

UNAIDS

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

Report



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The purpose of this evaluation was to assess the relevance, coherence, effectiveness and equity of the UNAIDS Joint Programme support for key populations – where gaps and inequalities in access persist despite progress in the HIV response. An evaluation of this complexity required the engagement of a large number of participants and we are grateful to everyone who contributed.

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The evaluation included six country case studies conducted in Cameroon, Kenya, Peru, Thailand, Tunisia and Ukraine. The country reports stand on their own as national situation analyses and inform this report. They are published as a separate volume to go along with this report.

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We believe that the findings and recommendations of this evaluation are very relevant, timely and will shape and improve the future contribution of the Joint Programme towards reducing inequalities – with key populations at the forefront of the HIV response – to reach the goal of ending the AIDS as a public health threat.

UNAIDS Evaluation Office

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Evaluation Reference Group

People living with HIV and key population-led networks

Global Network of Sex Work Projects (NSWP), Ruth Morgan Thomas
MPact Global Action for Gay Men's Health and Rights, Andrew Spieldenner
GATE and International Reference Group on Transgender Women and HIV/AIDS, Joanne Keatley
International Network of People who Use Drugs (INPUD), Judy Chang
Global Network of Young People Living with HIV (Y+), GNP+ and ICW Global, Jessica Whitbread

Key population experts from United Nations agencies (including members of the inter-agency task team (IATT) on key populations)

WHO: Annette Verster, IATT
WHO: Rachel Baggaley, Key populations lead
UNODC: Ehab Salah, IATT (prisons)
UNODC: Monica Ciupagea, IATT (people who inject drugs)
UNFPA: Tim Sladden, IATT
UNDP: Boyan Konstatinov, IATT
UNDP: Deena Patel, focal point for the African key populations expert group (AKPEG)
UNICEF: Su Myat Lwin * young key populations

Global AIDS coordinators and focal points for HIV/AIDS

UNESCO: Christopher Castle; Ariana Stahmer
ILO: Kofi Amekudzi
WB: Marelize Gorgens; Nejma Cheikh; Katherine Ward
UN Women: Nazneen Damji; Elena Kudravtseva
UNFPA: Elizabeth Benomar
UNODC: Fariba Soltani, Ehab Salah
WFP: Allison Oman Lawi; Michael Smith
UNDP: Mandeep Dhaliwal; Ludo Bok
WHO: Andy Seale; Hywel Jones
UNICEF: Chewe Luo; Myungsoo Cho; Shaffiq Essajee
UNHCR: Ann Burton; Liz Tarney, Erin Anastasi

UNAIDS Secretariat

Keith Sabin, Senior Adviser, Epidemiology
Clemens Benedikt, Senior Adviser, HIV Prevention Coalition & Technical Support
Cleiton Euzebio de Lima, Senior Adviser, Civil Society Networking

From regions/countries

Elie Georges Ballan, Consultant, MENA
Marie Engel, Regional Programme Adviser, WCA
Alankar Malviya, Regional Fast-Track Adviser, ESA
Lev Zohrabyan, Strategic Information Advisor, EECA
Guillermo Eduardo Marquez Villamediana, Human Rights and Community Adviser, LAC
Marina Novachuk, Community Support Adviser, Ukraine

Partners

Global Fund: Ed Ngoksin, Key Populations Advisor, Community, Rights and Gender Department
PEPFAR: Parvies Hosseini

Evaluation management group

Joel Rehnstrom	UNAIDS, Director, Evaluation
Elisabetta Pegurri	UNAIDS, Senior Evaluation Adviser
Anand Sivasankara Kurup	WHO, Evaluation Office
Katherine Aston	UNODC, Evaluation Office
Verena Knippel	UNESCO, Evaluation Office

Euro Health Group evaluation team

Lawrence Gelmon	Team leader and Kenya case study lead
Clare Dickinson	Deputy team leader
Parinita Bhattacharjee	Advisor of key population programming and policy
Matthew Cooper	Equity analysis and theory of change advisor
David Lowe	Thailand case study – team leader
Hedia Belhadj	Tunisia case study – team leader
Kostyantyn Dumchev	Ukraine case study – team leader
Tiburce Nyama	Cameroon case study – team leader
Carlos F. Cáceres	Peru case study – team leader
Ximena Salazar	Peru case study – co-lead
Michele Gross	Administrative and technical support
Lene Klosterskov Andersen	Administrative support

Evaluation team members identified by the global networks of key populations

Global:	Aditia Taslim; Alex Garner; Ruth Morgan
Thailand:	Verapun Ngammee; Surang Janyam
Tunisia:	Slim Ben Nasr; Faten Bouhaha
Ukraine:	Olena Stryzhak; Nataliia Isaieva
Cameroon:	Ndi Ndukong Titus; Jean Paul Enama; Jacques Ombilitek
Peru:	Jana Villayzan; Olinda Azucena Rodriguez del Corzo
Kenya:	Doreen Moraa; Jeffrey Walimbwa; John Mathenge

Report layout and design

Nathalie Gouiran	UNAIDS, Graphic Designer
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Abbreviations and acronyms

AIDS	Acquired immunodeficiency syndrome
AP	Asia Pacific Region
ART	Anti-Retroviral Therapy
ARV	Antiretrovirals
BDB	Breaking Down Barriers
BUF	Business Unusual Funds
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism (Global Fund)
CE	Country Envelope
CHW	Community Health Workers
COP	Country Operating Plan (PEPFAR)
CSO	Civil Society Organizations
DoL	Division of Labour
EECA	Eastern Europe and Central Asia
EHG	Euro Health Group
EMG	Evaluation Management Group
EQ	Evaluation Question
ERG	Evaluation Reference Group
ESA	East and Southern Africa
GAM	Global AIDS Monitoring system
GBV	Gender-Based Violence
GE	Gender Equality
GPC	Global (HIV) Prevention Coalition
HIV	Human Immunodeficiency Virus
IATT	Inter-Agency Task Team
IBBS	Integrated Biological and Behavioural Study
ILO	International Labour Organization
JP	Joint Programme
JPMS	Joint Programme Monitoring System
KII	Key Informant Interview
KP	Key Population
LAC	Latin America and the Caribbean
LGBTIQ+	Lesbian, Gay, Bisexual, Transexual, Intersex, Queer, and other non-binary persons
LMIC	Lower Middle-Income Country
M&E	Monitoring and Evaluation
MENA	Middle East and North Africa
MIPA	Meaningful Involvement of People living with and affected by AIDS
MoH	Ministry of Health
MoPH	Ministry of Public Health
MSM	Gay Men and other Men who have Sex with Men
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NSP	National Strategic Plan
OECD DAC	Organisation for Economic Co-operation and Development's Development Assistance Committee

