIV and TGW migrants. No specific activities have been implemented for FSW or Prisoners. However, FSW have been one of the groups that has benefitted from the cash transfers program with WFP. Moreover, thanks to their participation in the first pilot of the program, it was possible to include the variable "sex work" in the score card of eligibility for that program, making the vulnerability involved in sex work visible. In addition, sex workers have finally been included in the proposal presented by the country to the GFATM in September 2021, thanks to the advocacy carried out by UNAIDS and other members of the CCM in the last few years.

Both the tables (13, 14, 15, 16, 17 and 18), and some interviews show that some JP cosponsor agencies have contributed to the achievement of UBRAF outputs and intermediate outcomes, especially in areas aimed at KPs. Nevertheless, most areas need some strengthening, given that the UBRAF outputs are ambitious and, in many areas, need the political will of the Government; hence, they are challenging to achieve.

JP cosponsor agencies do not provide responsive and integrated services for the different KP groups directly – nor is it their role. However, WHO, UNICEF, and the UNAIDS secretariat indirectly support these services with technical assistance, in a context of slow incorporation and implementation by the government. For Government actors, the contribution of JP cosponsor agencies is significant (primarily technical assistance and advocacy with final policymakers, and intermediation between Government and Civil Society)

> "Obviously, throughout this process, and somewhat linked to what I already mentioned, technical assistance from UNAIDS for elaborating country projects has been fundamental.
>
> …and not only technical assistance and financial assistance (…) UNAIDS has played a significant role in giving us confidence. Confidence is key because it must be recognized that the Peruvian Government has turned back on Civil Society."

About the promotion of Gender Equality, Human Rights, and the reduction of criminal/discriminatory laws, stigma, and discrimination, the JP members that contribute are mainly the UNAIDS secretariat and UNFPA.

Support in mobilizing and empowering key population led organizations

The mobilizing and empowering support of JP cosponsor agencies has prioritized organizations and networks led by TGW, indigenous people, PLWHIV (young people and adults), and to some extent MSM, community NGOs who work with migrants from Venezuela (in the last three years). UNICEF has focused on adolescents in general.

There has been limited work with FSW and no work with prisoners. Some projects have been implemented with the *Red de Jóvenes Cambiando VIHDAS* (i.e. with young people with HIV, including LGBTI) such as the theater performance "The test" (December 2018). In 2021, two members of *Corazones Positivos*, new group of young people affected by HIV, were hired to support the MoH in updating and cleaning-up the database of PLH under treatment, in order to organize PLHIV's access to the Covid19 vaccine. In December 2021 *Corazones Positivos* finished its strategic plan 2022-2026, with technical support of UNAIDS.

This work has focused mainly on:

- Bringing government ministries and KP organizations together to discuss policy reform: E.g., a new National Human Rights Policy towards 2030.
- Promoting dialogue between KP organizations and government actors
- Participating in conflict resolution between KP organizations

  "There was the election of the PVV representative for the CCM. A group did not know the winner, so in a new assembly, the communities and the CCM secretariat chose UNAIDS so that it could mediate in this process and have a new election."

- Developing KP organizations and networks' capacities to carry out community appraisals, community strategic planning, community trainings for health providers
  - Community appraisal "COVID-19 and trans women in Peru" (See booklet in the reference section)
  - TGW organization in Callao Strategic Planning
  - Community training for health providers about Stigma, discrimination and Xenophobia against Venezuelan migrants)
- Supporting KP organizations and networks to undertake community monitoring (E.g., community monitoring of services for trans women)

However, related to Envelope resources the only JP members that have intervened in the mobilization and empowerment of KP organizations and networks are the UNAIDS Secretariat and UNFPA. On the other hand, in 2021 the WFP implemented a KP social protection assessment and funded the cash transfer program that targets KP; UNHCR worked in strengthening capacities of KP, and migrant and refugee PLH. Likewise, since 2020 IOM is carrying out the PLH and KP migrants and refugees IBBS, which is currently at the stage of data gathering (UNAIDS Secretariat linked IOM with MoH authorities to start the study, provided TA and is member of the study follow-up Steering Committee).

According to some KP interviewees, in the development of activities, KP organizations have participated exclusively in implementing activities; not so in their planning, monitoring, or evaluation.

> "So, they [KPs] are only the operatives. There is still that idea that they have assumed of being only operatives. Because you send them to protest marches and they are people prepared for that. But they do not this awareness that the communities have to generate changes."

Finally, concerning monitoring and accountability of policies and programmes and implementing services, the only actor with such experience in Peru is the CCM for Global Fund projects, where KPs are represented[141].

> "There has always been some support for communities approaching UNAIDS with exciting and impactful ideas. Each time they have asked for support UNAIDS has supported them to the extent of its possibilities."

The current practice of making small grants to KP organizations generates discomfort and the presumption of preferences; hence it damages equity, for which a new modality should be developed to award small grants to KP organizations and networks.

> "My perception about UNAIDS is that it works on HIV issues. And in my personal perception, I feel that there is not an egalitarian attitude with all organizations of vulnerable populations.
>
> There may be the impression that UNAIDS only works with specific groups or only with certain people. It may give that impression, but I do not think it is so."

[141] It is worth noting that this representation and participation is unequal in the KPs represented and that the representation mechanisms are very problematic given the volatility and the weak institutionalization of KP organizations

Response to COVID-19

The JP has responded to the two contextual factors experienced in Peru between 2018 and 2021: The political instability and the COVID-19 pandemic.

Concerning the COVID-19 pandemic, the response was built upon a WFP activity that was already being implemented for Venezuelan migrants in general. The Ministry of Foreign Affairs requested the United Nations' support to collaborate in providing humanitarian assistance to the Venezuelan population residing in the country since this Ministry could not count on any assistance for them from the National Social Protection System. Given the high number of migrants from Venezuela living with HIV in precarious economic conditions in mid-2020, the WFP turned to the UNAIDS Secretariat to organize new care initiatives for this population. Both organizations signed a UN-to-UN agreement, which eventually was extended to local members of KPs who were in extreme poverty and nutritional risk (TGW, MSM, FSW and PLWHIV).

> "Before the pandemic, business was low, but you could also work on other things; there was more work on weekends. When the pandemic arrived, everything began to disappear, clients and sex workers themselves no longer went out, and everything changed.
>
> When the pandemic started, it hit us strongly, and I was left with nothing. I tried to work on the street, but I couldn't because of the police.
>
> The UNAIDS cash-transfer bonus arrived through the organization because I have not received any other Government bonus. A lady called me and asked me about my situation, and I became a beneficiary of the Cash-Transfer Bonus."

A pilot test was carried out by UNAIDS with 20 TGW to validate the relatively rigid systems' functioning and make it responsive to the HIV and KP-related vulnerabilities (for example, to be transwomen, to live with HIV, to generate income through sex work, became specific criteria of vulnerability in the scorecard for evaluating the eligibility of applicants). After adjusting the criteria and the system, the UNAIDS/WFP project proceeded to a first phase that reached 200 people, and a second phase that reached 635 people; it is currently in the third phase that plans to serve 1900 people[142]. Community NGOs and KP Organizations supported recruitment and, in the second phase, the Global Fund, through Partners in Health, continued activities with more human resources. Finally, the third phase is being funded by USAID. This Cash Transfer Programme is accompanied by nutritional information for the beneficiaries. Beneficiaries still have to go through a complex validation process to finally receive the money[143].

> "Sometimes there is a delay to notify beneficiaries, then people despair; I ask them to be patient."

Collaborators in this initiative intend to advocate for the programme to be assimilated by the Ministry of Social Inclusion, as one additional social protection programme[144].

Response to contextual factors

Although we assume that the JP cosponsor's assistance is always available, according to some interviews, KP representatives feel that the defence by JP cosponsor agencies of KP organizations has not been made effective through official communications, when there have been hate crimes or other types of human rights violations against KP members[145]. However, UNFPA have been unconditional in defending, for example, the gender approach in the curriculum of the MoE and a Comprehensive Sexuality Education that, many times, conservative groups have intended to

[142] The coverage is limited, but it is meaningful since it concerns people who did not receive any support from the Government.
[143] According to some interviewees, between appearing on the list of beneficiaries and receiving the bonus, it can take up to 3 months.
[144] The purpose of upcoming advocacy activities is for the government to incorporate HIV-related criteria to assess the vulnerabilities, in order to make HIV more visible for the current social protection programs (cash transfers and others). It did not advocate for the creation additional social protection programs.
[145]This is the opinion of a representative KP, referred to the United Nations in General.

eliminate. Finally, it is important to mention the efforts made by UNFPA to strengthen multisectoral participation as well as coordination with spaces such as the Roundtable for the Fight against Poverty and the National Commission against Discrimination (CONACOD), among other advocacy spaces.

During a period (2014-2018) in which the JP had minimal resources and had to deal with dangerous political instability and constant changes of authorities work continued minimally.

> "We were left without any resources, like for five years, nothing at all. And it was simply to get together, and from the UNAIDS Secretariat try to mobilize things only at a technical level."

Sustainable financing and programming mechanisms

Sustainability of the activities is still an enormous challenge for the JP because it depends not only on the JP but also on the government's political will to turn certain activities into permanent programmes (which has not been achieved until now); in addition to the Government's slow uptake of some of the best KP response activities for their transformation into programmes, their inclusion into the budgets, and their implementation.

On the other hand, KP organizations and networks are not sufficiently empowered and solid to develop evidence-based advocacy strategies.

> "In this short time, I have been able to see that the community [KP organizations] does not handle strategic information. So, I think there is a weakness that should be identified. That is why it seems strategic to me that even though we have already had things outlined, we have been able to put the brakes on for a while, talk with organizations and tell them that it is necessary to think about sustainability in the future."

The JP strives to develop sustainable funding and programming mechanisms; part of the problem is that in the meantime, specific demands from local counterparts can appear, as well as demands from regional or central headquarters that cannot be rejected, and which were not planned/budgeted for, making sustainable financing and programming mechanisms difficult.

> "We program with a budget, but sometimes requests come in from local counterparts (government mainly) that we cannot reject, and that makes it difficult to schedule activities with the previously allocated budget."

Conclusions and considerations regarding future priorities for the JP

Summary conclusions: status of Peru's key population response

While in theory all JT members have the opportunity to get involved in activities that are directly or indirectly focused on KPs, the involvement in KP-related activities of several agencies is limited or non-existent. Only two agencies (i.e., UNFPA and the UNAIDS Secretariat) are fully on board with KP-related activities, while PAHO/WHO has done so indirectly. UNICEF is working on adolescents in general and vertical transmission, not considered direct KP related work. UNESCO was involved until 2018 in the dissemination of key messages as an input for communication activities and advocacy to contribute to eliminate stigma and discrimination of KP (including migrants). Other cosponsor agencies have been involved in relation to the humanitarian crisis: WFP, UNHCR and IOM. Finally, ILO, WB, and UNDP are not currently involved and do not seem to have been involved in any meaningful KP activities over the period of interest (See Table 5).

The Division of Labour is not functional in Peru at present, with very limited commitment of some cosponsor agencies mainly ILO, WB, UNESCO and UNDP. This may arise in part from limited assimilation of the concept of a UN JP on AIDS and from scarce resources that the JP has been able to mobilize. This has resulted in the UNAIDS Secretariat covering areas normally be covered by cosponsors.

In contrast, excellent harmonization with government and non-governmental external partners and alignment with national priorities takes place and represents good practice. However, there is no monitoring and evaluation system for KP-focused activities at JP level that can unquestionably show evidence of results thereby classifying activities as strategic, catalytic, effective and sustainable is challenging not to mention attributing impact or causality to certain activities. While there has been some progress regarding KPs in terms of a legal framework and access to services, it cannot be attributed to the JP without considering other actors' initiatives over a longer period, including the Global Fund grants and other donors in the past, communities, academic institutions and NGOs, and the government itself. (See Section 4.2.1)

Finally, the current practice by UNAIDS of awarding small grants to KP organizations generates discomfort and the presumption of preferences; which would suggest a different form of partnership with the KP communities

Considerations for future workplans

The development of future workplans should consider the priority areas of the Sustainable Development Goals, the UBRAF and the national priorities. Considerations should be given to the following areas.

Expand reach to additional KPs and related activities

- Consider, in addition to the current KPs with whom the JT works, the following:
  - Activities in Prisons (See Footnote 10)
  - To continue activities with/for FSW
  - To continue Activities with/for youth and adolescent KPs.
  - Internal migration of young and adolescent TGW as part of the spectrum of migration problems that need support.
- Continue technical assistance to KP organizations, the CCM, and government (including empowerment of KP organizations and networks)
- Continue technical and financial assistance in regulatory matters and research (including community monitoring and community appraisals)

- Include or continue social protection activities (See Section 4.2.3.)[146]
- Encourage a political dialogue on social contracting[147]

Expand upon priority actions to include:

- A critically review the JT division of labour, and clarify the level of commitment of each of the cosponsors[148]
- Specification of the role and workload of the UNAIDS Secretariat in relation to the role of other JT members
- Generation of a discussion, arriving at consensus, on gender equality and human rights issues among JT members. Clarify the understanding of "Gender Equality": a) Is it still referring to a traditional conceptualization of "equal opportunities between men and women"? or b) is it including sexual diversity and other intersectionalities? (See Section 4.1.3.)[149]
- Incorporating a monitoring and evaluation system at the JP level to monitor and prioritize the most relevant, effective, strategic, and catalytic activities
- Focusing on empowerment of KPs to engage in advocacy in public policy, enhance their knowledge of their reality through community research and appraisal, institutionalization, and the provision of community services of prevention, care, and linkages
- Defining clear selection criteria and processes for financing small projects implemented by KP organizations and networks
- A new modality should be implemented to work with KP organizations and networks to ensure de legitimacy of direct collaboration with communities
- Consideration of establishing a KP reference group as an advisory board for JT activities

[146] Phase III of the project showed the need of intensifying advocacy activities to institutionalize the lessons of this intervention and transferring them to the social protection system, in order to make it HIV sensitive.
[147] Political dialogue should be complemented by proper analysis of the legal framework and procedures of budget allocation / execution of domestic resources. UCO extended the contract of the consultant on social mobilization until April 22, in order to assess the structures and regulations that would potentially support social contracting in the framework of GFATM programs.
[148] It would be interesting to recommend the introduction of this dialogue in the UNCT. Furthermore, it would be really useful for the UNJT to receive an endorsement from the Secretary General, as happened in 2007 in the times when Mr. Kofi Annan sent a letter to all UNCTs about the UN JT on Aids.
[149] Since the approach to gender related issues depends on the policies of each UN agency, would it be possible to have this discussion in the PCB.

Annex 1: Key informants – Peru

The table below lists the names, job titles and organizational affiliations of the key informants who were interviewed as part of this country study.

Name	Position	Organization
Carlos Benítez	AIDS National Programme	MOH
Rocío Valverde	Technical secretary	CCM
Julia Campos	NGOs representative	CCM
Edgardo Rodriguez	Human Rights Director	Mo JUS
Patricia Bracamonte		UNAIDS Secretariat
Aldo Aliaga		UNAIDS Secretariat
Karen Suárez		UNAIDS Secretariat
Sandra Manggiante		UNAIDS Secretariat
María Eugenia Mujica	Deputy Director	UNFPA
Carmen Murguía	Envelope Funds	UNFPA
Edgardo Nepo	Envelope Funds	PAHO
Magaly Askate	Envelope Funds	UNICEF
Lena Arias	Nutrition expert	WFP
Iván BotTGWer	Cash Transfer programme	WFP
Karin Sosa,	Migrants project	IOM
Paulina Giusti	Principal Researcher	USAID
Representative		AHF
Representative		PARTNERS IN HEALTH - PERU
Representative		ILLARI AMANECER
Representative		NGO Prosa
Representative		Red Trans
Representative		Red Trans Lambayeque
Representative		Trans Organization Amigas x Siempre
Representative		Trans Organization Feminas
Representative		Female Sex Worker organization RETRASEX
Representative		Sex Worker organization RETRASEX
Representative		Sex Worker organization RETRASEX
Representatives		FSW Organization Fuerza Chalaca FSW Organization Esperanza FSW Organization Woman del Callao FSW Organization Hojas al viento

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Background documents

1. Memorandum de Entendimiento entre SOCIOS EN SALUD y el Secretariado de ONUSIDA en Peru.
2. UNAIDS/WFP: UN AGENCY TO UN AGENCY CONTRIBUTION AGREEMENT
3. "Humanitarian assistance to vulnerable population, which includes migrants and refugees, affected by the context of COVID-19 in Peru", hereinafter referred to as “the Project”
4. United Nations Perú. Marco de Cooperación de las Naciones Unidas para el Desarrollo Sostenible PERÚ 2022-2026. September 2021
5. United Nations. Marco de Cooperación de las Naciones Unidas para el Desarrollo en Perú. UNDAF 2017-2021.
6. UNAIDS. Nuevo Plan Conjunto de VIH 2017-2021 del Sistema de las Naciones Unidas en Perú. 2016
7. Reunión Equipo Conjunto Peru – Setiembre 2021
8. 2019 Country summary report for Peru
9. PERU 2020 country report. Prioritized country targets for 2021
10. Secretariat Workplan: 2020 Toptask Report for AL-Peru ACT 2020-21

Excel Templates

1. 2021 Country Envelop Perú Final
2. 2020 Activities List
3. 2018 Peru - Joint Plan 2018-2019
4. 2020. UNAIDS General Project Matrix
5. 2021. Peru projects. UNAIDS
6. 2019. Peru Activity Workplan One-page 04.12.19
7. 2020. Template for Risk Assessment 21.01.20
8. 2020. ACT Workplans Reprogramming
9. 2021. Peru add services coverage 29mar2021
10. Peru JPM

Annex 3: Activities implemented with UN JP Envelope Funds in Peru, 2018-2021

Year	Lead agency	No of activities	Note
2021	UNAIDS Secretariat	9	All KP focused/relevant
	UNODC	7	All KP focused/relevant
	UNDP	4	All KP focused/relevant
	WHO	1	KP relevant
	UNICEF	4	Primarily general adolescent health focus
	UNFPA	1	Primarily general/vulnerable youth focus
	UNESCO	1	School sexuality education – general youth focus
2021 Total	***7 agencies***	***27***	
2020	UNAIDS Secretariat	8	All KP focused/relevant
	UNODC	6	All KP focused/relevant
	UNDP	3	All KP focused/relevant
	UNICEF	3	All KP focused/relevant
	WHO	1	KP relevant
	UNESCO	3	Primarily general pop sexuality education & GBV
	UNFPA	2	Primarily general/vulnerable youth focus
	UNHCR	1	Refugee focus
2020 Total	***8 agencies***	***27***	
2018-2019	UNAIDS Secretariat	6	All KP focused/relevant
	UNICEF	5	4 KP focused/relevant
	UNODC	3	All KP focused/relevant
	UNDP	2	All KP focused/relevant
	WB	2	All KP focused/relevant
	UNESCO	3	Primarily general pop sexuality education & GBV
	UNFPA	2	Primarily general/vulnerable youth focus
	UNHCR	1	Refugee focus
	WHO	1	EMTCT focus
2018/19 Total	***9 agencies***	***25***	

Year	Activity	Implementing cosponsor	Focus on KP	Allocated funds
2018 - 2019	1.1 Updating and implementation at the national and subnational level of the technical standard for comprehensive health care for people living with HIV, trans women, and indigenous populations	**WHO**	No	USD 12,400
	1.2 updated Technical Regulations to facilitate inter-programmatic management of key populations and people living with HIV in both prevention and health care settings	**WHO**	Yes but not limited to KPs	USD 20,099
	2.1 Strengthening the health sector in Peru with an information system for monitoring mother-to-child transmission of HIV, congenital syphilis, and hepatitis	**UNICEF**	No	USD 42,500

Year	Activity	Implementing cosponsor	Focus on KP	Allocated funds
	B., with the active participation of the organized organization. civil society			
	2.2. Strengthening the competencies of the Loreto, Ucayali, Lima, and Callao regions for adequate programming, acquisition, and distribution of drugs, supplies, and treatment reagents for the prevention and care of mother-to-child transmission of HIV, congenital syphilis, and hepatitis B	**UNICEF**	No	
	2.3 The regions of Loreto, Ucayali, Lima, and Callao have inter-programmatic articulation processes between the areas of STI-HIV and Sexual and Reproductive Health to close gaps in the cascade of mother-to-child transmission of HIV, congenital syphilis, and hepatitis	**UNICEF**	No	
	3.1 Relevant indicators on the situation of key populations, people living with HIV, adolescents, and young people with HIV are monitored and disseminated to advocate for guaranteeing the human rights of these populations and the accountability of public policies	**UNESCO**	Yes	USD 12,000
	3.2 4 networks of companies and unions have incorporated the social inclusion of KP into their policies	**UNESCO**	No	USD 12,000
	4.1 National policies and regulations have been identified that represent barriers to exercising the rights of people with HIV, key populations, adolescents, and young people in vulnerable situations, emphasizing access to services and development opportunities, and there is a proposal for adaptation.	**UNFPA**	Yes	USD 12,500
	4.2 Civil society has a consensual agenda and advocacy capacities to ensure full compliance with the human rights of people with HIV, key populations, and adolescents and young people in vulnerable situations.	**UNFPA**	Yes	USD 22,000
	4.3. A communication strategy is implemented to promote human rights, gender equity and equality, and the inclusion of key populations as crucial social determinants of new HIV infections on the political agenda.	**UNFPA**	Yes	USD 16,000
2020	1.1 Technical support to the HIV Programme to identify gaps in the continuity of care and prevention services for maternal and child health within the framework of the strengthening and decentralization of the first level of care linked to the COVID-19 response in the country.	**UNICEF**	No	USD 35,000
	2.1. Technical assistance in the strengthening and decentralization of the care services provided by the Ministry of Health, with an emphasis on dispensing for more extended periods (MMD), infection prevention, and mental health support, seeking the articulation of these interventions with work at the first level in response to COVID-19 in the country	**WHO**	No	USD 35,000
	3.1. Strengthening the table on HIV and human mobility	**UNHCR**	No	USD 15,000

Year	Activity	Implementing cosponsor	Focus on KP	Allocated funds
	3.2 Formation of self-help groups for migrants living with HIV	**UNHCR**	No	
	4.1. Campaign Against Stigma and Discrimination	**UNFPA**	Indirectly	USD 40,000
2021	**1. HIV prevention key populations** 1) Evidence-based innovative strategies; 2) Advocacy to make sustainable the new intervention; 3) Strategic alliances with GFATM, Ministry of Justice (National plan of Human Rights) and community led services **Activities:** 1.1.1 Assisted notification strategy. Implementation of the assisted notification strategy in CERITS and UAMP in prioritized regions 1.1.2 M&E assisted notification strategy. Monitoring and evaluation of the implementation of the assisted notification strategy in prioritized regions	**WHO**	Yes	USD 17,500
	2. HIV care cascade & PMTCT 1) Evidence-based innovative strategies; 2) Advocacy to make sustainable the new intervention; 3) Strategic alliances with GFATM and community led services **Activities:** 2.1.1 Decentralization implementation. Services of professionals in charge of decentralizing ART to IPRESS of the first level of care in prioritized regions: Amazon, North Coast, South Coast 2.1.2 M&E Decentralization ART. Visits by the National Programme on VIH to monitor the progress toward the decentralization of TAR	**WHO**	Yes	USD 17,500
	2. HIV care cascade & PMTCT 1) Evidence-based innovative strategies; 2) Advocacy to make sustainable the new intervention; 3) Strategic alliances with GFATM and community led services **Activities:** 2.3.1 PMTCT in the context of COVID-19. 2.4.1 Implementation of the e-course. Support in the implementation of the virtual course on "Prevention and management of mother-to-child transmission of syphilis, HIV and Hepatitis B in the context of COVID-19" 2.4.2 Evaluation of the e-course	**UNICEF**	No	USD 35,000
	2. HIV care cascade & PMTCT 1) Evidence-based innovative strategies; 2) Advocacy to make sustainable the new intervention; 3) Strategic alliances with GFATM and community led services **Activities:** 2.2.1 Prevention and access to treatment. Conduct HIV prevention activities through mobile brigades and	**UNHCR/IOM**	Yes	USD 29,350

Year	Activity	Implementing cosponsor	Focus on KP	Allocated funds
	provision of humanitarian assistance to access to treatments for refugees and migrants			
	3. Human rights, stigma and discrimination 1) Strategic alliances with Ministry of Justice and civil society; Advocacy **Activities:** 3.3.1 Community based mechanism supported. Capacity development conducted to 2 self-supported groups of refugees and migrants living with HIV (one in Lima and one in Tumbes) including psychosocial support 3.3.2 Training conducted with key actors. 5 trainings and awareness activities conducted to sensitize public services on the access of refugees and migrants to treatment	**UNHCR/IOM**	Yes	USD 10,650
	3. Human rights, stigma and discrimination 1) Strategic alliances with Ministry of Justice and civil society; Advocacy **Activities:** 3.1.1 Campaign implementation. Production of communication pieces in 4 native languages (Quechua, Aymara, Shipibo and Ashaninka), 6 radio microprograms, composition and production of 1 educational song, graphic design of a children's story (digital format for viewing on networks, guideline for local radio broadcasting in the 5 selected regions, community mobilization and public awareness activities in selected regions 3.1.2 M&E of campaign. Design and measurement of the community campaign indicators 3.2.1 Consultation with SCO. Consultation with key civil society actors and key populations on the progress and challenges in the implementation of the National Human Rights Plan	**UNFPA**	Indirectly	USD 40,000

Consultants own elaboration, UNAIDS documents: Envelope Funds Work Plans.

Annex 4: Activities implemented by or through UNAIDS Secretariat – Peru

Year	Name of the activity	Receiving organization	Implementing organization	Focus on KPs	Allocated Funds	Other Contributions
2019	eMCT Certified			no	USD 1,400	
	Global Fund transition Plan (absorption by domestic resources both at national and sub national levels)			no	USD 300	
	TARV in 5 regions			Indirectly	USD 1,800	
	Exercise Human Rights. Peruvian Network of civil society organizations trained in advocacy, use of strategic information and human rights.			yes	USD 2,500	
	National Plan of Human Rights implementation			yes	USD 2,500	
	Public servers Human Rights. Peruvian Network of civil society organizations trained in providing support and linking to services migrants living with HIV			yes	USD 2,500	
	UCO team for Bolivia, Ecuador and Peru with skills and competencies developed to deliver the UNAIDS mandate			no	USD 1,800	
	Innovation. New business processes introduced in the UCO			no	USD 200	
	Govern. & UN Reform. The UCO contributes to the processes of implementation of the United Nations reform in Peru			no	USD 300	
2020	Emergency transfers for PLWHIV, KP and migrants and refugees in COVID-19 context	UNAIDS secretariat	Consultant	yes	USD 7732	USD186488 (WFP)
	Implementation of an evidence-based advocacy strategy on human rights, gender, HIV, and COVID-19	UNAIDS secretariat	Consultant	No	USD 8,500	

Year	Name of the activity	Receiving organization	Implementing organization	Focus on KPs	Allocated Funds	Other Contributions
	"Use of communication technologies for the prevention of HIV and COVID-19 through the radio program NUESTRAS NOCHES"	UNAIDS secretariat to SIDAVIDA	NGO SIDAVIDA	yes	USD 3,821	
	Developing capacities to strengthen the community response to COVID-19 from the perspective of migrant and Peruvian people living with HIV / AIDS	UNAIDS secretariat to Action Against Hunger	NGO CCefiro[150]	yes	USD 6,000	
	"Comprehensive response to strengthen adherence to Antiretroviral Treatment for HIV in the face of the COVID-19 Emergency in the East Lima Women's Community"	UNAIDS secretariat to PROSA[151]	The Community of Positive Women of East Lima	No	USD 4,571	
	Diagnosis "COVID-19 and trans women in Peru	UNAIDS secretariat to Red Trans	Red Trans	yes	USD 5,000	
	Program for the comprehensive care of Venezuelan migrants and refugees living with HIV / AIDS, whose condition of the vulnerability requires their entry into the integrated health system of PERU	UNAIDS secretariat to Illari[152]	NGO Illari	yes	USD 5,000	
	WAD 2020	UNAIDS			USD 1,966	
	Saving lives and protecting the rights of women from Amazonian indigenous communities in response to COVID-19	PAHO, UNFPA, WFP	PAHO, UNFPA, WFP, UNAIDS Secretariat	Indirectly	-	USD850000 (UNDOCO)
2021	Strengthening the environment of Human Rights and Gender Equity for those affected by HIV			Indirectly	USD 27,000	
	Andean Observatory of Migrants with HIV			Indirectly	USD 5,000	
	Support for humanitarian response with HIV and key populations.			yes	USD 23,900	

[150] CCefiro is a community NGO that works with PLHIV, mainly migrants from Venezuela

[151] PROSA is a PLHIV NGO

[152] Illari is an NGO that works with PLWHA, principally migrants from Venezuela

Year	Name of the activity	Receiving organization	Implementing organization	Focus on KPs	Allocated Funds	Other Contributions
	Community-Led Responses Project (CLR)			yes	USD 7,096	
	Capacity building CONAMUSA mobilization of resources 2022-2026			No	USD 17,599	
	Support bases contest Principal Recipient Global Fund			No	USD 1,372	
	Elimination of Stigma and Discrimination - Declaration of Paris. Municipality of Lima.			No	USD 7,000	
	Strategic Planning Community of trans women of Callao			yes	USD15,000	
	Project to link Migrants and refugees with HIV to ART and the Health System - Phase II			yes	USD 5,000	
	Project to link Migrants and refugees with HIV to ART and the Health System - Phase III			yes	USD 4,941	
	Emergency Bonds for Migrants with HIV - Phase II	WFP	UNAIDS Secretariat	yes	USD 13,360	
	Emergency Bonds Migrants with HIV - Phase III	WFP	UNAIDS Secretariat	yes	USD 35,250	
	Trading activity				USD 19,500	

Consultants own elaboration, UNAIDS documents: UNAIDS Secretariat Work Plans

Annex 5: JP meeting (September 2021) – Peru

JP Cosponsor	Attendants	Role	Shared Information	Focus on KP
UNAIDS Secretariat	7 participants	Lead the meeting and set the agenda	**Gives information about:** 1. The events in relation to the Program Coordinating Board (PCB), 2. The Global Fund, 3. The work with the Government, 4. A new study of new study of the Stigma and Discrimination Index 2.0 5. The evaluation in progress. Introduce the new members	
PAHO/WHO	1 participant	Report on activities.	**Envelope Funds:** - The care of PLWHIV is being decentralized to the first level of care (complete the Information) - follow the progress regarding assisted notification (complements the information) **Other funds:** - STI technical standard is being updated. - Work in the Condorcanqui Health Network (complements the information) - On Prep and combined prevention, PAHO supported MoH in the formulation of a technical standard. - PAHO has signed an agreement with the Army health to work on HIV and TB issues.	Indirectly Indirectly
UNFPA	1 participant	Report on activities.	**Envelope Funds:** - Campaign against stigma and discrimination (Complements the information) - Final evaluation of the National Human Rights Plan (Complements the information) - New national policy on Human Rights 2022+ (Complements the information) - Comprehensive sexuality education (ESI in Spanish) (Complements the information) - Support for the Ombudsman's Office (Complements the information) - Studies on the impact of COVID-19	Indirectly Indirectly Indirectly No No No
UNHCR	2 participants	Report on activities.	**Envelope Funds:** - Strengthening the PROSA Association (PLWHIV NGO) (complements the Information) - First meeting LTGBIQ Peruvians and Venezuelans 1. Community interventions with MoH for the last months of the project.	Yes Yes Yes
UNICEF	2 participants	Report on activities.	**Envelope Funds** - Course for prevention and control of mother-to-child transmission (PMTCT) (Complements the information)	No

JP Cosponsor	Attendants	Role	Shared Information	Focus on KP
UNAIDS Secretariat		Report on activities.	**<u>Migrants and HIV Project (USAID, IOM and UNAIDS)</u>** - HIV epidemiological surveillance study (IBBS = integrated bio-behavioural study) with Venezuelan migrant and refugee population - Two projects to strengthen services for migrants and refugees: one focused on health sector services, in charge of Local Health System Sustainability (LHSS), and another on strengthening services at the community level (ICAP). - PAHO and UNAIDS technically support these projects **<u>Emergency Cash Transfer Project (WFP-UNAIDS)</u>** - Start of phase III of the project (Complements the information) **<u>Other activities</u>** - Technical assistance to EsSalud (Social Security) (Complements the information) - Project MTPF Nuwa Tajimat (PAHO UNFPA, WFP and UNAIDS) in the indigenous area of Condorcanqui in sexual and reproductive health, gender violence and HIV PMTCT.	No Yes Yes No No

4. Thailand country study

24 January 2022

Consultants:
Team leader, Thailand Country Study: David Lowe
Key population team members: Surang Janyam, Verapun Ngammee and Dusita Phuengsamran

Global level team leader: Larry Gelmon
Global level deputy team leader: Clare Dickinson

Introduction and context

Purpose and scope of the Thailand country study

This case study is part of a larger evaluation to assess the relevance, coherence, equity, efficiency, effectiveness and sustainability of the UNAIDS[153] Joint Programme on AIDS (JP) support for key population (KP) programming at country level over the years 2018-2021, with a view to improving UNAIDS programming with and for key populations under the new UNAIDS United Budget, Results and Accountability Framework (UBRAF) 2022-2026. The primary unit of analysis for the evaluation is how the Joint Programme has supported KP programming at the country level. Six countries were chosen for the case studies, covering all UNAIDS regions and a variety of epidemics. The six countries are Cameroon, Kenya, Peru, Thailand, Tunisia, and Ukraine. The case studies have been supplemented by document review and key informant interviews (KII) at the global and regional levels.

The KPs, as defined by UNAIDS, are sex workers (SW), gay men and other men who have sex with men (MSM), transgender persons (TG), people who inject drugs (PWID), and prisoners, including young people who are part of these KPs.

Methods

The evaluation is theory-based and involved the development of a Theory of Change (TOC) which has served as an overall analytical framework for the evaluation. The TOC outlines the relationships between the Joint Programme activities and interventions and how these are expected to bring about change and results for KP responses. The TOC also includes a forward-looking component through use of the Strategic Priority Outcomes (SPOs) of the new Strategy 2021-2026, the intention being to help identify existing gaps for the achievement of the new strategy and to inform future KP programming recommendations. Ten evaluation questions, based on OECD DAC Evaluation Criteria[154] were identified refined and mapped to the TOC.

The country case studies focused on a qualitative analysis of the Joint Programme activities in relation to capacity and country needs, examining progress made in KP programming, to gain a comprehensive and nuanced understanding of UNAIDS support and contribution to KPs at the country level. Additionally, the case studies focused on eliciting lessons learned, good practices, and examples of factors helping or hindering UNAIDS work with and for KPs. This case study – in Thailand – was conducted through document review and KIIs with staff of the UNAIDS Country Office and Cosponsors, Thai government ministries, KP-led networks and NGOs working with and providing community services to KPs, other civil society organisations (CSOs), research institutes and academics and donors. A total of 44 interviews, involving 56 individuals were conducted in September and October 2021, using Zoom due to the COVID-19 situation in Thailand. A list of all KIs is in Annex as well as a bibliography of documents reviewed.

The UN Joint Programme on AIDS in Thailand has implemented a total of 79 activities from 2018-2021. Sixty-one of these activities had an exclusive or significant KP focus or were directly relevant to KPs. Due to the limited time available to conduct the country study it was not possible to conduct an in-depth evaluation of each and every KP-related activity. The purpose of the country case studies was to collect country evidence to answer ten overarching evaluation questions. The Thailand country study has examined how various activities have collectively contributed to relevance, coherence, equity, efficiency, effectiveness and sustainability, while also purposively focusing on a number of select activities of particular strategic importance.

[153] References to UNAIDS in this report refer to the Joint United Nations Programme on HIV and AIDS, consisting of the UNAIDS Secretariat and UN agency Cosponors. The UNAIDS Secretariat in Thailand is referred to as the UNAIDS Country Office (UNAIDS CO).

[154] https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

National HIV context and programme response

Thailand's HIV epidemic

Thailand is recognized internationally as having made considerable progress in control of HIV and AIDS. Estimated new HIV infections peaked in the early 1990s at close to 160,000 per year. By 2020, estimated new infections had declined to 6,600, a 56% reduction from 2010.[155] Currently, the most affected KP is MSM, accounting for around 40% of new infections per year. Sex workers, TG and PWID each account for around 10% of new infections per year. Half of Thailand's estimated new infections in 2020 (i.e., 3,300) occurred in young people aged 15-24 years, with adolescents (10-19 years) accounting for 14% of all new infections. While there is no data breaking down the percentage of new infections among young key populations (YKPs) versus the general population of youth, a recent regional aggregate analysis of new HIV infections among young people in Asia-Pacific indicated that 99% of infections are happening among YKPs and this is likely to be mirrored in Thailand.[156] Addressing the high infection rate among YKPs is clearly a high priority.

Estimated HIV prevalence among KPs is MSM: 7.3%; TG: 4.2%, PWID: 7.8%; male sex workers (MSW): 3.8% and female sex workers (FSW): 2.8% non-venue based and 0.7% venue based. Data from a 2019 cohort of Bangkok MSM indicate a decline in HIV incidence for the cohort as a whole, at around 3% per annum, but a resurgence in incidence among young MSM aged 13-21 at 10% per annum. This is consistent with the disproportionate number of HIV infections in YKPs.

Thailand's HIV response

Thailand's National Strategy to End AIDS, 2017-2030 seeks to eliminate HIV and AIDS as a public health problem by 2030 with 'due consideration to the principles of human rights and gender equality'. The strategy's three goals are to reduce new HIV infections to less than 1,000 cases per year, reduce AIDS-related deaths to less than 4,000 cases per year, and reduce HIV and gender-related discrimination by 90%. Key challenges identified by the strategy include improving coverage of KP programming to reduce high HIV prevalence, reducing social stigma and discrimination (S&D) against HIV and diverse sexual preferences, and the need for a new and sustainable financing system to support CSO programming.

Coverage of comprehensive HIV prevention programming[157] varies significantly by KP and is below the national target of 90% – FSW: 82%; MSM: 50%; TG: 44%; PWID: 32%; and MSW 28%. Access to harm reduction services is limited. On average, PWID are only receiving 12 needles and syringes per year in contrast to the WHO recommendation of 200 and only 9% of PWID are receiving opioid substitution therapy (OST), well below the 2025 global target of 50% OST coverage. One of the biggest challenges for access to HIV prevention and health services by PWID is discrimination and fear of legal penalties for drug use. The legal and enabling environment for harm reduction services is generally hostile.

While Thailand has met the first 90 target with 94.5% of PLHIV knowing their status, HIV testing coverage for KPs lags: MSW: 69%; TG: 68%; FSW: 66%; MSM: 53%; and PWID: only 38%. Given the HIV epidemic in Thailand is largely driven by KPs, the below national target rates for KP HIV testing are significant.

Thailand has a significant challenge with late HIV diagnosis, which in turn results in late commencement on treatment. In 2020, the median CD4 level of PLHIV at time of diagnosis was only

[155] The source of all epidemiological and coverage data in this section is from Shwe, YY. Overview and progress of HIV epidemic response in Thailand, September 2021 and HIV and AIDS Data Hub for Asia Pacific, Review in slides: Thailand, September 2021.

[156] Personal communication, Ye Yu Shwe, Technical Officer, UNAIDS Regional Support Team, Asia Pacific.

[157] This data is from IBBS surveys. Comprehensive HIV prevention programming is defined as receiving any 2 out of 3 services – condom and lubricants, counselling, and STI screening for SWs, MSM and TG or received clean needles and syringes for PWID.

