Agenda item 7

UNAIDS/PCB (51)/CRP3

CASE STUDY OF THE JOINT PROGRAMME'S WORK WITH AND FOR KEY POPULATIONS IN THAILAND

13 – 16 December 2022 | Chiang Mai, Thailand
UNAIDS Programme Coordinating Board
Issue date: 18 October 2022

UNAIDS

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

Country case studies

March 2022 | Evaluation offices of UNAIDS, WHO, UNODC and UNESCO

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

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[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 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[2] 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

[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 Thailand is referred to as the UNAIDS Country Office (UNAIDS CO).

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

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.

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.[3] 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.[4] 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[5] 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

[3] 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.
[4] Personal communication, Ye Yu Shwe, Technical Officer, UNAIDS Regional Support Team, Asia Pacific.
[5] 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.

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 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.[6]

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

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.[7] 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. 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.[8] 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

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[7] 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.

[8] 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.

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.[9]

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.

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[10] is the sixth largest in the world, with more than 70% of all inmates incarcerated for drug law violations[11]. 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

[9] Joint Programme Thailand, Leave No One Behind Analysis. LGBTI, HIV affected people and sex workers. 2020. p. 11.
[10] World Prisons Brief https://www.prisonstudies.org/country/thailand accessed 21 November 2021.
[11] Paungsawad, G. et al., Bangkok 2016: From overly punitive to deeply humane drug policies. Drug and Alcohol Dependence, 6138, 2016.

funding.[12] 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.)

In developing its 2021 plan the JP identified the following 'persistent challenges and gaps'[13]:

- 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

[12] Thailand Country Coordinating Mechanism. Global Fund Funding Request, 2021 – 2023. 2020. p. 71.
[13] UN Joint Team on AIDS, Thailand 2021 Joint UN Programme Plan, 2021. p. 2.

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.[14] 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.

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

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

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 1: 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[15]

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

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

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[16] content for young 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

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

- 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[17]

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

[17] 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?"

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 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[18]

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[19] 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 2: 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.

[18] This section addresses the evaluation question "To what extent are capacity and resources of the JP appropriate for work with and for KPs?"
[19] Agency core funds are regular or extra-budgetary resources of the Cosponsors; not funds the UNAIDS Secretariat mobilises and transfers to cosponsors.

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 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 3: 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.[20] 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[21]

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

[20] http://ihppthaigov.net/DB/publication/attachresearch/442/chapter1.pdf
https://www.hitap.net/documents/180532
[21] 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?"

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 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[22]

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.

[22] 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[23]

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[24]

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

[23] 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?"
[24] 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?"

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.

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.[25]

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.[26] 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.[27] 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

[25] TNP+, Role of the Continuum of Care Centre, CCC and TNP+ in response to the COVID-19 pandemic. June 2020. pp. 5-6.
[26] 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.
[27] 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.

(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 reduction, including vaccination."[28] 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.[29]

Contribution of the Joint Programme to outputs and intermediate outcomes[30]

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[31]

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.[32] The JP, in

[28] 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.

[29] Moderate evidence: good evidence on KP CSO and JP measures to migigate impacts but limited evidence on the outcomes of these measures.

[30] 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.

[31] 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.

[32] 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).

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 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[33]

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.

[33] 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.

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.[34]

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.[35]

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.[36] 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[37]

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.[38]

Improved tracking of 90-90-90 data[39]

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[34] Limited evidence: supported by some consultations and documentation.
[35] Strength of evidence: there is insufficient evidence to make a ranking.
[36] Moderate evidence: in relation to brokering role only as the guidelines are currently in development and the outcome of the work is unknown.
[37] Limited evidence: supported by some consultations and documentation.
[38] https://www.unaids.org/en/resources/presscentre/featurestories/2021/october/20211028_bangkok
[39] Moderate evidence based on a limited number of consultations.

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 HIV infection dropped from 61% in 2015 to 52% in 2019, and stigmatising attitudes from 85% to 81%.[40] [41]

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."[42]

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[40] UN Joint Team on AIDS, Thailand 2020 Joint Programme Monitoring (JPMS) Report, 2021. p. 2.
[41] Strong evidence: supported by MOPH and JP documentation.
[42] UNDP, Legal and policy trends impacting people living with HIV and key populations in Asia and the Pacific 2014-2019. 2021. p. 7.

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.[43]

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 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

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

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.[44] 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.[45]

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.[46]

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

[44] Moderate evidence: supported by documentation and consultations.
[45] Limited evidence: supported by some consultations and documentation.
[46] 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.

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[47]

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

[47] 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?"

most marginalised KPs such as PWID/PWUD, TG and prisoners, improving the enabling environment, and ensuring the long-term financial sustainability of KPLHS.

Sustainability of the results of the Joint Programme's activities[48]

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

[48] 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 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.

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.[49] 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

[49] UNDP, Situational Analysis of Substance Use Among LGBT Communities in Thailand. 2021.

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.[50] 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 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.

[50] 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.

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		

Name	Position	Organization
Representative		Raks Thai: Global Fund Principal Recipient (Civil Society)
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		

Name	Position	Organization
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

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