OST	Opioid Substitution Therapy
PAHO	Pan American Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	Person Living with HIV
PPB	Pharmacy and Poisons Board
PPE	Personal Protective Equipment
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
SDG	Sustainable Development Goals
SOGIE	Sexual Orientation, Gender Identity and Expression
SOP	Standard Operating Procedure
SRAs	Strategic Results Areas
SRH(R)	Sexual and Reproductive Health (and Rights)
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TG	Transgender Person
ToC	Theory of Change
ToR	Terms of Reference
TRP	Technical Review Panel
TSM	Technical Support Mechanism
UBRAF	Unified Budget, Results and Accountability Framework
UFE	Utilization-Focused Evaluation
UHC	Universal Health Care
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
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
WCA	West and Central Africa
WFP	World Food Programme
WHO	World Health Organization
YKP	Young Key Population

Executive summary

Whilst much progress has been made in global and country HIV responses since the first cases of AIDS were identified 40 years ago, this progress remains unequal and, in some contexts, acutely inadequate in meeting the needs of different key populations: sex workers, gay men and other men who have sex with men (MSM), transgender people, people who inject drugs and prisoners. Key populations accounted for at least 65% of new infections globally in 2020 and 93% of new infections outside sub-Saharan Africa. There has been slow progress in reducing new infections among key populations, limited scale-up of combination prevention, testing and treatment programmes, and slow progress in addressing the barriers that prevent key populations from accessing the HIV and health services they need.

Purpose and scope of the evaluation

The purpose of this evaluation was to assess the relevance, coherence, effectiveness and equity of the Joint United Nations Programme on HIV/AIDS (UNAIDS Joint Programme) support for key populations at the country level. The evaluation was designed for both accountability and organizational learning purposes, the findings, and recommendations of which aim to improve UNAIDS programming for key populations under the new UNAIDS Unified Budget, Results and Accountability Framework (UBRAF) 2022-2026 and contribute to accelerating progress towards the strategic outcomes and goals of the Global AIDS Strategy 2021-2026.

Evaluation approach and methods

A blended theory of change was developed during the inception phase to explain how and why the Joint Programme activities from the Fast-Track strategic period would achieve results and contribute to the intermediate outcomes including in relation to the Global AIDS Strategy 2021-2026. The theory of change provided the overarching analytical framework and informed the evaluation protocol and development of 10 evaluation

questions that probed relevance, coherence, effectiveness, and sustainability of the Joint Programme's work for key populations.

Evidence for the evaluation was generated principally through six country case studies, which were undertaken in a diverse set of regions and HIV epidemiological contexts - Cameroon, Kenya, Peru, Thailand, Tunisia, and Ukraine. The evaluation followed a standard methodology of document review and key informant interviews with almost all interviews being carried out virtually due to the COVID-19 pandemic. In addition to the case studies, evidence was also generated at the global and regional levels and provided context to the findings at the country level.

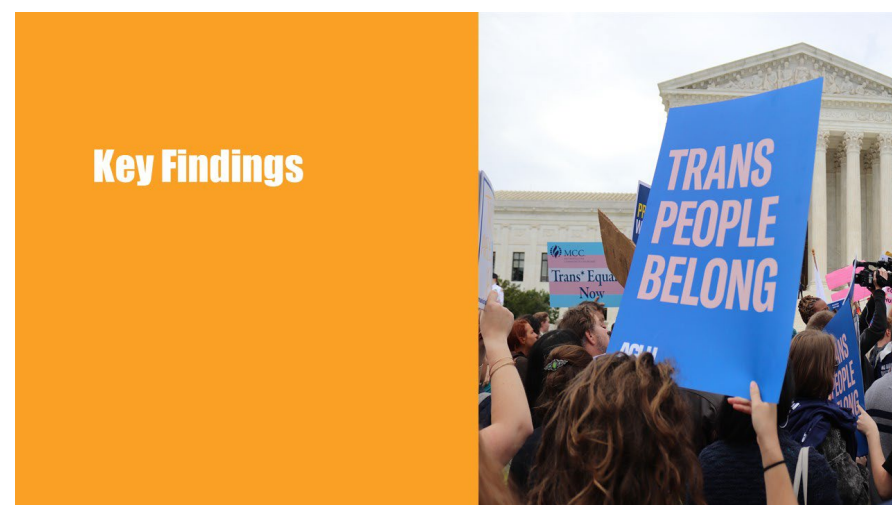
Representatives of key population communities were involved in all phases of the evaluation, with global key population network representatives contributing to the development of the methodology and findings, and national key population organization and network representatives participating in the country case studies. All groups contributed to the revision of the country studies and the global report. A reference group composed of Joint Programme agencies and global key population networks monitored the progress of the evaluation and contributed to the final report.

Limitations

Limitations to the study included the brief time available to review the large volume of documentation that has been produced by the Joint Programme at both the global and national levels over the past four years, and the necessity to produce an evaluation framework and theory of change that encompassed not only the differing issues surrounding the various key population communities, but also the differing strategies and modes of operation of the Joint Programme agencies. Some argued that, had there been more time and resources to conduct additional country studies, the report might have been more inclusive and reflected a broader spectrum of Joint Programme experience. However, the primary limitation of the evaluation was the COVID-19 pandemic, which prevented travel to and within the case study countries, enforced the need to

conduct almost all interviews virtually and made group meetings with beneficiaries at the national level problematic. Not all key informants who could have been interviewed were reached, and their unavailability, or non-response to requests for an interview, may also have been due to COVID-19. It also meant that the global and national evaluation team leaders were unable to meet in person for brainstorming, feedback and analysis, typical components of these types of evaluation.

Despite these limitations a large volume of evidence was gathered through document review, interviews and group discussions. The global and country reports contain rich evidence, the findings and recommendations from which are summarized below.



Area of work	Summary of findings
Overall global and regional findings	The Global AIDS Strategy 2021-2026 references key populations but the Strategy's broad scope may not provide sufficient prioritization of key populations, given their contribution to incidence in most regions

Area of work	Summary of findings
	<p>Advocacy is needed where it matters most – targeting resources to countries and key population groups where HIV transmission is not yet under control and where more specific and directed programme interventions are called for</p> <p>The Joint Programme plays a valuable role producing guidance, policy documents, key populations data and technical advice, as well as advocating for resources. Collaboration with the Global Fund and the President's Emergency Plan for AIDS Relief (PEPFAR) have benefitted from this support and influenced their key population programming and strategies</p> <p>The Global Prevention Coalition (GPC) and the technical support mechanism (TSM) are both involved in key population responses. However, the Global Prevention Coalition could do more and the technical support mechanism is underutilized in some vital areas such as improving data, building capacity of key population organizations and networks and working towards sustainable financing</p> <p>All regions have included key populations as an important component of regional strategies with country programmes supporting key population issues to a greater or lesser extent, assisted by the regional support teams. An analysis of regional trends in key population programming over the past four years was limited by the shortcomings inherent in the Joint Programme Monitoring System (JPMS)</p>
Relevance, harmonization and alignment <i>(findings from Evaluation Questions 1 and 3)</i>	<p>Key population groups are not systematically involved in Joint Programme strategic annual planning processes and strategic assessments of country key population needs do not always guide the prioritization of Joint Programme activities</p> <p>There is a greater focus on broader programming activities with varying degrees of relevance for key populations, than on activities for specific key population groups. There is evidence that the prioritization of activities in support of key populations could be strengthened</p> <p>The mix of activities does not necessarily leverage the comparative advantage of Cosponsor agency expertise but reflects the capacity levels of agencies to support key population programming</p> <p>There is a stronger focus on support to systems and services for key populations, and the enabling environment, and less support to sustainable financing critical to ongoing key population programming</p>