194, with 52% of PLHIV having a CD4 level of less than 199 at ART initiation. HIV and KP-related S&D is seen as a significant barrier to people seeking HIV testing. In the President's Emergency Plan for AIDS Relief (PEPFAR) supported key population led health services (KPLHS) the average CD4 level at diagnosis averages around 350, indicating that KPLHS are more effective at reaching and testing KPs. The late diagnosis and late initiation of ART is a significant factor in the high number of AIDS-related deaths – 12,000 in 2020, (although this was a 58% reduction from 2010).

There has, however, been considerable progressive scale up of ART coverage in Thailand, facilitated by its longstanding inclusion in the universal health coverage (UHC) scheme and early adoption of test and treat. In 2020, 394,598 PLHIV were on ART, representing 79% of Thailand's estimated 500,000 PLHIV. This was 2% short of the 90-90-90 related target of 81%. Given ready access to ART, Thailand would have comfortably exceeded the second 90 if HIV testing rates among KPs were higher. 77% of PLHIV on ART have achieved viral suppression which exceeds the target of 73%. However, 2020 HIV cascade data for MSM and TG in 22 hospitals in four provinces and Bangkok indicate HIV testing and ART uptake rates significantly below the PLHIV population as a whole. Only 76% of the estimated number of MSM and TG living with HIV knew their HIV status. Of these, only 64% were on ART and only 62% had achieved viral suppression.

In 2014, Thailand developed a service delivery model for implementation of a reach, recruit, test, treat, prevent and retain (RRTTPR) cascade. The model recognises the added value KP and PLHIV CSOs can bring to the cascade. This includes recruiting the hardest to reach KPs and the complimentary nature of CSO and government health services by improving links and retention across the cascade. There are three modalities for RRTTPR service provision, with varying levels of KP CSO engagement along the cascade:

- **Hospital model** – KP RRTTPR services are provided by public hospitals that do not have CSOs within their catchment area. Some hospitals may use National Health Security Office (NHSO) UHC funding to support outreach activities to recruit and refer KPs to the hospital or other sites for testing, pre-exposure prophylaxis (PrEP) and ART or take a passive approach and wait for KPs to self-present at the hospital.
- **Government facility-led services** with reach and recruit led by KP CSOs and other CSOs. These CSOs provide reach and recruit services to KPs through referrals for testing in hospitals or through mobile testing, with PrEP and ART provided through hospitals.
- **Key population-led health services** in collaboration with public hospitals. CSO clinics offer HIV testing and PrEP. Peer navigators support KP access to ART at hospitals and provide adherence support. Some CSO clinics initiate clients on ART and collaborate with hospitals on management of complex cases.[158]

In 2017, NHSO added a prevention care category under the UHC's HIV Care Fund (USD 6 million per annum) which is used for direct funding of KP CSOs through per capita reimbursement for each 'case recruited', 'case tested' and 'case retained' for MSM, TG, SWs and PWID. There is a significantly higher payment to CSOs for PWID in recognition of the more challenging nature of recruit, test, retain (RTR) work for this population. Direct funding of KP CSOs under UHC is a significant step, although comprehensive funding of CSOs under UHC has not yet been achieved. (See Section 4.2.4 for a discussion of JP activities on sustainable financing for CSOs.)

Condoms and PrEP are key components of combination HIV prevention in Thailand. In 2018, an estimated 131 million condoms were distributed – 59 million free condoms by the Ministry of Public Health (MOPH) and CSOs and 72 million commercial sales.[159] A revised National Condom Strategy 2020-2030 has been developed and a condom needs estimation study, supported by the UNAIDS Country Office (CO) UNAIDS CO, resulted in a significant increase in condom funding under UHC.

[158] KP CSOs are involved in the second and third modalities of service provision but with different roles.

[159] Ministry of Public Health, UNAIDS Thailand and Naresuan University, Fast-Tracking Condoms as Part of HIV Combination Prevention Addressing the Last Mile Towards Zero New HIV Infections: Introducing the Condom Needs Estimation Methodology and Tool in Thailand. 2019, p. 5. The 2018 condom distribution estimates cover HIV, STI and family planning programming.

Following a successful national pilot of PrEP in 2020, it was scaled up to 150 health facilities in 2021 and included in the UHC scheme, with no cap on the number of people who can be enrolled. Following a JP supported trial of PrEP among adolescents, it is now available to all age groups. While these are important steps forward, PrEP usage is still well below estimated national need, although there has been a significant increase in enrollment. See section 4.2.4 for information on the role of the JP in relation to PrEP.

Thailand has a long history of KP CSO provision of HIV programming which has been reinforced through the service delivery model for the RRTTPR cascade, along with UHC funding for CSOs, although this is a work in progress. There are a number of long established and well-capacitated MSM and SW CSOs working in Bangkok and key provinces. Interviews with KIs indicated that the capacity of smaller and newer TG and PWID/PWUD NGOs appears to be variable.

Enabling environment

The enabling environment for HIV and KPs in Thailand is a mix of positive and negative aspects.[160] On the positive side, Thailand does not criminalise same-sex acts or TG people, although there is no gender recognition law for TG people. The Gender Equality Act prohibits unfair discrimination against males, females and persons who have gender expressions different from their original sex and for the first time officially recognise the rights of lesbian, gay, bisexual, transgender, and intersex (LGBTIQ+) people, although the Act does not fully recognise the diversity of gender among the population or intersectionality. Another positive aspect is that adolescents can access HIV testing and PrEP without the need for parental consent.

Consideration is currently being given to a number of laws and policies that would improve the enabling environment for KP HIV programming. This is a significant focus area for UNDP in partnership with KP CSOs and relevant government ministries. JP activities related to human rights and the enabling environment are discussed in section 4.1.2 and 4.2.4.

S&D by health care providers is not uncommon and, along with marginalisation and criminalisation of some KPs, serves as a barrier to accessing services, as does self-stigma. In response, the MOPH, in partnership with health professionals, KP groups and the UNAIDS CO and other development agencies has established a national framework to routinely monitor status and progress in reducing S&D in health care settings. This includes measurable S&D targets using standardised indicators and the use of data to inform the development of S&D reduction interventions. The framework is supported by training and sensitisation of health staff on S&D. This has been complemented by a MOPH – civil society partnership which developed a web-based Crisis Response System (CRS) to respond to complaints of human rights violations and S&D against PLHIV and KPs. A costed national action plan for the elimination of S&D has been completed and endorsed by the subnational committee on AIDS rights protection and promotion under National AIDS Committee with UNAIDS CO assistance. A 2020 online survey found that S&D was the top concern of all KPs in being 'left behind in the AIDS response', particularly for PWID and PLHIV.[161]

While Thailand is often perceived as being more open and accepting of MSM and TG, there is a body of evidence which documents that they and other KP groups commonly experience S&D in a range of settings. The civil code of Thailand does not allow same sex marriage or registration of civil partnerships.

The 2020 Leave No One Behind analysis, led by the UNAIDS CO and UNDP, found that to end AIDS by 2030 greater attention needs to be paid to the human rights of KPs and the elimination of S&D through more enabling policy and legal environments, including removal of barriers to accessing prevention, testing and treatment services. Another issue that needs to be addressed is HIV testing without consent for job applicants and employees which is not uncommon.

[160] Information in this section is drawn from the Thailand Leave No One Behind Analysis and a range of key informant interviews with Joint Team members and KP CSOs.

[161] Joint Programme Thailand, Leave No One Behind Analysis. LGBTI, HIV affected people and sex workers. 2020. p. 11.

A major impediment to HIV programming for sex workers is the criminalisation of sex work which results in police harassment of sex workers and a lack of labour protection rights, including access to social security. A significant barrier to evidence-based programming for PWID and PWUD is Thailand's punitive approach to drug use and treatment, with considerable resistance to harm reduction programming. Currently, PWID and PWUD apprehended by law enforcement agencies are almost exclusively subject to non-evidence based compulsory treatment in detention centres or imprisonment. Thailand's prison population of 286,677[162] is the sixth largest in the world, with more than 70% of all inmates incarcerated for drug law violations[163]. The recently passed narcotics law may indicate a rethinking of Thailand's approach to drug use. The Act emphasises prevention and community-based treatment rather than punishment for drug users, with tougher measures against organised crime, which could lead to a drop in the large numbers of drug users in Thai prisons. The law provides for an enhanced role for the MOPH and the health sector in prevention and treatment and will allow, by way of regulation, trials of harm reduction programming for PWID and PWUD.

Financing of the HIV response

Thailand has made significant advances in mobilising domestic financing for its HIV response. In 2021 it was anticipated that budgeted domestic funding for HIV would total USD 258.6 million and external funding USD 16.8 million (primarily Global Fund). Domestic and external resources account for 94% and 6% respectively of total anticipated financial resources in 2021. The current funding gap for Thailand's HIV response is estimated to be USD 70 million in 2021, or 25% of total anticipated funding.[164] The funding gap for KP programming in 2021 was estimated to be USD 13.9 million. A National AIDS Spending Assessment found that although KPs account for more than 50% of new HIV infections in Thailand, only 36% of prevention programme spending in 2019 was allocated to KPs. Nonetheless, expenditure on KPs increased from USD 3.8 million in 2015 to USD 12.8 million in 2019. This increase came from UHC funding of KP services and the 2015 operational plan to end AIDS.

The funding gap may have since been further addressed by additional domestic funding for specific programming areas. The recent inclusion of funding for PrEP under UHC is an example.

The current Global Fund grant for HIV (2021-2023) is valued at USD 40.6 million over 3 years, with a 50% allocation to PWID/PWUD programming to address limited domestic funding and low coverage rates. Despite its upper middle income status, Thailand's high HIV disease burden means that it is likely to remain eligible to receive Global Fund grants for the foreseeable future. The value of Global Fund grants for HIV has, however, declined over time. The other major external donor is PEPFAR with funding of USD 11.9 million in fiscal year 2022. The focus of CDC and USAID activities is primarily technical assistance for KP programme innovation and scale up.

UNAIDS Joint Programme key population response

Strategic orientation and programmatic approaches

Each of the annual plans of the JP for 2018-2021 categorise activities into four priority areas: 1) HIV prevention, 2) HIV testing and treatment for attaining 90-90-90 targets, 3) human rights and S&D, and 4) investment, efficacy and sustainability. Of the 79 planned JP activities since 2018, 37 fall under HIV prevention (although 14 of these have a non-KP primary focus), 21 relate to human rights and S&D, 14 fall under HIV testing and treatment, and 7 under investment and sustainability. 77% of all JP activities were KP focused or directly relevant to KPs. (See section below for more analysis on the relevance of JP activities to KPs and in Annex for JP activities by priority area and KP focus.)

[162] World Prisons Brief https://www.prisonstudies.org/country/thailand accessed 21 November 2021.
[163] Paungsawad, G. et al., Bangkok 2016: From overly punitive to deeply humane drug policies. Drug and Alcohol Dependence, 6138, 2016.
[164] Thailand Country Coordinating Mechanism. Global Fund Funding Request, 2021 – 2023. 2020. p. 71.

In developing its 2021 plan the JP identified the following 'persistent challenges and gaps'[165]:

- Insufficient HIV prevention and testing among KPs, particularly TG, PWID and youth and delayed HIV diagnosis
- Innovative approaches in HIV service delivery are not taken to scale to generate national impact
- S&D and gender inequality continue to be major barriers especially for PWID and LGBTIQ+ people
- Gaps in sustainable funding for community-led responses
- The adverse impact of COVID-19 on income security of KPs and KP HIV programming.

The annual plans for 2018 - 2020 are based on a similar analysis. These challenges and gaps are consistent with this evaluations analysis of the national HIV context and programme response outlined in Section 2.

In 2020 and particularly 2021, the JP decided to prioritise PWID/PWUD-related activities in recognition that this is the most underperforming area in Thailand's KP programming. This included a successful Business Unusual Fund (BUF) bid for increasing PrEP use and HIV self-testing (HIVST) among PWID/PWUD. A total of 14 PWID/PWUD specific activities have been implemented since 2018, which is the most for any KP. Key areas for UNODC activities included comprehensive HIV and hepatitis C programming, identifying entry points for increased harm reduction services, and NGO training on harm reduction services for stimulant drug use and on the needs of female PWID.

In response to persistently high HIV prevalence among TG persons, activities for this KP were also prioritised with 7 TG specific activities implemented since 2018. This is the second highest number of activities for any KP. Most TG activities fell under the human rights and S&D priority area and were implemented by UNDP. Activities included training of TG sex workers in economic empowerment, a scoping study on S&D, training of law enforcement officers in S&D, a draft legal gender recognition law, and addressing access to health care.

A total of four activities relating to prisoners have been undertaken including improved rights-based management of TG prisoners, advocacy on an integrated health service delivery model for PWID in prisons, and training for emergency preparedness for health crisis in prison settings.

Nine activities focused on all KPs. Most of these were in the investment and sustainability priority area, including a study on effective CSO contracting models for HIV service delivery, a cost analysis of KP service interventions, and certification of KP CSOs and community health workers (CHWs).

Priority was not accorded to sex work related activities with the exception of LGBTI sex workers, a recent initiative on decriminalisation of sex work, and activities in response to the economic impact of COVID-19 on sex workers. The stated reason for the lack of priority accorded to sex work activities is because of the relatively low HIV prevalence among female SWs and high programme coverage rates compared to other KPs. In deciding not to undertake MSM focused activities the Joint Team took account of the prioritisation for MSM programming by PEPFAR. JP activities of relevance to all KPs addressed the needs of SWs and MSM.

In addition to activities focused on one or more KPs, the JP has undertaken 24 broader programmatic activities between 2018-2021 that are directly relevant to KPs but also other populations. These activities encompass areas such as HIV cascade analysis, PrEP, S&D and HIVST.

For KP programming, with the exception of the adolescent PrEP pilot project, the current PrEP initiative focused on PWUD, and UNODC funding for implementation of its Strong Families Programme, the JP has not been funding service delivery.[166] Its work has appropriately been focused on providing normative advice and advocacy on evidence based programming and human rights-related law reform, assistance in guideline and policy development, studies to generate strategic information and to inform programmatic approaches, including sustainable financing.

[165] UN Joint Team on AIDS, Thailand 2021 Joint UN Programme Plan, 2021. p. 2.

[166] However, UNICEF, UNFPA and UNESCO have been funding service delivery for general population adolescent and youth programming with lesser direct relevance to KPs.

As indicated by the examples of JP activities cited above, there is a diversity in the type of activities implemented. There is also a significant degree of variation in the scale of activities and budget allocations ranging from the USD 80,000 allocation to support the adolescent PrEP trial to the USD 2,000 for advocacy on CSO accreditation and certification within the health system, supplemented by USD 20,000 for related consulting services. Budget allocation is, however, not necessarily a guide to the significance of activities. For example, the small allocation on sustainable CSO financing has the potential to achieve a very significant outcome.

Currently, the agencies undertaking KP focused or relevant activities are UNAIDS, UNODC and UNDP (and UNICEF up until 2020) – see Table 1. A number of cosponsors have deprioritised their HIV work in recent years which is discussed in section 4.1.1 below.

Table 28: Joint Programme activities by lead agency and number of activities, 2018-2021

Year	Lead agency	No of activities	Note
2021	UNAIDS Secretariat	9	All KP focused/relevant
	UNODC	7	All KP focused/relevant
	UNDP	4	All KP focused/relevant
	WHO	1	KP relevant
	UNICEF	4	Primarily general adolescent health focus
	UNFPA	1	Primarily general/vulnerable youth focus
	UNESCO	1	School sexuality education – general youth focus
2021 Total	***7 agencies***	***27***	
2020	UNAIDS Secretariat	8	All KP focused/relevant
	UNODC	6	All KP focused/relevant
	UNDP	3	All KP focused/relevant
	UNICEF	3	All KP focused/relevant
	WHO	1	KP relevant
	UNESCO	3	Primarily general pop sexuality education & GBV
	UNFPA	2	Primarily general/vulnerable youth focus
	UNHCR	1	Refugee focus
2020 Total	***8 agencies***	***27***	
2018-2019	UNAIDS Secretariat	6	All KP focused/relevant
	UNICEF	5	4 KP focused/relevant
	UNODC	3	All KP focused/relevant
	UNDP	2	All KP focused/relevant
	WB	2	All KP focused/relevant
	UNESCO	3	Primarily general pop sexuality education & GBV
	UNFPA	2	Primarily general/vulnerable youth focus
	UNHCR	1	Refugee focus
	WHO	1	EMTCT focus
2018/19 Total	***9 agencies***	***25***	

The relevance of activities to the needs and priorities of KPs is discussed in 4.1.1 below

Main partnerships of the Joint Programme

Based on documents reviewed and interviews with the UNAIDS CO, cosponsors and their partners there is strong evidence of the JP partnering with a broad range of entities:

- **Government partners:** the key partner, particularly for the UNAIDS CO and WHO has been the Division of AIDS and STI (DAS) in the Department of Disease Control and to a lesser extent the NHSO in relation to UHC funding. UNODC's principal government counterpart has been the Office of the Narcotics Control Board (ONCB) and DAS to a lesser extent. UNDP's primary focus on human rights and gender equality has resulted in partnerships with a range of government entities regarding legislative and policy reform, including the Department of Women's Affairs, Department of Corrections, Department of Rights and Liberties Protection and the police.
- **Civil society:** the JP has worked closely with a broad range of KP CSOs from all the KP groups and PLHIV networks. Liaison with many of the larger and well established KP NGOs to a significant degree occurs through various national committees such as the National AIDS Commission and the Global Fund country coordinating mechanism (CCM) and through various programmatic-related projects. For smaller NGOs, UN agencies, particularly UNDP, have played a role in facilitating a place at the table on work with government entities on legislative and policy reform.
- **Researchers:** there has been close collaboration between UN agencies and various research institutes in Thailand, individual academics and influential retired senior government officials now working as consultants, and other consultants. This has mostly taken the form of studies to generate strategic information and to inform programmatic and strategic approaches. These collaborations have mostly been initiated by the UNAIDS CO, UNODC, UNDP and the World Bank (WB).
- **Donors:** the JP has collaborated extensively with the two principal external donors, the Global Fund and PEPFAR and also the French government via 5% French initiative.

Case study findings

Relevance and coherence of Joint Programme activities

In summary, 77% of planned JP activities were KP focused or directly relevant to KPs. This high degree of relevance was somewhat diluted by SRH and other activities primarily targeting general population adolescents and youth, which did not have a significant focus on addressing the HIV-related needs and priorities of KPs. The KP focused activities undertaken in each of the JP's four priority programming areas are highly relevant to addressing the 'persistent challenges and gaps' in the Thai response to HIV that have been identified by the Joint Team (see 3.1 above). These activities are relevant to KP needs and priorities. For example, increasing HIV prevention, testing and treatment coverage, particularly for underserved KPs, promoting scale up of PrEP and HIVST, addressing enabling environment barriers to uptake of services by KPs, and sustainable funding for KP CSOs. Overall, there is a high degree of relevance to KP needs and priorities in most JP activities. (Strong evidence: supported by good quality data/documentation and majority of KIs.)

Relevance of activities to key population needs and priorities[167]

The activities of the JP fall into one of the following three categories:

- Activities with an exclusive or significant KP focus. Some of these activities apply to all KPs (e.g., unit cost of KP CSO services), although most activities focus on one particular KP. A limited number of activities relate to intersectional populations (e.g., TG people in prisons). Activities with a significant KP focus also encompass broader populations (e.g., Stigma Index survey).
- Broader programmatic activities that are directly relevant to KPs but also other populations (e.g., PrEP and S&D).
- Activities that primarily focus on other populations, with a lesser KP focus. This is mostly adolescent and youth sexual and reproductive health (SRH) programming implemented by UNICEF and UNFPA which have a predominant general population focus.

Table 4 in Annex sets out the JP activities from 2018-2021 by priority area and the above three categories of activities. As shown by the table, 77% of all JP activities were KP focused or directly relevant to KPs. Of the 79 planned activities, 37 focus exclusively or significantly on either all KPs or a particular KP group (category 1 above), 24 are broader programmatic activities directly relevant to KPs (category 2), and 18 activities primarily focus on other populations (i.e., non-KP), with some limited reach to KPs (category 3).

Although the activities the JP is supporting are an appropriate mix of interventions, this is not a result of leveraging the comparative advantage of each UN agency due to the deprioritisation of HIV by some cosponsors. This has resulted in the UNAIDS CO undertaking activities which would normally be undertaken by cosponsors. Examples include activities related to PrEP, HIVST and sustainable financing.

The overall capacity of the JP to undertake KP relevant programming has been diminished by the deprioritisation of HIV work by a number of cosponsors. UNICEF has in recent years been phasing out from HIV work and is now focusing on integrated health services for adolescents, primarily targeting general population adolescents, mainly in the areas of SRH, teen pregnancy, mental health and adolescent nutrition. While UNICEF's broader integrated health work has some KP coverage, this is primarily incidental - the UNICEF supported online health platform for adolescents still has KP relevant content from previous UNICEF work, such as the Lovecare YM2M[168] content for young

[167] This section addresses the evaluation question "How relevant are the JP activities for addressing the needs and priorities of each key population group?"

[168] Online sexuality and health service with real-time counselling and referrals to sexually active young men including MSM and TG through chat rooms

MSM. In previous years, UNICEF has made valuable contributions to KP programming in areas such as efforts to improve the 90-90-90 cascade data collection and analysis, and national adoption of PrEP for adolescents. With the phasing out of its HIV specific programming, UNICEF's future contribution to KP programming will be significantly diminished.

UNFPA is taking a similar broad SRH approach, targeting vulnerable youth, but not specifically KPs. Their web-based work targets youth with disabilities and reached some hearing impaired sex workers, although they were not the primary target audience. Despite the division of labour, UNFPA has not been conducting any substantive sex work programming. Raks Thai Foundation work with vulnerable youth, funded by UNFPA, with some limited reach to PWUD/PWID and MSM, but without a significant HIV focus.

In 2021, the JP country envelope (CE) funding was allocated to UNDP, UNODC, UNESCO and UNFPA. UNDP and UNODC activities were exclusively focused on KPs. UNESCO was allocated USD 26,500 for school based comprehensive sexuality education and UNFPA was allocated USD 27,000 for SRH programming for vulnerable young people which is a significantly broader construct than KPs as defined by UNAIDS. This amounts to more than one-third of the CE. In 2020, UNESCO was allocated USD 20,000 from the CE for a review of sexuality education digital media, an activity which did not have a KP focus. Also in 2020, UNFPA was allocated USD 30,000 for youth led advocacy on SRH and condom promotion among general young people and young people with hearing impairments. All of these activities primarily had a general adolescent/youth focus, although of some relevance and likely limited reach to KPs. The key issue is given the limited CE funding of only USD 150,000 per year and Thailand's KP driven epidemic, there is a strong case for JP funding to prioritise high impact KP programming rather than funding for general population programmes. The issue is not whether there is a need for this broader type of programming but whether it is appropriate for limited HIV funding to be allocated to these activities. Deprioritisation of HIV by some cosponsors is further discussed in section 4.1.4 below.

A significant number of JP activities can be regarded as catalytic. Examples, which demonstrate key dimensions of catalytic activities (brokering role, leveraging of funding and partnerships, innovation, and scale up), some of which have delivered tangible results, are:

- Brokering and scale up: The UNAIDS CO brokered the development of PrEP target setting and a national M&E framework for PrEP that was used in a nationwide PrEP pilot. Following the UNAIDS CO supported evaluation of the pilot, PrEP was included in the UHC Scheme which enabled nationwide scale up. Data from the target setting exercise and the evaluation were significant factors in the decision to cover PrEP under UHC
- Innovation: Inclusion of PrEP for adolescents in national guidelines, including funding under UHC, following an adolescent PrEP pilot project funded through the JP and advocacy by UNICEF and the UNAIDS CO
- Brokering TA and leverage of convening power: The brokering role of UNDP in providing technical assistance on a range of human rights legal and policy issues and leverage of its convening power by bringing parliamentarians, government departments and KP CSOs to the table
- Additional funding and scale up: A UNAIDS CO commissioned national condom needs estimation study found a significant gap in UHC funding of free condoms. This resulted in scale up following a tripling of the annual budget from USD 0.94 million to USD 3.1 million

The catalytic nature of some JP activities is further explored in section 4.2.4 on the JP's contribution to outputs and intermediate outcomes.

Human rights and gender equality[169]

Collectively, the human rights and gender activities are an appropriate response to the significant limitations in the enabling environment in Thailand. There is an appropriate prioritisation of the most vulnerable KP groups: PWUD/PWID and transgender people, and to a lesser extent prisoners. Strong evidence: supported by good quality data and the majority of KIs.

Human rights is one of the four priority areas for each of the JP's annual plans since 2018. Human rights and gender equality has been a particularly strong focus of UNDP's work and is also a significant component of the UNAIDS CO and UNODC's activities.

UNDP's key activities have involved working together with a range of ministries, parliamentary committees and KP organisations in relation to:

- Development of strategic information on the human rights of KPs through commissioning a range of studies such as a national survey on experiences of discrimination and social attitudes towards LGBTIQ+ people in Thailand; qualitative research on stigma and discrimination against Thai transgender people in accessing health care and in other settings; and a legal and policy review of legal gender recognition in Thailand
- Evaluation of the implementation of the Gender Equality Act and a handbook designed to promote implementation of the Act by the Department of Women's Affairs
- Engagement with committees of the Thai parliament on a range of legal and policy issues relevant to KPs, particularly civil partnership registration of LGBTIQ+ couples, legal gender recognition of TG people, involuntary HIV testing in employment (with UNICEF), access to HIV services in prisons for PWID (with UNODC), and criminalisation of sex work
- Development of standard operating procedures (SOPs) for the management of transgender prisoners, integrating aspects of gender and human rights
- Training and sensitisation of law enforcement officers in engaging with TG people, PWUD and on sexual orientation, gender identity and expression
- Working with KP CSOs on S&D and equal access to health care and social services for transgender people and LGBT sex workers
- Training of TG sex workers to promote their economic empowerment.

A significant number of activities have taken an intersectional approach with activities with and for PWID/PWUD being predominant. These include multiple activities on female PWID/PWUD, LGBT PWUD, PWUD and all KPs, PWUD and prisoners, PWUD and YKP, and PWUD and MSM/TG/SW. This is appropriate as drug use is not uncommon among all KP groups. Some transgender focused activities have also adopted an intersectional approach: TG sex workers and TG prisoners. The JP's focus on Intersectionality goes beyond simply looking at overlapping communities of risk to examine how a range of factors can negatively impact on the human rights and HIV-related risks of various KPs. This is particularly the case for UNDP as it works with a range of sectors/ministries beyond health on broader enabling environment issues through an intersectional lens. The 2020 'Thailand Leave No One Behind Analysis: LGBTI, HIV Affected People and Sex Workers', led by UNDP and the UNAIDS CO, identified the human rights of KPs and the elimination of S&D as a critical intersectionality issue.

A distinguishing feature of Thailand's response to HIV-related S&D has been that it goes beyond just identifying the significance of the impact of S&D by adopting a series of concrete steps to monitor the status and progress of reducing S&D in health care settings. This has been done by setting measurable targets using standardized indicators and using the data collected to develop S&D reduction interventions. This includes extensive training of health care workers (HCWs) and the establishment of a web-based complaints mechanism. While these initiatives, in which the UNAIDS

[169] This section addresses the evaluation question "To what extent has the JP considered human rights, gender equality and more vulnerable populations in the design and choice of activities undertaken?"

CO has played a significant role, largely pre-date the 2018-2021 focus of this evaluation, the UNAIDS CO has been active in supporting the continued national roll-out of this work, including scale up of e-learning on S&D reduction for HCWs and enhancing the development of e-learning for nursing and medical students. Since 2020, UNAIDS, in conjunction with government and civil society partners, has taken a leading role in the development of a multisectoral costed national action plan for the elimination of S&D, accompanied by an M&E framework. The action plan is designed to broaden S&D initiatives beyond the health sector and to place an emphasis on S&D against KPs in addition to PLHIV. The UNAIDS CO is also funding the planning of work for the roll-out of the Stigma Index version 2. The S&D work supported by the UNAIDS CO relates to the wider UNAIDS Global Partnership on the Elimination of S&D.

Capacity and resources of the Joint Programme[170]

In summary, the low level of CE funding (not all of which is allocated to KP work) and the limited number of staff in Joint Team agencies are constraints on the capacity of the JP's work with and for KPs. This has been exacerbated by a contraction in the expertise available to the JP that has resulted from some cosponsors deprioritisation of HIV work. An increase in agency core funds for KP work has ameliorated limited CE funding. Strong evidence: supported by good quality data and majority of KIs.

The limited availability of financial and human resources are significant constraints for the work of the JP. Thailand's CE is only USD 150,000 per year which, along with Cambodia, is the lowest level of CE funding for Asia Pacific. Programming is heavily dependent on cosponsor agency core funds[171] which have increased from USD 208,500 in 2018 to USD 463,000 in 2021 (see Table 2 below). While mobilisation of agency core funds ameliorates the low level of CE funding, a significant proportion (32%) of core funds are spent on activities of limited direct relevance to the HIV needs and priorities of KPs (see Table 3 below). The JP has been successful in attracting BUF for innovative programming approaches. In 2021, USD 70,000 was allocated to increasing uptake of PrEP and HIVST among PWUD and in 2020 USD 80,000 was allocated to conduct an adolescent PrEP pilot project and advocacy for inclusion of PrEP for adolescents in national policy and the UHC benefits package.

Table 29: Joint Programme's annual budget, Thailand, 2018-2021

Year	Country Envelope	Agency core funds	Non-Core funds	Business Unusual	Total
2018	$150,000	$208,500*	-	-	$358,500
2019	$150,000	$208,500*	-	-	$358,500
2020	$150,000	$145,000	$118,300	$80,000	$493,300
2021	$150,000	$463,000	-	$70,000	$683,000

* A total of $417,000 from agency funds was available across 2018-19. It is assumed the funds were available in equal amounts for each year.

Table 3 sets out the JP's budget allocations for 2021 by source of funding (agency core funds, CE and BUF) to activities which are KP focused or relevant vs activities with a lesser KP focus. For 2021, 70% of total funding from all sources was budgeted for KP focused or relevant programming, with 30% of total funds spent on activities with a lesser KP focus or relevance. The total allocation for activities with a lesser KP focus was predominantly sourced from agency funds over which the Joint Team has no control. The total budget for activities with a lesser KP focus or relevance was USD 202,200 of

[170] This section addresses the evaluation question "To what extent are capacity and resources of the JP appropriate for work with and for KPs?"

[171] Agency core funds are regular or extra-budgetary resources of the Cosponsors; not funds the UNAIDS Secretariat mobilises and transfers to cosponsors.

which 74% was sourced from agency core funds and 26% from the CE. The agencies which allocated core funds to activities with a lesser KP focus were UNESCO, UNFPA and UNICEF, with all other active agencies undertaking only KP focused or relevant activities.

Table 30: Joint Programme budget allocation by source of funding and KP focus/relevance, 2021

Agency	Agency Core Funds		Country Envelope		Business Unusual Fund	
	KP focus or relevant	**Lesser KP focus**	**KP focus or relevant**	**Lesser KP focus**	**KP focus or relevant**	**Lesser KP focus**
UNAIDS	$190,000	-	-	-	-	-
UNDP	$18,519	-	$50,000	-	-	-
UNESCO	-	$10,000		$26,500	-	-
UNFPA	-	$10,000		$27,000	-	-
UNICEF	$55,000	$128,700	-	-	-	-
UNODC	$41,500	-	$46,500	-	$70,000	-
WHO	$9,346	-	-	-	-	-
Total	$314,365	$148,700	$96,500	$53,500	$70,000	
Percentage	**68%**	**32%**	**64%**	**36%**	**100%**	**0%**
	Total: $463,065		Total: $150,000		$70,000	

UNDP has been able to fund KP-related work from multiple sources in addition to core agency funds. There is a high degree of synergy in the work of the UNDP regional project Being LGBTIQ+ in Asia, which is funded by multiple donors, and the Thailand JP activities of UNDP. Funding from other donors has been leveraged to enable UNDP to undertake additional KP work beyond the auspice of the JP such as JICA funding for a training needs assessment and mapping of training for sex workers in Thailand.

Staffing levels devoted to KP programming are generally limited. Staffing of the UNAIDS CO is made up of the UNAIDS Country Director UNAIDS Country Director and an Administrative Assistant. This is somewhat ameliorated through technical support from one staffer in the UNAIDS Regional Support Team (RST) Asia Pacific in the area of strategic information (up to 30% level of effort (LOE)), and technical inputs from the RST on PrEP and human rights and law. There is no dedicated LOE for PrEP and human rights support. Competing demands to support regional and other country work limit the availability of these regional staffers. The UNAIDS CO has made good use of short-term consultants to address its limited staffing and also leverages the products of Thai research institutes and the work of external donors to further its agenda.

UNDP country office staffing for JP work is of 50% of the time of a Project Manager and 35% LOE for both a Coordinator and project assistant. UNDP regional office staffing support for Thailand work is 50% of a human rights and gender equality consultant and 50% LOE for one other staff.

While UNODC has significantly increased its JP work in Thailand over the last 2 years, a limiting factor is the work is undertaken by a three-person regional office team (2 program staff and one administrative position) as there is no country office. The competing demands of regional and other country work limit the time that can be spent on Thailand programming. UNODC highlighted the restriction on employment of staff with UBRAF funds as a problem.

The WHO country office used to have two medical officers who undertook a significant amount of HIV work but this work is now undertaken by one officer with many other responsibilities. This has resulted in the UNAIDS CO taking on much of the work that would normally be undertaken by a WHO country office, although WHO does provide technical inputs to the extent possible.

In 2018-2019 the WB funded two important studies relevant to the sustainability of KP programming in Thailand - an effective social contracting model for CSO HIV service delivery and a cost analysis of KP HIV interventions.[172] The WB has subsequently decided to deprioritise HIV work in Thailand due to its upper middle income status and relatively advanced status in relation to HIV programming, although Thailand has the option of purchasing advisory services from the WB. Ongoing work to address sustainable financing of KP services has now been taken up by the UNAIDS CO.

A key priority for the JP is to address the high rates of new HIV infections occurring among young and adolescent KPs. The expertise of UNICEF and UNFPA in working with youth and adolescent KPs would be beneficial but is largely not available to the JP due to their deprioritisation of HIV. UNICEF's shift to integrated health services programming for adolescents has been accompanied by HIV specialist staff leaving the agency which has further reduced their capacity to respond to the needs of KPs.

Despite the Division of Labour, UNFPA has not been undertaking any substantive work in relation to sex work or condoms. The UNAIDS CO led on the condom estimation work. UNFPA did undertake a small condom project in 2020 but the work was said to be ineffective due to its small scale.

Coherence of Joint Programme activities[173]

In summary, the JP's planning processes appear to be effective and result in a coherent set of KP relevant activities to address the four priority areas and related key challenges. Based on document review and interviews with UN agencies and their government, CSO and donor partners there is strong evidence that different agencies in the JP have effectively leveraged the UN's convening power to bring together the range of partners in activities of strategic importance to Thailand's HIV response. This is particularly the case for the UNAIDS CO and UNDP. Moderate evidence: supported by documentation and consultations with external partners and the JT, although more limited evidence on day-to-day collaboration within the JT.

The JP's annual plan is developed through a participatory process involving the UNAIDS CO and cosponsors and consultations with national and international donor partners. The Joint Team is updated with epidemiological data and national programme data and there is evidence that the plan is informed by an analysis of the data. For example, the prioritisation of PWID in response to low coverage rates. The plan is also informed by PEPFAR's sustainability index dashboard which is updated every two years through a collaboration between PEPFAR and the UNAIDS CO. The planning process seeks to identify key strategic priorities, including gaps and areas where the UN can add value. The UNAIDS CO states that the priorities of government and other partners are considered to ensure alignment with national needs and complementarity with the work of donors such as the Global Fund and PEPFAR. The Joint Team agrees on biannual outcomes for the nominated four priority areas: 1) HIV prevention, 2) testing and treatment, 3) human rights and S&D, and 4) investment, efficacy and sustainability. Following this, agencies are asked to develop activity proposals for presentation to the Joint Team. In developing proposed activities each of the JP agencies consults with relevant partners regarding complementarity, feasibility and opportunities for collaboration. These consultations are with relevant Ministries, the Global Fund principal recipient (PRs), PEPFAR and KP CSOs. Country envelope allocations are agreed by consensus.

Overall, the JP activities appear to coherently address the four priority areas. Activities intended to improve various components of prevention, testing and treatment programmes of relevance to all KPs are complemented by activities to address the specific needs of particular KPs, particularly the most underserved such as PWID/PWUD. While a human rights based approach is a common theme of most activities, human rights specific programming particularly focuses on access to health care and improving the enabling environment for KPs and is therefore coherent with activities in

[172] http://ihppthaigov.net/DB/publication/attachresearch/442/chapter1.pdf
https://www.hitap.net/documents/180532

[173] This section addresses the evaluation question "To what extent are the activities of the JP harmonised and aligned internally within the JP, and harmonised and aligned externally, with other actors' interventions in the country?"

prevention, testing and treatment. Activities on investment and sustainability of KP programming cohere particularly with the prevention, testing and treatment activities.

The extent to which the leadership of UN agencies is committed to KP programming appears to be variable. As indicated above, the bulk of KP programming work is being undertaken by 3 agencies, following deprioritisation of HIV work by a number of agencies. This diminishes the intent of the division of labour which is designed to leverage the comparative advantages of different agencies. Nonetheless, the UNAIDS CO, which has assumed responsibility for activities that would normally be undertaken by agencies such as WHO and WB, appears to be doing so effectively, although is no doubt overloaded.

Based on consultations with Joint Team members and an analysis of collaborative activities, it can be concluded that collaboration within the Joint Team has improved. Previously, Joint Team meetings were reported by some cosponsors to have primarily focused on updated reporting but are now seen as more collaborative. Examples of collaboration drawing on cosponsor comparative advantages include PrEP (UNICEF, UNODC, WHO and UNAIDS CO); prisons (UNODC and UNDP); discrimination against young PLHIV in employment (UNDP, UNICEF and UNAIDS CO). An example of one cosponsor brokering an entry point for another cosponsor is UNICEF, which has a long-standing relationship with the Department of Juvenile Observation and Protection and facilitated UNODC's initial contact with the Department in relation to capacity building on evidence-based drug use prevention for youth in the criminal justice system.

One agency stated the division of labour can result in a siloed approach when a more intersectional approach would be appropriate or, alternatively, a vacuum in work if an agency is not undertaking designated work according to the division of labour.

The UNAIDS Country Director is an active member of the CCM and has had a significant role in the development of funding proposals and in ongoing dialogue with the Global Fund Secretariat on strategic directions. There has also been collaboration between the UNAIDS Country Director and the two PRs. There has been liaison between UNODC and the Global Fund Secretariat in Geneva on harm reduction, including development of evidence-based guidelines on drug prevention, treatment and harm reduction, although to a lesser extent during the COVID-19 pandemic. A high level of collaboration between the Global Fund Secretariat and the WHO has reduced significantly because of the reduction in HIV staffing in the WHO country office.

There is close collaboration between the UNAIDS CO and PEPFAR in the development of the PEPFAR regional and country operational plans. UNAIDS takes an inclusive approach by suggesting KP groups to be invited to the PEPFAR annual 'town hall', beyond PEPFAR's CSO implementing partners. PEPFAR's work is focused on technical support for programming in KPLHS in 13 high burden provinces, with an emphasis on testing innovative approaches in reaching hard to reach KPs for HIV testing and PrEP or ART initiation. The comparative advantage of PEPFAR and its implementing agencies is technical expertise in generating evidence from innovative community-based programming. The complimentary comparative advantage of the JP is convening a range of national partners from government to civil society in considering adoption of evidence in policies and programming. Some KIs were of the view that government agencies were more receptive to normative advice from UN agencies than from bilateral donors. Sustainability of KP CSOs through UHC financing and CSO and CHW certification is a shared high priority area for PEPFAR and the JP.