Area of work	Summary of findings
Human rights, gender equality and more vulnerable key populations (findings from Evaluation Question 2)	Human rights and gender equality considerations are very evident in the design of Joint Programme activities and include key population-specific human rights work and broader enabling environment programming, which often go beyond HIV
	While all key population groups are marginalized, young key populations, transgender people and prisoners receive less attention as per evaluation case study countries
	Current definitions of key population groups do not adequately reflect the diversity of key populations or the intersectional vulnerabilities and needs across and within key population groups. This has implications for relevance and effectiveness of the Joint Programme's work with key population groups
Appropriate capacity and resources (findings from Evaluation Question 4)	Joint Programme capacity to undertake key population work has been hit hard by funding cuts since 2016 and this has impacted on staffing, expertise, scope and scale of activities
	Funding cuts have accelerated the repositioning of HIV and key population programming in agency strategies and work programmes, arguably with a lesser focus on key populations
	Raising resources beyond UBRAF funding for key populations is difficult due to the nature of the work. External funding can promote a project-by-project approach with implications for the strategic direction and coherence of global and country plans for key populations
	There is limited guidance and direction for the prioritization of UBRAF resources in relation to delivering the strategic priorities of the Global AIDS Strategy 2021-2026.
	Notable Joint Programme gaps in capacity and expertise identified include: HIV prevention, gender and sexuality issues, not enough staff working on data, not enough key population staff including transgender people and young key populations, few staff at country level with key population expertise.
Empowering key population organizations (findings from	The Joint Programme's monitoring system cannot be used for strategic programming. Getting a sense of the volume of investment for key populations, as well as the activities and results of the Joint Programme's work is difficult and this poses a threat for future funding contributions
	The Joint Programme has successfully convened and brokered relationships between governments and some key population groups and has supported engagement of these groups in national consultations, strategy and coordination processes and decision-making forums

Area of work	Summary of findings
Evaluation Question 6)	However, the Joint Programme's role in capacity-building of key organizations varies considerably in case study countries and is invariably small scale due to limited funding, with bilateral and multilateral donors and other funders doing much more
	Challenges remain in ensuring key population engagement is influential in national planning and Global Fund funding requests, particularly for the prioritization of resources and ensuring planned allocations (for example in funding requests) are translating into actual budgets for key population programming
Responding to key population needs in humanitarian settings and during COVID-19 (findings from Evaluation Question 7)	The Joint Programme has been proactive in responding to the COVID-19 pandemic and initiatives have focused on mitigating the impact of the pandemic on key population groups. Flexible reprogramming of UBRAF funds and support to mobilize funds has facilitated action
	Available case study data for how the Joint Programme has responded to key population needs in humanitarian settings is very limited. It is therefore difficult to determine the extent to which key population groups, as defined for the purposes of this evaluation, are being targeted and addressed through the Joint Programme's humanitarian work
	There are concerns that the Joint Programme's strategic pivot to addressing the dual pandemics of HIV and COVID-19 and pandemic preparedness will reduce attention to HIV and specifically key population programming at a time when this should be scaled up
Achieving targets and effective contributions (findings from Evaluation Question 5 and 8)	Overall, data and evidence for the Joint Programme's activities are available; data and evidence for the results and achievements of the Joint Programme's work are significantly more challenging
	There is evidence that Joint Programme activities have updated and integrated evidence into policies, guidance and implementation models and this is contributing to the enhanced service delivery approaches or increased provision of services for key populations
	Joint Programme activities have increased legal and policy literacy among key population organizations and this has helped with advocacy and community mobilization in support of policy and legislative change. Human rights work is informing HIV strategy and policy documents but progress in law reform and significant policy change in the enabling environment has been slow
	Compared to intermediate outcomes 2 and 3, and with the exception of Thailand and Ukraine, fewer activities have focused on developing and implementing sustainable financing and

Area of work	Summary of findings
	programming mechanisms for key population groups, representing a strategic gap
Response to contextual factors and sustainable results (findings from Evaluation Question 9 and 10)	<p>Global and country evidence for how the Joint Programme is responding to contextual factors is limited but in the more mature key population epidemics, the Joint Programme is responding to issues concerning the sustainability of the key population programming</p> <p>Although sustainable financing and programming mechanisms to support key population-led responses are recognized globally as essential, this has not been a priority area of work for Joint Teams in the countries studied</p> <p>Many transition strategies have not worked due to limited government ownership and are therefore aspirational in nature and unlikely to result in sustainability</p> <p>For key population programming there is a need to: i) sustain donor support for key population programming; ii) advocate for a greater domestic share of key population programming from domestic allocations; and iii) support efforts to integrate key population programmes and costs in universal health coverage</p>

CONCLUSIONS



The key findings of the evaluation, which cut across the countries studied, and are drawn from global and regional informants and supporting

literature, lend themselves to the following conclusions, most of which are not standalone, but have relevance and bearing on one another.

- 1. The Joint Programme is a well-respected body that has been instrumental in developing and supporting key population responses but its role as an advocate for human rights and related legislative change is perceived to have reduced.**

The Joint Programme is a key stakeholder in countries and one whose neutrality gives it the authority to convene meetings, bringing government and civil society to the table. However, as the champion for supporting key population rights and HIV responses, there is a strong perception that this neutral voice is not being used powerfully enough, and that the Joint Programme has been less visible and proactive in advocating for all key population groups in recent years.

In the context of the latest data, where at least 65% of new HIV infections are found within key population groups, and the increasingly conservative contexts in which the Joint Programme operates, there is an urgent need to intensify advocacy efforts. The Joint Programme, in collaboration with key population groups, is well positioned to step up its advocacy for change in punitive legal environments, to campaign for greater efforts to reduce stigma and discrimination targeting these populations, and to defend rights to access services.

- 2. The increase in new infections occurring among key populations together with the Global AIDS Strategy focus on tackling inequalities presents a strong case for strengthening the prioritization and focus on key population programming.**

HIV programming has been strategically repositioned in some Cosponsor agencies with increased integration of HIV and key population programming mainstreamed into core work, with trade-offs in the relevance of such activities for key populations. Funding

cuts have impacted significantly on human and financial resources across the Joint Programme, affecting most agencies' capacity to sustain the same level of support to HIV and key population programming. However, data on new infections among key population groups, and the focus on addressing inequalities in Global AIDS Strategy 2021-2026, necessitate a stronger prioritization and focus on key populations in the Joint Programme's work. This prioritization must be done, with the evidence showing that high incidence among key populations is occurring not just in the high priority countries (Fast-Track countries and members of the Global Prevention Coalition) but also in small countries that do not have a high overall HIV burden, and in middle-income countries that are no longer eligible for, or are transitioning from, donor support.

3. There is scope to increase the relevance and impact of the Joint Programme's work for key populations through inclusive planning processes and through having a more explicit focus on specific key population groups in Joint Programme interventions.

There is scope to increase the relevance, accountability and potential results of Joint Programme support through consultations with key population communities in Joint United Nations Team on AIDS (Joint Team) annual planning processes and through ensuring that updated strategic assessments of country needs drive the prioritization of Joint Programme resources. Additionally, Joint Programme plans, strategy documents, systems, and mechanisms (such as the Joint Programme Monitoring System (JPMS) and the technical support mechanism) do not always go far enough in differentiating between key population groups and other priority and vulnerable populations. Lack of clear definitions and adherence to definitions of key populations, particularly in relation to other 'priority vulnerable populations', can dilute funding allocations to key population groups, giving the impression that more work is focused on key population groups than perhaps is the case. In operationalizing the Strategy, it will be important to rebalance plans and increase the share of activities that

explicitly address key population groups while also strengthening the focus on key population groups in broader programming work.

Further disaggregation is also needed between key population groups. The current labelling of key population groups fails to recognize and understand the complexity of individual and community identities and the need to address the intersectional needs and vulnerabilities within and across key population groups. This will be important for scaling up the delivery and use of 'people-centred' services that are tailored accordingly.

4. The Joint Programme's interventions have focused more on supporting key population services and systems, and addressing structural barriers that undermine access to services, with a lesser emphasis on the programmatic and financial sustainability of key population responses.

The evaluation evidence makes a case for a balance of investments both for continued and scaled-up HIV-specific key population programming and for the integration of HIV services including within universal health coverage (UHC) frameworks - with an enhanced and tailored focus on key populations. However, Joint Programme key population programming and strategic direction in many countries have yet to adjust to new initiatives towards universal health coverage with HIV and key population communities infrequently engaging or 'being at the universal health coverage table'.

The effects of the COVID-19 pandemic are likely to affect the achievements of the Global AIDS Strategy. While synergies exist among the HIV and the COVID-19 responses, the Joint Programme should prioritize its mandate to ensure that HIV and targeted key population responses remain 'in focus' in the wider pandemic response.

- 5. In many contexts, community-led responses and programming have yet to be embedded or taken to scale in country HIV responses. Involvement of key population organizations in the planning and implementation of Joint Programme activities and in national planning and funding mobilization processes varies and should not be considered as achieving the goal of community-led programming.**

While Joint Programme members have helped establish and mobilize key population organizations and networks and their engagement in national decision-making processes, the case studies reveal large differences in the degree of key population engagement in these endeavours. Challenges remain in ensuring that key population participation on country coordinating mechanisms (CCMs) or in national strategy and Global Fund funding processes is influential and translates into the meaningful prioritization of resources and budgets necessary for community-led service delivery at scale.

The Global AIDS Strategy 2021-2026 sets an ambitious target for the delivery of HIV prevention services for key populations by community-led organizations. The increased demands on community-led organizations come at a time when the trend is one of decreasing support for these groups. Yet in order for key population-led organizations to play a greater role in leading responses they will need sufficient resources (human and financial) and strengthened management capacity. The revised Division of Labour (DoL) in the UBRAF 2022-2026 tasks the Secretariat and all Cosponsor agencies with the responsibility of empowering community-led organizations. Understanding what this means for the Joint Programme and how this will be realized and reflected in responsibilities across Cosponsors will be a priority as the necessary next step to progress the implementation of the Global AIDS Strategy 2021-2026.

- 6. The Joint Programme Monitoring System (JPMS) does not adequately reflect key population activities. Overall resources have reduced, and it is difficult to ascertain the level of investment in key populations and corresponding results.**

Much of the reporting, both in the JPMS as well as in country budgets and plans, does not distinguish between key population groups, but discusses them as a homogenous entity, all equally at risk. Weak quality of monitoring and reporting data, partial reporting of investments for key population work across funding sources and outputs that are 'distinct' from the Joint Programme's work, all make it difficult to systematically identify, monitor and report on the results of the Joint Programme's work for key populations. At a time when HIV is competing to stay on donor agendas and there is a need to retain international funding for key population work, challenges in articulating results could lead to further reductions in financial contributions to the Joint Programme, with a negative impact on HIV and key population responses at a time when more action is needed if the Global AIDS Strategy 2021-2026 targets are to be met.

RECOMMENDATIONS

The following recommendations aim to support the positioning of work for and with key populations to ensure key population programming becomes a central plank of the Joint Programme's work for the 2021-2026 strategic period. Much of the success of the Joint Programme's work will depend on the willingness of Joint Programme agencies to collaborate

and the ability of the Joint Programme to close the gap between commitments and policies developed at the global level and implementation support to key population groups at the country level.

Recommendation 1: Urgently increase the prioritization and strategic focus of the work for and with key populations (*UNAIDS Secretariat and Cosponsor agencies*)

- 1.1 Prioritize a set of countries for accelerated action for key population programming based on where infections are happening and align resources and capacity. Devise and test a relevant set of outputs and indicators for measuring progress with the Joint Programme's work in these countries.
- 1.2 Systematically engage all key population groups equally in Joint Programme work, including representatives from more neglected communities – transgender people, people who inject drugs, and young key populations – and develop different strategies to engage prisoners.
- 1.3 Develop and agree a clear definition across the Joint Programme, and with funding partners, for the differentiation of key populations from 'other vulnerable populations'. Additionally, systematically differentiate between key population groups. Act on this differentiation - strategies, plans, programming, and reporting at all levels of the Joint Programme - and work with partners to ensure consistency.
- 1.4 Increase the prioritization of key population funding in UBRAF guidance and strengthen oversight mechanisms for coherence of country plans. Ensure the allocation of funds are based on data-informed strategic assessments of country needs. Prioritize key population-led organizations as partners in the planning, monitoring and implementation of the Joint Programme activities, including for Country Envelope funds.

- 1.5 Scale up advocacy for key populations and be a proactive and outspoken defender of the rights of key populations in all settings, strongly advocating for decriminalization, gender identity and diversity, funding for prevention services, community-led responses and use of data to drive programming. Work as equal partners with key population groups to devise and implement advocacy strategies.