Key informant interviews with government, CSO and external donor partners indicated that the KP-related work of the UN agencies is well regarded and indicated satisfaction with partnership arrangements.

Efficiency and effectiveness of Joint Programme activities

Implementation of activities[174]

Given the breadth of activities undertaken by the JP since 2018 it has not been possible for this evaluation to explore in detail whether they have been implemented efficiently, although some broad observations are possible based on KIIs.

The annual funding cycle for JP activities is problematic for work which requires longer time horizons, particularly in the areas of legislative and policy reform. Working with government departments, particularly non-health sector departments, can take extra time to negotiate approvals and this is compounded by government staff turnover which can result in the need for renegotiation and bringing new staff up to speed with the work. The problem of a short twelve-month implementation period is compounded by UBRAF funding disbursement delays.

One UN agency stated that activities only lasting 12 months results in more short-term project work and limits sustained efforts due to uncertainty on whether there will be continued funding, but did concede that UBRAF funding had helped to sustain some of their work on a longer term basis. The brevity of the one-year implementation period was mitigated to some extent by a continuation of activities in the following year in those years when roll-over of funds was permitted. In addition, several activities are designed to build on the work undertaken in previous years.

Not surprisingly, all agencies encountered COVID-19 related delays in implementation due to multiple pandemic waves and lockdowns.

A number of KIs both in UN agencies and in partner organizations stated there were advantages in having Thai national staff in UN agencies due to better knowledge of the local context which results in more effective coordination with local partners, and the lack of language barriers, particularly in liaison with mid-level government officials who may not be confident in speaking English. Most UN staff interviewed for this evaluation were Thai nationals.

UN agencies with both a regional and country offices in Bangkok were seen as having a comparative advantage to agencies with only a regional or country office as regional staff provided additional LOE and opportunities for collaborative work.

There is some evidence of the work of the Joint Programme at global and regional levels influencing country level work. For example, UNDP's regional study on legal and policy trends impacting PLHIV and KPs in Asia Pacific has informed the Thailand country office work. Similarly, UNDP's regional level work in mapping good practices in the management of TG prisoners was taken up by UNDP Thailand in its work with the Department of Corrections. UNDP Thailand work has also influenced work in other parts of the region. The recent situational analysis of substance use among LGBTIQ+ communities in Thailand has informed UNDP's Global Fund work in Pakistan. More generally, UN normative best practice guidance documents were seen by one UN agency as being too long. Language can also be a barrier.

[174] This section addresses the evaluation questions: "How well is the JP implementing the activities for KPs and achieving the UBRAF outputs? Which areas require further strengthening and why?" The contribution to UBRAF outputs is discussed in Section 4.2.4.

The contribution of JP activities to outputs and intermediate outcomes is discussed in 4.2.4 below.

Support in mobilising and empowering key population led organisations[175]

In summary, there is evidence that the UNAIDS CO and cosponsors use their convening power to ensure a seat at the table for KP-led CSOs, particularly for smaller organisations from more marginalised KP groups, including consideration of issues that would not be on the agenda in the absence of JP facilitation. KP CSOs and PLHIV groups have played a key role in development and monitoring of Thailand's S&D elimination initiatives. Moderate evidence: supported by a majority of KIs.

A common characteristic of the work of the UNAIDS CO and UNDP has been leveraging of their convening power to bring government ministries and KP CSOs around the table to consider law reform, policy development, new areas of programming and monitoring the implementation of services. For UNDP, this has enabled joint government and community consideration of issues that would not have been considered in the absence of UNDP's initiative, such as management of transgender prisoners. The UN's convening power has been particularly important in facilitating a place at the table for the smaller CSOs, and particularly for CSOs representing the more marginalised groups such as TG people and PWID, and conversely less important for the larger and well established MSM and SW CSOs. The Department of Rights and Liberties Protection stated that UNDP has played a valuable role in identifying relevant smaller CSOs to be involved in its work which extended beyond the larger, well known CSO groups.

Support for KP organisations to undertake community led monitoring is primarily being provided under PEPFAR, although the UNAIDS CO has been continuously supporting the involvement of PLHIV groups in the national S&D monitoring framework. Recent examples of ongoing support are PLHIV involvement in the working group developing the costed national action plan on S&D and accompanying M&E framework and the recent initiative by the UNAIDS CO to support a PLHIV led working group to oversee the study protocol development and roll out of the Stigma Index version 2 survey.

Over the past 5 years UNICEF has been supporting the capacity development of the Network of Youth Living with HIV (TNY+). This has included capacity development on advocacy regarding S&D in employment, particularly focusing on pre-employment HIV screening and workplace S&D. This has included facilitating TNY+ representation on the Thai National AIDS Foundation subcommittee on the promotion of PLHIV rights and, in collaboration with UNAIDS CO and UNDP, linking the network with the Employers' Confederation, the Ministry of Labour and parliamentarians to address workplace S&D.

Response to COVID-19 pandemic[176]

CSOs and Joint Team members reported that COVID-19 resulted in a significant adverse impact on access to HIV services due to lockdowns and a reluctance of people to visit clinics. In July 2020 the JP issued a statement calling on government and all partners to ensure the provision of quality, non-discriminatory HIV and other health services to KPs and migrants in the context of the COVID-19 pandemic and to rapidly adapt service provision to take into account the new realities of the COVID-19 pandemic. In addition, the UNAIDS CO translated COVID-19 information into Thai and widely disseminated this to KP CSOs to provide essential information to KPs. UNOCD has undertaken COVID-19 training, inclusive of HIV prevention, for health care staff in the Department of Corrections to strengthen the emergency preparedness of the correctional health system.

[175] This section addresses the evaluation question: "How effective are the JP activities in mobilising and empowering KP-led organisations and networks in monitoring and accountability of policies and programmes and the implementation of services?"

[176] This section addresses the evaluation question: "How effective has the JP been in responding to humanitarian and other emergencies that affect KPs during the COVID-19 pandemic?"

The National AIDS Commission, MOPH, UNAIDS CO, WHO, PEPFAR and PLHIV and KP groups promoted multi-month dispensing (MMD) of ARVs. Data from PEPFAR supported sites in 13 provinces indicated a significant increase in MMD of ARVs from the beginning of the pandemic through to Q3, 2021. Continued access to ART was facilitated by MMD and community dispensing having been incorporated in national treatment guidelines prior to the advent of COVID. Continued access to ART was also facilitated by Thai Network of Positive People (TNP+) and KP CSOs who provided home delivery by peers and post. TNP+ undertook a thorough assessment of COVID-related barriers to accessing treatment services and in consultation with government authorities and hospitals, developed a comprehensive set of work-arounds to overcome problems, particularly for access to ARVs. With technical assistance from the UNAIDS CO, TNP+ developed recommendations for improving HIV service systems and policies, based on lessons learned during the COVID-19 pandemic.[177]

CSOs reported that COVID-19 lockdowns inhibited their ability to conduct outreach and recruit people at risk for HIV testing, although the evaluation does not have data on the extent of the impact. It is also likely that the pandemic reduced demand for PrEP as people were reluctant to visit health services. The impact on PrEP may have been mitigated by the pre-COVID dispensing modality of 1-3 months, with potential for moving to 3-6 months for those with good adherence. At the national level, there were generally no problems with the supply chain for ARVs during COVID-19, but PrEP supplies were disrupted. In response, KP clients were informed of different options for effective use of PrEP.[178] KPLHS such as SWING, a sex work CSO, kept their clinics open to ensure ongoing access to HIV testing and PrEP and worked with government clinics to ensure ongoing access to ART and COVID-19 testing.

COVID-19 had a particularly severe economic impact on sex workers due to the closure of entertainment establishments. A rapid survey of sex workers by SWING, with financial and technical support from the UNAIDS CO, found that almost all could no longer work and had lost all income because of the lockdown and closure of entertainment venues. Most were unable to cover the costs of food and shelter. Sex workers were not eligible for COVID-19 related government financial assistance which stemmed from the criminalisation of sex work and not being regarded as employees.[179] This highlighted the marginalisation of sex workers in Thailand and pointed to the need to decriminalise sex work and ensure that sex workers are entitled to equal labour rights and inclusion in government social protection programs. An article on SWING's survey was published in WHO's regional public health journal, highlighting the opportunities to build back better in regard to the marginalisation of SWs. CSOs such as SWING and Raks Thai Foundation mobilised funding from various sources to provide food and other basic necessities, including personal protective equipment (PPE), to the most affected KP groups. SWING's rapid assessment was used for advocacy, resulting in USD 15,000 funding from the British Embassy to assist in SWING's COVID-19 mitigation activities.

Some reprogramming of UBRAF funds allocated to UNDP and UNODC was allowed to enable cosponsors to respond to the pandemic. UNDP provided small grants of around USD 10,000 each to four SW and LGBTIQ+ CSOs in Bangkok and 3 provinces to procure necessities such as food, water and PPE over a three-month period for 3,200 LGBTI sex workers.

While some countries included PLHIV within the groups given priority access to COVID-19 vaccination, this was not the case in Thailand. Two recent papers in the Lancet HIV "add to the accumulating evidence for worse outcomes for people with HIV and support early guidance that people with HIV, particularly those with immune suppression, should be prioritised for COVID-19 risk

[177] TNP+, Role of the Continuum of Care Centre, CCC and TNP+ in response to the COVID-19 pandemic. June 2020. pp. 5-6.
[178] UNAIDS Regional Office for Asia and the Pacific, A rapid assessment of multi-month dispensing of antiretroviral treatment and pre-exposure prophylaxis in the Asia-Pacific Region. August 2020. p. 45.
[179] Janyam, S. Phuengsamran, D. Pangnongyang, J. et.al., Protecting sex workers in Thailand during the COVID-19 pandemic: opportunities to build back better. WHO South-East Asia Journal of Public Health, 9(2). 2020.

reduction, including vaccination."[180] This was not an issue addressed by the JP in advocacy to the MOPH, perhaps because there was less evidence on this until recently.

In summary, KP CSOs, with the support of some JP agencies, were active in attempting to mitigate the impact of the COVID-19 pandemic on access to HIV services and basic survival. Measures to ensure ongoing access to treatment services appear to have been effective, although outreach prevention services were curtailed. The social and economic impact of COVID-19 was particularly severe for the most marginalised KPs such as SWs. While KP CSOs made sustained attempts to lessened these impacts, with some JP support, the scale of the problem may have limited impact.[181]

Contribution of the Joint Programme to outputs and intermediate outcomes[182]

This section outlines the key areas where the JP has contributed to outputs and intermediate outcomes as defined in the JP's Theory of Change that was retrospectively developed for this evaluation. JP contributions are grouped under relevant outputs and related intermediate outcomes.

Comprehensive and integrated services

JP output	JP intermediate outcome
People centred comprehensive service packages established and innovative service delivery models	Increased provision of comprehensive and integrated service packages targeting KPs including YKPs in user friendly & safe settings

PrEP[183]

In recent years, in recognition of the need to scale up PrEP, Thailand has been consolidating a range of primarily donor funded PrEP implementation models into a national PrEP programme, covered under the UHC scheme. From 2016 to Q3, 2021, the number of people enrolled on PrEP increased more than 13 times to 16,434 but was still well short of the estimated need for PrEP.[184] The JP, in collaboration with other partners, particularly DAS, NHSO, PEPFAR and the Institute for HIV Research and Innovation (IHRI), has been involved in a number of complementary PrEP initiatives designed to scale up access to PrEP and secure sustainable UHC financing including:

- Target setting: In 2019, the UNAIDS CO commissioned a study on estimation of PrEP targets for key and high-risk populations in Thailand in order to assist government agencies in considering the inclusion of PrEP under UHC coverage. The study, which was based on global UNAIDS guidance for PrEP target setting, estimated that for the year 2020, 148,500 persons nationally would benefit from PrEP.
- M&E framework: Also in 2019, the UNAIDS CO, in collaboration with DAS, NHSO and local partners commissioned international consultants to develop an M&E framework for a planned national pilot of PrEP, using standardised indicators across all providers which are compatibility with the UHC compensation mechanism.
- PrEP pilot: In 2020, the NHSO launched a national 12-month PrEP pilot project involving 2,000 enrolees in a mixture of service centres, including KPLHS, using the recently developed M&E

[180] Boffito, M. and Waters L., More evidence for worse COVID-19 outcomes in people with HIV. The Lancet HIV. Vol 8:11. November 01, 2021.
[181] Moderate evidence: good evidence on KP CSO and JP measures to migigate impacts but limited evidence on the outcomes of these measures.
[182] This section addresses the evaluation question "How effective is the JP in contributing to the intermediate outcomes 1) provision of comprehensive services for KP groups, including the most vulnerable KP groups, 2) promotion of human rights, gender equality and removal of discriminatory laws and S&D, and 3) sustainable financing and programming mechanisms for KP groups?" The contribution of the JP to UBRAF outputs is also considered in this section.
[183] Strong evidence: JP role was significant in the range of PrEP initiatives which were reported by multiple key informants as being influential in scale up and funding decisions.
[184] UNAIDS Thailand, Estimation of PrEP for Key and High-Risk Populations in Thailand, 2020-2022. 2019 and Shwe, YY, Overview and Progress of HIV Epidemic and Response in Thailand. 2021 (Powerpoint).

framework. The UNAIDS CO leveraged funding from the Global Fund for the pilot and provided a significant level of technical support. The pilot was successfully implemented with no adverse findings in relation to risk compensation, STI incidence and HIV seroconversions. The positive findings of the evaluation were reported by multiple KIs as being important in the decision of the NHSO to include PrEP in the UHC benefits package. PrEP has now been scaled up to 150 health facilities and there is currently no cap on the number of people who can be enrolled.

- Extension of PrEP to adolescents: Following an adolescent PrEP pilot project funded through the JP and advocacy by UNICEF and the UNAIDS CO, PrEP for adolescents has now been included in national guidelines and included in the UHC benefits package.

The JP's contribution as outlined above will assist with the scaling up of PrEP to maximise its potential in reducing new infections. The PrEP initiatives are linked to the JP's work to secure sustainable funding for KPLHS as they are the major service provider for PrEP. The extension of PrEP eligibility to adolescents is important given the high number of new infections among young and adolescent populations.

The adolescent PrEP project overseen by UNICEF is a good example of brokering an influential partnership to achieve the desired outcome. Siriraj Hospital, a leading teaching hospital in Bangkok was chosen as the pilot site as it a highly respected and influential hospital with a strong paediatric unit, with professorial staff sitting on high level national health committees. Beyond UHC funding, lessons learned from the pilot were incorporated into the national prevention guidelines such as the need for active adolescent recruitment in the community and through online platforms.

The JP's current PrEP initiative is collaborative work between UNODC, IHRI and the Ozone Foundation, a PWID/PWUD CSO, to assess effective implementation models for increasing PrEP uptake and HIVST for PWID as part of a comprehensive harm reduction package, with a model of service delivery that will be fundable under UHC to ensure sustainability.

Condoms[185]

The UNAIDS CO played a key brokering role in support of a national condom needs estimation study conducted in 2019 as a key part of development of the National Condom Strategy 2020-2030. The study used the global level "Condom Needs and Resource Requirement Estimation Tool" developed by the UNAIDS Secretariat and UNFPA and found a significant gap in UHC funding for free condoms. The study and revised National Condom Strategy resulted in the NHSO tripling the annual budget for condom procurement from USD 0.94 million to USD 3.1 million and an improvement in NHSO logistics management to ensure a more effective distribution system.

Harm reduction

UNODC has undertaken various training activities to improve the capacity of government and CSO service providers in evidence-based drug use prevention and treatment, including harm reduction. This has encompassed a broad range of areas including harm reduction approaches to stimulant drug use, community-based drug treatment, gender mainstreaming and addressing the needs of YKPs and female PWID and PWUD. There is evidence of UNODC activities influencing the programming approach for PWID/PWUD in the current Global Fund grant and evidence of UNODC guidance being adopted in CSO service provision.[186]

In addition, UNODC has been advocating for the implementation of comprehensive HIV and hepatitis C programming for PWID, including harm reduction, and the need for scale up. The new narcotics law appears to present an opportunity to significantly improve Thailand's response to drug use. There is insufficient evidence to conclude whether advocacy by UNODC and others on the need for evidence-based approaches to drug use has contributed to adoption of the new law.[187]

[185] Strong evidence: the role played by the UNAIDS CO in brokering these activities is supported by documentation and interviews, with the NHSO indicating the UNAIDS COs work resulted in the increased funding.
[186] Limited evidence: supported by some consultations and documentation.
[187] Strength of evidence: there is insufficient evidence to make a ranking.

HIV self-testing (HIVST)

HIVST is one of the innovations in HIV programming that has not yet been taken to scale. In April 2021 the Thai FDA approved 2 HIVST kits for commercial sale. The UNAIDS CO is currently partnering with DAS, PEPFAR, WHO and KP groups to develop (by late 2021) and roll out national HIVST guidelines. The UNAIDS CO and PEPFAR have played an important brokering role to give impetus to this work.[188] Given that S&D is a barrier to HIV testing, resulting in the below target rates of HIV testing among KPs, HIVST has the potential to significantly increase KP HIV testing rates. This could assist in reducing late diagnosis of HIV infection and late treatment initiation.

Bangkok Fast Track Cities initiative[189]

UNICEF, UNODC and the UNAIDS CO have, in partnership with PEPFAR and IHRI, supported enhancing the Bangkok Metropolitan Administration's (BMA) health services as part of the global Fast Track Cities initiative. Key achievements have been sustained political leadership to achieve Fast Track targets; significant improvement in performance against the 90-90-90 targets; integration of HIV testing into all BMA primary health care centres, with a 90% uptake rate for same day initiation of ART; launching of BMA ARV Service Centres to integrate HIV treatment into primary care to improve access; TA to strengthen STI programming; strengthening of KPLHS services resulting in higher HIV testing and PrEP uptake rates, including for young people; and documentation of accomplishments to use lessons learned in expanding the initiative to other cities. As a result, Bangkok received the Circle of Excellence Award from the Fast Track Cities Institute in Lisbon in October 2020.[190]

Improved tracking of 90-90-90 data[191]

In 2018-2019, UNICEF and the UNAIDS CO collaborated with the MOPH to improve data management and tracking of performance against the 90-90-90 targets by addressing problems with under reporting and duplicate reporting from different data sources. A roadmap was agreed for rebuilding the HIV data management system in order to harmonise data from multiple sources to more effectively track the 90-90-90 indicators. This work, coupled with follow on work by US-CDC to disaggregate 90-90-90 related data by KP in 13 high burden provinces, has resulted in a significant improvement in the quality of data inputs to measure the 90-90-90 indicators.

Policy and legal reforms and stigma and discrimination

JP outputs	JP intermediate outcomes
▪ Legal and policy reforms catalysed and capacity for legal and literacy and access to justice expanded ▪ Constituencies mobilised to eliminate stigma and discrimination in different settings	▪ Policy changes enacted ▪ Removal of criminal and discriminatory laws ▪ Stigma and discrimination reduced

Stigma and discrimination

The UNAIDS CO has continued to support Thailand's health facility-based S&D reduction initiatives. The intervention package has moved from piloting to national scale up, although coverage of S&D interventions in health facilities is still regarded as low. To increase scale up the UNAIDS CO has supported HCW e-learning curriculum development and roll out. In Bangkok, 90% of city council health care clinics have participated in e-learning and by 2020, 20,000 HCWs in 71 out of 77 provinces had completed the e-learning module. Baseline, endline and follow up surveys among recipients of S&D interventions are used to measure the impact of S&D interventions and refine future work. There is evidence of a reduction in S&D by HCWs, but the extent of the reduction shows that progress is incremental and sometimes not particularly significant. For example, HCW fears of

[188] Moderate evidence: in relation to brokering role only as the guidelines are currently in development and the outcome of the work is unknown.

[189] Limited evidence: supported by some consultations and documentation.

[190] https://www.unaids.org/en/resources/presscentre/featurestories/2021/october/20211028_bangkok

[191] Moderate evidence based on a limited number of consultations.

HIV infection dropped from 61% in 2015 to 52% in 2019, and stigmatising attitudes from 85% to 81%.[192] [193]

The UNAIDS CO has played a brokering role in supporting more than 30 partners from government, civil society and private sector in the development of a costed five-year national multisectoral action plan on S&D to broaden S&D mitigation measures beyond the health sector and to focus on KPs in addition to PLHIV. The plan, with an M&E framework, has been completed and endorsed by the DAS National Subcommittee on Human Rights Protection and Promotion.

Human rights and legal and policy issues

UNDP has been playing an important brokering role in providing technical assistance on a range of human rights legal and policy issues and bringing parliamentarians, government departments and KP CSOs to the table. "There is a large body of international evidence demonstrating that decriminalisation and introduction of protecting and enabling laws [and policies] result in significant health benefits to key populations by reducing stigma and supporting improved access to health and HIV services."[194]

While it can take time to achieve results, particularly for law reform, there is evidence of contribution to Joint Programme outputs through incremental progress regarding influencing the legislative and policy agenda, increased legal and policy literacy among KP CSOs, and effective training of government officials and the private sector on human rights.[195]

UNDP has had a long-standing relationship with the Department of Rights and Liberties Protection in the Ministry of Justice in providing technical inputs on a draft civil partnership registration bill for LGBTIQ+ couples. While consideration of the Thai Government's Bill on civil partnerships is making slow progress, UNDP's inputs, including facilitating the involvement of a range of LGBTIQ+ community groups in liaison with the Department and the relevant parliamentary committee, have been highly valued by the Department and CSO groups.

In other legislative work, UNDP facilitated a consultation with a parliamentary committee and TG CSOs on proposals for a gender recognition law. This resulted in agreement to merge four CSO sponsored drafts laws into one, which should help this initiative move forward.

In 2019, UNDP partnered with the Department of Rights and Liberties Protections to develop a curriculum to sensitise law enforcement agencies and correctional facilities on sexual orientation, gender identity and expression (SOGIE). The SOGIE curriculum has been incorporated as a module in the Department's human rights curriculum for law enforcement officers. Training is conducted at least twice a year, with the active participation of LGBTIQ+ CSOs.

UNDP in partnership with the Sisters Foundation, a Pattaya based TG CSO, has been conducting ongoing training of local police to address S&D towards TG SW. The Sisters Foundation reports that there has been a reduction in complaints from TG women regarding police harassment and improved relations with the police.

Another UNDP partnership with the Department of Liberties and Rights Protection has involved training to address discrimination in employment against LGBTIQ+ people in the private sector. This work has supported the Department's national action plan on business and human rights which encourages private sector employers to have a policy on LGBTIQ+ inclusion. A range of LGBTIQ+ CSOs participate in the training. The Department reports positive feedback from the private sector, particularly large companies.

The Department of Women's Affairs values the UNDP supported evaluation of the Gender Equality Act and UNDPs capacity building of officers through the training curriculum and handbook on

[192] UN Joint Team on AIDS, Thailand 2020 Joint Programme Monitoring (JPMS) Report, 2021. p. 2.

[193] Strong evidence: supported by MOPH and JP documentation.

[194] UNDP, Legal and policy trends impacting people living with HIV and key populations in Asia and the Pacific 2014-2019. 2021. p. 7.

[195] Strong evidence: these outputs were clearly evident from a range of interviews with government departments and KP CSOs.

implementation of the Act. The Department also values the links with CSOs that UNDP had facilitated. The Department regards the recent UNDP commissioned training needs assessment for sex workers as very useful in identifying quality of life issues for SWs and the limited opportunities for alternative employment training and says it now has a better understanding of SW's training needs. The need to empower SWs was identified by the Department as a key need.

While progress on development of SOPs for improving the management of TG prisoners has been slow, the Department of Corrections (DOC) has indicated their recognition of the vulnerability of TG prisoners and a commitment to improving their rights. When formally adopted, the SOPs will form the basis for training of prison officers. The DOC indicated that it was not possible to follow UNDP advice on all aspects of management of TG prisoners where this conflicted with laws relating to the incarceration of prisoners. Nonetheless, adoption of the SOPs and their implementation should result in an improvement in the rights-based treatment of TG prisoners. The DOC indicated their high degree of satisfaction with UNDP's role in sharing international best practice as they do not have the resources to undertake this type of research. The DOC indicated it will sign the Memorandum of Understanding with UNDP which will form the basis of an ongoing working relationship.

Resource mobilisation and sustainable funding

JP outputs	JP intermediate outcome
▪ Domestic and external resources mobilised on NSPs ▪ Sustainable financing mechanisms for health and other social sectors	▪ Sustainable financing mechanisms and integrated KP services implemented

Resource mobilisation

As indicated above, JP outputs on PrEP were a significant contribution to achieving the intermediate outcome of inclusion of PrEP in the UHC Scheme and a substantial increase in UHC funding for free condoms. For PrEP, this has allowed a transition from donor supported funding to government funding. UHC funding for PrEP and condoms can be regarded as sustainable.

Harm reduction funding

A 2019-2020 Integrated bio-behavioural survey (IBBS) for PWID in Bangkok and 2 provinces with technical support from the UNAIDS CO filled a gap in evidence on risk behaviours and service coverage. The survey, which not surprisingly found a need for scale up of comprehensive treatment and harm reduction programmes, including CSO services, was used by the UNAIDS CO to inform Thailand's funding proposal for the current Global Fund grant.[196] Similarly, findings from a 2018 UNODC/UNAIDS CO supported survey on the availability of HIV and related services in Thai prisons was used to inform scale up of services under the current Global Fund grant and has been used to inform UNODC training in prisons.[197]

Sustainable financing for CSOs

A key objective of the JP is to secure sustainable financing for KPLHS under UHC. Although CSOs currently receive some UHC funding, they are primarily funded by the Global Fund and PEPFAR. A prerequisite for the extension of UHC funding to CSOs is the certification of CSOs and the accreditation of their CHWs. A key initiative by the UNAIDS CO to advance the sustainable financing agenda was brokering a study on international best practices for certification of CSO CHWs. The UNAIDS CO also worked with the MOPH in the development of national guidelines on certification of CSOs and accreditation of CHWs. In 2019 the MOPH issued a regulation for the certification of CSOs as providers of selected clinical services including HIV screening and dispensing of PrEP and ART prescribed by a physician. In 2020 the MOPH issued a CHW Certification Implementation Guide.[198]

[196] Moderate evidence: supported by documentation and consultations.
[197] Limited evidence: supported by some consultations and documentation.
[198] Strong evidence: the role played by the UNAIDS CO in brokering these activities is supported by documentation and interviews and there is a clear link to achievement of the certification regulation.

The work on CSO and CHW accreditation and certification complements two World Bank commissioned studies, one on social contracting models for CSO service delivery and a cost analysis of KP CSO service interventions. These studies have formed the basis for productive discussions involving NHSO, MOPH and the UNAIDS CO on finding a suitable model for the social contracting of CSOs providing HIV services, including the KPLHS model. While this is still a work in progress, there is recognition by the MOPH and NHSO of the value of CSO services and their comparative advantage in reaching hard to reach populations and the need to establish a sustainable financing system under the UHC benefits package to replace donor funding. The objective is for accredited CSO services to be recognized as a core part of the health system and to be funded using equivalent or similar systems as are used for government health services. The UNAIDS Country Director is giving high priority to this work. KII indicate there is agreement in principle by government counterparts with the funding concept so the prospects of success appear to be promising.

KPLHS currently contribute approximately 50% of the number of new HIV diagnoses in Thailand and around 60% of enrolment in PrEP, despite only working in 10 sites. A sustainable financing mechanism for KPLHS may facilitate scaling up of this model which in turn could result in an increase in HIV diagnoses and enrolment in treatment and an expansion of PrEP coverage.

Response to contextual factors[199]

The strategic focus of the JP appears to match Country needs. The problem is that there are significantly fewer UN agencies undertaking KP programming, resulting in a heavy workload for the remaining agencies. In effect, the sense of complacency or deprioritisation of HIV programming is not just an external contextual factor; it is also occurring within the Joint Programme.

In many countries the key contextual factors for KP HIV programming are decreasing overall funding as external donors phase out support and conservative socio-political environments which can be hostile to KPs. In Thailand, while donor support for HIV has reduced over time, there has been an increase in government funding (see Section 2.4). Total HIV funding has been quite stable in recent years, with a modest increase in total available funding. Although there is a well-documented need for an improvement in the enabling environment for HIV, particularly in regard to marginalised KPs, Thailand has not seen a conservative backlash in relation to groups such as gay men and other MSM, as has occurred in some other south-east Asian countries. While much is still to be achieved in the areas of legal and policy reform, incremental progress in various initiatives is evident.

In Thailand, the key contextual factor is that the county's overall successful response to HIV is leading to a degree of complacency and deprioritisation for HIV programming. This is compounded by Thailand's upper middle income status, which is resulting in a reduction in external support. This is reflected in the low level of Thailand's UBRAF CE funding of only USD 150,000 per year. There is the danger that the success of Thailand's response leads to the assumption that Thailand is on course to successfully reach the goal of ending AIDS by 2030. While Thailand has notched up many considerable HIV achievements and continues to do so, there is still much to do to realise the ambitious 2030 goal of ending AIDS.

The response of those UN agencies that remain active partners in KP programming has been to focus on key priorities to address the challenges that must be met if Thailand is to successfully meet the 2030 target. These key priorities primarily relate to scaling up evidence-based approaches to KP prevention, testing and treatment programming, enhancing programme coverage, especially for the most marginalised KPs such as PWID/PWUD, TG and prisoners, improving the enabling environment, and ensuring the long-term financial sustainability of KPLHS.

[199] This section addresses the evaluation question: "How well is the JP responding to influential contextual factors such as the increasingly conservative political environment and decreasing resources and other factors for HIV and KP programming?"

Sustainability of the results of the Joint Programme's activities[200]

The JP's contribution to inclusion of PrEP in the UHC benefits package and leveraging increased UHC funding for condoms is highly likely to be sustainable. For PrEP, Thailand is no longer largely reliant on donor funding. In effect, PrEP and increased condom funding are now a part of recurrent government UHC expenditure. This is a major contribution to sustainable financing of the two primary combination prevention products.

The system for accreditation and certification of CSOs and CHWs has been adopted by way of government regulation so is seems sustainable. This is a significant contribution as accreditation and certification are preconditions for an extension of UHC financing for KPLHS. As outlined in section 4.2.4, consideration of extending UHC funding of CSOs is well advanced and the prospects of achieving this goal appear to be promising. If this is achieved this will be a major step in securing the sustainability of KP HIV services.

The health sector's systematic framework for S&D reduction, initiated in 2014, has been sustained through ongoing training of HCWs, regular monitoring of the levels of S&D using standardised indicators, the use of this data to inform the development of S&D reduction interventions, and the Crisis Response System to respond to complaints. The level of commitment by the MOPH, the JP and PLHIV and KP CSOs to ongoing roll out of the S&D framework appears strong, as is evidenced by the recent development of a multisectoral S&D elimination strategy to broaden the scope of this work beyond the health sector. The systematic framework approach increases the likelihood of sustainability, although ongoing prioritisation and commitment by key partners will be needed to ensure this.

Given that progress in achieving KP-related human rights legislative and policy reforms has been slow, achievements have been more at the output rather than outcome level. Progress regarding influencing the legislative and policy agenda and increased legal and policy literacy among KP CSOs, along with a high degree of commitment by UNDP and a reasonably receptive attitude by key government departments provide a basis for building on outputs and possibly achieving sustainable results.

The sustainability of harm reduction programming for PWID is not assured as this is primarily financed through the Global Fund. Prospects for sustainability may in large part be determined by whether the new narcotics law provides an opportunity to scale up evidence-based approaches to drug use and treatment.

Conclusions and considerations regarding future priorities for the Joint Programme

Summary conclusions: status of Thailand's key population response

The focus of JP activities in the time frame within the scope of this evaluation (2018-2021) has been to seek to enhance the considerable foundations of Thailand's overall successful response to HIV by focusing on the key challenges facing KP programming. The positioning of the Joint Programme has been to focus on evidence-based technical assistance in key areas of strategic significance to improving KP programming such as scale up of PrEP. In carrying out its work the JP has brokered a broad range of partnerships including with government ministries, civil society, research institutes and multilateral and bilateral donors. A key feature of this work has been to facilitate space for key population-led groups in decision making processes.

[200] This section addresses the evaluation question "How sustainable are the results of the JP's work, including for KP-led organisations and KP-led responses?"

The key contributions of the JP have been in the areas of sustainable financing of PrEP and condoms, its contribution to shaping Global Fund programming, ongoing involvement in national initiatives to reduce stigma and discrimination, the Bangkok Fast Track Cities initiative, the development of CSO and CHW accreditation and certification systems and the foundational work in identifying options for social contracting of CSOs.

While the enabling environment work in the area of human rights law reform and policy has been slow to achieve results, there has been incremental progress in regard to influencing the legislative and policy agenda, increased legal and policy literacy among KP CSOs, and effective training of government officials and the private sector on human rights.

It is possible that ongoing advocacy by the JP and others on the need for evidence-based programming in relation to drug use prevention and treatment, including harm reduction, has contributed to the new narcotics law, although there is insufficient evidence to come to this conclusion.

If the current work of NHSO, MOPH and the UNAIDS CO results in a sustainable UHC financing mechanism for CSOs this will represent achievement of one of the intermediate outcomes in the Theory of Change developed for this evaluation – "sustainable financing mechanisms and integrated KP services implemented". This in turn would provide a pathway for, over time, achieving one of the strategic priority outcomes – "KP high impact HIV services are fully resourced, sustainable, efficient and integrated in social safety net protection mechanisms".

Given the potential for KPLHS services to increase coverage of KP services based on their comparative advantage in reach, sustainable financing may potentially contribute to achievement of the Theory of Change intermediate objective – "increased provision of comprehensive and integrated service packages targeting KPs in user friendly/safe settings". This in turn would provide a pathway for, over time, achieving another of the strategic priority outcomes in the Theory of Change – "equitable and equal access to KP high impact HIV services and solutions maximised – which is also a strategic priority outcome for the UNAIDS Global Strategy 2021-2026".

Future considerations for the Joint Programme

The key priorities of the JP should continue to be informed by an analysis of key opportunities and challenges facing KP programming. In the development of future work plans consideration should be given to the following areas.

Country envelope funding
Given the limited amount of CE funding, the KP-driven nature of Thailand's HIV epidemic and the many competing high priorities for funding, consideration should be given to only funding KP-specific activities in future JP annual plans. While the need for general population focussed programming such as adolescent and youth SRH and sexuality education is important, and of relevance to KPs, greater impact will be achieved by funding of KP focused activities.

HIV prevention for YKP
There is a need for technical support for HIV programming tailored to young and adolescent KPs, particularly MSM, MSW, TG and PWID/PWUD that is age and gender sensitive, particularly in the areas of demand creation, integrated STI/HIV prevention and harm reduction.

PrEP
While sustainable financing of PrEP, which has been achieved, is a pre-condition for national scale up, it is unlikely to be sufficient. Additional areas of work may include demand creation, promotion of the benefits of PrEP to prescribers, extension of the availability of PrEP through additional hospitals and clinics, etc. The issues of PrEP adherence and discontinuation of PrEP may also need to be addressed.

HIV testing and linkage to care and treatment
As previously outlined, late HIV diagnosis which results in significant delays in HIV treatment initiation is a long-standing issue in Thailand. The JP should prioritise activities to promote early HIV

diagnosis with effective links to care and treatment. The design of activities should preferably be informed by developing a profile of the types of people most commonly being diagnosed late to enable targeting. Activities may include enhancing KPLHS and KP CSO responses to increase HIV testing coverage, including effective case finding strategies, and ensuring effective linkages to treatment. Effective roll out of the forthcoming HIVST guidelines has the potential to significantly increase HIV testing rates among key populations and should attract high priority.

New narcotics law

The new narcotics law may present a significant opportunity to substantially improve Thailand's response to drug use in the areas of law enforcement, the high rates of incarceration, evidence-based drug treatment, particularly at the community level, and harm reduction. The first step is to analyse the provisions of the law and identify and prioritise short and medium term strategic opportunities for the JP to work with government, researchers and civil society to maximise positive outcomes in how the law is implemented, particularly in regard to the enhanced role of the MOPH in the area of drug use and opportunities for collaboration with CSOs. There may also be a need to mobilise significant levels of technical assistance to support the development of evidence- based community drug treatment services at the local level for government and CSO providers.

A potential constraining factor is the limited resources available to UNODC in Thailand as all HIV-related work is undertaken by a small team in the regional office. This resource constraint needs to be addressed to ensure this opportunity is not missed. This could include use of short-term consultancies with Thai and other experts in evidence-based drug policy and treatment and using the UN's convening power to bring other partners to the table, including CSOs, academics and health professionals, to share the workload. Given the weakest area of KP programming in Thailand is around PWID/PWUD, taking advantage of the opportunities provided by the new narcotics law should be regarded as one of the highest priorities for the JP.

Evidence indicates a correlation between use of stimulant drugs and HIV acquisition, particularly among MSM.[201] Harm reduction programming increasingly needs to take a broader key population focus, in addition to more effectively meeting the needs of PWID. This may include building the capacity of PWID/PWUD groups to work with a broad range of key populations and skilling other KP groups such as gay/MSM CSOs on effective programming approaches to stimulant drug use.

Decriminalisation of sex work

It has long been recognized that criminalisation of sex work is a significant inhibitor of effective HIV programming with and for SW. The severe impact of the COVID-19 pandemic on the economic well-being of Thai SWs was made worse by their inability as a marginalised and criminalised population to access government COVID-19 related social welfare.[202] There is a realisation in Thai society that the pandemic demonstrated the very fragile foundations of many people's health and welfare. The opportunity exists to build back better by committing to a longer-term vision for the societal inclusion of SW, which should include decriminalisation of SW to ensure equal labour rights and eligibility for government social protection programmes. Decriminalisation of sex work should be one of the priorities for the JP's work on legal reform.

Other legal and policy reforms

Continued high priority for the range of legal and policy reforms being pursued by UNDP in partnership with KP CSOs, recognising that progress can often be incremental. Similarly, the JP should continue to give priority to supporting stigma and discrimination elimination initiatives, particularly the roll out of the new national multisectoral S&D plan.

Sustainable financing

Significant progress has been made in recent years in regard to UHC funding of CSOs undertaking HIV work with KPs and related initiatives such as certification of CSOs and CSO CHWs. This is, however, a work in progress, with a significant unfinished agenda. As sustainability of the work of KP CSOs is key

[201] UNDP, Situational Analysis of Substance Use Among LGBT Communities in Thailand. 2021.

[202] Janyam, S. Phuengsamran, D. Pangnongyang, J. et.al., Protecting sex workers in Thailand during the COVID-19 pandemic: opportunities to build back better. WHO South-East Asia Journal of Public Health, 9(2). 2020.

to Thailand's ongoing HIV response, high priority needs to continue to be given to this area of work to realise the objective of KPLHS being fully integrated and funded within the UHC system.

The PEPFAR sustainability index indicates that institutionalising systems for government funding under UHC for KPLHS is the most critical factor for ensuring sustainability.

Joint Programme operational issues: leverage

A significant constraint for the JP has been the limited number of staff for KP work in the UNAIDS CO and among cosponsors. Strategies that have been used by some Joint Team agencies to mitigate this constraint have included the use of the technical support mechanism and other consultants, working in partnership with others such as DAS, KP CSOs, Thai research institutes and universities and PEPFAR, and mobilising funds from non-UN sources. These models of leverage could be more broadly applied by all active Joint Team agencies.

Annex 1: Key informants – Thailand

The table below lists the names, job titles and organizational affiliations of the key informants who were interviewed as part of the Thailand country study. Due to the COVID-19 situation, all interviews were conducted remotely, using Zoom.

Where more than one person is listed in the same row this indicates a joint interview. Where people from the same organization are listed in separate rows this indicates separate interviews.

Name	Position	Organization
UNAIDS Secretariat and Cosponsor Agencies		
Patchara Benjarattanaporn	Director	UNAIDS Secretariat
Heather-Marie Schmidt	Regional PrEP Advisor	UNAIDS Secretariat
Ye Yu Shwe	Technical Officer	UNAIDS Secretariat
Kathryn Johnson Suparnee Pongruengphant	Human Rights and Gender Equality Consultant Project Manager, Gender Equality and Social Inclusion	UNDP Bangkok Regional Hub
Kullwadee Sumalnop	Communications Specialist	UNFPA Thailand
Duangkamol Ponchamni	Acting Officer in Charge/Program Analyst	UNFPA Thailand
Karen Peters Zin Ko Ko Lynn Watjana Arunrangsi	Associate Drugs and Health Officer Drugs and Health Officer Program Assistant	UNODC Regional Office, South East Asia & the Pacific
Sirirath Chunnasart	Adolescent Development Specialist	UNICEF Thailand
Deyer Gopinath	Medical Officer	WHO Thailand
Sutayut Osornprasop	Senior Health Specialist	World Bank Thailand
Thai Government Agencies		
Rattaphon Traimwichanon	Assistant Secretary General	National Health Security Office
Cheewanan Lertpiriyasuwat Darinda Rosa Parichart Chantchara Plearnpit Prommali Yuttapoom Srikhamjean	Director Medical Physician Social Worker Public Health Technical Officer Public Health Technical Officer	Division of AIDS and STI, Department of Disease Control, Ministry of Public Health
Bussaba Tantisak	Office of the Global Fund Principal Recipient (Government PR)	Department of Disease Control, Ministry of Public Health
Nareeluc Pairchaiyapoom	Director, International Human Rights Division	Department of Rights and Liberties Protection, Ministry of Justice
Jintana Janbumrung and three staff members	Director General	Department of Women's Affairs and Family Development, Ministry of Social Development and Human Security
Supodjanee Chutidumrong	Director, Drug Treatment and Social Reintegration Division	Office of the Narcotics Control Board
Antika Onprom Pornpreeya Jumnongbut	Director of Social Work and Welfare Penologist	Rehabilitation Division, Department of Corrections, Ministry of Justice
Civil society organisations		
Representative		Raks Thai: Global Fund Principal Recipient (Civil Society)

Name	Position	Organization
Representative		Ozone Foundation
Representative		Path 2 Health Foundation
Representative		Foundation of Transgender Alliance for Human Rights (ThaiTGA)
Representative		SWING Foundation
Representative		SWING Foundation
Representative		Asia Network of People Living with HIV (APN+)
Representative		Rainbow Sky Association of Thailand
Representative		Thai People Living with HIV Network
Representative		Foundation of AIDS Rights. National Sub-Committee on Human Rights Protection and Promotion
Representative		Mplus. Global Fund Thailand CCM Partnership Committee
Representative		Sisters Foundation
Representative		Raks Thai Foundation
Researchers		
Kritsanapong Phutakul	Head of Criminology Faculty	Rangsit University
Nittaya Phanuphak	Executive Director	Institute of HIV Research and Innovation
Suwat Chariyalertsak	Dean, Faculty of Public Health & HIV Prevention CRS Leader, THAI CTU, Research Institute for Health Sciences	Chiang Mai University
Dittita Tititampruk	Lecturer in Criminology	Social Science and Humanities Faculty, Mahidol Univesity
Kriengkrai Srithanaviboonchai	Associate Professor, Department of Community Medicine, Faculty of Medicine *and* Deputy Director, Research Institute for Health Sciences	Chiang Mai University
Apinun Aramrattana	Independent consultant and Department of Family Medicine, Faculty of Medicine	Chiang Mai University
Other implementing agencies		
Yuthiang Durier	Counselling Nurse	Siriraj Hospital (PrEP pilot project for adolescents)
International donors		
Philippe Creac'H	Fund Portfolio Manager, Thailand	Global Fund Secretariat
Heather David Pimpanitta Saenyakul Panus NaNakorn	Acting Senior Regional HIV Technical Advisor HIV Deputy Team Leader Project Management Specialist	Office of Public Health, Regional Development Mission Asia, USAID
Consultants		
Petchsri Sirinirand	Independent Consultant	
Pascal Tanguay	Independent Consultant	

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Annex 3: Joint Programme activities by priority area and key population focus – Thailand

2018-2021

Table 4: Joint Programme activities by priority area and key population focus, 2018-2021

Priority area	ALL KPs	YKP	MSM SOGIE	TG	PWID & PWUD	SW	Prisoners	Lesser level KP focus	KP relevant activities*	Total activities
HIV prevention	-	2	-	1	7	-	2	14	11	37
HIV testing & treatment	1	-	-	1	4	-	1	2	5	14
Human rights & S&D	3	-	1	5	3	-	1	2	6	21
Investment & sustainability	5	-	-	-	-	-	-	-	2	7
Total activities	9	2	1	7**	14	0^	4***	18	24	79

Source: Thailand JP Annual plans, 2018-2021. Only planned activities are included in this table. The table does not include ad hoc/unplanned activities such as those undertaken in response to COVID-19.

* Activities in this column are directly relevant to KPs but do not have an exclusive KP specific focus

** One of the TG activities related to TG sex workers and one to PWUD

^ Two activities focusing on TG sex workers are listed in the TG column

*** Three of the prisoner activities were intersectional – one with TG and two with PWUD/PWID

5. Tunisia country study

21 January 2022

Consultants:
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Introduction and context

Purpose and scope of the Tunisia case study

This case study is part of a larger evaluation to assess the relevance, coherence, equity, efficiency, effectiveness and sustainability of the UNAIDS[203] Joint Programme on AIDS (JP) support for key population (KP) programming at country level over the years 2018-2021, with a view to improving UNAIDS programming with and for key populations under the new UNAIDS United Budget, Results and Accountability Framework (UBRAF) 2022-2026. The primary unit of analysis for the evaluation is how the Joint Programme has supported KP programming at the country level. Six countries were chosen for the case studies, covering all UNAIDS regions and a variety of epidemics. The six countries are Cameroon, Kenya, Peru, Thailand, Tunisia, and Ukraine. The case studies have been supplemented by document review and key informant interviews (KII) at the global and regional levels.

The KPs, as defined by UNAIDS, are sex workers (SW), gay men and other men who have sex with men (MSM), transgender persons (TG), people who inject drugs (PWID), and prisoners, including young people who are part of these KPs. Although migrants are included in the Joint Team on HIV-AIDS programmes in Tunisia, they will not be covered by this evaluation.

The evaluation focuses on HIV services and HIV-related outcomes but attempts to explore programmatic linkages to related health issues and other services supported by the Joint Programme such as contraception, Sexually Transmitted Infections (STIs), Tuberculosis (TB), Hepatitis and other virus prevention efforts for key populations.

In Tunisia, the evaluation was conducted by a team consisting of one lead evaluator, and two civil society representatives active in the HIV response. The two members on the evaluation team were particularly pro-active, moderated all interviews and group discussions among the KP community, and contributed to the findings of this report.

Methods

The evaluation is theory-based and involved the development of a Theory of Change which has served as an overall analytical framework for the evaluation. The TOC outlines the relationships between the Joint Programme activities and interventions and how these are expected to bring about change and results for KP responses. The TOC also includes a forward-looking component through use of the Strategic Priority Outcomes (SPOs) of the new Strategy 2021-2026, the intention being to help identify existing gaps for the achievement of the new strategy and to inform future KP programming recommendations. Ten evaluation questions, based on OECD DAC Evaluation Criteria[204] were identified refined and mapped to the TOC.

A mixed-method approach was used combining key informant interviews and review of UNAIDS Joint Programme reports, documents, data, and national and Global Fund reference documents. Information stemming from secondary data sources was crosschecked through data retrieved from primary data collection methods (interviews, group discussions). The key informants comprised 51 participants (21males /29 females/1 self-identified as TG), with interviews conducted virtually or face-to-face, small group discussions (3 to 5 participants), the observation of an HIV service delivery site at the Infectious Diseases Department (HIV/AIDS care unit, Monastir University hospital) and discussions with the attendant personnel. The site was recommended for the high quality of its services. In addition, group discussions with KPs were conducted in Sfax located in the south-east of Tunisia.

[203] References to UNAIDS in this report refer to the Joint United Nations Programme on HIV and AIDS, consisting of the UNAIDS Secretariat and UN agency Cosponsors. The UNAIDS Secretariat in Tunisia is referred to as the UNAIDS Country Office (UNAIDS CO).

[204] https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

The team reached 25 KP members (4 individuals and 5 group discussions); UNAIDS Secretariat and 6 Cosponsor agencies (WHO (2); UNFPA (2); UNDP (2); WFP; UNODC (2); UN Women; 4 personnel from Government institutions: Ministry of Health, Department of Basic Health Care/DSSB and the Office de la Famille et de la Population/ONFP, which serves as the Global Fund Principal Recipient (PR); 8 Civil Society Organisations (CSOs) and KP networks (ATP+; ASF; ATL+ (2); ATSR; Mawjoudin (LGBTIQ+); Bouthayna Sex Workers Foundation; ATIOST (2); and Global Fund CCM Executive Director and Chair.

The documents reviewed for the evaluation can be found in Annex.

National HIV context and national response

Tunisia HIV epidemic

Tunisia is a middle-income country with a population estimate of **11,991,870**[205] as of 27 November 2021. Since January 2011, the country has been in the midst of changes, at the political and social level, with rapid turnover of leadership in public sector institutions. This period has also been an opportunity for open dialogue across population groups and political parties, with recognition of an unfinished human rights agenda. Tunisia counts numerous civil society organisations that work across human rights and development sectors. The poor socio-economic situation, exacerbated by the COVID-19 epidemic, is a major impediment for public investments in social sectors.

The analysis of the epidemiological situation of HIV, based on the triangulation of data from notifications of HIV/AIDS cases, screening programmes and programmatic data from CSOs, as well as the results of bio-behavioural studies of key populations shows that the HIV epidemic is concentrated both geographically, in the coastal regions, and at the population level, within the main key population groups.[206] According to the same data source, the HIV prevalence at national level is at <0.1%. This prevalence remains 11.2% for men who have sex with men (MSM), 1.2% for sex workers (SWs), and 6% for people who inject drugs (PWID) according to the 2018 bio-behavioural study. The preliminary 2021 bio-behavioural survey results show the following prevalence rates: 8% for MSM, 0.5% for SW and 11% for PWID. People living with HIV are estimated at 4,500 according to the UNAIDS Global Report 2021[207].

The main modes of HIV transmission based on the 2015 KP mapping[208] (self-declared data) are through heterosexual transmission (59.2%), injection drug use (20.8%), same sex transmission (12.2%), maternal-foetal transmission (4.2%), and contaminated blood products (3.6%). In 2017, 6.9% of pregnant women knew their serological status, and the early diagnosis of infants had dropped by 40% in 2015, 31% in 2016 and 13% in 2017 (UNAIDS, 2017)[209]. The increasing trends in prevalence among KPs can be seen in Table 1.

[205] Worldometer elaboration of the latest United Nations data: https://www.worldometers.info/world-population/tunisia-population/

[206] Ministère de la Santé Publique. Direction des Soins de Santé de Base (DSSB). Plan Stratégique National de lutte contre les IST et le VIH/sida 2021-2025 de la Tunisie.

[207] GLOBAL AIDS UPDATE | 2021 CONFRONTING INEQUALITIES- https://www.unaids.org/sites/default/files/media_asset/2021-global-aids-update_en.pdf

[208] Ministère de la Santé Publique. Direction des Soins de Santé de Base (DSSB). Cartographie des sites des populations clés et des prestataires des services de prévention et de prise en charge VIH//SIDA en Tunisie. Tunis, Décembre 2015

[209] Ministère de la Santé Publique. Direction des Soins de Santé de Base (DSSB). Plan Stratégique National de lutte contre les IST et le VIH/sida 2021-2025 de la Tunisie; Draft 3, VERSION DU 10 JUIN 2021

Table 31: HIV Prevalence trends in key populations 2011-2021 (Bio-behavioural surveys)

Populations	Size estimation 2014	Prevalence 2011 (%)	Prevalence 2014 (%)	Prevalence 2018 (%)	Prevalence [210] 2021 (%)
PWID	9000	2.40	3.90	6	11
SW	47 000	0.61	0.94	1.2	0.5
MSM	28 000	13	9.1	11.20	8

According to the UNAIDS 2020 report, only 51% of PLHIV know their status in Tunisia.

There are cross-risk behaviours of vulnerability, namely drug use and sex work. Programme data from two bio behavioural surveys undertaken in 2009 and 2017/2018[211] indicate that among MSM, people tested for HIV and who know their HIV status in the past 12 months increased from 18% to 32%. From the same data sources, for SW there was a clear decline between 2009 and 2018 (14.1% in 2009 and 7.8% in 2018), while among PWIDs, the percentage remains stable between 2009 and 2017 (around 20%). HIV testing coverage figures especially for PWIDs should be interpreted with caution due to a likely underestimation of the population size. There are also variations for HIV testing rates among regions, attributed to the lack of attractiveness of government CCDAGs (centres for free counselling and testing) in some locations. According to the cascade analysis report[212], 30% of MSM would have sexual intercourse with women and 23% of them with men as paid sex.

Key population age trends

The 2015 KP mapping[213] revealed that among the MSM surveyed 35.4% were in the age group 18-24 years, and 44.6% 25-29 years; 1.5% only have used drugs; 71% have used the internet to reach clients. Among the SW: 34.6% were in the 18-24 years age group and 38.5% were 25-29 years; only 3.8% have used drugs; 61.5% indicate they have used the internet to reach clients. There is a demonstrated high use of virtual means to connect in both KP groups.

The young age factor of vulnerability to injecting drugs is well documented. The KP mapping mentioned above showed that 30% were in the 18-25 year age group. The 2017 bio behavioural survey among PWID[214] showed that the initiation to injecting drugs took place in about half of the cases (47.7%), between 15 and 19 years; in 19.6% of the cases, it took place before the age of 14. The national MedSpad survey[215] conducted in schools in 2017 among high school students showed that nearly a third (31%) of young people aged 15-17 years reported having consumed at least one drug during their lifetime other than tobacco and alcohol compared to almost a quarter (24.6%) in 2013. This prevalence was significantly higher among boys compared to girls (36.5% vs. 27.7% in 2017). According to the latest available data from the 2019 World Drug Report Global estimates[216], the most commonly used drugs in Tunisia are cannabis (7.96%), followed by opiates (1.2%), cocaine (0.8%) and ecstasy (0.78%). According to the same data source in 2013, 4,000 people were under treatment for drug use.

[210] IBBS 2021- in analysis stage- unpublished data

[211] Ministère de la Santé Publique. Direction des Soins de Santé de Base (DSSB). Plan Stratégique National de lutte contre les IST et le VIH/sida 2021-2025 de la Tunisie; Draft 3, VERSION DU 10 JUIN 2021

[212] Étude sur la cascade du Conseil et Dépistage Volontaire, PEC et PTME du VIH/Sida en Tunisie= Rapport préliminaire- WHO- Novembre 2018

[213] Ministère de la Santé Publique. Direction des Soins de Santé de Base (DSSB) Cartographie des sites des populations clés et des prestataires des services de prévention et de prise en charge VIH//SIDA en Tunisie. Tunis, Décembrre 2015

[214] Ministère de la Santé Publique. Direction des Soins de Santé de Base, Programme National de lutte contre le sida et les MST, Association Tunisienne d'Information et d'Orientation sur le Sida (ATIOST), (2017). Enquête séro-comportementale du VIH/HVC auprès des usagers de drogues injectables en Tunisie.

[215] Ministère de la Justice, Direction Générale des Prisons et de la Rééducation- UNODC : Evaluation rapide des services de soins & prévention du VIH, des IST, des hépatites virales et de la Tuberculose en milieu carcéral en Tunisie. Juillet 2020

[216] UNODC- DATAUNODC- Annual prevalence of drug use (latest year available) relative to the 2019 global estimate. https://dataunodc.un.org/content/Country-profile?country=Tunisia

Condom use among PWID remains insufficient. According to the IBBS 2017[217], 43.7% of the surveyed PWIDs used a condom the last time they had sex. This percentage decreased to 36% in the course of 4 years (IBBS 2021). According to the same data sources, sexual activity while under the influence of alcohol or drugs was very common (83.0% IBBS 2017, 60% IBBS 2021). Coverage with comprehensive Hepatitis B vaccination was extremely low, less than 5%, despite opportunities to offer vaccination in prisons, since a large proportion of PWID are or have been in prisons.

Information is very limited with regards to the transgender population. Stigma and discrimination (S&D) cause social isolation and constitutes a significant barrier to access for sexual and reproductive health (SRH) services. The Tunisian Association for Positive Prevention (ATP +), with the support of UNFPA in Tunisia, carried out a mapping of transgender sites in Tunisia[218] (Tunis + 3 other cities) in 2019. Only 1.4% of the population surveyed said they had injected drugs in the last 12 months preceding the survey. 43.3% of transgender people surveyed said that they had not used a condom the last time they had sex in the last month before the survey while 98.1% have had a sexually transmitted infection (STI).

According to data from the World Prison Brief[219], as of September 2021, the prison population was estimated at 23,484 prisoners, of which 3.3% are women and 0.2% juvenile, detained in 32 institutions. About 29% are jailed for drug-related offenses. Transmission among detainees is exacerbated by congestion (occupancy 126.4% in 2021), an insufficient number of doctors with a doctor to detainee ratio 3 times below international standards, little or no screening activities for communicable diseases (HIV, TB, STIs, viral hepatitis, etc.), sparse HIV, TB, viral hepatitis and STI prevention activities, the non-availability of ARVs and anti-TB drugs and/or insufficient coordination to ensure the continuity of antiretroviral and anti-TB treatment after release, and insufficient mental health interventions. An unpublished study (2015) showed an incidence of *TB 30 times higher than* in the general population after systematic screening at the entrance to prisons from a number of more than 18,000 inmates over a period of time.

The health care system with regard to services for KPs in Tunisia is composed of three levels:

Level 1: Basic health centres (Centres de Soins de Santé de Base) nearing 2,500. These facilities provide a minimum package of integrated primary care with preventive actions and routine care free of charge. Some of them offer SRH services, but HIV is not integrated in most of them. District hospitals and peripheral maternity hospitals are also considered as first-level structures.

HIV testing and counselling for KPs is specifically provided through 25 anonymous and free counselling and testing centres (CCDAG) set up by the Ministry of Health since 2009 in 19 of the 24 administrative regions (or governorates). The Global fund grants contribute to the purchase of rapid tests and reagents. Nine CCDAGs are under ONFP supervision, five are located in CSO settings and, and the other CCDAGs are part of the primary health care centres under DSSB supervision. The service delivery through public institutions is thus complemented by services provided as part of the KP thematic programmes of the 5 most active non-governmental organizations[220]:

1. The Tunisian Association for Information and Orientation on AIDS and Drug Addiction (Association Tunisienne d'Information et d'Orientation sur le Sida et la toxicomanie – ATIOST): PWID, Prisoners, and PLHIV
2. The Tunisian Association Against STDs and AIDS (Association Tunisienne de Lutte contre les MST et le SIDA – ATL-Sida) in Tunis: MSM, PWID, and SW

[217] Ministère de la Santé Publique. Direction des Soins de Santé de Base, Programme National de lutte contre le sida et les MST. Association Tunisienne d'Information et d'Orientation sur le Sida (ATIOST). (2017). Enquête séro-comportementale du VIH/HVC auprès des usagers de drogues injectables en Tunisie, p 53 Table 29.
[218] ATP+Association Tunisienne de Prévention Positive. Cartographie des sites de la population transgenre en Tunisie. Réalisée avec le soutien du Fonds Mondial de lutte contre le Sida, la Tuberculose et le Paludisme et du Fonds des Nations Unies pour la Population (UNFPA). Tunis 2019
[219] World Prison Brief- Tunisia, accessible https://www.prisonstudies.org/country/tunisia, last seen 26 Nov 2021
[220] World Bank- APMG Health- focused country evaluations Tunisia HIV evaluation field-based evaluation. March 2019 (Tunisia WB GF Field-Based HIV Evaluation Report- 11July2019)

3. ATL-SIDA National Office (ATL-SIDA Bureau National) based in Sfax: MSM, PLHIV, SW, Prisoners, and migrants
4. The Tunisian Association of Reproductive Health (Association Tunisienne de la Santé de la Reproduction - ATSR): SW and migrants
5. The Tunisian Association for Positive Prevention (Association Tunisienne de Prévention Positive-ATP+): MSM and PLHIV.

CSO work in Tunisia is focused on combination prevention, access to HIV testing and counselling, including organising campaigns through peer interventions for MSM, SW and PWID. Community based testing campaigns are also organised with health professionals of CCDAGs. These CSOs also support newly diagnosed persons for referral and treatment, and PLHIV for improved adherence to treatment. The Global Fund supports technical and management capacity building for some of them. Global Fund grants contributed to the establishment of community-based groups for PLHIV and key populations, mostly LGBTIQ+ groups (such as ATP+, Damj or Ness).

Level 2: Regional hospitals, often located in the capital of each governorate, provide general medical services, general surgery, obstetrics, paediatrics, ear, nose and throat (ENT) and ophthalmology. They also provide treatment for STIs and supplies such as condoms.

Level 3: University hospital centres: there are four centres providing HIV treatment and care, and highly specialised care as day hospitals for ART patients, and are located in Tunis, Sousse, Monastir, and Sfax.
Regarding the elimination of HIV mother to child transmission (eMTCT), Tunisia has relatively well established public antenatal care services throughout the country. However, and while the country adopted an eMTCT strategy, they do not apply systematic HIV services due to tests stock-outs and weak monitoring. At the end of 2018, eMTCT services were available in 9 of the 24 governorates.

Tunisia HIV response

Tunisia's HIV response is administered by a national AIDS programme (NAP). A national committee for the response to HIV (CNLS) theoretically exists but has been inactive for years and substituted by the NAP. In addition a coordination mechanism is entrusted to the Global Fund country coordinating mechanism (CCM) to mobilize and oversee Global Fund's grants. The successive national plans have covered the periods 2006-2010/11, 2012-2016, 2014-2017, 2015-2018, 2018-2022 and currently 2021-2025. The 2018-2022 National Strategic Plan aimed at 4 outcomes:

1. New HIV infections reduced by 60% by 2022; 80% of KP (SW, MSM, PWID) adopt preventive behaviours and 80% of PWID adopt risk reduction behaviours; 90% of the most vulnerable adolescents and young people have adequate skills to protect themselves from HIV and STIs
2. HIV-related mortality reduced by 60% by 2022
3. In 2022, the social and legal environment protects PLHIV and vulnerable populations against discrimination and the national strategy contributes to reducing gender inequality and gender-based violence
4. The national response to HIV is sustainable and coordination is strengthened towards accelerating the elimination of HIV by 2030; community role in strategic decision making and implementation; financial sustainability and a functional information system.

The multisectoral nature of the national response to HIV remains a strategic guiding principle.

These outcomes, like those set in earlier strategic plans are highly ambitious and unrealistic, given the little prospect for additional investment in the HIV response from the NAP. To offset the delays incurred in the implementation of the previous plans since 2015, the national partners and JUNTA agreed to submit an acceleration plan in 2019 to achieve better and more efficient implementation of the GF plan.

All the national strategic plans so far have referred to the three KP populations only: MSM, SW and PWID. Following the Transgender population mapping, the National Strategic plan 2021-2025 has

included in the document, for the first time, reference to transgender populations focused interventions.

Challenges in the national response

The 2018-2022[221] plan indicates, based on a participative evaluation that (i) the prevention and care services for STIs and HIV are not sufficiently adapted to meet the specific needs of the KP populations; (ii) the poor capacity and the stigmatizing attitudes of service providers hamper the access of KPs to prevention, care and support services; (iii) the CCDAGs have not completely achieved their objectives, due to a lack of promotion, resources and quality of services to attract KPs. The national testing strategy had not been updated[222] since 2014 and still remains confined to the same CCDAGs. A new national testing strategy has just been finalised and is awaiting approval.

In terms of outcomes, the first cascade analysis showed that in 2018 the 90-90-90 targets[223] were not achieved with: 1) HIV diagnosis was estimated at 68%; 2) ART follow up of those diagnosed was estimated at 50%; and 3) undetectable viral load among those under treatment was estimated at 59%. It should be noted that at the time (2018) the prescription of ART was carried out taking into account the threshold of 500 CD4/mm3, although some prescribers have adopted the "Treatment for All" promoted in the WHO recommendations.

Tunisia first mentioned opioid substitution therapy (OST) in its 2015-2018 NAP. A national drug treatment and harm reduction strategy has been endorsed on December 1, 2021. There is no HIV testing activity in prisons[224] during detention. Care is limited to ensuring a continuity of antiretroviral treatment and clinical, biological and viral load monitoring of those who know their status. On discharge, the prison medical service structure does not provide a liaison letter for the PLHIV so that they can return to their care service.

Activities aimed at mitigating stigma and discrimination were carried out on a small scale and were with very limited impact[225]. Among the tangible outputs of the NAP is a reference guide for the public at large on aspects related to health, legal framework, communication and religion, and HIV. The CSO Avocats Sans Frontières funded by the Global Fund launched a legal support initiative with a pool of 17 lawyers in 5 regions; a digital platform for legal support in connection with violation of rights and a mapping of existing legal support services; training of health professionals on HR, medical ethics also addressed to communities of PLHIV, migrants, prisoners and KP and their peer educators and the recruitment of community workers for legal support through CSOs. Between 2016-2018, the Global Fund has supported 231 peer educators and 9 peer educator supervisors within five CSOs (ATL Tunis, ATL Sfax, ATP+, ATIOST, ATSR) and 10 peer educators under the Office de la Famille et de la Population Youth centres to provide outreach and referral services for all three key populations (MSM, SW, and PWID).

Furthermore, weaknesses of the national programme have been recognized in the NAP and reported by several KIs. They include a lack of coordination among governmental and non-governmental partners, a perception of a weak internal support by the specific government entity DSSB, a lack of technical expertise in the area of human rights and HIV, and weak linkages with the Ministry of Justice, Ministry for Women, Family, Children and Seniors, and the Ministry for Social Affairs. Furthermore, the quality in health personnel technical and inter-personal communication training and links with community-based networks needs improvement.

The Global Fund[226] plays a major role in HIV related health services strengthening, in addition to its support to data collection, national strategy development and capacity building of CSO and KP

[221] Ministère de la Santé. Direction des Soins de Santé de Base (DSSB). Programme National de Lutte contre le Sida et les Infections Sexuellement Transmissibles. (2018). Plan Stratégique National de la riposte au VIH/Sida et aux IST 2018-2022
[222] Global Fund - CCM Tunisie, Demande de financement : Modifications majeures, 2019-2021
[223] Étude sur la cascade du Conseil et Dépistage Volontaire, PEC et PTME du VIH/Sida en Tunisie- Rapport préliminaire novembre 2018
[224] MoJ UNODC evaluation services 2020
[225] Ministère de la Santé Publique. Direction des Soins de Santé de Base (DSSB). Plan Stratégique National de lutte contre les IST et le VIH/sida 2021-2025 de la Tunisie; Draft 3, VERSION DU 10 JUIN 2021
[226] APMG HEALTH- focused country evaluations Tunisia hiv evaluation field-based evaluation March 2019

networks. The role of the Global Fund in procurement and supply management systems is essential for the HIV response. From 2016-2018 it supported the development of a new logistics management information system; the upgrading of two warehouses at central level and four warehouses at regional levels; capacity building for quality control of condoms, HIV test kits, and a part of the antiretroviral medications; capacity building of supply managers at the central and regional level; and provided TA for inventory and improvement of supply of health products. As an order of magnitude, the 2016-2018 grant supported the procurement of seven million condoms at a cost of USD 85,026 for male condoms (including coloured and flavoured condoms for MSM) and USD 22,683 for female condoms (2017-2018 Global Fund budget).

The Global Fund also supports NGOs and community-based organisations to carry out outreach and prevention services to KPs, including a package of six different interventions adapted to the needs of MSM, SW and PWID: (1) behaviour change communication (BCC), (2) access to condoms and lubricant, (3) HIV testing, (4) prevention and treatment of STIs, and (5) referral to medical care in the event of HIV-positive test results, with (6) syringes and harm reduction components for PWID.

An evaluation of the Global Fund 2016-2018 grant showed gaps in terms of stock outs of paediatrics ARVs, condoms and supplies and an uneven quality across condom batches. The question of condoms was raised by WHO during the evaluation, and voiced by KP and CSO KIs as needing special joint attention between the NAP, Global Fund and JP.

Enabling environment

The revised 2014 Tunisian Constitution[227] upholds many key civil, political, social, economic, and cultural rights and freedoms, including rights to free opinion, expression, association, right to privacy, the right to health and protection by the state of human dignity and physical integrity. In real life, high levels of stigma and discrimination, as well as harassment by the police, towards KPs, particularly LGBTIQ+ has been reported[228]. Discriminatory attitudes towards PLHIV documented in the 2018 Multiple Indicator Cluster Survey[229] showed 66.4 % of women and 60.5 % of men report discriminatory attitudes vis a vis PLHIV.

Stigma or criminalisation of KPs is reported to have deteriorated in the past few years because of the unstable political environment, the lack of accountability, the inexistence of litigation processes and the recent dissolution of parliament, and the disempowerment of national independent litigation and oversight institutions. Tunisia has been seeing repeated socio-political changes and social tensions ever since January 2011.

The main human rights barriers identified by the Global Fund's Baseline Assessment Report[230] are the existing laws that criminalize pre-marital and same sex activities, sex work, drug use, and limit the rights of migrants[231]. There are also police practices which continue to be described as authoritarian, punitive, abusive against PWID, SW, MSM and migrants from sub-Saharan Africa and

[227] The Constitution of the Tunisian Republic. Unofficial translation, UNDP, International IDEA. http://www.constitutionnet.org/sites/default/files/2014.01.26_-_final_constitution_english_idea_final.pdf

[228] Collectif civil pour les libertés individuelles- Rapport Annuel : Etat des libertés individuelles Mars 2020-mars 2021 : l'année de toutes les menaces- Juin 2021.

[229] UNICEF, Institut National de la Statistique, Ministère de la Santé. Enquête par grappes à indicateurs multiples (MICS), 2018. Rapport Final des Résultats Février 2019

[230] The Global Fund: Baseline Assessment – Tunisia -Scaling up Programs to Reduce Human Rights- Related Barriers to HIV Services. 2018.

[231] Laws discriminating against minorities (source: Human Rights and KP- 2019)

- Article 230 of the Penal Code penalizes same sex intercourse by a sentence of for up to three years in prison
- Article 226 bis of the Penal Code the sentence for" breaching good morals" is of six months in prison and a fine of 1,000 Tunisian dinars (US $ 416). Transgender people in particular are at risk of being arrested and prosecuted under section 226, when their actions or appearance are considered to be a violation of morality.
- Article 231 of the Criminal Code: sex workers face up to two years in prison.
- Law 52 (1992) provides for a minimum sentence of one year in prison for "drug use". In 2017, it was amended to allow magistrates to take into account attenuating circumstances to avoid imprisonment in certain cases. However, the application of Law 52 by the police and the judiciary continues to have a considerable impact on the lives of many young Tunisians.

the prevailing gender norms and social attitudes regarding sex and sexuality often equate to barriers. HIV-related stigma makes people fear testing or disclosing their HIV status to partners or family members and causes them to refuse to seek ARV treatment.

Gender inequalities and discrimination against women continue to create disparities in access to quality care. Women are still discriminated against for example in matters of child custody and inheritance under Article 58 of the Personal Status Code, although the constitution enshrines gender equality (Human rights and HIV strategy). The law adopted in 2017 on Violence against Women and Girls includes domestic violence and protects women against harassment in public spaces and against economic discrimination. However, its implementation has been limited, due in part to cultural pressures, and a lack of trained officers to deal with complaints and pressure to avoid taking cases to court. The Global Fund Baseline Assessment Report also indicates that women living with HIV are highly stigmatized and the services offered are not gender sensitive, as they are not tailored to the specific needs of people based on their sex, age, or gender identity.

Financing of the HIV response

The sources of funding for the HIV response in Tunisia include the state budget, other ministries (national education, social affairs, defence), the National Health Insurance Fund (CNAM), direct household payments, the Global Fund, Bilateral and Multilateral Partners. The state budget covers exclusively general prevention activities delivered through public institutions, ARVs, reagents for the tests, equipment, and personnel costs (at primary health care services, 4 hospital specialised care units, CCDAGs and the cost of one coordinator at the ministry of health). All activities related to CSOs that are KP centred are provided through Global Fund resources or other donors (e.g., Drosos Foundation for activities in prisons).

Table 2 shows total government commitments towards the HIV response estimated budget. The commitments vary but are above 60% of estimated financial needs, and exceed 70% in 2020, 2021 and 2022 of the total response (noting the denominator downwards changes for 2020-2022).

Table 32: Tunisia overall HIV estimated budget and domestic co-financing commitments (in USD Million)- Year 2018 to 2022

Budget type	2018	2019	2020	2021	2022
HIV response Total Estimated budget*	16.61	16.78	15.34	15.65	15.65
Total Government Contribution**	10.40	10.69	10.98	11.28	11.58

* Source: Final Report/Co-financing of HIV-AIDS response in Tunisia –Nov 2021 (paper commissioned by UNAIDS) – (Figures have been rounded)
** Tunisia overall domestic co-financing commitments made for 2017-2019 allocation-
Source: Global Fund 2020-2022 Allocation Letter to CCM

The gap between the estimated budget and government commitments are to be filled by the Global Fund and other sources. For the period January 2019 to December 2021, Tunisia submitted a funding request to the Global Fund for a total of USD 7,680,992 of which catalytic funds (USD 1,004,564) were planned for human rights interventions[232].

Based on Tunisia's gross national income (lower-middle income country) and disease burden (low or moderate disease burden) Global Fund transition was foreseen in 2025 and further extended to 2028[233].

[232] Global Fund- CCM Tunisie, Demande de financement: Modifications majeures, 2019-2021
[233] APMG HEALTH- focused country evaluations Tunisia hiv evaluation field-based evaluation March 2019- World Bank GF outputs evaluation, 2019

There are very few donors interested in funding HIV and KP. Among them Drosos Foundation allocated USD 899,329 between 2016-2020 to Tunisia for an initiative in prison settings led by UNODC with the Ministry of Justice and the Department of prisons authority.

UNAIDS Joint Programme key population response

Strategic orientation and programmatic approaches

The 2020-21 planning of UNAIDS Joint Programme (JP) in Tunisia identified the following priority areas that are linked to the 2018-2022 National Strategic Plan and based on the UNAIDS 2019 data.

Priority Area 1. HIV Testing and treatment to address the gaps in combination prevention through a roll out of a testing strategy, the accreditation of CSOs and KP community agents for HIV testing and an increased adherence to treatment through nutrition security for PLHIV.

Tackling the low adherence to treatment (24% according to UNAIDS 2019, 20.2% based on 2016 national data) for PLHIV who know their status and are under treatment. This will be achieved through empowering the PLHIV and KP communities to partner with treatment centres and accompany the newly tested PLHIV, a proportion of whom are MSM, SW and PWID.

Priority area 2. HIV sensitive social protection by assessing nutrition and food security of vulnerable populations and KPs.

Priority area 3. HIV related comprehensive sexuality education (CSE) in 13 pilot colleges, tackling prevention among young people and adolescents, including young KP, identified as a vulnerable population group in the NAP 2018-2022.

Priority area 4. Decreasing stigma and discrimination within the CCDAGs and the 4 specialised hospital-based treatment facilities.

Priority area 5. Investment and efficiency: transition for financial sustainability, risk assessment, and integration of HIV in CCA-UNSDAF.

Cosponsor activities are aligned with the National strategic plans and are coordinated with NAP. The NAP addresses KP and a proportion of the programme focuses on prevention directed towards other vulnerable groups and the general population at large. Hence cosponsor activities follow the same scheme but also support a combination of activities for KPs and for the general population.

Table 33: Joint Programme activities by lead agency and number of activities 2018-19/ 2020-21

Year	Lead agency	Number of activities planned	KP Relevance/focus
2018-2019	UNAIDS	4	All KP relevant, 2 KP focused: Data (KP size and bio-behavioural survey) and brokering/mediating are KP focused
	WHO	4	All KP relevant: Review 3 HIV hospital-based centres; National testing strategy; cascade analysis and World AIDS day
	UNFPA	7	6 KP focused: mobile app for KPs; SW life skills capacity building; policy paper on KP rights; promotional materials on HIV for SW; capacity building SW network institutional organisation; transgender mapping
	UNDP	2 planned	1 Activity KP focused: legal assessment not done, but participation KP in regional conference
	UNODC	4	All KP focused: high-level awareness-raising workshops. study tour Ministry Justice and Exec Prison management authority; equipment for voluntary counselling and testing and treatment of HIV, HCV, HBV, TB and STI in six

Year	Lead agency	Number of activities planned	KP Relevance/focus
			pilot Tunisian prisons; mapping relevant NGOs and government institutions providing services in drug use, HIV, tuberculosis and hepatitis prevention and treatment, social inclusion
	UN Women	2	All KP centred: female IDU community accompanied to access testing and treatment; workshop re amendments of discriminatory laws LGBTIQ+ and KP
	UNICEF	3 planned, 1 done, 1 started not completed	One KP relevant (e MTCT): positive parenting in Community Maternal and Child health centres; evaluation eMTCT national strategy -trainer guide developed with the support of UNAIDS; training in 9 of 24 governorates; eMTCT strategy implemented in prison settings (not done yet)
Total	7 Agencies	26	22 KP relevant or KP focused activities implemented
2020-2021	UNAIDS	5	All KP relevant, 3 KP focused, two of them delayed: KP Size estimate; national testing strategy; financial transition study; integration HIV in CCA; UNDAF Stigma index
	WHO	2	2 KP relevant: revised testing strategy; PrEP implementation feasibility study- underway, delayed
	UNFPA	4	All KP relevant, of which 2 are KP focused: pilot phase of training and accrediting key populations community-based testing agents; online platform CSE (comprehensive sexual education) materials to several populations including key and vulnerable populations; development of technology based CSE for in school adolescents and youth educational tool; development of a M&E mechanism for the implementation of the national Adolescent and Youth health strategy 2020-2030
	UNDP	2 planned, 1 completed	Address Stigma in health care settings: advocacy and mobilization of partners for stigma action plan (not done); 1 KP focused: Legal Environment Assessment (LEA) planned since 2017/18, replaced by chapter on HR in 2021-2025 national HIV strategy
	UNODC	2	All KP focused: provide voluntary HIV counselling and testing programme in 4 prisons; support on-going HIV, HCV and STIs prevention, treatment, and care programme in 10 closed settings in Tunisia (9 done)
	UNWOMEN	0	0
	WFP	3	All KP relevant: nutrition education to PLHIV community for better adherence to treatment; evidence on HIV-sensitive social protection through food security and nutrition assessments; advocacy to fast-track PLHIV access to free health coverage and social services
	UNICEF	0	0
Total	6 Agencies	18	15 KP relevant or KP focused activities (implemented)

Source: JPMS

During the period under review (2018-2021), the JP conducted three types of interventions: KP centred, directed to the general population but with relevance to KPs, and interventions aimed at the general population which are remotely relevant to KPs. The JP planned 44 activities, of which 37 were KP relevant, and among these, 24 were exclusively KP focused (source: JPMS).

From among the KP centred activities, three activities were directed towards female sex workers for capacity building aimed at better prevention and protection. Promotional material was developed for sensitization of SW on risks and information on services availability and location. A highly relevant and strategic institutional building component benefited a sex worker network, the Bouthayna Foundation in Sfax. Capacity building sessions targeting sex workers focusing on life skills were also conducted. Activities for SW were all conducted during the 2018-2019 plan with no follow up during the next period, due to unavailability of UBRAF funds for this area.