Recommendation 2: Strengthen support to community-led programming (*UNAIDS Secretariat, Cosponsor agencies*)

- 2.1 Develop clear guidance, internal policies and oversight mechanisms to ensure responsibilities for community-led programming across the Joint Programme, including at the regional and country levels, are understood and programming is aligned to the Global AIDS Strategy 2021-2026 and related targets.
- 2.2 Formulate guidance that better addresses the diversity of key population groups and the intersectional needs within and between these groups and support staff understanding on gender and sexuality.
- 2.3 Broaden engagement with, and scale up technical support, for community-led implementors to strengthen capacity to deliver services, and for community-led research, monitoring and data generation/use in national systems.
- 2.4 Increase accountability to key populations through monitoring community engagement and influence in national strategic planning and Global Fund funding request prioritization processes, from funding request through to grant making, in order to ensure limited HIV resources target high impact key population programming and planned allocations are translated into budgets.

Recommendation 3: Intensify support to ensure financial and programmatic sustainability of key population responses (UNAIDS Secretariat, Cosponsor agencies)

- 3.1 Increase involvement and dialogue with universal health coverage stakeholders, platforms, and forums. Support consultations with key population groups and the meaningful engagement of different key population groups and networks in such forums.
- 3.2 Strengthen guidance to, and support for, ways in which universal coverage mechanisms and social contracting models can address access to community-led services tailored to different key population groups in a range of different settings.
- 3.3 Increase technical support directed to assisting countries to plan for sustainable financing that addresses reliance on external funding for key population services.
- 3.4 Embed and sustain effective systems and services developed and implemented during the COVID-19 epidemic and explore opportunities to improve the sustainability of programmes.

Recommendation 4: Accelerate data generation for key population programming including through the JPMS (UNAIDS Secretariat and Cosponsor agencies)

- 4.1 Urgently expand programme data by identifying and filling key population data gaps, including size estimates for people who inject drugs, transgender people, diverse groups of young key populations, and prisoners, all differentiated by gender and age.
- 4.2 Overhaul the JPMS monitoring system for key population programming and strengthen assurance of data quality and reporting. Implement a system for tagging key population investments across funding streams.

- 4.3 Promote the use and adaptation of the reconstructed theory of change as a model to operationalize and monitor the implementation and results of key population programming by country teams, key population groups and other partners.

Recommendation 5: Enhance the operational effectiveness of the work of the Joint Programme for and with key populations (UNAIDS Secretariat and Cosponsor agencies)

- 5.1 Lengthen the UBRAF planning and disbursement cycle from one year to two years, with the intention of enabling more strategic planning and programming of funding.
- 5.2 Track the use and uptake of guidance produced by the Joint Programme for key population programming in order to ensure relevance and added value of Joint Programme products and outputs.
- 5.3 Enhance and increase the monitoring and learning function of the Joint Programme including through:
 - Increasing evidence for Joint Programme results on work with different key population groups, and how these have catalysed change.
 - Supporting partners such as the Global Fund with more in-depth joint learning.

1 Background, purpose, and scope of the evaluation

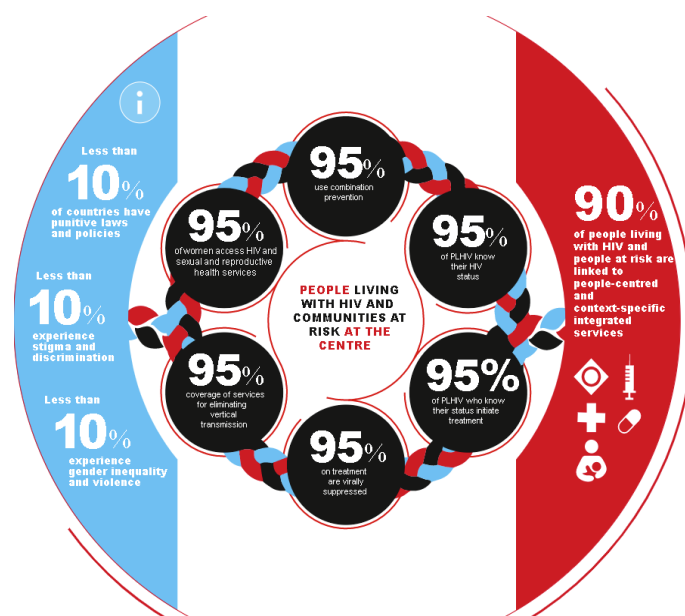
While much progress has been made in global and country HIV responses since the first cases of AIDS were identified 40 years ago, this progress remains unequal and, in some contexts, acutely inadequate in meeting the needs of different key populations - sex workers, gay men and other men who have sex with men (MSM), transgender people, people who inject drugs and prisoners.¹

The terms of reference (ToR) for this evaluation note that the global goal to end the AIDS epidemic by 2030 is off track and acknowledge the slow progress made in reducing new infections among key populations, the limited scale-up of combination prevention, testing and treatment programmes, and the slow progress in addressing the barriers that prevent key populations from accessing the HIV and health services they need. The implications of these gaps have been borne out with key populations and their sexual partners accounting for at least 65% of new infections globally in 2020 and 93% of new infections outside sub-Saharan Africa.²

A recent UNAIDS evidence review³ indicates that inequalities underpinning stigma, discrimination, and criminalization related to key populations (such as the criminalization of sex work and same sex relations) are why the global targets were missed. Most people who are newly infected with HIV and who are not accessing HIV services are key populations residing in contexts where inadequate political will and funding, as well as restrictive laws and policies, specifically restrict their access to health care. Moreover, the impact of the COVID-19 pandemic on health systems, supplies and services has set progress back further. It is recognized that to end AIDS, more needs to be done to achieve the targets for reducing HIV incidence and this requires making it a priority to reach and serve the needs and concerns of key populations.

Figure 1: UNAIDS Global AIDS Strategy targets

The recent Global AIDS Strategy 2021-2026 - End Inequality, End AIDS (the Strategy) places the reduction of inequalities that continue to hold back progress in the response to HIV. The Strategy includes ambitious coverage targets for HIV prevention interventions for all key populations and posits that “if the underlying inequalities are addressed, including gender inequality, stigma and discrimination, both prevention and treatment outcomes will improve”. The Strategy also includes ambitious prevention targets for key populations to be delivered by community-led organizations.⁴ Countries and communities everywhere are expected to strive to achieve the targets (see Figure 1) and commitments of the Strategy across all populations and age groups. The Strategy focuses on community-centred approaches and on the use of granular data to understand why and for whom the current response is not working. It also calls for the reallocation of resources away from less effective HIV interventions.



¹ The key population groups stated here are those defined in the evaluation's terms of reference and were agreed in the evaluation's inception report. Also refer to footnote 8 for an explanation of the most “vulnerable” key populations.

² UNAIDS Data Report, 2020. https://www.unaids.org/sites/default/files/media_asset/2020_aids-data-book_en.pdf

³ [UNAIDS-2016-2021-Strategy-Evidence-review_en.pdf](#)

⁴ For an organization to be considered community-led, the majority (at least 50% plus 1) of governance, leadership, and staff comes from the community being served.