The JP prioritised evidence on TG, a group that has been ignored in all national plans prior to 2021. To address this gap mapping was conducted, with KPs as implementers. The results of this work, the first of its kind in Tunisia, influenced the content of the new strategic plan 2021-2025 where specific TG focused interventions are included.

To address access to testing and treatment among women who inject drugs a needs assessment for a pilot intervention was implemented in the Women Support Centre, les Jasmins, in 2018/19. Unfortunately, this activity was no longer under UN Women leadership, although it continued through ATL+ (CSO) with support from the Global Fund.

Two realized contributions directed to PWID include (i) a rapid situation analysis of the care and prevention services in prison settings for HIV, hepatitis, STIs and TB in partnership with the Ministry of Justice (2020); and (ii) TA for the first harm reduction national strategy in prison settings 2019-2023.

In addition, four activities were directed towards prisoners and include (i) high-level awareness raising workshops and a study tour for the Ministry of Justice and executives from prison management institutions to observe non-penitentiary alternatives to PWID care; (ii) provision of equipment for voluntary counselling, testing and treatment of HIV, Hepatitis C, Hepatitis B, TB and STI in six pilot Tunisian prisons; (iii) mapping of relevant NGOs and government institutions providing services in drug use, HIV, TB and hepatitis prevention and treatment, social inclusion etc. was adapted into informational leaflets distributed among prisoners at the time of their release; and (iv) education and counselling programmes were integrated in 10 closed settings to address the combination of risks in the overcrowded prison settings.

In response to increasing stigma, discrimination and violations of human rights of KPs three activities were focused on improving the environment and protecting the rights of KPs in general: (i) a policy paper to advocate for key population rights and to create a legal environment that protects vulnerable populations from discrimination (UNFPA); (ii) a series of advocacy activities conducted in 2019 promoting amendments of discriminatory laws (UN Women); (iii) UNAIDS supported the study on Human rights and HIV; (iv) the Legal Environment Assessment (LEA) planned to be conducted by UNDP led to the training of a team of CSOs and government representatives on LEA in Istanbul during 2018. The LEA activity was not completed as the Global Fund was conducting a human rights-based programming baseline assessment in the country, and UNDP was requested to postpone the LEA to 2020. Given the onset of the COVID-19 pandemic implementation has not been possible.

Two technology-based activities to improve access of KPs to medical, psychological and legal services include: (i) a HIV human rights app targeting key populations to assist in locating sexual and reproductive health services; and (ii) services for victims of gender-based violence for SW. Although not exclusively KP centred, a comprehensive sexuality education platform included a component addressed to young KP.

Among the JP priorities to enhance community-based testing UNFPA and ATSR – CSO teamed up to launch a training and accreditation programme of KP community-based testing agents. Actual training will start in early 2022.

Of those activities that are not KP centred but have high relevance to KPs, JP priorities for testing and treatment included four activities: (i) the introduction of screening guidelines; (ii) the PrEP feasibility study and (iii) launch of the cascade training; and (iv) the assessment of 3 out of the 4 hospital based PLHIV treatment and support services.

Social protection for PLHIV is one of JP priorities during the period under review. Given the high representation of KPs within the PLHIV community, they also benefit from the social protection interventions. A PLHIV COVID-19 nutrition needs assessment, later extended to MSM, was conducted in April to May 2020. The findings were used to kick off two activities in collaboration with the National Institute of Nutrition, NAP, and UNAIDS Secretariat: (i) strengthening the capacity of health personnel on PLHIV nutrition needs; (ii) and raising awareness among PLHIV communities on nutrition. Leveraging the study, the JP advocated with the Ministry for Social Affairs for fast-track PLHIV access to free health coverage and social services.

As regards JP outputs on financial sustainability, technical assistance was secured to the CCM for a risk analysis and a transition strategy in the light of Global Fund imminent transition.

Activities directed primarily to the general population but may have relevance to KP include: (i) the technology based CSE for in school adolescents and the App" Sexo-santé" implemented by ONFP; and (ii) an M&E mechanism for the implementation of the national Adolescent and Youth health strategy 2020-2030.

Remotely relevant to KP, is the integrated essential package of quality services in maternal and newborn heath, positive parenting in community maternal and child health centres; the eMTCT trainer guide developed and the training conducted with Global Fund support in 9 out of 24 governorates. Activities planned but not completed include the evaluation of the eMTCT national strategy with support to NAP and the eMTCT strategy in prison settings.

The agencies that have conducted KP centred, or highly relevant activities are the UNAIDS Secretariat, UNFPA, UN Women (in 2018-2019), UNODC, and WFP (in 2020-2021).

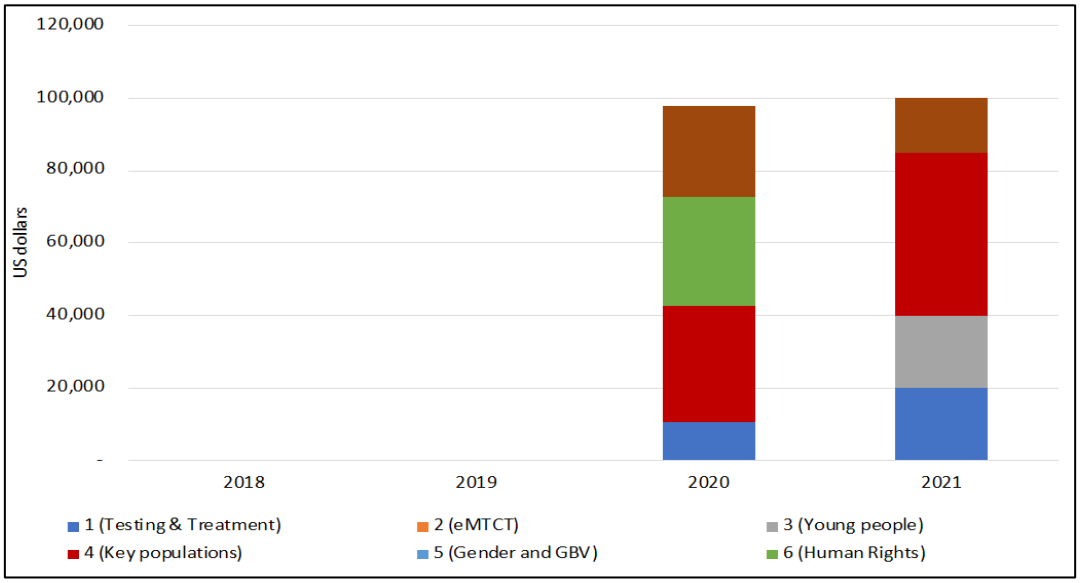
Budget wise, based on JPMS data, JUNTA in Tunisia received UBRAF funds equivalent to USD 100,000 in 2018, and Business Unusual Funds in amount of USD 92,800 in 2020 and USD 100,000 in 2021; about USD 35,000 and USD 45,000 were spent on KP strategic area 4 in 2020 and 2021, respectively. KPs may have benefitted as well from the other strategic areas: SRA 1 testing and treatment (USD 10,000 and USD 20,000 for 2020 and 2021), and SRA 6 Human rights (USD 35,000 in 2020).

In terms of distribution by agency:

- UBRAF: 2018-2019 out of the USD 100,000 total, USD 38,890 went to UNFPA, all for KP centred activities (about 40% of total allocation).
- BUF: in 2020, USD 92,800 total allocation to Tunisia was distributed as follows: USD 20,000 to WFP, USD 21,400 to UNODC, USD 21,400 to WHO and USD 30,000 to UNDP. In 2021 the total allocation (USD 100,000) was distributed as follows: USD 29,900 to WFP, USD 34,900 to UNODC, and USD 35,200 to UNFPA.

Some of these JPMS reported figures must be interpreted with caution, due to their limitation.

Figure 10. Country envelope budget by SRA (includes BUF budget in 2020 and 2021)



Source: JPMS

Partnerships of the Joint Programme in Tunisia

A close partnership exists with:

- The National AIDS Programme at the Division des Soins de santé de Base, Ministry of Health, and the Office de la Famille et de la Population (Principal recipient of Global Fund), Ministry for Social Affairs, Ministry of Justice, Ministry of Women, Family, Children and Seniors; the Central Pharmacy, Reference laboratories.
- Health professionals, professional societies, University experts
- Key Population networks, individuals, and PLHIV communities, thematic HIV/AIDS Civil Society Organisations.
- Professional societies (Conseil de l'Ordre des Médecins, des Pharmaciens, Societé Tunisienne de Gynécologie et Obstétrique, Association Tunisienne des Sages –Femmes)
- The Global Fund. UNAIDS and WHO are standing members of the CCM. The CCM is a systematic forum for consultations and inclusion given its structure with KP well represented (MSM, PLHIV, PWID etc). The CCM substitutes for a national coordination board for HIV, which is seen by some as a problematic governance issue. Furthermore, the JP is providing technical support for almost every activity under the Global Fund grants. UNAIDS is leading the Oversight Committee of the CCM and ensures full briefing and updates of the JUNTA at their regular briefings.
- Donors. Drosos Foundation supported UNODC.
- International NGOs, such as Médecins du Monde (migrants care and HIV).

Case study findings

Relevance and coherence of Joint Programme activities

Relevance of activities to key population needs and priorities[234]

This section addresses Q1: How relevant are the JP activities/initiatives for addressing the needs and priorities of different KP groups?

Summary on relevance of activities to KPs: JP contributed a combination of interventions directed to the general population and to KPs: 44 activities were planned, of which 37 were KP relevant and among these 24 were exclusively KP focused. Cosponsors who work in HIV are limited to 6 to 7 agencies, with a general trend of de-prioritisation of HIV, and some cosponsors changing the course of their focus from one biennium to the next, with the risk of jeopardizing the effect of their interventions. Between 2018/19 and 2020/21, there has been a loss in SW capacity building interventions, replaced by broadened general KPs interventions. Similarly, protection/prevention capacity building among women who inject drugs was abandoned in 2020/21. Whereas in Tunisia the HIV epidemic is KP driven, the allocation of UBRAF/BUF funds, already very limited, showed a KP priority area allocation limited to 35% and 45% of the total envelope in 2020 and 2021 respectively. The JP played a catalytic role in a few areas, such as advocating to place interventions in prison settings on the national agenda or using innovative and technological means for KPs to access information and services. The evidence supported by KIIs, and available documentation is strong.

As indicated above in Section 3.1. between 2018 and 2021, the JP planned 44 activities, of which 37 were KP relevant and among these 24 were exclusively KP focused (source: JPMS).

Apart from a few cosponsors, there is a trend of de-prioritisation of HIV and KP focus among cosponsors, with some discontinuing HIV related activities. On the other hand, outside the JP, new partners emerged: IOM, OHCHR, and UN Habitat. Cosponsors not represented on the team include the World Bank, UNESCO, and ILO. The World Bank comparative advantage in supporting social protection and financial sustainability approaches is hence missing on the team.

There is also a trend for cosponsors, to change course in their focus from one biennium to the next. For example, it was cited that UNFPA conducted highly relevant capacity building activities among sex workers in 2018-2019, then discontinued the activities due to unavailability of UBRAF funds for this area. In the next biennium, UNFPA focused on broader KP interventions including the App for locating KP services, CSE for young KPs. There was also a focus on general population interventions such as the CSE in schools, the maternal and new born health strategy and, and the M&E mechanism of the national youth strategy. Although the App and the youth KP centred interventions are highly relevant to KP in general, there is a loss in the specific coverage of SW, whereas data is showing that the voluntary testing in SW dropped over the years.

Incidence rates of gender-based violence have increased concomitantly, in particular among vulnerable women, with a peak in GBV reported during the mobility constraint in relation with COVID-19 epidemic[235]. UN Women have conducted capacity building on prevention/protection activities for women who inject drugs. However, the activity was discontinued in 2020/21 and so did UN Women involvement in HIV.

UNICEF had three activities planned in the JP plan in 2018-2019 some of which were not completed. UNICEF discontinued HIV related activities thereafter. None of the UNICEF activities are KP centred.

[234] Evidence: strong. KIIs (cosponsors); Refs: NAP 2016-2020 and 2021-2024. National AIDS report 2019. JPMS agencies' reporting, Business Unusual Funds proposal. Other reports: Drosos UNODC evaluation; National Harm reduction in prison setting strategy.

[235] UN Women leaflet on GBV and COVID-19

UNDP country-based activities were supported by the regional level, with Tunisian participation in capacity building for legal environment assessments (LEA) through a regional consultation. However, the LEA activity was not as previously mentioned. Hence the role of UNDP as per the Division of Labour and leadership for stigma mitigation at health service level and for legal reforms has not been visible at country level during the period under review. UNDP supported the chapter on human rights under the new 2021-2025 National Strategic Plan. However, given that stigma and discrimination is the JP area lagging furthest behind, a more outspoken role is expected from all cosponsors who have the capacity to influence the legal environment, and particularly from UNDP.

The allocation of UBRAF, then of the Business Unusual Funds (BUF) shows that about 35% and 45% of the total country BUF were allocated to KP in 2020 and 2021 respectively. This distribution of funds is explained by the fact that cosponsor activities follow NAP priorities, which include KP centred activities, as well as activities directed towards other vulnerable and general population groups (young people, women).

During the period under review, some JP interventions were clearly catalytic. A few examples follow:

Brokering role: WFP built a partnership with the UNAIDS Secretariat to implement a PLHIV (extended to MSM) COVID-19 nutrition needs assessment[236]. KPs were implementers of this activity. The needs assessment showed the drastic precarious situation PLHIV and MSM were living under. The findings were used to kick off two health personnel training and community awareness activities, creating a pool of community educators. The study helped lobby the Ministry for Social affairs for an HIV sensitive social protection scheme and cash transfers to PLHIV.

Innovation. Using technology-based support: with Business Unusual/UBRAF Funds, UNFPA set up "my sexual health" mobile app for young people that is KP relevant. In addition, UNFPA through a national CSO ATSR supported a HIV-human rights App targeting key populations (mainly SWs) to locate sexual and reproductive health services and services for victims of gender-based violence.

Scale up: Building on high level public awareness and advocacy activities, with UBRAF and Drosos Foundation [237] funds, UNODC supported the introduction of voluntary testing and treatment centres in six prisons, awareness raising of inmates, and the development of a draft drug prevention and human resources strategy in prison settings in 2019. This project further aimed to strengthen the partner CSOs (ATL MST/SIDA Tunis and Beity-a CSO that provides shelter and services for women victims of violence including SW and women who inject drugs) to deliver reintegration, harm reduction, HIV, viral hepatitis, TB prevention and substance use disorders activities. The initiative is now being extended to 12 prisons across the country, with information leaflets on service locations provided to inmates at the time of their release from prison.

Leveraging of funding and partnerships: The brokering role of the UNAIDS Secretariat, by securing TA to the CCM, accompanying the development of a financial risk assessment exercise, advocating to secure funding for KP activities during COVID-19 epidemic, has been recognized by all KIs.

[236] WFP. Food security and Nutrition assessment of people living with HIV Tunisia- Study Report 2021

[237] Drosos Foundation was established in late 2003 in Zurich, Switzerland. It is ideologically, politically and religiously independent. It aims at improving the living conditions of particular population groups. Accessible on https://drosos.org/en/about/#foundation

Human rights and gender equality[238]

This section addresses Q2: To what extent has the JP considered human rights, gender equality and more vulnerable KP groups in the design of JP's activities?

Summary of human rights and gender equality section: while human rights and gender are well spelled out in cosponsors plans, KIs have pointed out that the JP has not had a sharp focus on the groups most vulnerable, for example young PWID. Furthermore, KP led CSOs and peers call for JUNTA urgent action to help protect their security through high-level advocacy for law changes and mediation with the concerned government institutions (police, justice etc). Moderate evidence supported by documentation and KIIs.

Most cosponsors address adequately aspects of human rights and gender in their HIV related plans. UNAIDS Secretariat, with participation of JP, supported the elaboration of the 5 year strategic plan on HIV and Human rights that allowed the mobilisation of human rights matching fund within GF NFM (New Funding Model) 2 and at present, NFM3. Such strategy is also the basis for JP planning.

Equity is generally well understood by cosponsors. However, there is a large disconnect in perception between cosponsors, CSOs and KP communities regarding the targeting of the most vulnerable, and in spite of all efforts, the Joint Programme is perceived as intended for the general population more than for KPs.

Several diverse KIs indicated that collectively the JP should do more to address security concerns in connection with the criminalisation of CSO KP related activities. Indeed, the exposure of CSOs members and KPs who are arrested while carrying condoms, for example, to harassment and detention from the police is seen as a major risk, which the JP has not addressed. CSOs and KPs also called upon the JP to place attention on stigma at health facilities from the part of the health personnel, and the reception staff, that prevents many from using CCDAG and other public health centres. There was an urgent need for awareness raising and education on human rights and respect for diversity in sexual orientation to be directed to attending personnel across CSOs, and public institutions (health, judiciary, MoSA etc) and it was expressed that the JP should champion such courses of actions.

According to CSOs interviewees and as validated by the bio-behavioural data sources (IBBS 2009, 2014, 2018) for PWID the age of beneficiaries has fallen for PLHIV seeking care and the profile of care seekers has changed, with more educated young people among the newly infected (university, colleges, and schools) drawing attention of the JP to the double vulnerability of age and being a KP.

Coherence of JP activities[239]

This section addresses Q3: To what extent are the activities of the JP harmonised and aligned internally, and externally, with other actors' interventions?

Summary on coherence of the JP: There is a broad consensus that JUNTA works well as "one" voice around UBRAF priority areas. However, cosponsors commitment to HIV and KPs is variable. With very limited UBRAF resources, the JP depends on the willingness of cosponsors to mobilise, dedicate funds or – most often- to integrate the activities in their on-going programmes. But integration into broader agency activities runs the risk of the JP to lose its focus on KPs. The JP works well with the NAP, CCM and CSOs and JP non cosponsor members (OHCHR, member since 2011- UN-Habitat, IOM etc). Communication on the JP content for KP networks needs to be improved. The UNAIDS Secretariat is first to identify technical resources where JUNTA is not active. Internal coordination will benefit from a detailed planning at country level to prevent the fragmentation of JP outputs. Strong evidence: supported by good quality data and majority of KIs.

[238] Evidence: medium: UNAIDS/GF (2020) Human Rights and KP- KP KIIs, ATIOST, ATL+, UNAIDS, UNODC KIIs

[239] Evidence: strong. Supported by: NAP 2016-2020 and 2021-2025. National AIDS Report 2019. JPMS, Business Unusual funds proposal; UNFPA, UNAIDS Secretariat and UN Women, CCM and KP KIs (PLHIV, MSM).

The JP members that played a major role in implementation in 2018-2019 were: the UNAIDS Secretariat, WHO, UNFPA, UN Women, UNODC. For 2020-21, UN Women dropped its activities, with a change in the focal person to JUNTA, and WFP started a new set of interventions. New partners came into the picture: IOM, UN-Habitat, in addition to OHCHR and JUNTA established good working relationships with them. As indicated earlier, UNICEF was not active during the whole period under review. World Bank is not active in HIV in Tunisia, although they support a large cash transfer distribution programme to families below poverty level. UNESCO has a project officer in the country, but not active in the local team. UNHCR focuses on displaced populations and refugees, whereas IOM and UN-Habitat have supported access to HIV prevention and care to migrants. ILO has not been active so far on KPs but has approached the JUNTA to explore future collaboration. The UNAIDS Secretariat is often the broker to identify technical resources where the JUNTA is not active.

The JP contributions are assessed by the majority of KIs across sectors and available documentation as coherent to UBRAF and the identified national priorities. However, although commending, some KIs spoke about the length of finalizing tools and data collection exercises, as a result of headquarters required approvals, and complicated procedures such as the recruitment of consultants, tendering for subcontracts etc.

JUNTA works well as “one” around JP priorities (KIs). Although some cosponsors would have preferred, for the year 2018-2019, an enhanced joint country level detailed planning, at the level of outputs prior to cosponsors sending requests to their respective headquarters. So far, the agencies access UBRAF funds on the basis of a broadly agreed framework, a process that may lead to fragmentation and missed opportunities to leverage technical and financial resources for achieving more efficiently the jointly agreed outputs.

In Tunisia, cosponsors respect the division of labour and the varying beneficiary KP groups’ self-defined priorities. However, some KIs (among whom MSM KIs) claim that DoL does not take into account country level agencies’ comparative advantage. For example, some KIs questioned UNFPA comparative advantage in working with adult MSM, others questioned UNDP capacity in addressing stigma at the level of health facilities.

Cosponsors commitment to HIV and KPs is variable. Core and non-core investments as they appear in JPMS (that is the monitoring and reporting system of the Joint Programme) reflect a varying commitment among cosponsors, particularly that UBRAF brings little or no resources. Hence, in the absence of UBRAF available resources (like the country envelope), the JP depends on the willingness of cosponsors to dedicate funds or – most often- to integrate the activities in their on-going programmes as per their mission. But integration into broader agency activities runs the risk of the JP to lose its focus on KPs.

There is close coordination with the Global Fund. The CCM is the main coordinating body for the HIV response in Tunisia, informally substituting for the National Commission on HIV AIDS since 2012. All organisations represented in CCM harmonise their activities and align to the NSP. The UNAIDS Secretariat is leading the CCM oversight committee and ensures information sharing among JUNTA. The UNAIDS Secretariat role in coordination was acknowledged by almost all KIs.

Global Fund financed CSOs, believe that the JP as a trusted broker between government, the CCM and Civil society, could play a role in data coordination, to avoid production and reporting of multiple and sometimes conflicting sources of KP related data. Linkages with other areas of work have included advocacy for the integration of HIV (in general) in the CSE in school curricula, started in 2018.

Interviews with KPs highlighted insufficient knowledge in this group about the JP as a joint programme. Some knew selected United Nations agencies only. This could be due to an insufficient and inadequate communication of UN agencies on their KP activities. Cosponsors are known by different means: through associations, by the media (WHO COVID-19 TV awareness spots) and by internet (consultation of scientific articles, documentation and consultation of job offers), hence, the importance for the JP to diversify and adapt their communication channels/materials for a higher visibility among key populations.

The influence of ***the global and regional levels*** on JUNTA is described as having some value added. The input most valued was UNAIDS projections and size estimate data, WHO technical tools/guides from HQ level, and the support from the regional level in the form of terms of reference drafting and selection of experts by the UNAIDS regional office. Tools developed at the regional level were described as not necessarily adequate for Tunisia which is different from other EMRO/MENA countries, as cultural backgrounds, laws and practices are different. This calls attention to the importance of involving all the countries within a region during the development of tools.

Capacity and resources of the Joint Programme[240]

This section addresses Q4. To what extent are the capacities and resources of the JP appropriate for the work with and for different KP groups?

Summary of capacity and resources section: Both the human and financial resources dedicated to the JP are insufficient compared to KP HIV response needs in Tunisia and in the light of little prospects for additional investments from the public sector. Financial resources available to the JP are limited for HIV and less than 40% is allocated to KP interventions. The agencies active are the UNAIDS Secretariat, UNFPA, UNODC, WFP and WHO. A varying presence of cosponsors results in missed capacities weakening the team as a whole. To off-set the missing technical capacity, the UNAIDS Secretariat and the rest of JUNTA mobilise ad-hoc expertise. However, continuous access to specialists in the law, human rights and KP, resource mobilisation, communication, and health economics could have helped achieve UBRAF targets in a timely manner. Strong evidence: supported by good quality data and majority of KIs.

Both the human and financial resources dedicated to the JP are described by all KIs, without exception, as insufficient compared to KP HIV response needs in Tunisia. Human resources wise, the UNAIDS Secretariat has only one person who undertakes all roles entrusted to the secretariat: convenor, coordinator, TA source for data and advocacy. The rest of the cosponsors dedicate between 5% to 20 % of one person to HIV related functions. WFP, UNODC, UNDP have regional focal points from the respective regional offices. The latter have been active in supporting country activities as part of multi country initiatives or in response to specific demands from the country level but to varying degrees. KIs from different sectors indicated that the JUNTA was lacking capacity in human rights and KP, the law, resource mobilisation, communication and in health economics, noting that this capacity was accessible on demand through experts and consultants.

Table 34: KIs self-reported percentage of focal person time dedicated to HIV (Oct 2021) by agency

Agency	UNAIDS Secretariat	WHO	UNDP	UNFPA	WFP	UNODC	UN WOMEN	UNICEF
% of individ-uals time	100%	5% of a medical officer	5% of Local area manager + regional support	15% of Programme officer	20% of Senior officer + regional support	1% consultant + regional support	0	0

Financial resources available to the JP are limited. The total budget by funding source across all UBRAF 2018-2021 Strategic Results Areas (SRAs) and agencies/cosponsors between 2018 and 2021, shows that there was no budget from the country envelope for 2018-2019. BUF budget was about USD 100,000 in both 2020 and 2021, albeit with different allocations between SRAs in each year. The cosponsors have also changed from one year to the other. Non-core resources remained very

[240] Evidence: Strong. Supported by government, CCM, cosponsorss, CSOs KP KIIs. JPMS funds distribution. Human resource distribution table (JUNTA self-reported)

limited: in a range of USD 20,000 and USD 30,000 in 2018 and 2021 respectively, reflecting very limited efforts, or successful efforts, in resource mobilisation by JUNTA.

Although the role of the UNAIDS Secretariat is well recognized, it is overstretched to address the array of KP TA needs. The situation is exacerbated by the lack of government ability to invest in KP prevention response, which is exclusively supported by the Global Fund.

Efficiency and effectiveness of Joint Programme activities

Implementation of activities, UBRAF targets[241]

This section addresses Q5: How well is the JP achieving the UBRAF outputs and which areas needs strengthening and why?

Summary of efficiency and effectiveness and mobilisation of KP led communities: Delays due to the COVID-19 pandemic and lack of mobility affected the implementation across the JUNTA. Notwithstanding, reporting in the JPMS as per UBRAF planned outputs show good use of resources for advancing some targets that are highly relevant to KPs (see below). However, lengthy procedures affected the implementation of activities. JP efforts in advancing the areas of testing and treatment, social protection, human rights, young people, and financial sustainability have been uneven. Access to testing is still a major challenge for all KPs, but mostly for SW and PWID. Stigma, discrimination and law reforms have not seen advances during the period under review. Analysis for preparedness and the transition were completed, but long-term financial sustainability will remain a standing issue for the JP. Cosponsors and the Secretariat have been effective in ensuring the participation of KP in policy and programme planning exercises. Evidence supported by documentation and KIIs is moderate.

Delays due to the COVID-19 pandemic resulted in mobility issues which in turn affected JP implementation across JUNTA. Notwithstanding, reporting in the JPMS as per UBRAF planned outputs show achievements in the targets that are highly relevant to KPs (see below). However, lengthy procedures in connection with calls for proposals, committee decisions, and consultant recruitment further affected the implementation of activities. Creative means allowed for continuation of the JP activities during the pandemic related restrictions including virtual workshops, internet-based consultations and telephone-based problem solving/mediation took place.

The contribution of JP activities (as of end 2020[242]) to outputs and intermediate outcomes is discussed in 4.2.4 below by the following priority areas:

1.HIV Testing and Treatment: The 90-90-90 targets was reported in JPMS as being “on track”. The cascade analysis undertaken in 2018 shows that targets were very far lagging behind (first 90: 68%; second 90: 50%; and third 90: 59%). Given the lack of improvement in testing among KPs, the national targets (on which JP is aligned) are unlikely to have been achieved. The operational plan of the national testing strategy is currently being finalized and signed off. It includes the operationalization of testing innovations including self-testing and community-based testing.

HIV prevention among key populations. The target related to 80% of MSM, PWID and SW having access to combination prevention is reported on JPMS as on track. Strategic data is now available: a needs assessment was conducted in partnership with the NAP and CSOs on combination prevention services; The preliminary results from the IBBS 2020-2021 were shared on 1 December 2021 and the KP size estimation survey is being finalised. A national workshop launched a consultation process for stakeholders on introducing PrEP in the country. The cascade of PrEP training is also to be launched in a near future.

[241] Evidence; Medium: Reports from JPMS, review of cosponsors documents, Gov, cosponsors KIIs
[242] Joint UN Programme on HIV AIDS- Tunisia Country Report 05.05.21- internal UNAIDS Draft

As an indication of the magnitude of the interventions, for example in prison settings, by the first trimester of 2019[243], through a Drosos funded UNODC project, testing and counselling services were delivered in partnership with an NGO to 1,112 prisoners, including 223 female prisoners. Additionally, 700 HIV/Hepatitis C tests were performed inside prisons; those testing positive for HIV were referred to the primary infectious diseases department in Tunis. In addition to training and information activities, the prison health programme has expanded from six to 10 prison sites.

Overall data shows that testing remains well below national/UBRAF targets. Whereas testing seems to have slightly increased among MSM[244], the 2018 rates of 7.8% among SW, and 20% among PWIDs are very low and warranted major efforts from the JP in this area of intervention.

The doubling of HIV prevalence rates (from 6% in 2017 to 11% in 2021) among PWID as per the IBBS 2021, indicates that attention had not been sufficiently focused on addressing the needs of PWIDs, although trends were already upwards for several years. The national harm reduction in prison setting strategy exists but has yet to be translated into budgeted interventions. Mention was already made about the younger age of KPs that need attention with approaches more attractive to enlist this age group.

2.HIV-sensitive social protection. The target for 2021 on social protection was reported to be on track. WFP and the UNAIDS Secretariat used the results of the survey on PLHIV nutritional needs to lobby the Ministry for Social Affairs to secure financial compensation for PLHIV. However, KPs do not benefit from such compensation unless they are at the same time PLHIV. This area needs JP attention until it is fully institutionalised.

3. HIV-related health and education needs of school children, adolescent and youth. The target "supportive adolescent and youth sexual and reproductive health policies in place" is on track. UNFPA Tunisia, in partnership with the Arab Institute for Human Rights and ATSR, and in collaboration with line ministries linked with education, and CSOs resumed their activities after the COVID-19 mobility restraint. A curriculum and accompanying training tools were developed for roll-out in over 130 schools across 13 governorates; implementation began in September 2021. Given that sexuality education is a sensitive issue, the JUNTA teamed up for a media advocacy campaign. This achievement stands out given the multiple turnovers of the ministers of education and the uncertain commitment to CSE within the Ministry of Education. Components of the CSE address respect of diversity and human rights. Yet, this area of work intended to address adolescents and young people in general does not necessarily meet young KP needs.

4. Human rights, stigma and discrimination. The related target "by 2021, 50% reduction of cases of stigma and discrimination against KP and PLHIV with focus on health settings; and law reform launched in newly elected parliament" is off track. The UNAIDS Stigma index 2.0 was not implemented neither was the UNDP LEA. However, the new national strategic plan 2022-25 has taken into account recommendations from the UNAIDS Secretariat supported analysis of human rights and HIV and UNDP supported the chapter on human rights of the 2021-2025 NAP. Furthermore, as a partner, OHCHR together with the UNAIDS Secretariat and CSOs facilitated the integration of KP HIV rights in the Universal Periodic Review (UPR) of Tunisia[245] in 2017, a highly strategic intervention well noted in the questions of the Human Rights Council to the country and is currently leading a consultative review prior to Tunisia 2022 UPR.

5. Investment and efficiency. The target "by the end of 2021, the country has prepared for transition and sustainability for the HIV response including funding" is reported as being on track. The UNAIDS Secretariat supported TA for a transition preparedness study. However, the long-term achievement and feasibility of the strategy seem uncertain, given the limited interest of donors and government inability to make additional commitments at this time to cover KP related aspects of the response.

[243] APMG HEALTH- Focused Country Evaluations- Tunisia HIV Evaluation- Field-based Evaluation- The World Bank and Global Fund- March 2019 (GF outputs evaluation)

[244] MSM testing increased from 32% in 2017/18 to to 36% in 2021, Source: IBBS 2018 and 2021 GAM

[245] United Nations Human Rights Council. Universal Periodic Review – Tunisia - Summary of stakeholders' submissions on Tunisia* Report of the Office of the United Nations High Commissioner for Human Rights

Since the onset of the COVID-19 epidemic in Tunisia, the UNAIDS Secretariat was pro-active within the CCM to secure around USD 235,000 from the Global Fund. This includes coverage with PPE for health professionals in KP and PLHIV care delivery centres and for PLHIV and communities. It also covered the costs of PCR/GeneXpert machines for COVID-19 testing. Furthermore, within the CCM, the JP assisted with developing a request for up to USD 1.5 million from the Global Fund in 2021. The funding was foreseen to contribute to the reduction of COVID-19 impact on the HIV response, and securing continuity of services for KPs. Funds were also mobilised to inform, orient and educate PLHIV and KPs on HIV and COVID-19 prevention and care (USD 20,000 through the UN multi-partner trust fund for social COVID-19 impact).

Some KPs were critical with regard to the training delivered by the Global Fund financed CSOs or by the cosponsors. They indicated that material used was rather obsolete; it needed to be updated with the latest technical information, and its content needed to be more attractive to break away from repetitiveness. The JP was solicited to help put in place a "training standard" mechanism for KP directed training content.

KP members who have multiple needs (subsistence, health, psychological and legal support etc) require an integrated approach (including OST for PWID) rather than a fragmented implementation of activities (attributed by some KIIs to the division of labour which fragments inputs across cosponsors). CSOs working with young KPs indicated that this group needs more technology-based approaches. To address needs of sero-discordant spouses/partners and family members (children, adolescents) different skills and services, like paediatrics, sexual and reproductive health services and psychological support are required.

Support in mobilising and empowering key population led organisations

This section addresses Q6: Role of the JP in mobilising and empowering KP-led networks in the monitoring and accountability of policies and programmes and implementation of services?

The UNAIDS Secretariat ensures inclusion of KP in monitoring and evaluation processes as part of the CCM and the NAP. As indicated earlier KPs feel that their recommendations are not included in full, particularly in the NAP. Looking at cosponsors KP centred institutional capacity building, UNFPA set a good practice by supporting a strategic organisational capacity building in a SW association.

Major CSOs (ATP+, ATL Tunis, Sfax, ATIOST) have the capacity and experience to work with KPs as described in the Global Fund grant documents. These CSOs benefit from tangible institutional support for infrastructure, vehicles, staff salaries, and resources to buy TA, that allow implementation of the activities/plans funded by the Global Fund. The situation is much different for community and local KP groups. Cosponsors and CSOs describe the potential for KP groups to leverage new knowledge for transformational changes, and to integrate it as part of their own community-based activities as very low. The more socio economically vulnerable the group is, the lower the return on capacity building and empowerment. MSM are perceived as in a better position to leverage support and resources as they are generally better educated, have a higher socio-economic level and know better how to benefit from a large network. There is a certain level of mistrust among CSOs and KP networks.

Response to COVID-19 pandemic[246]

This section addresses Q7: How effective has the JP been in responding to KP needs in humanitarian settings and KP needs during the COVID-19 pandemic?

Summary of the JP response and COVID-19: The JP response was timely, nimble and achieved the following: submission of a Business Unusual Funds proposal that was subsequently funded; UNAIDS advocated for the issuance by MoH/NAP of travel permits for CSOs personnel, and to maintain the continuity of selected services (e.g., treatment and care for PLHIV); UNFPA distributed PPE to primary health care centres; WHO advocated for donations to mitigate test shortages and mobilised funds for PPE. While public services closed down, through existing coordination mechanisms the JP promoted the effective action of KP networks and peers through alternative service delivery, such as home distribution of treatment and supplies. The community-based approach which allowed to address holistically an array of needs was particularly appreciated by KPs. Strong evidence: supported by good quality data and majority of KIs.

At the time of the outbreak of COVID-19, many primary health care services were closed and hospital departments were diverted for COVID-19 patients. CCDAGs were closed and hospital-based facilities were running at minimum while CSO led facilities were temporarily closed. Fear of transmission perceived by health personnel, lack of PPE and absence of clear guidelines linking HIV and COVID-19[247] exacerbated the situation. The crisis has had a great impact on the psychological, financial, health and social situation of PLHIV and KP as documented in the WFP survey referred to previously in this report. Centralisation and heavy bureaucracy severely hampered the efforts of stakeholders, at the beginning, particularly CSOs in the care of PLHIV (e.g., difficulty in securing travel authorizations, no clear health protocols to protect members of CSOs and beneficiaries of HIV services).

The JP response was timely, nimble and achieved the following: submission of a Business Unusual Funds proposal; UNAIDS advocated for the issuance by MOH/NAP of travel permits for CSO personnel and to maintain the continuity of selected services (e.g., treatment and care for PLHIV); UNFPA distributed PPE to primary health care centres; WHO mediated to get a donation and filled test shortages along with mobilising funds for PPE. While public services closed down, using existing coordination mechanisms the JP promoted the effective action of KP networks and peers through alternative service delivery, such as the home distribution of treatment and supplies[248].

Lessons learned from COVID-19 response to HIV and KP were documented in a compendium of good practices and will be built upon and addressed in national strategies. From among the observations made by KPs and government KIs the JP cosponsors contributed to bringing services to the beneficiaries, meeting their needs in a holistic and tailored manner. However, the assessment of their initiatives showed that the community-based HIV service delivery during the COVID period reached only partially KP groups. The detailed data on the number of beneficiaries and effect are not available at this time[249].

*"*The COVID-19 health crisis and the collaboration that we have experienced between NGOs and centres of support allowed me to see on the field what the right of access to health care is. I have supervised many patients who risked interrupting their treatment because of the difficulty in accessing hospitals but also stigma they experience at each of their visit. I keep the memory of a mother and her two children to whom I distributed the treatments, which were impossible to move for lack of financial means *"KII from a PLHIV support group that includes KPs (source: Capitalisation report).*

[246] Evidence: strong. Supported by "Capitalisation COVID-19, HIV" Report and gov., CSOs, KPs and cosponsors KIs
[247] Rapport de Restitution_CapitalisationVIH-COVID19 (pdf form) - UNAIDS
[248] Restitution CapitalisationVIH-COVID19 (available in PDF form) - UNAIDS
[249] Ministère de la Santé Publique. Direction des Soins de Santé de Base (DSSB) et ONUSIDA. Capitalisation des bonnes pratiques et innovations en matiere de riposte au VIH pendant la période de crise COVID-19. Novembre 20.

Contribution of the Joint Programme to outputs and intermediate outcomes

This section addresses Q8: How has the JP contributed (intermediate outcomes->strategic priority outcomes?

The following review links the JP outputs to intermediate outcomes with some examples as per the Theory of Change (TOC):

Example 1, from data to improved services:

JP output	JP intermediate outcome
Data informs strategic planning processes which support investments in high impact health and enabling strategies and interventions targeting high burden KP groups and locations.	Increased provision of comprehensive and integrated service packages targeting KPs including youth KP in user friendly /safe settings.

During the period under review, the JP contributed significantly to making available strategic and essential data: epidemiological data, and information from consecutive bio behavioural surveys (2009, 2014, 2018, 2021); projection data for KP size estimates; and nutritional needs in PLHIV, including KPs. Size estimates and bio behavioural data trends constituted a basis for the NAP 2021-2025, the new testing strategy as well as the Global Fund proposal development (in 2019 and to inform the transition).

A rapid situation assessment on HIV, STI, viral hepatitis and TB, in four prisons including a juvenile detention centre was conducted. The results were used to develop a drug and HIV prevention, treatment and care national strategy for prison settings. The strategy is under the purview of the Ministry of Justice and Prison management authority. The full endorsement and implication of these institutions in the HIV response with focus on PWID is an achievement. The ensuing steps, in terms of organising, budgeting and ensuring continuity of the services will depend on these institutions and the partners, including Global Fund to make it happen. Until now, the extension to ten prisons is an indication of solid commitment (Drosos and BUF funding).

The TG mapping done in 2018-2020 by UNFPA was the first of its kind and was meant to influence targeted prevention interventions. A specific intermediate outcome can be seen in the 2021-2025 national strategic plan reads “95% of transgender populations in all their diversity, access and benefit from the combined prevention service package according to national standards based on their needs and specifics and sensitive and gender”.

Notwithstanding, there are serious gaps in availability of national quality data on KPs: absence of service use data and of baseline service quality across public and non-governmental services and the non-completion of the Stigma index coupled with a lack of details in JPMS information (quality and quantity). JP financial expenditure data was very difficult to access as it is not compulsory in JPMS, and unavailable from other sources. Service data would allow addressing the regular stock out and quality of condoms, ARV stock management (expired ARVs), and of reagents for analyses (CD4 / CV).

Example 2: <u>From people centred/community service delivery to Increased access to a package of social services</u>

JP output	JP intermediate outcome
People centred comprehensive service packages established and innovative service delivery models. Linkages to other health/social services.	Increased provision of comprehensive and integrated service packages targeting KPs including youth KP in user friendly /safe settings.

The survey on PLHIV, including MSM, and nutritional needs which was executed by PLHIV and KP volunteers and community agents allowed a first-hand assessment of beneficiaries needs for: food, psychological support, and cash (to pay rent and purchase basic supplies). This data was used by KP volunteers, and community agents to drive a multi-sectoral approach combining home based distribution of ARVs (3 to 6 months doses) and condoms/lubricants, personal protection equipment (masks and gel) collected from the health facilities, together with food collected by non-profit organisations and individuals. The approach also connected the beneficiaries to hotlines for psychological support. This was described to have contributed to good adherence to HIV treatment (testimonies, no hard data) and to minimising the risk of exposure to the virus. This initiative highlighted the success to address HIV in a holistic approach and the findings are likely to influence the delivery of the social package by government structures with a bearing on how the JUNTA capitalizes on its different comparative advantages in addressing PLHIV and KP needs.

Although not under the JP purview, KP directed services are secured through CSOs financed by the Global Fund or public facilities (CCDAGs, ONFP and primary health care centres) that are generally poorly equipped and staffed[250]. KPs indicate that an array of services has become available these past years such as for psychological and legal support, social assistance and medical assistance. However, the services are not well known by the community, are not adapted to needs and are often uncoordinated. The accreditation of community agents, including KP peer educators that was launched by UNFPA and ATSR will allow the delivery of services to the hard to reach, with an expected higher satisfaction with the quality of services.

Response to contextual factors[251]

This section addresses Q9: How well is the JP responding to contextual factors such as harsher/more conservative political environments, decreasing resources, other?

Summary of the JP response to contextual factors: the JP efforts in changing the enabling environment, in light of ambivalent social values and emerging conservative voices, were not commensurate with the needs. UNDP, whose role is to lead in this area, needs to step up its leadership role and work within JUNTA and with other partners such as OHCHR and CSOs. As for financial sustainability, beyond providing technical support to analysis and resource mobilisation, the JP needs to step up its own resource mobilisation actions with donors and local private sector, as part of social solidarity initiatives. Evidence is weak

Enabling environment and stigma and discrimination. The environment regarding respect of KPs has deteriorated ever since 2011, with the emergence of religious conservative parties and social influencers. The situation is particularly dire in terms of stigma, punitive laws and a lack of reporting

[250] Ministère de la Santé Publique. Direction des Soins de Santé de Base (DSSB). Plan Stratégique National de lutte contre les IST et le VIH/sida 2021-2025 de la Tunisie; Draft 3, VERSION DU 10 JUIN 2021

[251] Evidence is weak. KIIs, JPMS reporting, NAP 2021-2025: JUNTA reporting of activities tended to be over stated; did not translate into actual changes; KP KII critical of JP in this area.

for abuses and violations[252]. In spite of JP efforts thus far, such as supporting the national strategic plan on HIV and human rights with full ownership of the MoH, advocacy in other circles (CCA/UNSDCF, OHCHR letters to the government on rights violation case (LGBTQ+, etc.), UNAIDS chairing CCM Oversight and appeals to eliminate stigma in treatment centres, etc.), the JP needs to step up its collective weight in this context to ascertain protection and enforcement of positive laws and removal of negative and hostile laws and practices. This was echoed by many KIs.

KP KIs and the service assessment studies[253] have reported deteriorating attitudes of health personnel in primary health care centres including specialised PLHIV care centres. UNDP had an activity planned to address stigma in health settings, however it was not completed.

Sustainability of the HIV response/ transition. UNAIDS provided technical expertise to the CCM to develop a risk assessment exercise for 2022-2025 and prepare a transition proposal for the interim period prior to the Global Fund exit predicted in 2028. The transition project has been finalised and highly appreciated by government, non-government partners and the CCM higher management. However, the JP needs to take responsibility directly for resource mobilisation and reach out to new partners, including local private sector enterprises in the context of social solidarity for vulnerable populations.

Sustainability of the results of the Joint Programme's activities

Summary of the sustainability section: HIV has ceased to be considered a priority on the national agenda. However, health systems are relatively solid to sustain, with Global Fund financing, some level of KP response. Ensuring continuity of funding is vital, as CSO KP activities are funded in majority from non-state funds. A sustainable response requires building CSOs and KP networks capacity in managerial and financial management. The JP recent activity for accrediting community agents for testing is one good approach towards sustainability of prevention activities. Bureaucratic and lengthy procedures impede the full involvement of small KP networks due to lack of financial and managerial capacity. From the financial sustainability angle, KIs expect the JP to approach donors, including the private sector, as a team, and to prioritise and promote one priority issue at a time. Evidence is moderate.

Sustainability of the results[254]

HIV has ceased to be considered a priority on the national agenda, hence government political and resource commitments to HIV have remained the same towards the purchase of treatment, supplies, and to cover the costs of personnel in public institution, with no budgets specifically allocated for KP prevention interventions in the NAP, these being drawn from GF, except in the last 2021-25 NAP. On the other hand, health systems are relatively solid to sustain, with Global Fund financing, some level of KP response. The JUNTA and CSO advocacy efforts have provided the necessary technical support but were unable to improve government commitment to HIV KPs in light of continuing political and administrative instability and overall economic difficulties affecting the public health budget as a whole.

A more sustainable response requires CSOs to demonstrate a capacity to sustain programme implementation while being self reliant (own resource mobilisation, volunteers networking, innovative ways..). For example, the CSOs accreditation for prevention initiated by JP is likely to develop skills in a standardized fashion for the delivery of community-based services, as a complement to public and CSO services and likely to contribute to continuity of prevention and quality services for KP.

[252] Ministère de la Santé Publique. Direction des Soins de Santé de Base (DSSB). Stratégie nationale sur les droits humains et le VIH-SIDA 2019-2023

[253] UNFPA Etude sur l'accès et la qualité des services SSR / PF en Tunisie- 27 Juin 2021, accessible at https://tunisia.unfpa.org/fr/publications/etude-sur-lacc%C3%A8s-et-la-qualit%C3%A9-des-services-ssr-pf-en-tunisie

[254] Evidence: medium. Gov. CSOs and Cosponsors KIIs, GF documents, cosponsors reporting in JPMS

As expressed by several KIs, bureaucratic and lengthy procedures impede the full involvement of KP networks. For example, JP, NAP and the Global Fund CCM, impose financial managerial capacity as a condition to be eligible for project execution. This capacity does not exist within small local CSOs. These conditionalities prevent small networks from becoming implementing partners.

KP CSOs also called for the JP to broker KP representation in essential ministries as full staff (e.g., Ministry of Health and Social Affairs) as a way to lobby and keep a KP focus in the ministries budget allocations.

Financial sustainability

As indicated in the financial response section, government resources are limited and there is little expectation that government will invest resources towards KP needs in the immediate future. On the other hand, the Global Fund has been quite responsive, including in meeting emerging requests (i.e., the Acceleration Fund in 2019, COVID-19 in 2020). In this context, the JP collectively could have exerted more efforts to reach out to the private sector and to bilateral donors during this phase.

In order to address sustainability issues KIs expressed that innovation and out of the box approaches, like a more attractive evidence-based communication strategy involving social media is needed. Because of lack of visibility as a Joint Programme many KIs were not aware of the existence of a Joint Programme on HIV AIDS in the country and were unfamiliar with the agencies and their missions.

Conclusions and considerations regarding future priorities

Summary conclusions: status of Tunisia key population response

Political instability, turn over in government officials and of focal points in public institutions, serious economic challenges resulting in a reduction in sectoral budgets, and diversion of priorities in health and social sector altogether were exacerbated by COVID-19 related socio-economic problems. The JP has played a strategic role over the years in the HIV response and targeting KPs. The UNAIDS Secretariat secured essential projection and KP size estimate data and international TA to the CCM for a national financing transition plan in view of the Global Fund exit predicted in 2028. Other cosponsors supported developing and introducing tools (WHO), operations research (UNODC) in prison settings, and overall reached out to groups not addressed so far including TG (UNFPA). The JP contributed to capacity building of sex worker networks (UNFPA), women who inject drugs (UN Women), informed about PLHIV nutrition needs and supported a health and nutrition national plan to build the capacity of health personnel and PLHIV, including KP communities themselves (WFP). The JP worked very closely and secured timely TA to Global Fund CCM, to NAP, government institutions and CSOs at their demand. JP active cosponsors have been responsive in a timely manner and adapted to emerging new priorities such as those emanating from the COVID-19 epidemic.

HIV has ceased to be a priority for both national institutions and several cosponsors at the country level. Consequently, only a few cosponsors bear the responsibility for the KP response and show continuous commitment. Furthermore, agency human and financial core resources dedicated to Tunisia are minute, resulting in a tendency to address HIV prevention in the general population, and losing the KP focus, with exceptions. In the light of the epidemiological profile in Tunisia, where HIV transmission is dominant among KPs, there is a need for JP to revise its allocation and to redirect its major -if not exclusive- focus on KP interventions to drive changes.

Health systems are relatively solid to sustain, with the Global Fund financing, some level of response for KPs. However, with the prospects of the Global Fund exit, the JP needs to help the government and CSOs find alternative funding. The JP will need to endeavour to help NAP mobilize the resources needed for the continuity of services should the Global Fund phase out. Integration into national and

public and private social initiatives call for a role of the JP along with a more active World Bank in social protection and funding in Tunisia.

The JP role in supporting KP networks in programme implementation consisted in lobbying for KP inclusion in all aspects of decision-making around national strategies and the Global Fund programming. Additional leveraging /brokering of social contracts and simplification of procedures is needed to allow KP participation in programme implementation, and to break away from bureaucracy and conditionality and build financial and implementing capacity of KP groups and networks. The JP has a role to play to foster and reinstate trust between major CSOs and KP networks.

The JP should also consider promoting representation of KPs in sectoral ministries as part of the department full staff in order to better influence planning and budgeting: Ministry of Women, Ministry of Social Affairs, of Youth etc. and protecting KP rights, paying attention to the young KP and their different needs.

In conclusion, the JP has worked hard in putting prevention responses back on track after COVID-19. Combination prevention, and increase of treatment adherence, testing among KPs will remain central to the success of the JP.

“In a country where Government is unable to commit resources and personnel, where Global Fund is exiting, the only way to respond and protect KPs in the context of HIV, co-infections and sexual and reproductive health is through a reshaped UN” KI.

Considerations

The multiple discussions and the review of the available documentation highlight the need to re-energize the role of the JP to close the gap in the response. In moving forward, the JP may wish to consider focusing in the next two to three years on:

Allocation of UBRAF and Country Envelope: The distribution of BUF funds shows that 35 and 45% of funds were allocated to KP exclusive focus in 2020 and 2021. This is a good percentage, however, given the limited UNAIDS core resources, and in the light of the epidemiological profile of the epidemic in Tunisia, resources should clearly be allocated to highly effective KP focused interventions, rather than for general population aimed interventions.

Testing and treatment in prison settings: The JP needs to institutionalise government (MoJ) preparedness for integrating prevention and access to care and support services in prison settings across the republic and advocate for the rapid expansion from 10 to the 32 existing institutions. The integration would level up combined prevention/testing (HIV, TB, Hepatitis C and B) in prisons based on the UNODC pilot studies.

Harm reduction for the general population: The JP is in a position to strongly advocate for the operationalization of the newly approved harm reduction strategy for the general population, given the prevalence data among PWID, the little information available about this population group and their exposure to multiple risk behaviours and social and economic exclusion. The younger age of KPs in this group requires innovative/attractive communication and services, delivered through different entertainment and other outlets (night clubs, festivals etc and social media)**.**

Quick Roll out of PrEP: PrEP introduction was initiated and a great demand has been created among partners and beneficiaries alike. The PrEP Protocole is currently available. WHO and UNAIDS need to accompany the MoH and CSOs for a quick roll out throughout the country. Some CSOs have already conducted advocacy for their members to anticipate its quick implementation.

High-level advocacy to mitigate stigma at health facility level and decriminalise CSO activities: The JP role in bringing forward and opening a dialogue with Ministry of Justice, and the Ministry of Interior at the highest level is long overdue. Heads of agencies must work collectively and the UNRC should take responsibility for protecting the rights and safety of KPs and CSOs. Changes in the law will require longer collaboration with the civil society, the judiciary and lawmakers (once the

parliament is reinstated). JP needs to rally with the activists to further introduce decriminalisation of drug use (further changes to Penal code Article 52). **Financial sustainability and collective resource mobilisation for KP in HIV response:** Building on the CCM risk analysis and the financial transition, the JP must work collectively to mobilise resources, working as "One", and prioritising areas of focus. The involvement of the heads of agencies and of the Resident Coordinator will help in approaching bilateral and multi-lateral donors and public-private entrepreneurs in line with "Leave no one behind" principle. Social solidarity is currently being promoted by government and non-government partners, to address poverty and the underserved and socially excluded population groups, and the JP can leverage this opportunity to include KPs.

Beef up/strengthen JP capacity: The situation justifies increasing or leveraging from global and regional levels managerial and technical human resources and financial resources to support the JP particularly the UNAIDS Secretariat to effectively meet the national HIV goals and those of KPs.

The supply chain and quality of condoms deserve reflexion within the JUNTA, from an advisory and technical perspective, as an essential element of quality of services for KP. JP together with NAP and CCM should consider an assessment towards action oriented solutions, re-thinking the tendering criteria based on lowest costs, and exploring other MENA region country experiences such as joint procurement, joint quality control committees.

To optimize the use of human and financial resources in Tunisia context, HIV interventions intended for the general population, or that have very limited relevance to KP focus, such as the maternal and new born health package, CSE, and positive parenting in maternal and child health centres appear of a lesser priority for addressing HIV goals. They can be funded from other sources and should be phased out.

Finally, the JP should undertake annual risk assessments and regular evaluations to readjust the course of its focus ensuring its ongoing relevance in line with the epidemiological trends and varying contextual factors, etc.

Annex 1: Key informants – Tunisia

The table below lists the names, job titles and organizational affiliations of the key informants who were interviewed as part of the Tunisia country study.

Name	Position	Organization
UNAIDS Secretariat and Cosponsor Agencies		
Lassaad Soua	UNAIDS Country Manager	UNAIDS Secretariat
Yves Souteyrand	Representative	WHO
Ramzi Ouhichi	Programme Officer	WHO
Rym Fayala	Head of Office	UNFPA
and Olfa Lazreg	Prog. Officer Focal point for HIV	UNFPA
UNDP Sellema Houij	Program associate; HIV focal point	UNDP
UNDP Elfatih Abdelraheem (Cairo)	Regional Officer	UNDP
Latifa Beltaiefa	Program officer	WFP
Tariq Sonnan (Cairo)+	Regional Officer	UNODC
Yassine Kalboussi (Tunis)	Consultant	UNODC
Hela Skhiri	Former focal point JUNTA	UN Women
UNICEF (excused herself)	Representative	UNICEF
Government institutions		
Dr MoH Faouzi Abid	GFATM project management unit coordinator, former National AIDS programme coordinator at MoH	Global Fund/ CCM
Dr Samir Mokrani	National AIDS Programme coordinator	Ministry of Health/DSSB
Dr Khaled Kheireddine	Consultant, former GFATM project management unit coordinator	Office de la Famille et la Population- Principal recipient Global Fund
Dr Fatma Temimi	Director, Focal HIV programme	Office de la Famille et la Population- Principal recipient Global Fund
CSOs and KP networks		
Representative		ATP+ Association Tunisienne de Prévention Positive
Representative		Avocats Sans Frontières- ASF
Representative		Association Tunisienne de Lutte contre les MST/SIDA-Tunis
Representative		ATL+ Association Tunisienne de Lutte contre MST/SIDA Tunis
Representative		ATSR Association Tunisienne pour la Santé de la reproduction
Representative		Mawjoudin- LGBTIQ+
Representative		Association Boutheina – Safx

Name	Position	Organization
Representative		ATIOST- l'Association Tunisienne d'Information et d'Orientation sur le SIDA et la Toxicomanie
Representative		ATIOST
Global Fund		
Dr Ahmed Maamouri	Exec. Director	CCM
Dr Mohamed Chakroun	Chair and head of PLHIV Centre-Monastir Hospital	CCM
Key populations		
Representative, Tunis		
Representative, Tunis		
Representative, Sfax		
Representative, Tunis		
Representative, Tunis		
Representative, Tunis		
Representative, Tunis		
Representative, Monastir		

Annex 2: Bibliography/Background documents – Tunisia

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29. Wahid FERCHICHI - LES CIRCULAIRES LIBERTICIDES: Un Droit souterrain dans un État de Droit!
30. Ouvrage collectif - 2018
31. Wahid FERCHICHI - Les libertés individuelles, garantie de la non-répétition » Les libertés individuelles dans le Rapport de l'Instance vérité et dignité Etude élaborée par le professeur - Dec 2020; accessible at https://tn.boell.org/sites/default/files/2020-12/3.%20Etude%20les%20libert%C3%A9s%20individuelles%20dans%20le%20rapport%20de%20l%27IVD.pdf
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6. Ukraine country study: final report

17 January 2022

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Introduction and Context

Purpose and scope of the Ukraine case study

This case study is part of a larger evaluation to assess the relevance, coherence, equity, efficiency, effectiveness and sustainability of the UNAIDS[255] Joint Programme on AIDS (JP) support for key population (KP) programming at country level over the years 2018-2021, with a view to improving UNAIDS programming with and for key populations under the new UNAIDS United Budget, Results and Accountability Framework (UBRAF) 2022-2026. References to the Joint Team (JT) in this report refer to the United Nations Joint Team on AIDS in Ukraine, consisting of the UNAIDS Secretariat Country Office (UNAIDS SCO) and UN agency Cosponsors. The primary unit of analysis for the evaluation is how the Joint Programme has supported KP programming at the country level. Six countries were chosen for the case studies, covering all UNAIDS regions and a variety of epidemics. The six countries are Cameroon, Kenya, Peru, Thailand, Tunisia, and Ukraine. The case studies have been supplemented by document review and key informant interviews (KII) at the global and regional levels.

The KPs, as defined by UNAIDS, are commercial sex workers (CSW), gay men and other men who have sex with men (MSM), transgender persons (TG), people who use and inject drugs (PWUD and PWID), and prisoners, including young people who are part of these KPs.

Methods

The country case studies focused on qualitative analysis of JT and the Joint Programme activities in relation to country needs, examining progress made in KP programming, to gain a comprehensive and nuanced understanding of JT support and contribution to the KP HIV response at the country level. Additionally, the case studies focused on eliciting lessons learned, good practices, and examples of factors helping or hindering JT work with and for KPs. This case study was conducted through document review and KIIs with staff of the UNAIDS Country Office and Cosponsors, Ministry of Health of Ukraine, PEPFAR country team, the Global Fund and PEPFAR grant recipients, KP-led networks and NGOs working with and providing community services to KPs, other civil society organizations. A total of 19 interviews, involving 39 individuals were conducted in September-November 2021, using Zoom. A list of all KIs is provided in Annex.

The document review covered all documentation available in the Joint Programme Monitoring System (JPMS; including workplans, reports, funding proposals), statutory documents of national coordinating bodies and working groups, JT meeting minutes, activity reports and publications, applications and workplans of other donors (the Global Fund and PEPFAR), national strategies, policies and operational plans. Additionally, the contextual documents such as epidemiological publications and other assessments reports were reviewed. A bibliography of documents reviewed is in Annex.

The purpose of the country case studies was to collect country evidence to answer ten overarching evaluation questions, guided by the Theory of Change. There was a total of 115 activities implemented by the Ukrainian JT in 2018-2021 according to JPMS. The case study did not intend to provide a comprehensive audit of each activity. Instead, it has examined how various JT activities have collectively contributed to answering questions in the areas of relevance, coherence, equity, efficiency, effectiveness, and sustainability. While the direct attribution of the efforts of the JT Cosponsors to the country-level changes (successes and failures alike) is not possible to verify, the salient contribution of the JT in Ukraine is reported.

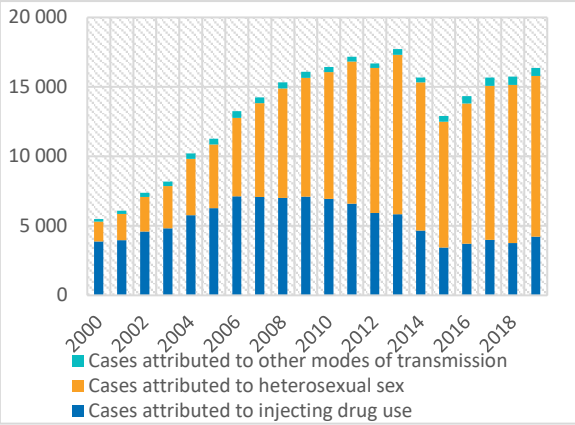
[255] References to UNAIDS in this report refer to the Joint United Nations Programme on HIV and AIDS, consisting of the UNAIDS Secretariat and UN agency cosponsors. The UNAIDS Secretariat in Thailand is referred to as the UNAIDS Country Office (UNAIDS CO).

National HIV Context and Programme Response

Ukraine's HIV Epidemic

Eastern Europe and Central Asia (EECA) is one of the few regions globally where the HIV epidemic continues to grow. UNAIDS estimates that between 2010 and 2020, the number of new adult HIV infections decreased globally by 23%, whereas in EECA, there was a 72% increase, the highest rate among all regions. Ukraine is one of the countries most affected by HIV in Europe, with an adult prevalence of 1.0%. It has experienced multiple crises since it emerged from the Soviet Union in 1991 including under two revolutions, the 2014 Crimean annexation, and the ongoing war in eastern Ukraine which had severe implications for the capacity and effectiveness of the public health system.

Figure 11. Number of HIV cases registered in Ukraine by year by mode of transmission



In 2020, the Ministry of Health of Ukraine (MoH) together with UNAIDS estimated that there were 257,000 people living with HIV (PLHIV in Ukraine.[256] The epidemic was initially driven by transmission among people who inject drugs (PWID). Overall prevalence among PWID in bio-behavioural surveys significantly decreased between 2009 and 2013 (24.2% to 18.1%, p=0.01), but then increased to 22.0% in 2015[257] and 22.6% in 2017.[258] The number of new HIV cases registered in health facilities decreased from the peak 21,177 in 2011, to 15,658 in 2020. The proportion of cases reported to have acquired HIV through heterosexual intercourse has steadily increased, reaching 71% in 2016 and remained stable until 2020 when it decreased to 59% due to resurgence of injecting drug use-related cases. However, a risk factor study indicated that at least 57% of cases registered in 2015 were among PWID.[259]

This evidence suggests that the epidemic in Ukraine continues to be driven by key populations. Table 1 shows the estimated population size and HIV prevalence for four KPs according to a national integrated biobehavioural surveys. There are studies indicating a possibility of outbreaks among MSM in several Ukrainian cities.[2,4]

Table 35. KP size and HIV prevalence estimates[5]

	Year	Prevalence	Population size
PWID	2020	20.9	350 300
MSM	2017	7.5	179 400
CSW	2017	5.2	86 600
TG	2017	11.7	8 200
Prisoners	2020	8.0	48 714

[256] Public Health Center of the MoH of Ukraine. HIV infection in Ukraine Informational Bulletin #51. Kyiv. 2020. https://phc.org.ua/kontrol-zakhvoryuvan/vilsnid/monitoring-i-ocinka/informaciyni-byuleteni-vilsnid).
[257] Dumchev K, Sazonova Y, Salyuk T, Varetska O. Trends in HIV prevalence among people injecting drugs, men having sex with men, and female sex workers in Ukraine. International journal of STD & AIDS 2018; 29(13): 1337-44.
[258] Sazonova Y, Saliuk T. Main results of bio-behavioural surveillance among key populations. Alliance for Public Health, Kyiv, Ukraine. 2018. http://aph.org.ua/wp-content/uploads/2018/10/OSNOVNY-REZULTATY-A4-ENG-site-version-16.10.2018_red.pdf).
[259] Dumchev K, Kornilova M, Kulchynska R, Azarskova M, Vitek C. Improved ascertainment of modes of HIV transmission in Ukraine indicates importance of drug injecting and homosexual risk. BMC public health 2020; 20(1): 1288.

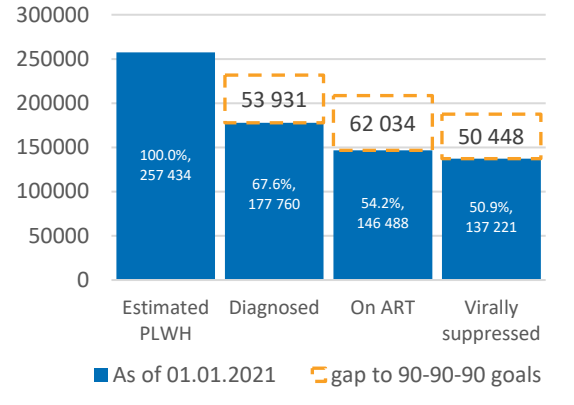
Ukraine's HIV Response

Ukraine made significant progress toward epidemic control reflecting strong stakeholder engagement from the Ministry of Health, the Public Health Centre of the MoH (PHC), international organizations including UN, donor agencies, and civil society.

HIV prevention coverage in Ukraine is one of the highest in the EECA region. It has been evolving gradually since the beginning of the Global Fund round 1 grant in 2004. In 2020, coverage of HIV prevention services was 73% among PWID, 28% among MSM, 57% among CSW, and 33% among transgender people. Despite the high prevention coverage, the number of syringes distributed per PWID per year was 87 (representing a minimal improvement from 75 in 2011),[260] much below the recommended target of 200 syringes per PWID per year recommended by WHO/UNODC/UNAIDS.[261] Harm reduction services are provided by a strong network of civil society organizations (CSOs) and are available in all regions of Ukraine.[262] Prevention programmes were funded exclusively by donors until recently. Due to implementation of the Transition Plan (see below Section 2.4), the GOU took over funding for prevention and is currently providing the basic prevention package to KPs through CSOs using a 'social contracting' mechanism. PrEP is available in Ukraine since 2018 through PEPFAR and the Global Fund support, but coverage remains very limited (<3000 total clients in 2020).

Opioid Substitution Treatment (OST) became available in Ukraine through donor-funded projects in 2004 and by 2016 has transitioned to the government funding. PEPFAR and the Global Fund projects continue to support psychosocial support for OST patients, quality improvement activities, and structural interventions aiming to facilitate scale-up. The scale-up was impressive compared to other EECA countries – currently about 16,000 people are receiving OST[263]. However, this represents only 5% of people who inject opioids, which is also lower than the recommended coverage of 20-40%.[6]

Figure 12. National HIV treatment cascade in Ukraine.



There has been a significant progress in the HIV diagnosis and treatment area, however the national HIV care cascade reveals large gaps between the number of people diagnosed with HIV, the number in active care, on ART, and virally suppressed. Among the approximately 257,000 estimated PLHIV in Ukraine, only 146,488 (54%) are receiving ART as of 01 December 2021.[1] The latest national bio-behavioural survey data show that only 52% of PWID are in HIV care, 38% are on ART and 28% are virally suppressed.[264] ART coverage among MSM was 46%, among CSW 29% (2017), among TG 41%, and 92% among prisoners (2020).[5]

In the past, the HIV response in Ukraine was governed by five-year-long National AIDS Programmes, which were approved as a law and as such had annual budget cycles. In 2019, the GOU made a decision to shift from single-disease programmes to more comprehensive long-term sectoral

[260] Ukrainian Global AIDS Monitoring reports data 2016-2020 [Available from: https://phc.org.ua/sites/default/files/users/user90/Indicators_GAM_2016_2020_fin.docx]
[261] WHO. Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations: supplement to the 2014 consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations Geneva, Switzerland; 2015 [Available from: https://apps.who.int/iris/handle/10665/177992].
[262] WHO. Good practices in Europe: HIV prevention for people who inject drugs implemented by the International HIV/AIDS Alliance in Ukraine 2014 [Available from: http://www.euro.who.int/en/countries/ukraine/publications3/good-practices-in-europe-hiv-prevention-for-people-who-inject-drugs-implemented-by-the-international-hivaids-alliance-in-ukraine-2014].
[263] National OST statistics [Available from: https://phc.org.ua/kontrol-zakhvoryuvan/zalezhnist-vid-psikhoaktivnikh-rechovin/zamisna-pidtrimuvalna-terapiya-zpt/statistika-zpt]
[264] Sazonova Y, Kulchynska R, Sereda Y, et al. HIV treatment cascade among people who inject drugs in Ukraine. PloS one 2020; 15(12): e0244572.

programmes with three-year workplans and budgets. As a result, the National Strategy for HIV/AIDS, Tuberculosis and Viral Hepatitis for the period up to 2030 (National Strategy 2030) was approved by the Cabinet of Ministers in Ukraine in 2019. It sets ambitious targets for the HIV response, including 95-95-95 for HIV status awareness, treatment, and viral suppression; 90% coverage of key populations by prevention; and 40% coverage of opioid users with OST by 2030. This strategy has provided a framework for related work plans, including the PEPFAR country operational plan (COP), the Global Fund grants for 2020-2023 and HIV-COVID, and the National Work Plan for 2021-2023 (not yet approved).

The community of stakeholders responding to HIV in Ukraine is reasonably well connected through a number of forums and mechanisms. The most important is the National Coordination Council on HIV and Tuberculosis, which was established as a Country Coordinating Mechanism (CCM) for the Global Fund programmes, and now addresses a broader public health agenda per its terms of reference.

Enabling Environment

While there have been improvements generally in the legal and human rights environment relevant to HIV in Ukraine, certain barriers persist. Recent studies examined the existing structural legal and human rights-related barriers that hinder access by key populations to HIV prevention and treatment services, and highlighted the following:

- stigma and discrimination related to HIV, drug use, homosexuality, transgender identity continue to be the major barriers to HIV services;
- the level of unauthorized disclosure of a HIV-positive status and information about patients who take part in OST remains high;
- the implementation of the state drug policy has a repressive impact on the ability to treat people living with HIV and using drugs;
- the negative attitudes of the police and fear of police among PWID, CSW constitute barriers to HIV prevention and treatment services as well as other medical care;
- the state policies and practices regarding sex work has a repressive impact on the ability to treat sex workers living with HIV;
- barriers associated with HIV testing based on an opt-out principle, criminalization of HIV transmission;
- due to isolation of health services in penitentiary institutions from the general health care system, there is no proper regulatory framework for provision of comprehensive services on HIV prevention and treatment in penitentiary institutions and detention centres.

There is significant evidence that such barriers undermine efforts to accelerate the response to HIV epidemic, affect prevention services[265], reduce the likelihood that people will be tested and learn about their status, increases losses throughout the treatment cascade[266], and thus undermines the effectiveness of domestic and donor investments in HIV in Ukraine.

At the same time, Ukraine is one of the few countries that can demonstrate a significant reduction in stigma towards people living with HIV. Stigma Index studies carried out in 2010, 2013, 2016 and 2020 reveal a substantial reduction in various forms of stigma. However, stigma was still cited by most key informants as one of the most important barriers to KPs accessing health and other services.

The government of Ukraine jointly with all key stakeholders in the HIV response demonstrate commitment to improving the legal and human rights-related environment. This is marked by an important decision of the National Coordinating Council on HIV/TB on the approval of the Strategy

[265] Kiriazova T, Go VF, Hershow RB, et al. Perspectives of clients and providers on factors influencing opioid agonist treatment uptake among HIV-positive people who use drugs in Indonesia, Ukraine, and Vietnam: HPTN 074 study. Harm reduction journal 2020; 17(1): 69.

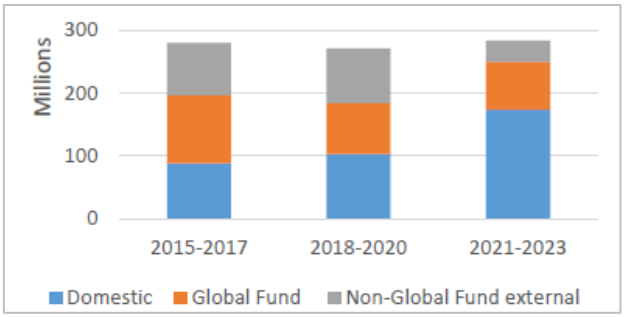
[266] Sereda Y, Kiriazova T, Makarenko O, et al. Stigma and quality of co-located care for HIV-positive people in addiction treatment in Ukraine: a cross-sectional study. Journal of the International AIDS Society 2020; 23(5).

for a Comprehensive Response to Human Rights-related Barriers to Accessing HIV and TB Prevention and Treatment Services until 2030. The strategy identifies priority actions for Ukraine under the Global HIV Prevention Coalition and is also integrated into the National Strategy for 2030.

Financing of the HIV Response

The Global Fund to Fight AIDS Tuberculosis and Malaria (the Global Fund) and PEPFAR have been the major contributors to Ukraine's HIV response since its beginning, and the Government of Ukraine (GOU) has been gradually increasing its share over the past decade despite serious economic constrains (Figure 3). According to the most recent National AIDS Spending Assessment, conducted by the MOH with UNAIDS support in 2016, the total expenditure on the HIV response was approximately USD 223 million: Global Fund contributed 49 percent, PEPFAR contributed 20 percent, and the GOU contributed 22 percent. The GOU significantly increased the state AIDS budget from USD 12.5 million in 2016 to USD 32 million in 2020 in response to intensive advocacy efforts of CSOs and UNAIDS to embrace the global commitment to achieve epidemic control.[267] The 2020 state AIDS budget included USD 13.5 million for procurement of ARVs, also covering most of the laboratory commodities related to facility-based HIV testing, including HIV tests for pregnant women and blood donors. Local GOU budgets cover baby formula for Prevention-of-Mother-to-Child-Transmission (PMTCT), staffing, and operational costs of health facilities.

Figure 13. Funding for HIV response in Ukraine.



In 2017 the GOU committed to a gradual transition from donor funding to funding from the state and local budgets for priority activities to end the HIV/AIDS epidemic. The document confirming the political support of transition for the period 2018-2020, known as the "20-50-80 Transition Plan," was approved by the Cabinet of Ministers of Ukraine on 22 March 2017. Implementation of the plan was challenging but with support from numerous stakeholders, including UNAIDS and UNDP, the GOU through the Public Health Centre of the MOH began to address HIV prevention services in July 2019.[268] The Public Health Centre has developed a package of guidelines and norms that govern the provision of HIV prevention services by NGOs with state funding. The budget code of the health programme has been changed to include a dedicate line for prevention programmes. In 2020, the Ukraine state AIDS budget allocated USD 6 million for procurement of HIV prevention services, covering 100% of the basic service package for KPs in government-controlled areas. Nevertheless, numerous challenges persist in sustaining the coverage and quality of prevention services for KPs.

PEPFAR allocates funds to maximize impact in priority areas, including index testing, mobile case-finding for PWID, improving viral load testing coverage and suppression scale-up of PrEP, quality improvement activities for prevention, OST and ART, and retention packages. The COP 2020 plan emphasizes financial sustainability, focusing resources on rapidly completing health systems investments and relying on local partner expertise for efficient ART uptake.

The current 2021-2023 Global Fund HIV-TB grant to Ukraine allocates around USD 110 million for Ukraine's HIV program, primarily focusing on KP services, including in Donetsk and Luhansk non-government-controlled areas (NGCA). The current grant includes activities with high KP impact, innovative community-led prevention and linkage strategies, tackling human rights barriers to health services, and support for resilient and sustainable systems for health.

[267] Ukraine 2021-2023 HIV/TB funding request to the Global Fund [Available at: https://data.theglobalfund.org/location/UKR/documents]
[268] 20–50–80 to reach 100 in Ukraine. [Available from: https://www.unaids.org/en/resources/presscentre/featurestories/2020/november/20201106_ukraine-20-50-80]

UNAIDS Joint Programme Key Population Response

JP strategic orientation and programme approaches

The main goal of the UN Joint Team on AIDS (JT), as a unity of cosponsors under the leadership of the UNAIDS Secretariat, is to consolidate support to countries to end AIDS as a public health threat by 2030. The JT in Ukraine consists of the UNAIDS Secretariat Country Office (the Secretariat) and ten co-sponsors, ILO, UNFPA, UNODC, UNHCR, UNICEF, UNESCO, UNDP, UN-WOMEN, World Bank, and WHO. The JT is guided by the Division of Labour framework based on the respective mandates of the Cosponsors.

The JT in Ukraine developed its five-year programme document - Joint Programme of Support on AIDS 2018-2022 (JP). The Joint Programme is based on the Unified Budget, Results and Accountability Framework (UBRAF). The UBRAF incorporates specific regional and country priorities and targets and includes provisions for country envelopes to leverage joint action to support achievement of prioritized country targets.

The JP identified three main challenges in Ukraine's HIV response:

- Gaps in the HIV treatment cascade, primarily for case finding and ART initiation
- Sustainability of HIV prevention services and reliance on donor funding
- Barriers to HIV services related to human rights, stigma, and discrimination.

Table 36. Joint Plan Priority Areas and corresponding targets for two planning cycles.

The three challenges are translated into strategic high priority areas. Following the UBRAF structure, the JT defines one or more targets for each high priority area in each biannual planning cycle. The evaluation period covers two planning cycles, 2018-2019 and 2020-2021. The priority areas and corresponding targets for the two cycles are outlined in Table 2. There were no changes in the definitions of priority areas between the cycles, whereas evolution of targets is evident, reflecting the achieved progress and emerging priorities.

JP priority area	2018-2019 targets	2020-2021 targets
1. Optimized HIV treatment cascade	Optimized HIV treatment cascade to enrol 80% of PLHIV into services with effective ART to 167,000 PLHIV eMTCT certification road map access to HIV services in NGCA (16,000 on ART)	213,300 (90%) of PLHIV, including in the non-government-controlled areas, know their status 191,970 (90% of PLHIV who know their status) receive ART elimination of MTCT of HIV is certified
2. Sustainable HIV response, particularly among key populations	50% of a basic HIV prevention package, including community service delivery, is funded by domestic funding 15,000 people who inject drugs receive OST funded by domestic resources	90% of key populations have access to prevention programmes, 80% of which are domestically funded 18,400 people who inject drugs receive OST that is funded by domestic resources
3. Human rights, stigma and discrimination	Barriers to HIV services for key populations are removed	50% of primary healthcare doctors improved their skills in reducing discrimination towards HIV patients and KP affiliation barriers to HIV services for key populations are removed.

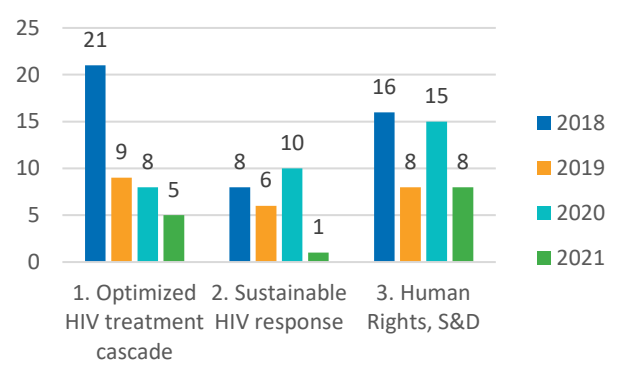
Based on the priority areas and targets, the JT develops annual workplans, which define deliverables and activities and reflect the annual financial commitments of the cosponsors. The definitions of

deliverables, however, in many cases is not quantitative or even qualitative and represents an area of work rather than a measurable goal. The development of the activities is supposedly driven by value-added and the UN common goal to maximize the effectiveness of UN assistance within the competing national development priorities and multiple donor environment. During the planning process, the JT is tasked to ensure that deliverables are aligned with the national fast-track targets and relevant strategic frameworks and workplans of other stakeholders.