1.1 Purpose and scope of the evaluation

The purpose of this evaluation is to assess the relevance and coherence, effectiveness and equity of the UNAIDS Joint Programme (Joint Programme)⁵ support for key populations at the country level. The evaluation has been designed both for accountability and for organizational learning purposes. The findings and recommendations of the evaluation aim to improve UNAIDS programming for key populations under the new UNAIDS Unified Budget, Results and Accountability Framework (UBRAF) 2022-2026 and to contribute to accelerating progress towards the strategic outcomes and goals of the Global AIDS Strategy 2021-2026.

The scope of the evaluation involves examining the Joint Programme's efforts to address key population needs, in the context of broader country HIV responses, in six countries (**Cameroon, Kenya, Peru, Thailand, Tunisia, and Ukraine**) for the period 2018-2021. The Joint Programme's work at the global and regional levels is also considered in the way it supports the country level. The evaluation aims to assess the work and positioning of the Joint Programme among other stakeholders and aims to improve understanding of how and the extent to which the Joint Programme engages strategically with government stakeholders to improve prioritization, policies, and the enabling environments for key populations. It also looks at the role of the Joint Programme in brokering space for key population-led groups and networks in decision-making processes and how the Joint Programme has contributed to supporting the prioritization of investments for key population responses in different settings.

The evaluation covers the support of the Joint Programme in relation to sex workers, gay men and other men who have sex with men, transgender people, people who inject drugs, prisoners, and young people among these groups. Joint Programme and national responses to intersectional needs within and between key population groups (principally young key populations), services for key populations in humanitarian settings and COVID-19-related responses addressing key population needs have also been considered.

This report incorporates feedback from the UNAIDS Evaluation Office, the Evaluation Reference Group (ERG), the Evaluation Management Group (EMG) and the evaluation's own country teams. The report is based on data collection and analysis work carried out between August and November 2021.

2 Evaluation approach and methods

2.1 Utilization-focused evaluation (UFE)

The perspective of the evaluation is both **retrospective** in that it assesses the design, implementation and results of the Joint Programme's work for key populations since 2018 and **formative** in that it informs the continued development and implementation of the 2022-2026 UBRAF through evidence-based findings and learning. The evaluation has adopted a utilization-focused evaluation approach (UFE),⁶ which is designed to create engagement and a sense of ownership among intended users so that the evaluation findings and recommendations will be more accurate and meaningful and more likely to be acted upon. As part of this approach and in keeping with the terms of reference, the evaluation prioritized the inclusion of the perspectives of the communities that are intended to be served by the Joint Programme's strategies and activities, including by ensuring that the evaluation team incorporated these perspectives at global and country levels and through different stages of the evaluation (design, implementation, and analysis). This has been done principally through:

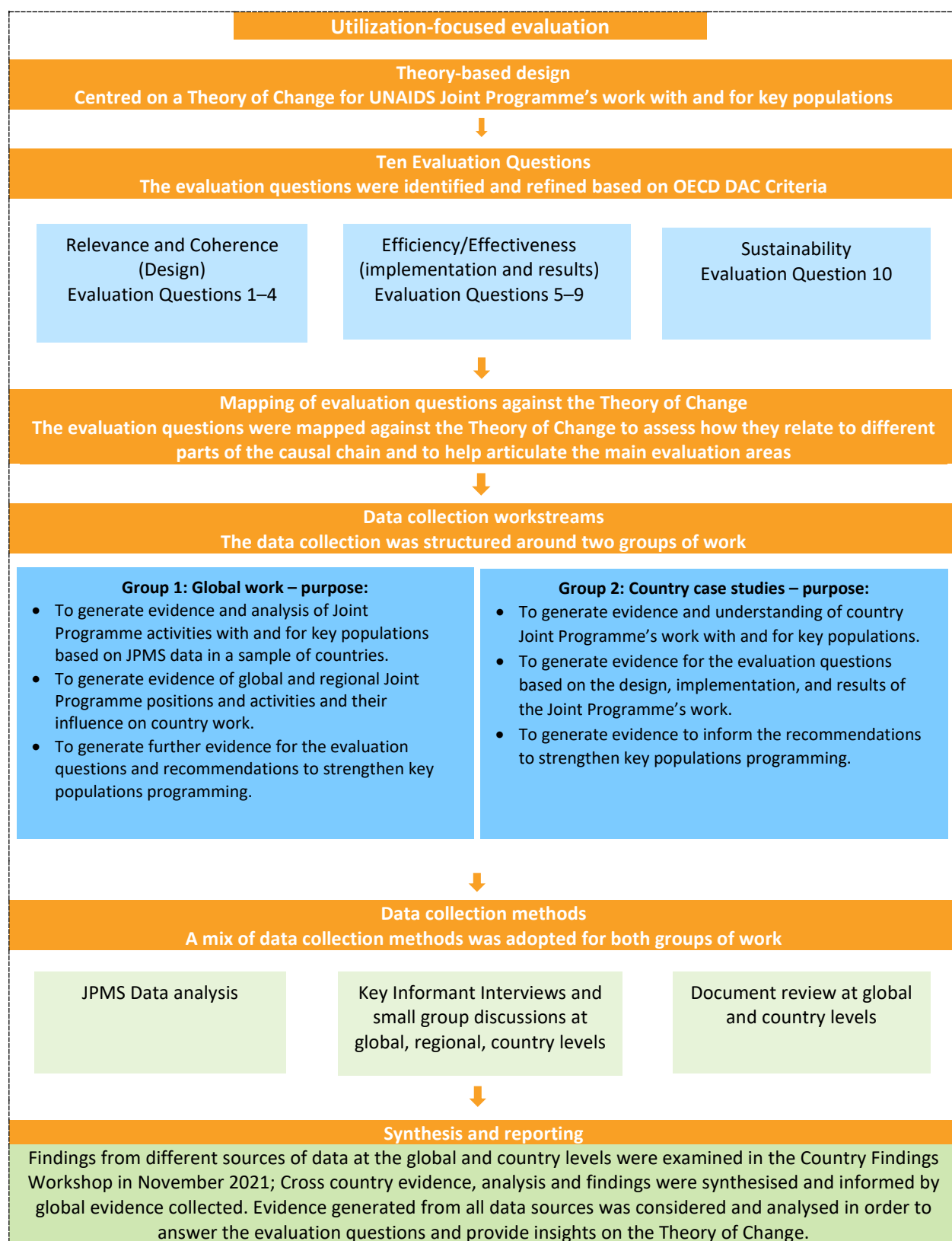
⁵ The UNAIDS Joint Programme constitutes the Cosponsor agencies and the UNAIDS Secretariat.

⁶ Patton, MQ 2002, 'Utilization-Focused Evaluation (UFE) Checklist' viewed 20 July 2014, https://www.betterevaluation.org/en/plan/approach/utilization_focused_evaluation

- **Global-level engagement of key population network representatives**, who have acted as key informants and informal advisers to the evaluation core team. The representatives have been interviewed in their capacity as experts and/or engaged on a regular basis to provide rapid feedback, provision of relevant documents and perspectives on evaluation findings, emerging issues or other key population-related queries arising as the evaluation was implemented. Two representatives actively participated in the country findings workshop.
- **Country-level engagement of key population representatives** from at least two or three key population communities who either led and/or supported the country evaluation team leads with the implementation of the evaluation case studies through data collection (undertaking key informant interviews (KIIs) and/or acting as key informants (KIs)). In most cases, findings and recommendations of the case studies were shared with key population representatives for feedback and in this way supported the analysis and generation of findings.

With the UNAIDS Evaluation Office, the evaluation team has worked to ensure the management and governance arrangements for the evaluation, as outlined in the terms of reference, have been adhered to, including engagement with the evaluation management group (EMG) and Evaluation Reference Group (ERG) at key points in the evaluation process.

Figure 2: Utilization-focused evaluation

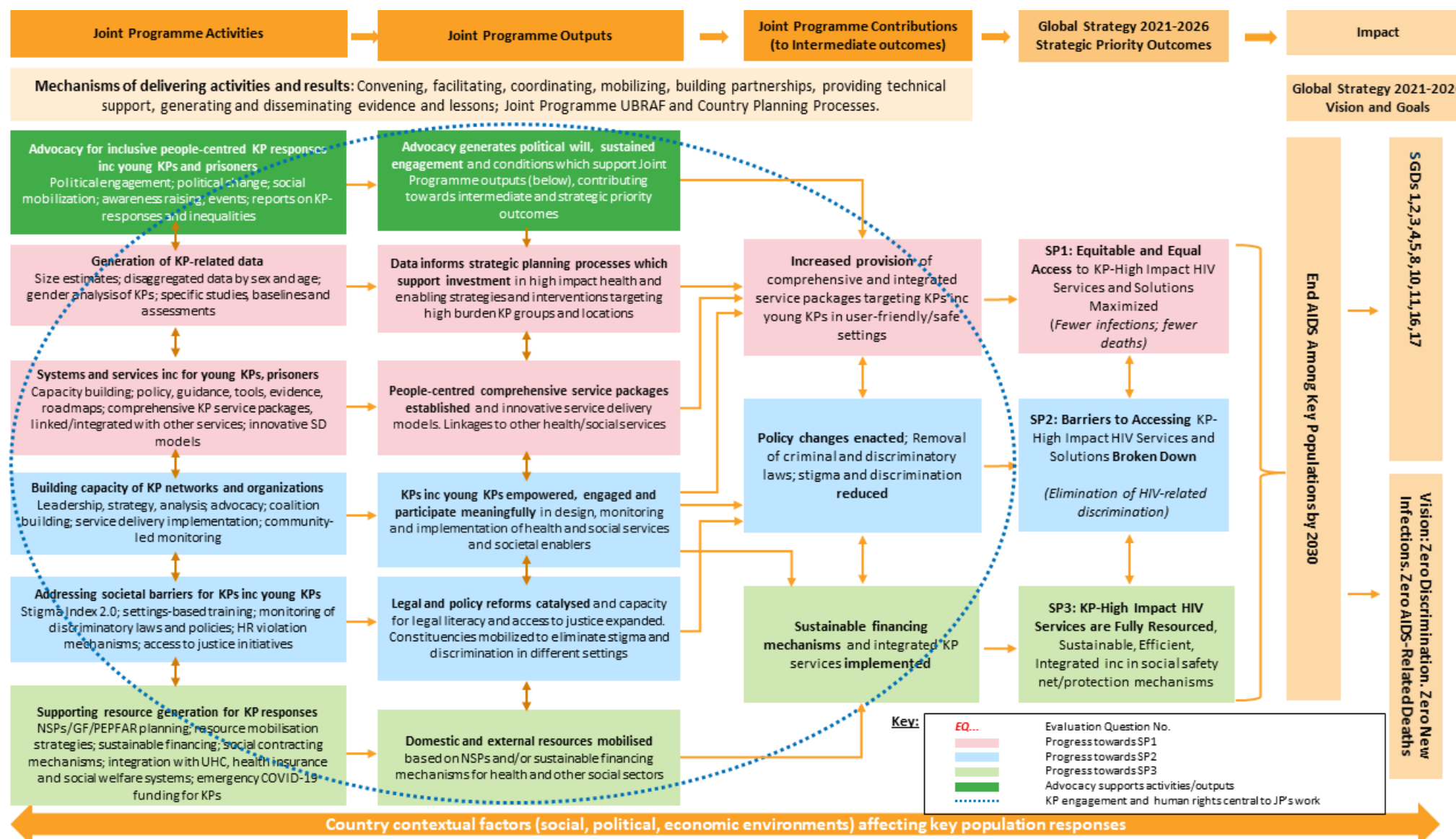


The evaluation is theory-based and involved the development of a theory of change (ToC), as seen in the Figure 3, which has served as an overall analytical framework for the evaluation. Findings from the evaluation have informed a revised version of the theory of change and the corresponding narrative (see Annex 3).

As per the terms of reference, the evaluation was asked to develop a theory of change that considered both the UNAIDS 2016-2021 Strategy and the Global AIDS Strategy 2021-2026 with related UBRAFs as guiding documents. **The theory of change is largely retrospective but blends forward-looking language, strategic results (SRs) and the strategic priorities (SPs) of the new Strategy.** In developing the theory of change, the team specifically considered alignment issues between the two strategies including:

- The activities and outputs of the 2016-2021 Strategy and UBRAF (which are included in left hand columns of the theory of change and which cover the period of the evaluation).
- Intermediate outcomes aligned to the strategic results areas (SRAs) of the 2016-2021 Strategy and UBRAF and the results areas (RAs) of the new 2021-2026 Strategy and UBRAF (2022-2026).
- The new 2021-2026 strategic priority outcome areas, which were included to help identify existing gaps influencing progress towards the new outcomes, and their ultimate impact.
- The activities from the 2016-2021 Strategy and UBRAF, which were cross-checked with those from the new Strategy and draft UBRAF 2022-2026 to ensure the main activity areas are relevant and have been captured.
- The three strategic priority outcome areas, defined in 2021 for the new Strategy at the end of/after the evaluation period, which were cross-checked with the desired outcomes of the previous 2016-2021 Strategy and aligned (fewer infections, fewer deaths, and elimination of HIV-related discrimination) and marked in the theory of change.

Figure 3: Theory of change



The theory of change outlines the relationships between the Joint Programme activities and interventions and how these are expected to bring about change and results for key population responses. The theory of change embeds ten evaluation questions that have been based on a modified version of the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD DAC) evaluation criteria⁷ and were identified, refined and mapped to the theory of change as per the evaluation's inception report (see Table 1).