In the latest 2021 annual plan, the JT proposed to deploy its capacities and maximise the UN value-added by assuming the following roles:

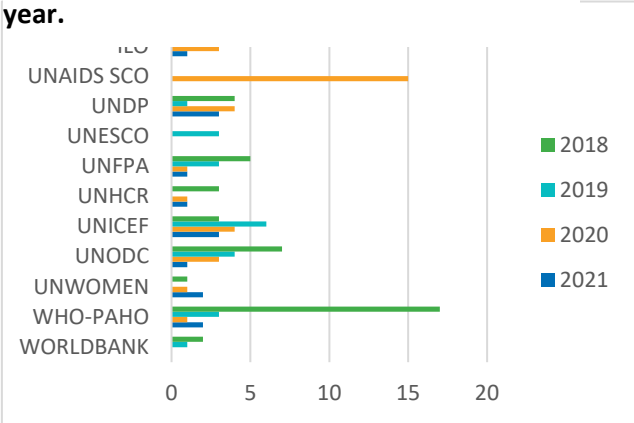
- Convening role for all multi-partner processes and discussions on the human rights related issues
- Delivering international expertise and overseeing the adherence to the ratified agreements and guiding principles in the area of human rights at national, regional and municipal level
- Connecting and coordinating the strategy development, priority setting and planning processes involving main partners in Ukraine
- Monitoring progress and raising early alerts though the implementation cycles
- Fundraising and aligning pledged resources for more optimal allocations (domestic and donors).

Figure 14. Number of activities by Joint Plan Priority Area by year



According to the Joint Programme Monitoring System (JPMS), there were 115 planned and funded JT activities in 2018-2021, with uneven distribution by year: 45 (2018), 23 (2019), 33 (2020), 14 (2021). The distribution of activities by priority area is presented in Figure 4. The notable decrease in the number of activities in 2021 may indicate the incompleteness of data in the JPMS (see section 5.1 for details).

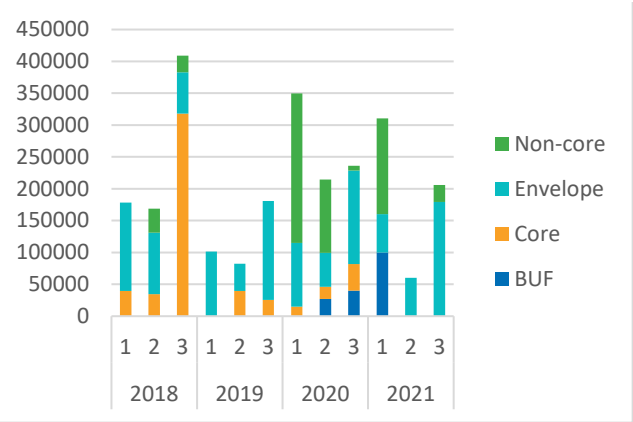
Figure 15: Number of activities by agency by year year.



The greatest total number of activities is planned by WHO (23), followed by UNICEF (16), UNAIDS SCO (15), UNODC (15), UNDP (12), UNFPA (10), and ILO (9), with others having less than 5 activities over the four years (Figure 5).

The financial commitments by the UNAIDS Secretariat and cosponsors are coming from four main sources: envelope (for top priority activities), core, non-core, and business unusual fund (BUF). The total commitment in 2018-2021 according to JPMS was USD 2,5 million with USD 756,392 in 2018, USD 365,069 in 2019, USD 800,023 in 2020, and USD 576,999 in 2021. The distribution by source of funding, by year and priority area is presented in Figure 6. The amount of funding per one activity ranged from USD 5,000 to 60,000. It has to be noted that the total amount for 19 activities is not available in JPMS (primarily WHO non-core and UNAIDS Secretariat core funds), which leads to inconsistencies in the chart and limits the ability to interpret the trend over time.

Figure 16: Funding commitments by source, by year and Priority Area (1, 2, 3)



The programmatic focus of the JT, as determined by the epidemiological context, is primarily addressing the needs of KPs. High priority area 1 is not exclusively focused on KPs but given that the majority of PLWH in Ukraine are former or current KPs, the activities under this area are directly relevant. High priority areas 2 and 3 explicitly mention KPs in the targets, although not specific to any group. The human rights and similar activities are likely to benefit other populations as well.

The detailed analysis of relevance of activities to KPs is provided in Section 4.1.1.

Main partnerships of the Joint Programme

In implementing its activities, the JT have partnered with a broad range of entities. The main partners include the following:

The government of Ukraine. The vast majority of JT activities in HIV area are coordinated with and supported by the Ministry of Health of Ukraine (MOH). On the technical level, the main collaborator is the Public Health Centre of the MOH. It was established in 2015 on the basis of the National AIDS Centre; both have been a key recipient of technical assistance and capacity building from JT. Other activities that address specific population groups are coordinated with the Ministry of Education, Ministry of Family, Youth and Sports, Ministry of Social Policy, and Ministry of Justice, including the Penitentiary Department. One of the recent human rights initiatives by UNDP has been implemented at the bases of the Parliament of Ukraine.

Civil society. The work of JT has been coordinated closely with major implementers of the National HIV Programme. The main recipients of the Global Fund and PEPFAR funding in Ukraine are Alliance for Public Health and 100% Life (formerly the Network of people living with HIV/AIDS). At the local level, the JT activities are implemented by or conducted in collaboration with local NGOs which provide services to KPs. Additionally, the JT has been actively working with KP-led organizations (for more details see Section 4.2.2).

International donors. The main funders of the HIV response in Ukraine, besides the government, are Global Fund (implemented by three principal recipients), and PEPFAR (represented by USAID and CDC, who contribute additional funding to HIV aside from PEPFAR). Importantly, the UNAIDS Secretariat and WHO receive funds from Global Fund and PEPFAR to carry out the activities included in the Joint Programme.

Case Study Findings

Relevance and coherence of Joint Programme activities

Relevance of activities to key population needs and priorities (Evaluation question 1)

Methodological note. The assessment of relevance of activities to KP needs and priorities has to take into account that the HIV epidemic in Ukraine is concentrated and continues to be driven by the KPs, therefore all activities, at least to some extent, may be relevant to KPs. In this context, the programmatic focus of the JT is primarily addressing the needs of KPs.

Summary of findings in this section. The majority of JT activities in Ukraine do not have an exclusive focus on KPs and address the needs of all people living with or at risk of HIV. This is justified by the epidemiological context and configuration of the national HIV response, in which the services are provided by other players and the JT has a catalytic technical assistance role. The fraction of activities that are not relevant to KPs is small, but has been increasing, budget-wise, over the past four years.

Strength of evidence: strong - supported by good quality documents and multiple KIIs.

There is no dedicated needs assessment or a strategy that explicitly define the KP needs and priorities (vis a vis other population and also among them), thus the understanding of this issue varies among national stakeholders. The KP organizations and NGOs interpret KP needs broadly, suggesting that all KP-focused interventions mentioned in guidelines or best practice reports (e.g., safe spaces, housing assistance, food or hygienic packages, cash vouchers) are addressing their needs. On the other hand, public health authorities and international stakeholders tend to adhere to evidence-based principles and support interventions that have demonstrated impact on the HIV epidemic. Given that the strength of evidence in many cases is weak, this debate continues to take place every time when a programme is planned.

The analysis of the Joint Programme 2018-2021 plans suggest that all activities may be categorized in terms of their relevance to KP needs and priorities as follows:

1. ***Activities with exclusive or significant KP focus.*** Descriptions of these activities mention KPs in general or specific populations and according to the description should be directly relevant to one or more KPs. These activities may also indirectly benefit other populations.
2. ***Activities with broader focus.*** Activities in this group are relevant to KPs but also benefit other populations. This category includes all technical assistance, structural interventions, strategic information activities, and non-specific policy guidance addressing all people living with or at risk of acquiring HIV. In Ukrainian context, most of these people are current or former KPs, therefore these activities are directly or indirectly relevant to KP needs.
3. ***Activities that primarily focus on other populations.*** This category includes a few activities in the Joint Programme that were not HIV-specific or were clearly focused on general population.

Figure 17: Number of activities by agency

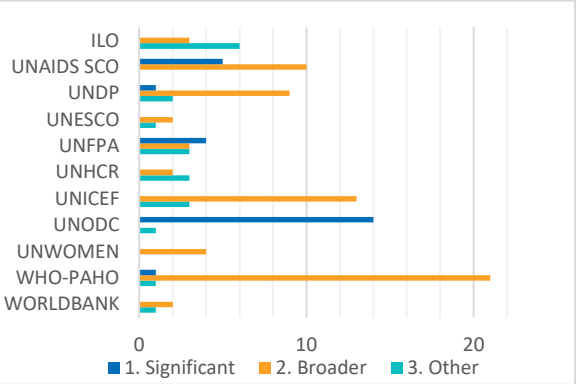
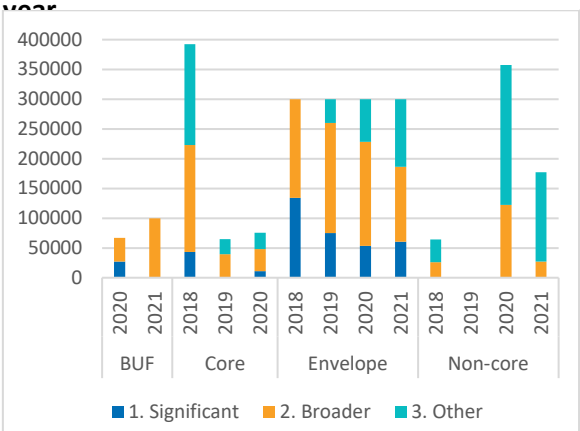


Figure 18: Budget allocation by KP focus by year



Of all 115 activities, 25 (22%) were significantly focused, 69 (60%) had broader focus, 21 (18%) were relevant to other populations. The complete list is presented in Annex. This corresponds to the priority areas, which, as mentioned above, are defined based on KP needs.

Looking at the distribution by agency in Figure 7, it is evident that some agencies have a more specific focus on KPs (UNODC, UNFPA), whereas others concentrate on all populations living with or at risk of HIV, or systemic issues. As explained in more details below, this is explained by the epidemiological and other context in Ukraine, as well as the core mandate of UN agencies.

The analysis of budgetary data in the JMPS suggests that the share of activities with specific KP focus within the envelope funding has reduced gradually from 44% in 2018 to 20% in 2021. Inconsistency of funding from other sources over the years suggests that data on non-envelope activities and related budget in the JMPS may be incomplete. (More details on funding are provided in Section 4.1.3).

UNAIDS Secretariat. The main areas of involvement for the UNAIDS Secretariat were strategic leadership, advocacy and policy guidance, and strategic information, which were categorized as indirectly relevant to KPs. Another important role for the Secretariat was to coordinate and facilitate engagement of KPs in programming at the national level. The notable examples of activities include the co-sponsorship and content development for public awareness events, conferences, and high-level meetings, including the participation of Ukraine at the High-level meeting on AIDS at the UN General Assembly in 2021, which highlights the meaningful engagement of KPs in the HIV response in Ukraine. One landmark activity of the Secretariat was the establishment (in 2017) and facilitation of the KP Platform - a national level coordination mechanism for capacity building of communities of sex workers, people who inject drugs, MSM and former prisoners.[269] The support from the JT to the KP Platform members included steering group meetings, mobilizing funding opportunities, capacity building in various aspects, and consolidating and supporting the voice of KP representatives at national and international forums. The strategic information activities of the Secretariat included technical assistance in development of HIV epidemiological estimates, population size estimates for KPs and PLHIV, coordination and collection of data for the GAM and other global reporting, and guidance for the national AIDS spending assessment and PLHIV stigma index surveys. UNAIDS has provided expertise and guidance in the development of key strategic documents – the National Strategy on HIV, Hepatitis and TB until 2030, the corresponding Action Plan and the Transition Plan.

In 2020 all key stakeholders in Ukraine were involved in the preparation of the funding request to the Global Fund for 2021-2023. The JT, led by the Secretariat, was actively participating at several levels – at the technical working groups, Country Coordination Mechanism (CCM), and as a moderator of the KP Platform. In similar capacity, the JT was involved in the preparation of Ukraine's funding request for COVID-19 Global Fund funding in 2021.

[269] The National Platform of Key Populations [Available from: https://ckpp.org.ua/en/]

KIs[270] suggest that the aforementioned roles and contribution of the UNAIDS Secretariat are recognized and appreciated by the national partners. All stakeholders interviewed trust and actively use the data, estimates, reports, and guidelines produced by UNAIDS. At the same time, multiple KIs noted that the advocacy and leadership potential of UNAIDS (in terms of visibility and impact at the country level) has diminished over recent years, especially compared to the period preceding 2018.

The contribution of the JT to both Global Fund funding requests, especially that of the Secretariat and WHO was considered essential in several aspects. In the planning process, the role of the KP Platform was to consolidate the proposals and opinions of the KP representatives, which was instrumental to mainstreaming the KP aspects in both applications. The JT was actively involved in the discussions with the technical working groups, providing expertise and critical appraisal of the submitted proposals. In a number of instances, the JT was criticized for not being sufficiently firm or outspoken in assessing the proposals that were not based on evidence or were lower priority (e.g., shelters for MSM). Due to strong pressure from KPs, some activities not supported by the JT were included in the final application, and some proposals from the JT were declined by other group members. This was one of several factors that prompted the JT to recommend the UN RC to abstain during the vote on the application at the CCM.

WHO. WHO has the largest number of staff working on HIV among JT agencies in Ukraine and, according to the JPMS, has the highest number of activities (23). The key role of WHO is to provide technical assistance, primarily in a form of expertise and policy guidance, to national stakeholders in all aspects related to HIV prevention and treatment. The notable examples include contribution to the simplified HIV testing algorithm, updates to the National HIV testing and treatment protocol (approved by the MOH in 2019), and development of the National Strategy 2030 and corresponding action plan, Transition Plan and ART adherence standard. WHO was actively involved in the Global Fund funding request preparation, providing technical expertise and steering the working groups. This work was categorized by the evaluators as relevant to KPs among all other groups.

Together with UNICEF, WHO has been actively working on eMTCT. Together, there were 20 activities dedicated to eMTCT (17% of the portfolio), 7 for WHO and 13 for UNICEF. This work was carried out with envelope funding (USD 390,000 for four years). The activities included support for the eMTCT Validation Committee, technical working groups at the national and local levels, M&E (UNICEF), technical advice to the MOH, and review of eMTCT validation submission. Elimination of MTCT has been continuously set as a target in the Joint Programme, and in 2019 the national MTCT rate in Ukraine decreased to 1.6%. The JT continues to provide technical assistance to certify eMTCT, and to maintain the low rate. Many of 2,000-3,000 women living with HIV who become pregnant each year belong to one or more KPs, therefore this group of activities may be considered a part of KP programming.

Since 2018, WHO supported PrEP scale up in Ukraine and facilitated the inclusion of PrEP into national policies, including the PrEP Service Standard and its update in 2021. Since PrEP in Ukraine is mainly provided to MSM and PWID, this work is directly focused on KPs.

Over the recent years, WHO staff and consultants became actively involved in the work at local level, which includes on-site technical guidance and direct mentoring support on scale-up of HIV testing and treatment, identification and linkage, index and other types of HIV testing, implementation of optimized ART regimens, rapid initiation to HIV treatment.

It is important to note that WHO is a recipient of donor funding from PEPFAR and Global Fund and therefore should be considered a co-implementer of the corresponding grants in Ukraine. The share of UBRAF funding in the total HIV-related WHO budget is rather minor compared to other sources, which may affect the allocation of staff and other resources in implementation of activities.

[270] The majority of the KIs, including the government and non-governmental sector

KIs[271] recognized the substantial contribution of WHO to the national policy development and Global Fund funding requests preparation. **The leadership of WHO was crucial in optimization of ART, which led to scale-up of safer and more efficient regimens (dolutegravir).**

Some KIs[272] expressed concerns about a potential conflict of interest in UN agencies proposing activities for themselves during the Global Fund application preparation. Those activities are mostly of technical assistance nature and lack tangible outcomes in the grant performance frameworks, which exacerbates the concerns given the substantial budget allocation. Importantly, WHO Country Office representatives disagree with these interpretations, indicating that they have a jointly agreed workplan for their Global Fund sub-agreement which has well defined activities and indicators (the workplan and corresponding reports were considered outside the scope of this evaluation).

UNICEF. The core portfolio of UNICEF in Ukraine is not HIV-related, but there are notable areas where UNICEF contributed significantly. First is the series of activities on eMTCT, implemented in collaboration with WHO (see above), which may be considered related to KPs. After the key normative and legislative work was completed and the elimination threshold reached, UNICEF engaged into more granular local-level activities, such as support to the regional PMTCT committees, coordination between community-based organisations (CBOs) and health care facilities, and regional M&E, etc. Second is integration of youth-friendly services at all levels of health care. HIV testing and reproductive health services are part of the package that is relevant for young KPs. UNICEF organized provision of clinical monitoring and psychosocial support to children living with HIV and children born to HIV positive mothers with limited access to medical care in conflict affected areas including NGCA. Additionally, UNICEF was serving as a procurement agent for ARV procurement, which was instrumental in the military conflict and COVID-19 contexts.

The leadership role of UNICEF in eMTCT area is recognized by the governmental stakeholders. Other KIIs, including representatives of KP organizations, were less aware of other UNICEF activities with the exception of medication procurement and support for children in NGCA.

UNODC. The activities of UNODC, according to its global mandate, are focused on people who use drugs and prisoners. UNODC assumes an important advocacy role in the development and revision of National Drug Policy, aiming to decriminalize drug use, liberalize drug control, and improve availability of medical opioids including methadone. At the municipal level, UNODC was working to improve collaboration between law enforcement and HIV service providers by providing trainings for police officers and developing referral pathways. In the recent years UNODC focused a series of its activities on the new psychoactive substances (NPS) and improving access to services for NPS users. This included a detailed assessment, intervention development and piloting.

Overall, the involvement of UNODC in drug policy arena has been noticeable, according to available evidence.[273] In several instances support from UNODC was critical to oppose the restrictive policy initiatives by lawmakers or law enforcement. However, given that the key drug use decriminalization goals have not been achieved after more than a decade-long involvement, the efficacy of the approach was questioned. There was an overall decrease in the presence of UNODC in Ukraine and their impact since the end of USAID funding in 2018. The KIIs highlighted the contribution of UNODC to scale up of OST, although in the recent years when strategic efforts were made by various stakeholders to introduce OST into prisons, the support from UNODC was less tangible.[274] Other smaller scale activities of UNODC were not widely known among KIIs.

UNDP. The key role of UNDP is the strategic leadership in promoting human rights principles. The activities included HR-related capacity building for several target groups, advocacy to mainstream HR in the national policy development as well as the local programming (in fast-track cities), assessments of legal environment and development of recommendations. UNDP served as a procurement agency for medical products during the transition period before the new state mechanisms were established.

[271] Multiple KIs, including the government and non-governmental sector.
[272] Several KIs representing organizations participating in the funding request preparation.
[273] Interviews with KIs involved in the drug policy area and proceedings of the national drug policy conferences.
[274] According to the KIs involved in OST scale up in Ukraine.

UNDP also supported procurement changes that led to price reductions of 89% for ARV drugs. In 2021 UNDP received envelope funding to conduct mapping of PLHIV-friendly primary care services. These activities may be considered indirectly relevant to the KPs.

The contribution of UNDP to the human rights agenda is known to the national stakeholders, although its connection to HIV and KPs is not always apparent.

UNFPA. In comparison to other agencies, the work of UNFPA is more often focused on the local service delivery level rather than national policy. The notable activities included integration of HIV testing into GBV services (intervention design and piloting, and guideline development), setting up mobile teams to provide reproductive heath (RH), sexually transmitted infections (STI) and HIV services in conflict-affected areas. Country envelope funding was used to develop and conduct trainings on eliminating stigma and discriminations for primary care physicians, and to promote and scale up their services. Due to the explicit mentioning of KPs in the description, the UNFPA activities have been categorized as KP-focused, even though they may not necessarily target any particular group.

Due to the narrow focus of UNFPA activities, they are not well known to the wider circle of country stakeholders, including KP organizations.

UNWOMEN. This agency has become resident in Ukraine relatively recently. Its main role initially was the advocacy of gender related issues during development of the National AIDS Programme 2018-2023 and the National Strategy 2030. Since 2020, UNWOMEN, using non-core funds, provided comprehensive capacity building to the network of women living with HIV, which included various trainings and promotion of their representatives into decision making bodies at the national and local levels. This support was highly appreciated by the recipients, some of whom also represent KPs, but the group of women who use drugs expressed a need for more direct assistance. The overall contribution to the gender issues was noted by some KIs.[275]

ILO and UNHCR. The work of UNHCR and ILO was primarily focused on combating stigma and discrimination through advocacy and capacity building in their respective sectors, including with migration authorities, and employers and trade unions (in maritime, railway, food and agriculture). These activities aimed to increase awareness about HIV, reduce S&D, develop non-discriminatory workplace policies and programmes, and improve access to services for staff and people served by the authorities. Both organizations do not work directly with KPs but awareness-raising and other activities help reducing stigma associated with KPs, particularly for those living with HIV. Due to the narrow focus, these activities are not widely known among stakeholders. Some KIs suggested that ILO, according to its mandate, was expected to provide leadership and facilitate the agenda in the area of HIV prevention at workplaces. These activities were not funded within UBRAF, but it remains unclear whether this area was clearly articulated as a priority by national stakeholders.

UNESCO and World Bank. Due to the limited involvement of these agencies in HIV and KP work, their work was not analysed in this evaluation.

Alignment with strategic priorities and the UN comparative advantage

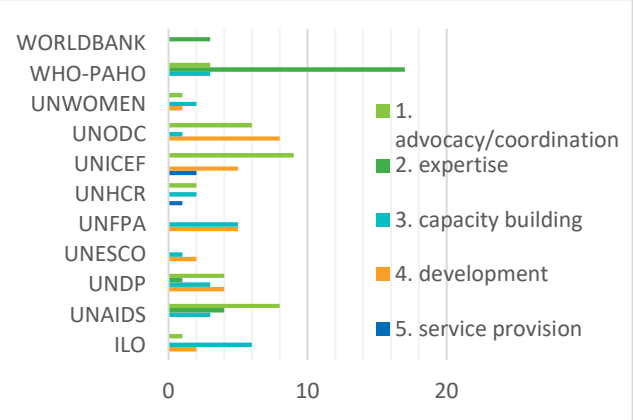
While the Joint Programme 2018-2022 takes a strategic approach to define priority areas, targets, and deliverables, the detailed workplans for 2018-2019 and 2020-2021 represent a combination of activities that are clearly determined by the strategic priorities and the UN comparative advantage, and others that appear to address needs unclear priorities.

By the type of work, all activities fall into one of the five categories:

1. High level advocacy or coordination of national partners
2. Provision of expertise
3. Capacity building
4. Development of documents, tools, service delivery models
5. Service provision and delivery of interventions

[275] Particularly by the governmental sector and KP representatives.

Figure 19: Distribution of activities by type by



From the distribution of activities presented in Figure 9, it is evident that some agencies concentrate on higher-level advocacy, coordination, and expertise provision, whereas others prefer to focus on concrete tasks with more tangible service-level outcomes.

The leadership, policy guidance and advocacy roles clearly correspond to the core functions of the JT outlined in the Joint Programme 2018-2022 and are based on the comparative advantage of the UN. The challenge in undertaking these tasks is to measure and attribute successes (or failures).

Activities focusing on development or service provision areas tend to have a specific focus or address emerging needs rather than as part of a strategic plan. These activities may have a short-term impact or serve a catalytic function leading to important innovations. However, the sustainability and scale up of the innovations requires a long-term approach and continued investment, which is always a challenge (especially given the JT annual budget cycle).

Typical examples of these activities include the work conducted at the local (municipal) level, such as collecting granular data on programme implementation, analysis of gaps, facilitation of the local teams, service mapping, and creating detailed roadmaps and other types of support for service delivery (particularly for ART and PMTCT). The development of interventions or service delivery models for specific populations or situations, such as outreach to NPS users, police - harm reduction referral, piloting of mobile reproductive health teams, and provision of vouchers are examples of activities with unclear strategic alignment and sustainability concerns.

Promotion of global and regional Joint Programme KP-related tools and evidence

The UN organizations are commonly referred to as a source of reliable evidence and effective recommendations. Evidence-based guidelines from WHO, UNAIDS, UNICEF are widely known to the national stakeholders and are used in programming.[276] However, according to KIIs, the JT does not promote sufficiently the new tools and documents when they come out and this limits their potential impact.[277] This is supported by the fact that only two activities in the annual JT workplans supported dissemination events for new guidelines or tools (not KP-specific though). Several KIIs also admitted that in some cases the recommendations are too high-level and not very practical.

Human rights and gender equality (Evaluation question 2)

Summary of findings in this section. The work of JT is strongly based on human rights and equity principles and is adequately addressing significant challenges in the enabling environment in Ukraine. The JT demonstrates leadership in promoting the human rights agenda in the HIV response.

Strength of evidence: strong - supported by good quality documents and multiple KIIs.

The importance of human rights, S&D, and gender issues in the HIV response has been recognized by all key stakeholders in Ukraine. Each major programme has been designed with these considerations in mind and many programmes address these issues either directly or indirectly. This is also an important part of the Joint Programme, evidenced by the fact that UN Development Assistance

[276] Recognized by KIs from all sectors.

[277] For instance, the "Practical guidance for comprehensive HIV/STI programmes" (for four KPs) were known only to one NGO representatives, but not to the governmental sector.

Framework is based on the key guiding human rights principles and the results of a gender assessment.

As described above, UNDP is known as a leading agency in human rights promotion, undertaking a number of strategic as well as focused activities, in the HIV field and beyond. The UNDP Ukraine Gender Equality Strategy 2019-2022 provides a road map to elevate and integrate gender equality into all aspects of UNDP work that is relevant but is not specific to HIV and KPs. The work of UNODC was notable in promoting rights of PWID and prisoners, including women. UNFPA, UNICEF, ILO, and UNHCR were supporting de-stigmatisation and provision of KP-friendly services in various settings. UNWOMEN were active in advocating for gender-sensitive policy development and programming. The UNAIDS Secretariat provided guidance to the latest national PLHIV Stigma Index survey, and as a convener of the Global Partnership for Action to Eliminate All Forms of HIV-Related Stigma and Discrimination, consistently contributes to the mainstreaming of human rights and gender issues in HIV response in Ukraine.

An important issue raised by the national stakeholders is the location of the regional UNAIDS office in Moscow. The Russian Federation is a country known for notorious violations of human rights principles, at the individual level (including access to essential health services, e.g. OST)[278] as well as in international relations.[279] Russia openly opposed the rights-based approach in the Political Declaration on HIV and AIDS at the UN High Level Meeting on AIDS in June 2021.[280] The location of UNAIDS office in Moscow may be interpreted by a wide range of international partners as a silent approval of these violations and a double standard with regard to human rights.

Capacity and resources of the Joint Programme (Evaluation question 4)

Methodological note.

In answering this evaluation question, it is important to note that JT resources, both financial and human, constitute a small fraction of the entire HIV spending in Ukraine. Therefore, the appropriateness may be assessed only in relation to the specific roles or functions of the JT within the whole program.

Additional challenges in the analysis related to the fact that core and non-core commitments of agencies are not fully accounted for in the JPMS, which may be partially due to some activities or budget lines that may be only partially related to HIV.

Summary of findings in this section. The capacity and resources of the JT are adequate in relation to the core functions specified in the Joint Programme 2018-2022. The dependence of JT agencies on extra-budgetary funding poses a challenge in terms of long-term strategic planning and prioritization of activities.

All national stakeholders interviewed unanimously agree that the key functions of the JT are to provide political leadership and strategic guidance in HIV programming in general and in KP-specific areas, facilitate KP dialogue and liaise with the government, and deliver international expertise. Overall, this function has been performed adequately well, and according to JT members, is sufficiently resourced both in terms of staffing and funding.

The UNAIDS Secretariat is comparatively big compared to other countries in the region and has a full-time staff member dedicated to work with KPs (other agencies do not have staff exclusively working on KP-related activities). However, a number of stakeholders[281] agreed that the Secretariat could

[278] Carroll JJ. Sovereign Rules and Rearrangements: Banning Methadone in Occupied Crimea. Med Anthropol. 2019;38(6):508-522. doi:10.1080/01459740.2018.1532422

[279] Russia's ongoing violations of human rights in illegally annexed Crimea, Ukraine: UK statement [Available from: https://www.gov.uk/government/news/russias-ongoing-violations-of-human-rights-in-illegally-annexed-crimea-ukraine-uk-statement]

[280] Russia Stuns UN High-Level Meeting on AIDS by Refusing to Support Consensus Declaration. [Available from https://healthpolicy-watch.news/87348-2/]

[281] This opinion was shared by some JT members, government, and non-governmental sector KIs.

have more staff in order to strengthen its involvement in strategic processes and coordination at the national level.

Naturally, availability of staff reflects the availability of resources (JT staffing allocation is presented in Annex). Agencies with sufficient overall funding are able to support staff working on HIV and KPs from their funds (UBRAF non-core) (UNICEF, UNFPA). Other agencies look for donor funding, and the success of these efforts determines the number of staff. For example, the WHO office has grown substantially since receiving additional funding for HIV from donors, whereas UNODC has reduced staffing after the end of their grant. From the donors' result-based standpoint, this approach to staffing is appropriate because the funding for staff is closely linked to the grant implementation. On the other hand, if expectations are based on the overall mandate or Division of Labour rather than specific grants, there are cases when agencies are not adequately resourced to perform their core functions (e.g., UNODC, the UNAIDS Secretariat).

The JPMS budget data analysis (table 3) reveals that the country envelope funding allocated to Ukraine remains consistent over the years. The distribution among agencies is also consistent, suggesting that it is allocated systematically. In many cases, however, envelope funding constitutes a small fraction of the overall agencies' budget, which theoretically may affect the relative priority of these activities.

Table 37. Budget distribution by year by source by agency (JPMS data).[282]

Year/ Agency	Envelope	BUF	Core	Non-core	Grand Total
2018	$299,781	$-	$392,239	$64,372	$756,392
ILO			$51,250	$38,092	$89,342
UNDP			$67,808	$26,280	$94,088
UNFPA	$45,000		$97,200		$142,200
UNHCR			$98,674		$98,674
UNICEF	$100,000				$100,000
UNODC	$64,781		$64,725		$129,506
UNWOMEN			$12,582		$12,582
WHO-PAHO	$90,000				$90,000
2019	$299,998	$-	$65,071	$-	$365,069
ILO	$40,125				$40,125
UNDP	$58,592				$58,592
UNESCO			$65,071		$65,071
UNFPA	$43,092				$43,092
UNICEF	$56,945				$56,945
UNODC	$56,732				$56,732
WHO-PAHO	$44,512				$44,512
2020	$299,998	$67,000	$75,820	$357,205	$800,023
ILO	$19,998		$27,820		$47,818
UNDP	$47,999	$40,000			$87,999
UNFPA	$48,600				$48,600
UNHCR	$29,998				$29,998

[282] Data on Core and Non-core funding in the JPMS is incomplete.

Year/ Agency	Envelope	BUF	Core	Non-core	Grand Total
UNICEF	$50,290			$234,705	$284,995
UNODC	$53,465	$27,000			$80,465
UNWOMEN				$2,500	$2,500
WHO-PAHO	$49,648				$49,648
UNAIDS SCO			$48,000	$120,000	$168,000
2021	$300,000	$99,999	$-	$177,000	$576,999
ILO	$30,000				$30,000
UNDP	$60,400				$60,400
UNFPA	$48,743				$48,743
UNHCR	$40,000				$40,000
UNICEF	$60,402			$150,000	$210,402
UNODC	$60,455				$60,455
UNWOMEN				$27,000	$27,000
WHO-PAHO		$99,999			$99,999

The majority of envelope funded activities address the KP needs indirectly, and the share of unrelated activities has been increasing over the past four years (Figure 8). As some KIs suggest,[283] in the circumstance of limited resources, the JT should prioritize its high-level functions and reduce local-level focused activities. This may include re-orientation of the country envelope funding from small-scale projects to support staff performing strategic roles.

Coherence of JT activities (Evaluation question 3)

Summary of findings in this section. Due to the active involvement of the JT in the national planning processes, the JT activities are well informed by and aligned with the national HIV response. At the same time, the Joint Programme planning is not transparent and does not sufficiently involve national stakeholders including KPs.

Strength of evidence: moderate - High level of agreement between the KIs and evidence from the program workplans.

In Ukraine, under the UN Partnership Framework and Joint Programme 2018-2022, a coordinated HIV response is a key strategic priority. The JT is actively involved in the key elements of HIV programming, specifically the preparation of the Global Fund funding requests, PEPFAR COP discussions, and the development of National AIDS Programmes/Strategies. One of the key functions of the JT is to coordinate the work of the technical working groups and facilitate KP engagement in the preparation of these documents. This role has been adequately performed by the JT in recent years.[284]

The Joint Programme 2018-2022 and annual workplans are supposed to be informed by and be fully coherent with the epidemiological situation, general configuration of the national HIV response and the other implementers' workplans. **Based on document review no overlaps or duplications were of the JT activities and other organizations (PEPFAR COP, workplans of the Global Fund principal recipients) were noted**.

[283] Including JT members and GOU stakeholders.
[284] Evidenced by the working group membership lists, meeting notes, and confirmed by all KIs.

However, KIs, including government stakeholders, NGOs, KP representatives and donors have agreed that the JT planning process in neither participatory nor transparent, and they were not involved in any form. Discussions of JT priorities traditionally took place in the form of an open retreat, and there is evidence of participation of GOU representatives in the recent years.[285] However, the lack of more systematic multisectoral involvement and lack of feedback led to the impression of "closed" JT planning discussions. This is in stark contrast to PEPFAR, which conducts at least two country-level open meetings in preparation of its COP each year.

At the implementation stage, the JT is well connected with all stakeholders. The JT has a voting seat in the CCM (officially held by the UN Resident Coordinator) and participates actively. As a rule, the JT is represented in all strategic meetings, conferences, media events, and technical working groups related to HIV and KP programming.

Within the JT, coordination is done through the team meetings, which convene on average quarterly. The planning process and implementation, according to the Joint Programme and UBRAF, should be coherent and consensus based. However, **some JT members express concerns about the efficiency of coordination and cooperation within the team, and the extent of commitment of some UN agencies to HIV or KP programming.** Firstly, some agencies do not attend the JT meetings regularly, or delegate participation to technical staff who may not be prepared for strategic decision-making. Secondly, there is a lack of strategic discussions within the JT (which happens mostly at the heads of agencies level). The JT meetings are dedicated primarily to the next year country envelope funding distribution, without tackling the longer-term strategy. The agencies come up with their proposals for the envelope/BUF funding on their own and present them to the Team. There is no guidance or criteria on how the envelope funding should be distributed, and there is no clarity on how the review of proposals is carried out. As a result, **the country envelope supports a set of standalone projects connected to the priority areas to a varying extent, rather than a cohesive strategic set of activities**. Some agencies express concerns that their opinions or proposals are being deliberately ignored by other team members. Some JT members mentioned a few instances of poor coordination between agencies, but such cases are rather an exception.

Overall, the role of the UNAIDS Secretariat in coordination of the JT is regarded highly by other agencies.

Efficiency and effectiveness of Joint Programme activities

Implementation of activities (Evaluation question 5)

Methodological note. An evaluation of technical assistance activities, such as advocacy, guidance, expertise, capacity building, is always challenging because their results are often long-term and are a product of combined efforts of multiple stakeholders. The deliverables defined in the Joint Programme 2018-2022, for example improved treatment cascade or elimination of MTCT, are ambitious, and even if the target was achieved, it is impossible to attribute the result to a single entity without a detailed assessment of each player's contribution. Given that, and the multitude of activities undertaken by the JT since 2018, it was not possible to conduct an audit of each activity in this evaluation. Therefore, the observations about efficiency and outcomes are based on KI interviews and inferred by the analysis of changes in epidemiologic situation and policy environment.

Summary of findings in this section. The high-level roles of the JT respond to the country needs and are fulfilled efficiently. The timeliness of implementation is satisfactory overall*. However, there are several factors that may in some cases decrease efficiency.*

Strength of evidence: moderate - The findings are based on consistent KI reports.

Overall, the national stakeholders at the level of CCM are aware of the key functions of the JT such as political leadership and strategic guidance in HIV programming, provision of expertise, and

[285] Record from the retreat of the JT, Kyiv, 16 October 2020

facilitation of dialogue with KPs. These roles respond to the country needs and are fulfilled efficiently. The small-scale activities and local projects, however, are largely unknown to the stakeholders who are not directly involved. Those who are involved were satisfied with their collaboration with the JT.

There are several factors that limit the efficiency of the work of the JT Cosponsors from the KIs perspective. Extended approval processes (particularly for consultancy terms of reference and assessment reports), that often require clearance at the Regional Office or Headquarters, may delay implementation of activities. This is particularly sensitive when urgent expert advice is requested and the response from the agency takes unacceptably long time. In some cases, these requests could be efficiently dealt with by the national staff. On the other hand, some KIs[286] agreed that expertise delivered by the JT in some cases should be more elaborate than simply restating what is written in the guidelines. Compared to the early days in the HIV response, the capacity of implementers in Ukraine has risen considerably (also due to the JT investment), and the invited experts are expected to bring unique knowledge that is not easily obtainable from online resources.

Another important limitation, at least in the current position of the UN in Ukraine, stems from the inability to influence conditions for macro-financial aid or other support to Ukraine.[287] For many issues in HIV programming, the political will is a crucial factor, and numerous good initiatives failed due to lack of political will. Ukraine is currently highly dependent on macro-financial aid and political support from the western countries. If certain HIV, KP or human rights-related conditions could be included in those agreements, it would almost guarantee the necessary political will for implementation. For example, the inclusion of public health requirements in the EU-Ukraine Association Agreement in 2014, which has played a key role in the development of the public health system.

The evaluators review of workplans, reports and supporting documentation suggests that **the JT agencies implement activities from the annual workplans with sufficient efficacy (intended for this purpose as timeliness).** The timeliness of implementation varies by agency and is satisfactory overall, although no-cost extensions or re-budgeting is often required. Most of the JT members indicated that the **annual funding-implementation cycle strongly limits the efficiency** because technical assistance in most cases requires a longer planning horizon. Development and testing of innovations also need more time due to the lengthy approvals required at the UN and government sides. The problem of a short twelve-month implementation period is compounded by UBRAF funding disbursement delays, which makes funding available no earlier than in February.

With regard to tangible outcomes, one area was brought up as an example of over-ambitious target setting at the national level. For over a decade, UNODC has been continuously involved in liberalization of drug policy. While this process may not be finite, certain specific targets, such as decriminalization of drug use (specifically to revise the threshold amount of substance that leads to criminal responsibility) have been repeatedly set but never been achieved. Multiple national stakeholders, advocates, ad KP organizations backed by UNODC tried to overcome the resistance of several ministries with no effect. At this point, the existing approach has proven its ineffectiveness and revision to the approach is needed as expressed by several KIs.

Mobilising and empowering key population led organizations (Evaluation question 6)

<u>Summary of findings in this section.</u> The JT has contributed substantially to mobilisation of KP organizations in Ukraine. The results of KP community strengthening are notable.

Strength of evidence: strong - The findings are based on good quality documentation and consistent KI reports.

[286] The KIs representing the organizations which were the recipients of technical assistance.
[287] According to the GOU KIs.

Mobilisation and empowerment of KP communities is one of the key functions of the JT, recognised by all stakeholders. The UNAIDS Secretariat is leading in this process by creating the space for governments and civil society to jointly engage in the national/global response planning and coordination and in building capacity for the governmental and non-governmental sectors to interact constructively with each other. The landmark activity in this area was the establishment and support for the National KP Platform – a national level coordination mechanism for the communities of sex workers, people who inject drugs, MSM and former prisoners. The support from JT to the KP Platform members included steering group meetings, mobilizing funding opportunities, capacity building in various aspects, consolidating and supporting the voice of KP representatives at national and international forums.

Feedback from the KIs suggests that the Platform was a promising initiative and did start as an active forum for KP dialogue. However, the KP representatives admitted that the discussions lacked concrete goals and outcomes, except when funding opportunities were discussed. After the Global Fund funding requests were submitted, the interest and engagement of the participants in the Platform dropped considerably. The government representatives, who were supposed to be the main targets of the Platform initiatives, also noted that they did not receive any official communication from the Platform, nor did they see any other deliverables.

Other forms of support to KP organizations from the JT include supporting them as members of the oversight bodies of the All-Ukrainian Network of People Living with HIV (100% Life) and All-Ukrainian Union of People who Use Drugs (VOLNA). The UNAIDS Secretariat has also been very active in promoting KP representatives at the global level. For example, Ukrainian PLHIV are members of the Programme Coordination Board of UNAIDS and speak at high-level international meetings.

Other JT agencies also work on building capacity of KP organizations. UNWOMEN have played a pivotal role in establishing the Positive Women CSO, which is now present at the CCM and coordination bodies at the regional level. UNODC actively collaborated with VOLNA, the union of PWID. UNFPA provided support to Teenergizer, an organization of young PLHIV. Teenergizer have become a pioneer best practice on the global scale, and now they are present at major international events.

Overall, capacity building efforts for KPs have taken place since the beginning of the HIV response and have proven to be effective. The civil society in Ukraine is very strong now, especially compared to neighbouring countries in the region. The KP communities are very strong and vocal, and their representatives are present at all relevant national councils and are involved in HIV response planning and implementation.[288] However, some stakeholders mentioned that when KP organisations are involved in implementation, especially in policy development, they may lack technical expertise and, in such cases, additional support from the JT or other professionals should be ensured.

As of yet, community-led monitoring has not been introduced in Ukraine. The UNAIDS Secretariat is planning to begin implementation from October 2021 with support from PEPFAR.

Response to COVID-19 pandemic (Evaluation question 7)

Summary of findings in this section. The JT agencies were involved in the COVID-19 response to a varying extent. The assistance in most cases was not HIV-specific, although there are notable examples of support to KPs.

Strength of evidence: moderate - The findings are based on KIIs and indirect evidence, such as public media.

[288] Evidenced by the membership lists of the National and Regional HIV/TB councils and working groups, meetings minutes, conference programmes and participant lists, etc.

The COVID-19 pandemic has significantly affected societies, economies, and the health system in Ukraine. Multiple health services were disrupted due to the re-orientation of health workforce, infection control measures, economic difficulties, and limitations in public transportation. In the HIV field, disruption to health services meant that people are not being as widely tested, diagnosed, or treated for HIV. In addition to the direct impact, the COVID-19 pandemic has revealed systemic issues in health systems in general, and in HIV programming in particular.[289]

The involvement of UN Agencies in COVID-19 response spanned far beyond the HIV field – WHO provided overall guidance, UNICEF was active in public communications, UNDP procured COVID-19 related medications and supplies nationwide, and several agencies were buying and providing personal protective equipment (PPE) for their partner organizations. In the HIV field, WHO contributed to the development of COVID-19-related guidelines for service providers, including the transition of OST patients to take-home administration, delivery of ART by mail, extension of ART prescription, and decentralization of clinical and laboratory services, etc. These practices helped the testing and treatment programmes to restore coverage by the end of 2020 and avoid increases in ART dropout and mortality. With UNFPA support, Teenergizer have adapted their psychosocial counselling services to an online format, addressing both HIV and COVID-19 related needs.

Collectively, the JT assisted Ukraine in preparation of the HIV-COVID-related funding request to the Global Fund in 2021, which included a wide range of KP-related activities. The involvement included facilitation of dialogue with KPs and participation in the working groups designing the activities.

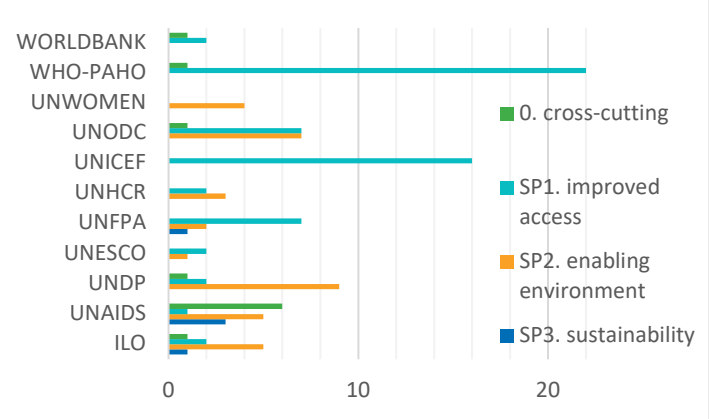
Contribution to outputs and intermediate outcomes (Evaluation question 8)

Methodological note. Given that the overview of activities by agency is provided in Section 4.1.1, and the assessment of overall effectiveness (considering the attribution challenges) is presented in Section 4.2.1, the following sections concentrates on the specific contributions by technical areas within the Theory of Change of this evaluation. This sub-section covers strategic priority (SP) areas 1 and 2, and sub-section 4.2.6 covers strategic priority area 3.

Summary of findings in this section. The JT has contributed substantially to the three strategic priority outcomes defined by the Theory of Change of the evaluation, namely improved access to services (SP1), improved environment (SP2), and sustainability (SP3). Due to the nature of the JT involvement, the activities in most cases had catalytic rather than direct effect.

Strength of evidence: moderate - Supported by documentation and majority of consultations.

Figure 20: Activities by Strategic Priority by



If categorized from the TOC perspective, of 115 activities 63 correspond to SP1 (improved access to services), 36 to SP2 (enabling environment and KP capacity building), 5 to SP3 (sustainability), and 14 would are cross-cutting (addressing all three priorities), see Figure 10.

The cross-cutting activities are related to the development of comprehensive strategies and workplans, and strategic information. **Contribution of the JT in the development of the national programmes and strategies and Global Fund funding requests is widely recognized, particularly for strategic guidance, KP facilitation, and provision of expertise.**

[289] Zeziulin O, Neduzhko O, Kiriazova T, Samko M and Dumchev K. Evaluation of the trends in HIV testing, linkage to care of PLWH and ART in Eastern Europe and Central Asia Kyiv: Alliance for Public Health; 2021 [Available from: http://aph.org.ua/wp-content/uploads/2021/05/Otsenka_dinamiki_testirovaniya_na_VICH_RRR.pdf].

Strategic priority 1 *- Equitable and equal access to KP-high Impact HIV services and solutions maximised*

Within the first strategic priority, the **most notable activities include the contribution of WHO to the development of national guidelines and policies on HIV testing and treatment**, which have been updated in 2019 to simplify testing algorithm, enable Test-and-Start approach, and optimize ART regimen prescription. The median time from HIV test to ART in Ukraine has decreased from three months in 2015 to two weeks in 2021. Optimized ART dolutegravir-based regimens now constitute 40% of all regimens, which has resulted in significant cost savings. **The involvement of WHO in introduction of PrEP in Ukraine was instrumental.** It included meetings and advocacy at the national level, establishment of the working group, and development of clinical standards and their recent update which included novel 2+1+1 options. The programme started in late 2019 with PEPFAR support, and now covers about 3,000 clients including MSM, PWID and other risk groups.

The PMTCT services, with key support from WHO and UNICEF, were implemented nationwide and resulted in formal elimination of MTCT in 2019 (reaching the annual rate of 1.6%, which is below the elimination threshold of 2%). Current technical assistance is focused on certification of eMTCT. To further reduce the rate, the activities would need to focus on the hard-to-reach group of women who inject drugs, which would require active outreach and service integration that can be a product of multisectoral and interagency collaboration.

This category also included the work of UNFPA to train healthcare providers on destigmatised service provision and 'smart technologies', which may potentially result in increased access to primary health care for KPs.

Ukraine is demonstrating significant progress in the prevention area, although coverage remains suboptimal, especially in KP groups other than PWID, namely MSM, TG, CSW and prisoners. Prevention programmes are run by strong national organizations with KP involvement, therefore the role of the JT in prevention scale up was focused on provision of guidance and advocacy. WHO supported dissemination, adaptation and implementation of global guidelines on HIV prevention in 2018. The UNAIDS Secretariat and WHO provided technical assistance in development of the MOH guide on HIV prevention services for KPs. UNODC has been consistently engaged in high level advocacy to promote international norms and evidence in drug policy and evidence-based HIV prevention and treatment for KP and prisoners. The recent innovative work of UNODC with new psychoactive substance users has laid the groundwork[290] for improved access to prevention services for this previously underserved group.

Both WHO and UNODC are involved in the MOH working group on OST, contributing to scale up which continued during the COVID-19 pandemic due to massive transfer of patients to take-home.

Strategic Priority 2 *- Barriers to accessing KP-high Impact HIV services and solutions broken down*

There has been slow but steady progress in the enabling environment for HIV KPs in Ukraine.[291] Due to the volatile political situation and frequent changes in the government, the law reforms and policy changes have been particularly challenging. The evidence[292] indicates of **substantial contribution of the JT to this progress, particularly through influencing the legislative and policy agenda, increasing legal and policy literacy among KPs, and effective training of government officials and the private sector on human rights.**

As a leader of the Global Partnership for Action to Eliminate All Forms of HIV-Related Stigma and Discrimination, UNAIDS has successfully advocated for Ukraine to join the Partnership.

[290] UNODC Regional Programme Office for Eastern Europe. People Who Use NPS/Stimulants: Basic Needs and Barriers in Access to HIV Related Medical and Social Services in Ukraine. Kyiv, Ukraine 2020 [Available from: https://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/NPS/NPS_Ukraine_English.pdf].
[291] Scaling up Programs to Reduce Human Rights Related Barriers to HIV and TB Services. Baseline Assessment – Ukraine. [Available from: https://www.theglobalfund.org/media/8148/crg_humanrightsbaselineassessmentukraine_report_en.pdf]
[292] Workplans and reports of the UNJP agencies.

UNDP is known as a leading agency in human rights and gender equity promotion, undertaking a number of strategic as well as focused activities, in the HIV field and beyond. UNDP plays an important brokering role in providing technical assistance on a range of human rights legal and policy issues and bringing parliamentarians, government departments and KP CSOs to the table.[293] **A notable achievement of UNDP in collaboration with the UNAIDS Secretariat is the creation of a cross-faction parliamentary association for human rights and freedom.** It serves as a discussion forum for parliamentarians and has a broad agenda to make it politically relevant; the JT is using it to mainstream the HIV and KP issues. KP representatives are invited to the meetings as associate members.

The continuous involvement of UNODC in drug policy reform was instrumental to counter punitive policies and practices that negatively impact KP access to critical services. UNODC has a long-standing relationship with the Penitentiary Department of the Ministry of Justice, which helped to promote human rights and health in prisons. The recent achievements include introduction of OST in prisons. The limited progress in decriminalization, however, calls for a change in the UNODC and JT approach to drug policy reform.

Response to contextual factors (Evaluation question 9)

Summary of findings in this section. The JT demonstrates full awareness of the contextual factors influencing the HIV response in Ukraine. A number of activities attempt to address the issues that are relevant to the mandate of the respective JT agencies.

Strength of evidence: moderate - Supported by most consultations.

As indicated by KIs, the most important contextual factors that jeopardize the Ukrainian HIV response are political instability, corruption, challenges in the ongoing reforms of governance and health care, and ongoing transition of prevention services to government funding.

While the political issues and corruption are beyond the scope of the JT, the other factors are being actively tackled by the agencies. **WHO has been involved in the health care reform, providing expertise and technical support, emphasizing evidence-based approaches.**[294] Currently the key work in this area is taking place in the technical working groups developing the content and cost of national insurance packages, where WHO is present. The JT played a key role in the revision of government financing mechanism for HIV treatment from a one to three-year cycle, which positively affects the stability of service provision.

The JT has been a consistent advocate and supporter of efforts of various stakeholders to help the national AIDS response transit from donor to domestic funding. This advocacy has resulted in 2018 in Ukrainian government's commitment to fund 80% of the national HIV prevention in three years, known as the 20-50-80 Transition Plan (see Section 2.4). The Secretariat has been an active member of the strategic group for the implementation of the Transition Plan, and together with other agencies provided guidance and expertise in developing the procedures, service packages, and quality criteria. Implementation of the Plan has faced numerous challenges and is not complete yet, and the work continues. The JT monitors and analyses the results of this new model of HIV service delivery in order to ensure its sustainability, effectiveness and consistency.

[293] UNDP brings together members of the judiciary to strengthen legal, rights support for HIV/TB patients. [Available from: https://www.ua.undp.org/content/ukraine/en/home/presscenter/pressreleases/2019/UNDP-brings-together-members-of-the-judiciary-to-strengthen-legal-rights-support-for-HIV-TB-patients.html]

[294] WHO and World Bank. Ukraine: overview of the reform of health care financing 2016-2019: Joint report of World Health Organization and World Bank 2019 [Available from: https://www.euro.who.int/__data/assets/pdf_file/0019/425341/WHO-WB-Joint-Report_UKR_Summary_Web.pdf?ua=1].

Sustainability of the results of the Joint Programme's activities (Evaluation question 10)

Summary of findings in this section. A significant part of the technical assistance provided by the JT in Ukraine is contributing to the sustainability of HIV response. There has been a notable involvement of the JT in the transition of funding for HIV to the national government and continuation of donor funding for critical areas. The sustainability of the JT outputs depends to a large extent on the country capacity and willingness.

Strength of evidence: strong - Supported by documentation and most consultations.

In Ukraine, under the UN Partnership Framework and Joint Programme 2018-2022, one strategic priority is a sustainable HIV response. To that extent, the evaluators believe that all technical assistance related to the core JT functions may be considered contributing to sustainability. Indeed, the adoption of evidence-based approaches in prevention and treatment, leads to more efficient programmes. The policy reforms create a lasting change in the environment as well as improve service provision. Promotion of human rights, gender and equality also create a foundation for lasting changes in policy making and service provision.

Another pillar of JT portfolio, capacity building activities (for programme planners and managers, service providers, advocates), could also translate into more efficient programming, improved access to and higher quality of services. However, the **sustainability of the capacity building results is vulnerable to issues like staff turnover and poor service financing**. For example, around 30% of youth-friendly clinics promoted and supported by UNICEF have already closed due to the health care reform and the police referral intervention launched by UNODC has also stopped due to the rapid changes in police staff.

However, as a positive example, **the results of capacity building for the KP organizations has led to remarkable results with a lasting impact**. The KP communities are strong and fully integrated in all relevant national coordination mechanisms and contribute meaningfully to the planning and implementation of HIV response.[295]

In terms of ensuring funding, the JT is advocating for efficient investment and transition to domestic funding and supporting the Sustainability Strategy and Transition 20-50-80 Plan in Ukraine (described above). At the same time, since donor funding is still required to support an essential part of Ukraine's HIV response, **the JT contributes significantly to the application process and coordination of implementation through the CCM and other mechanisms**.

Importantly, the sustainability of the UBRAF outputs and outcomes (which measure country level HIV response results and not direct Joint Programme results) depends on country capacity, willingness, and resources, which are largely outside the sphere of JT influence. In addition, the sustainability of the JT programming depends to a significant extent on cosponsor willingness to collaborate and contribute own resources – and less so on UBRAF funding.

[295] Evidenced by the membership lists of the National and Regional HIV/TB councils and working groups, meetings minutes, conference programmes and participant lists, etc.

Conclusions and Considerations Going Forward

Summary Conclusions

The JT role in the national HIV response. With the ultimate goal to support Ukraine in eliminating AIDS as a public health threat by 2030, the JT assumes the following core functions: leadership, policy guidance and advocacy; provision of thematic expertise; and engaging and building capacity of civil society. The evidence cited in the previous section suggests that the JT agencies carry out these functions adequately and with appropriate recognition from the national partners.

JT programmatic focus. By programmatic area, the key activities of the JT have been policy development for HIV testing and treatment, eMTCT, development of the National Strategy 2030 and corresponding Action Plan, and support for national estimations and reporting. The JT has been consistently promoting the human rights and gender principles through high-level advocacy, influencing the legislative and policy agenda, increasing legal and policy literacy among KPs, and effective training of government officials on human rights. Another important component of the enabling environment work has been the facilitation and capacity building for KP organizations individually and through the national KP Platform. In the sustainability area, the JT has contributed meaningfully to the coordination and development of funding requests to the Global Fund and supported the Transition Plan 20-50-80 for the government to take over HIV prevention funding.

JT Impact. Although direct attribution cannot be assessed, the evaluators believe that these activities have contributed to the scale-up and optimization of HIV testing and treatment, introduction and scale-up of PrEP, reduction of MTCT rates, and improved access to other health services for KPs. During the COVID-19 pandemic, the JT has helped to sustain the programmes and avoid major interruptions in access to key services.

Due to the JT leadership and advocacy, human rights principles and stigma reduction are prioritized in the key programmatic documents. While the radical law reforms such as decriminalisation of drug use are yet to happen, there is an overall improvement in the enabling policy environment. The capacity building of KP organizations, although started long ago, demonstrates remarkable results.

The involvement of the JT in the Global Fund funding request process has assured meaningful inclusion of KPs in the proposal development and contributed to more balanced and evidence-based programming. The transition of prevention funding from donors to the government, also promoted by the Global Fund, is ongoing and has been consistently supported by the JT.

Considerations

Programmatic Approach. The six core functions of the JT identified in the Joint Programme 2018-2022 are based on the comparative advantage of the UN and should be maintained.

In provision of policy guidance, a stronger position based on latest evidence may be helpful to mitigate the debates related to KP needs and priorities. In provision of expertise, the capacity of available national staff of the JT cosponsors should be used to maximize efficiency and timeliness of efforts. International high-quality expertise may be used if the complexity of request goes beyond the guidance available in international standards and requires a nuanced approach.

Admittedly, it is not within the scope of the JT to tackle political issues and corruption. However, given the importance of political will in achieving strategic outcomes such as decriminalisation of drug use and HIV transmission, liberalisation of drug policy, adherence to human rights and equality, it is worthwhile exploring whether the UN system may intervene at the macro-financial level and introduce human rights-related conditions to the Ukrainian aid packages.

The potential issue with the conflict of interest in country-level funding requests to the Global Fund or other donors should be assessed. The UN agencies are expected to provide an impartial judgement in evaluation of proposed activities, but if they propose activities to be carried out by themselves, it raises concerns among other co-implementers. If certain technical assistance is

required within the grant, it may also be questioned whether an UN agency (considering the complicated administrative procedures) may be a more efficient provider than a national entity.

Strategic Directions. A stronger involvement in the health reform process is essential to ensure sustainability of services in health care institutions. As the example of youth-friendly clinics shows, the system is going through a deep transformation and many service delivery models may become obsolete if appropriate funding is not secured. There is a window of opportunity with the National Health Service of Ukraine to incorporate key HIV and KP-related services into service packages and advocate for appropriate levels of funding.

Criminalisation of HIV transmission and drug use remains a major barrier to equitable access to services for KPs. Therefore, work on these issues should be continued. However, given the lack of tangible progress, the approach needs to be revised and possibly strengthened by other agencies.

Operational Improvement. To improve efficiency and longer-term planning, the annual planning-implementation cycles should be changed to three or five-year cycles. The current approach automatically favours short-term projects, which have questionable sustainability and strategic priority. The engagement of the JT in local-level implementation or small-scale projects may distract resources from more strategic tasks. Even though the local-level implementation may be catalytic, the comparative advantage of the UN becomes subtle if the work at this level does not require international expertise and can be done by a national organization. In a situation of limited resources, the JT should prioritize high-level core functions as opposed to focused short-term projects. In addition, UBRAF needs to provide clear guidance on prioritization of activities for county envelope funding.

Another area for improvement in JT work is the communication and coordination with national stakeholders. The annual planning process needs to be more transparent and participatory, with the involvement of KP community representatives as well as key national partners. This may improve programming in terms of addressing the KP needs, better position the JT within the National Strategy, as well as improve visibility and awareness about JT activities among stakeholders, creating potential synergies. Communication within the JT team should also be improved, particularly in order to facilitate collaborative strategic planning.

In the current shape, the outputs and targets in the annual workplans in JPMS do not correspond well to the activities. In multiple instances the deliverable is too general and cannot be attributed to the activity. The wording should be revised to better reflect the specific activity deliverables.

Annex 1: Key informants – Ukraine

The table below lists the names, job titles and organizational affiliations of the key informants who were interviewed as part of the Thailand country study. Due to the COVID-19 situation, all interviews were conducted remotely, using Zoom.

Where more than one person is listed in the same row this indicates a joint interview. Where people from the same organization are listed in separate rows this indicates separate interviews.

KI Name	Position	Organization
UNAIDS Secretariat and Cosponsor Agencies		
Raman Hailevych	Director	UNAIDS Secretariat
Olena Sherstyuk		
Natalia Salabai		
Naira Sargsyan		
Martin Donoghoe		WHO
Ihor Semenenko	NPO (HIV and hepatitis)	
Olena Brahinska	HIV/AIDS Officer	UNICEF
Svilen Konov	Chief Technical Advisor	UNDP
Zhannat Kosmukhamedova	Head, Regional Programme Office for Eastern Europe	UNODC
Sergiy Rudyi	National Programme Officer	
Halyna Meshcheriakova	Programme Specialist	UNWOMEN
Nurgul Asylbekova		
Pavlo Zamostian	Assistant Representative	UNFPA
Bohdan Pidverbetskyy	Reproductive Health Project Officer	
Liudmyla Shevtsova	Programme Analyst, Youth/HIV	
International donors		
Larisa Mori		PEPFAR
Jessica Grignon		
Volodymyr Chura		
Olga Dudina		
Yana Sazonova		
Nataliya Podolchak		
Ryan Keating		
Roksolana Kulchynska		
Ivan Doan		
Vitaliy Andres		
Oleksandr Lebega		
Government		
Ihor Kuzin	Deputy Minister	Ministry of Health
Taras Grytsenko	Advisor to the Minister	Ministry of Health
Larysa Getman	Head of HIV Treatment Programs Coordination Department	Public Health Center of the MoH of Ukraine
Iryna Ivanchuk	Head of the Viral Hepatitis and Opioid Dependency Department	

KI Name	Position	Organization
Olga Gvozdetska	Head of Project Management and International Cooperation Department	
Iryna Koroyeva		Secretariat of the National Council on TB/HIV/AIDS
Liubov Kravets		
NGOs		
Representative		100% Life (All-Ukrainian Network of PLHIV)
Representative		
Representative		VOLNA
Representative		
Representative		Legalife
Representative		Alliance.Global
Representative		Positive women
Representative		Free zone
Representative		Cohort

Annex 2: Bibliography/Background documents – Ukraine

1. APMG Health (for the Global Fund). Global Analysis: Assessment of HIV services packages for key populations in six regions. 2018.
2. The document of the Joint UN Programme of Support on AIDS in Ukraine
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Annex 3: JT activities by priority area and key population focus (as assessed by the evaluators), 2018–2021 – Ukraine

Year/ Priority Area/ Deliverable	UN agency	Relevance	Activity Name
2018			
Optimized HIV treatment cascade			
Access to HIV treatment/care for PLHIV	UNHCR	2. Broader	Maintenance of access to essential services for PLHIV and risk groups in Donetsk and Lugansk NGCA
	WHO-PAHO	2. Broader	Provided expert HIV technical assistance and support to MoH/CPH
	WHO-PAHO	2. Broader	Provided HIV treatment mentoring support to Ukrainian treatment specialists
	WHO-PAHO	2. Broader	Provided HIV treatment training to Ukrainian treatment specialists
	WHO-PAHO	2. Broader	Provided policy advice, strategic guidance and advocacy support on key HIV issues for NGCAs
	WHO-PAHO	2. Broader	Provided technical support, strategic guidance to develop and institutionalize HIVDR
	WHO-PAHO	2. Broader	Supported MoH/CPH in priority HIV activities
	WHO-PAHO	3. Other	Supported post-market surveillance of in vitro diagnostics (IVDs)
	WORLDBANK	2. Broader	Improve quality of HIV/AIDS prevention and treatment services
eMTCT certification	UNICEF	2. Broader	Launch of PMTCT national working group
	UNICEF	2. Broader	PMTCT database introduction in 25 regions
	UNICEF	2. Broader	PMTCT Roadmap development and introduction in the most affected regions
	WHO-PAHO	2. Broader	Assistance/expertise to MoH on integration of MCH and HIV services
	WHO-PAHO	2. Broader	Assistance/expertise to MoH to contribute to the elimination of MTCT and to linking mothers
	WHO-PAHO	2. Broader	Support to EMTCT validation and certification process
	WHO-PAHO	2. Broader	Supported the validation of EMTCT of HIV, system strengthening to improve prevention of PMTCT of HIV
Intensified community-based support	WHO-PAHO	2. Broader	Supported community-based prevention interventions including HIV Pre-Exposure Prophylaxis (PrEP)
Optimization of treatment cascade	WHO-PAHO	2. Broader	Provided policy advice, strategic guidance and advocacy support on key HIV issues
	WHO-PAHO	2. Broader	Reviewed the national HIV protocol and presented evidence and policy options for HIV
	WHO-PAHO	2. Broader	Supported dissemination, adaptation and implementation of global guidelines on HIV prevention
	WORLDBANK	2. Broader	Mathematical modeling to support resource optimization for primary care services and HIV treatment
Sustainable HIV response, particularly among key populations			

Year/ Priority Area/ Deliverable	UN agency	Relevance	Activity Name
Re-configurated service delivery and innovative partnerships on HIV testing	ILO	3. Other	Advocacy for implementation of VCT at and through workplace in selected sectors/regions
	UNFPA	1. Significant	Advocacy trainings for community leaders among key populations
	UNFPA	1. Significant	Development of online platforms and databases of trained "friendly doctors" for key populations.
	UNFPA	2. Broader	Development of online training course for medical doctors
	UNFPA	2. Broader	Strengthening capacity of health serivice providers to address HIV/SRH based on SWIT/MSMIT
	WHO-PAHO	1. Significant	Direct technical assistance to MoH in HIV testing for key populations
	WHO-PAHO	2. Broader	Assistance/expertise to MoH to review HIV testing algorithm
The National AIDS Programme 2019-2023 prevention component	ILO	3. Other	Update/review of the National Tripartite Strategy on HIV and AIDS in the world of work
Human Rights, Stigma and Discrimination			
7 principles of human rights applied by community networks	UNDP	2. Broader	Empowering the network of HIV-positive women on SDG implementation and reporting
	UNHCR	3. Other	Scaling up community-based initiatives by mobilizing communities for SGBV prevention and response
	UNWOMEN	2. Broader	Advocacy of gender related issues to the HIV State Program
Access to justice for key populations and mechanisms to address HIV related stigma	ILO	2. Broader	Building the capacity of the ILO tripartite constituents to address HIV stigma and discrimination
	UNDP	1. Significant	Promoting the human rights of MSM/TG communities and introducing changes to relevant policies
	UNDP	2. Broader	Conduct an online video training for community police, gadgets and justice on HIV and human rights
	UNDP	2. Broader	Promoting the results and action plan of the TB and HIV LEA reports
	UNODC	1. Significant	Advocacy to scalle up the HIV prevention and treatment services among PWUD and in prisons
	UNODC	1. Significant	develop a standard operating procedure to enable front line police to refer PWID to HIV services
	UNODC	1. Significant	Develop referral pathways in each selected city
	UNODC	1. Significant	In 5 cities established and functional multi-sectoral TWG to ensure smooth implementation of activit
	UNODC	1. Significant	Produce a comprehensive directory of HIV/ TB/HCV and other relevant services
	UNODC	1. Significant	To support the MoI and national Police to adopt the national community policing protocol
	UNODC	3. Other	Adreessing the health needs of women in prisons
HIV integration into the GBV	UNFPA	3. Other	Establishing model health service delivery points for GBV survivors with integrated HIV/STI services

Year/ Priority Area/ Deliverable	UN agency	Relevance	Activity Name
response mechanisms			
	UNHCR	3. Other	Improving protection environment by enhancing medical centers near the line of contact
2019			
Optimized HIV treatment cascade			
eMTCT certification	UNICEF	2. Broader	Cascade coordination from national to regional and inter-regional level to build linkages
	UNICEF	2. Broader	Continuous scientific support of PMTCT WG by a national expert
	UNICEF	2. Broader	Launch eMTCT Validation Commetee under MOH. Meetings of PMTCT Coordination body up to 6 times / year
	UNICEF	2. Broader	Prepare the set of required documents for application on eMTCT validation
	UNICEF	2. Broader	Support secretariat of PMTCT Coordinating body
	UNICEF	2. Broader	Support technical monitoring of eMTCT regional progress
	WHO-PAHO	2. Broader	Provide in-country technical advice and guidance to the MoH/CPH working group on eMTCT
	WHO-PAHO	2. Broader	Review Ukrainian eMTCT validation submission and provide written actionable recommendations
	WHO-PAHO	2. Broader	Technical assistance and policy guidance to the Ministry of Health of Ukraine (MOH) and the CPH
Sustainable HIV response, particularly among key populations			
Re-configurated service delivery and innovative partnerships on HIV testing	UNESCO	2. Broader	Boosting capacities for community-based HIV prevention and youth empowerment programming
	UNESCO	2. Broader	Strengthening capacities for HIV prevention/testing/treatment education
	UNFPA	1. Significant	Promote among primary health care doctors and support the certified on-line course
	UNFPA	1. Significant	Promotion, technical support, expanding doctors database on-line platform
	UNFPA	2. Broader	Development and launch of software solution (chat-bots) to redirect social medial & messenger users
	WORLDBANK	3. Other	Reforming service delivery for Non-Communicable Diseases and Primary Health Care
Human Rights, Stigma and Discrimination			
7 principles of human rights applied by community networks	UNODC	1. Significant	Development of technical guidelines & policies to guide HIV interventions among amphetamine/stimulan
	UNODC	1. Significant	High level advocacy to promote int'l norms and evidence in proportional approach in drug policy
	UNODC	1. Significant	Increase awareness of policymakers on alternatives to incarceration
	UNODC	1. Significant	Submission of the algorithm of referral of drug users to health, social, and other relevant services
Access to justice for key populations and mechanisms to	ILO	3. Other	Including HIV awareness-raising sessions in the agendas of training activities of the Maritime

Year/ Priority Area/ Deliverable	UN agency	Relevance	Activity Name
address HIV related stigma			
	ILO	3. Other	Trainings of trainers, workshops and other advocacy activities targeting young members of Maritime
	UNDP	2. Broader	Promote recommendations of the Global Commission on HIV and the Law
	UNESCO	3. Other	Strengthening education sector capacity to prevent and respond to GBV and HIV-related discrimination
2020			
Optimized HIV treatment cascade			
Elimination of MTCT of HIV is certified.	UNICEF	2. Broader	Compilation and finalization of national application package for EMTCT validation
	UNICEF	2. Broader	Technical assistance to national EMTCT group to follow-up on pre-assessment findings
	WHO-PAHO	2. Broader	Quality assurance of the national application package for validation of EMTCT of HIV
Intensified community-based support (prevention/care) as an element of the resilient and sustainable system for health	UNICEF	3. Other	Promote integrated youth friendly services for target population in line with on-going health reform
Pertinent guidelines, tools and strategic data are made available to inform the design of annual operational plans in support of the national AIDS strategy 2020-2030	UNAIDS SCO	1. Significant	Critical appraisal of key populations size-estimations results
	UNAIDS SCO	1. Significant	Development of HIV Estimations
	UNAIDS SCO	2. Broader	National AIDS Spending Assessment
PLHIV, including key populations, in the non-government-controlled areas have access to HIV treatment and care	UNICEF	3. Other	Improve HIV related services for target population in NGCA
Sustainable HIV response, particularly among key populations			
New National AIDS/TB/Heps Program	UNAIDS SCO	2. Broader	Development of new implementation plan of HIV/TB/Heps strategy till 2030
	UNAIDS SCO	2. Broader	National 2020 GAM report
Re-configured service delivery and innovative partnerships on HIV testing, including in Fast Track Cites	UNODC	1. Significant	Achieving 90/90/90 through addressing needs of people who use stimulant drugs/NPS

Year/ Priority Area/ Deliverable	UN agency	Relevance	Activity Name
	UNODC	1. Significant	Drop-out from treatment cascade is decreased by improving adherence to ART in PWID
	UNODC	1. Significant	Technical guideline on HIV related interventions among stimulants/amphetamine/NPS users are produced
	UNAIDS SCO	2. Broader	Enhancing quality of HIV prevention and care services
	UNAIDS SCO	2. Broader	Strengthening M&E capacity of Kyiv Public Health Centre
Transition Plan "20-50-80" is implemented.	UNAIDS SCO	1. Significant	Capacity building of Public Health Centre to function as national purchaser of HIV prevention in KP
	UNAIDS SCO	2. Broader	Development of request for funding to Global Fund
	UNAIDS SCO	2. Broader	National Strategy and Religious Leaders Dialogue
Human Rights, Stigma and Discrimination			
Access to justice for key populations improved and mechanisms to address HIV related stigma and discrimination are promoted at service delivery points and employment places	ILO	2. Broader	Non-discriminatory governmental refugee status procedure based on HIV/TB/LGBTQI status
	ILO	3. Other	Addressing HIV at JSC "Ukrzaliznytsya"
	ILO	3. Other	Capacity-building on HIV and workplace violence for agricultural sector
	UNDP	2. Broader	National web solution for mapping of HIV/TB medical and human rights counselling services
	UNDP	2. Broader	Support implementation of Human Rights and Healthy City Action Plan in Dnipro.
	UNHCR	2. Broader	Non-discriminatory governmental refugee status procedure based on HIV/TB/LGBTQI status
	UNAIDS SCO	2. Broader	Comprehensive response to Human Rights-related and legal barriers to services
Capacity of networks of PLHIV, of key populations (including young populations), of positive women to take meaningful part in policy- and decision-making at central and local levels is enhanced	UNWOMEN	2. Broader	Women living with HIV have enhanced capacity to advocate for women's rights and are mobilized for me
	UNAIDS SCO	1. Significant	Capacity building of National Platform of Key Populations
	UNAIDS SCO	1. Significant	LGBTI movement and its involvement in the AIDS response, inc. LGBT National Conference
	UNAIDS SCO	2. Broader	Capacity building of the Positive Women network
	UNAIDS SCO	2. Broader	HIV Stigma Index Study
HIV is integrated into GBV response mechanisms,	UNFPA	3. Other	Enhancing HIV Testing Services for GBV protection providers in Odesa City

Year/ Priority Area/ Deliverable	UN agency	Relevance	Activity Name
including in the context in armed-conflict situations.			
Knowledge and capacity of law enforcement officers and judges is strengthened to protect the rights of people living with HIV and key populations, including alternative measures to imprisonment.	UNDP	2. Broader	Establishment of all-party parliamentary platform on human rights and socially dangerous diseases
	UNDP	3. Other	Scaling up judicial dialogue within HIV and Law Commission recommendations implementation in Ukraine
2021			
Optimized HIV treatment cascade			
Addressing persistent gaps in the Ukrainian HIV treatment cascade	WHO-PAHO	2. Broader	Mentoring and site-specific guidance
	WHO-PAHO	2. Broader	Standardized ART profiles, simplified HIV testing algorithms and treatment/clinical pathways
Elimination of MTCT of HIV is certified.	UNICEF	2. Broader	Improve coordination, monitoring and evaluation of PMTCT programme at national and regional level
	UNICEF	2. Broader	Update of PMTCT-related legislation at national and regional level
PLHIV, including key populations, in the non-government-controlled areas have access to HIV treatment and care	UNICEF	3. Other	Support HIV -affected children and families in NGCA
Sustainable HIV response, particularly among key populations			
Re-configured service delivery and innovative partnerships on HIV testing, including in Fast Track Cites	UNODC	1. Significant	On-line outreach to NPS/stimulants users to facilitate access to HIV testing and ART
Human Rights, Stigma and Discrimination			
Access to justice for key populations improved and mechanisms to address HIV related stigma and discrimination are promoted at service delivery points and	ILO	2. Broader	Promoting stigma free working environment in the State Migration Service

Year/ Priority Area/ Deliverable	UN agency	Relevance	Activity Name
employment places			
	UNDP	2. Broader	Mapping of PLHIV-friendly primary healthcare services including dental services.
	UNHCR	3. Other	Promoting stigma free working environment in the State Migration Service
Capacity of networks of PLHIV, of key populations (including young populations), of positive women to take meaningful part in policy- and decision-making at central and local levels is enhanced	UNWOMEN	2. Broader	Women living with HIV are mobilized for meaningful participation in decision making
	UNWOMEN	2. Broader	Women living with HIV rights are advocated at regional and local levels
HIV is integrated into GBV response mechanisms, including in the context in armed-conflict situations.	UNFPA	3. Other	Scale up of integrated HIV/GBV service provision model in Odesa city
Knowledge and capacity of law enforcement officers and judges is strengthened to protect the rights of people living with HIV and key populations, including alternative measures to imprisonment.	UNDP	2. Broader	Support the implementation of the Fast-Track City initiative for Dnipro.
	UNDP	3. Other	Strengthen the judicial expertise on HIV infection and related comorbidities

Annex 4: JT staff resources (JPMS 2020–2021 data)

UN agency	SRA	Position	Grade	Time %
ILO	SRA 6	National HIV Focal Point	NOA	100
UNAIDS	SRA 7	UNAIDS Country Director	P5	100
UNAIDS	SRA 7	Fast-Track City Project Officer	NOB	100
UNAIDS	SRA 6	National Programme Officer	NOC	100
UNAIDS	SRA 4	Community Support Adviser	P4	100
UNAIDS	SRA 7	Strategic Information Adviser	P4	100
UNDP	SRA 6	Health Programme Specialist	P4	30
UNDP	SRA 6	HIV and Health Programme Specialist	SB-5	50
UNFPA	SRA 3	Programme Officer HIV and Youth	NOB	50
UNHCR	SRA 6	Field Associate (Protection)	G6	25
UNHCR	SRA 6	Protection Assistant	UN Volunteer	25
UNHCR	SRA 6	Protection Associate (Community based)	G6	20
UNICEF	SRA 1	HIV/AIDS Officer	NOB	100
UNICEF	SRA 1	Chief, Health, Nutrition and HIV/AIDS	P3	20
UNICEF	SRA 1	Health officer	NOB	20
UNICEF	SRA 1	HIV/AIDS and adolescent health specialist	P4	5
UNODC	SRA 4	National Programme Officer	NOB	50
UNODC	SRA 4	Regional HIV/AIDS Adviser	P4	40
WHO-PAHO	SRA 1	Senior Adviser TB, HIV and Hepatitis	P5	100
WHO-PAHO	SRA 1	National expert HIV Treatment (2)	Consultant NPOB equivalent	100
WHO-PAHO	SRA 1	NPO HIV and Hepatitis	NPOB	100
WHO-PAHO	SRA 1	National expert HIV M&E	Consultant NPOB equivalent	100
WHO-PAHO	SRA 1	National expert HIV Treatment	Consultant NPOB equivalent	100

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