To generate evidence for the evaluation questions, related assumptions about how change is expected to happen were developed for each evaluation question and these have assisted in the collection, analysis and synthesis of data and evidence from all sources. The theory of change also provides the foundation for the evaluation framework's assumptions, indicators, and data sources (see Annex 4), as well as structuring the tools for data collection including the documents to be reviewed, the question guides, and the formats for the case study reporting and country findings workshop. The synthesis and reporting phase focused on validating or refuting theory of change assumptions, developing findings informed from all sources of data and developing conclusions and recommendations. Figure 3 represents the final 'validated' theory of change following amendments informed by the evaluation findings with an updated narrative in Annex 3.

Table 1: Ten evaluation questions

	EQ	Evaluation question
Relevance and coherence (<i>Right things: design</i>)	1	How relevant are the Joint Programme activities for addressing the needs and priorities of each key population group?
	2	To what extent has the Joint Programme considered human rights, gender equality and the most vulnerable key populations ⁸ in the design of the Joint Programme's activities?
	3	To what extent are the activities of the Joint Programme harmonized and aligned <i>internally</i> within the Joint Programme and harmonized and aligned <i>externally</i> with other actors' interventions in the country?
	4	To what extent are the skills, capacities and resources of the Joint Programme appropriate and adequate for work with and for key populations?
Efficiency and Effectiveness (<i>Right way: implementation and results</i>)	5	How well is the Joint Programme implementing planned activities for key population groups and achieving the UBRAF outputs? Which areas require further strengthening and why?
	6	How effective is the Joint Programme in strengthening and empowering key population-led organizations and networks in the monitoring and accountability of policies and programmes and the implementation of services?
	7	How effective has the Joint Programme been in responding to: a) key population needs in humanitarian settings; and b) key population needs during the COVID-19 pandemic?
	8	How effective is the Joint Programme in contributing to: <ul style="list-style-type: none"> ■ Scaled-up provision of comprehensive services for key population groups including the most vulnerable key population groups? ■ The promotion of human rights and gender equality and the removal or reduction of criminal and discriminatory laws and stigma and discrimination? ■ Sustainable financing and programming mechanisms for key population groups (the intermediate outcomes)?

⁷ <https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm>

⁸ Some documents refer to "most vulnerable" key populations. All key populations could be considered "vulnerable" but for the purposes of this evaluation, and to address the equity questions from the terms of reference, we consider "most vulnerable" key populations to be those populations where risks are intersecting, such as young key populations, gay men and other men who have sex with men (MSM) or drug users who are also sex workers, and least accessible key population groups (e.g. key populations located in conflict areas) etc. There are also other intersecting vulnerability factors such as income or education level. As well, most vulnerable key populations in a country could be considered in country situations where stigma or discrimination has been reduced against one group (e.g. MSM) but still remains strong in another group (e.g. transgender people) who have not been included in recent statutory changes.

EQ Evaluation question		
	9	How well is the Joint Programme responding to influential contextual factors such as an increasingly conservative political environment, decreasing resources for HIV and key population programming, or other similar factors?
Sustainability	10	How sustainable are the results of the Joint Programme's work, particularly for the key population-led organizations, networks, and services?

The data collection phase was structured around two groups of work.

Group 1: Global desk review and key informant interviews: The global work comprised a desk review of key documents and the production of a short analytical summary of Joint Programme investments and interventions for key populations in a sample of countries by region/type of epidemic. Additionally, key informant interviews with UNAIDS Joint Programme staff at the global and regional levels, Evaluation Reference Group members and other relevant stakeholders such as PEPFAR, the Global Fund and key population global networks secretariats were conducted to help inform the overall findings, as well as those of the country work (please refer to Annex 1 and Annex in the Case studies Volume for details of key informants interviewed).

Group 2: Country case studies: A structured case study approach in six countries has been central to the overall approach and methodology. The case studies have provided more detailed information and analysis of UNAIDS Joint Programme interventions, results and outcomes across different contexts, and have enabled a more comprehensive and nuanced understanding of UNAIDS support and contribution to key populations at the country level. The rationale for the countries selected for case studies is outlined in Box 1 below.

Box 1: Summary of country selection criteria

The countries for this evaluation were purposively selected to identify a set with both good and limited progress in achieving results for key populations and with epidemics representing a range of most-affected key populations, as well as countries with different socioeconomic contexts and partner engagement. The following criteria were used to generate the sample of case study countries:

Criteria 1: Presence of Joint Programme (five or more United Nations organizations present) and functional Joint United Nations Team on AIDS.

Criteria 2: HIV prevalence in a minimum of four key population groups and with a majority having medium and high HIV prevalence; available data on size estimates; and inclusion of countries with large, estimated sizes of people who inject drugs and transgender people.

Criteria 3: Other characteristics to ensure a mix of countries including:

- At least one Global Fund transition country; at least one country with investments from PEPFAR and the Global Fund; and at least one Global Prevention Coalition priority country.
- Criminalization of key populations (also 'no data' counted).
- Quality of size estimates data for sex workers and gay men and other men who have sex with men (ranging from poor to good, reference internal UNAIDS assessment/nationally adequate estimates) and coverage of HIV prevention programmes for sex workers and gay men and other men who have sex with men (ref. global AIDS monitoring system (GAM) indicator).
- Only countries with no recent Joint Programme evaluations.

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

Country	Region
■ Cameroon	West and Central Africa
■ Kenya	East and Southern Africa
■ Peru	Latin America
■ Thailand	Asia Pacific
■ Tunisia	Middle East and North Africa
■ Ukraine	Eastern Europe and Central Asia

2.2 Data collection methods

The evaluation team used a mix of qualitative and quantitative methods for data collection, review and analysis. Triangulated evidence generated from each method was consolidated and assembled against the evaluation questions and related assumptions in an ‘evidence table’, thereby allowing traceable evidence from recommendations in this report to the data upon which they are based. Primary and secondary data sources were used to support the findings of the evaluation.

Secondary sources included: global, regional, and country-level strategies, joint plans, UBRAF documentation and the Joint Programme Monitoring System (JPMS) data and reports; documentation of Cosponsors’ programmes at the country level relating to key populations and HIV, including tools, reports and technical and normative guidance produced; national policies, strategies, and laws; epidemiological and socio-demographic studies; and other analysis documents such as evaluations, evidence reviews and academic papers relating to key populations and HIV. A complete list of documents reviewed at the global and country levels can be found in Annexes 4 and 5.

The evaluation collected primary data through key informant interviews and small group discussions. Key informants were identified at the country level through a stakeholder mapping developed in consultation with the UNAIDS Country Director and Cosponsors. At the global level, the UNAIDS Evaluation Office developed an initial list of key informants that was supplemented by suggestions from Cosponsors and Evaluation Reference Group members. A limited number of interviews were developed through ‘snowball’ sampling. Interview guides for the principal stakeholder groups were developed and adapted to different country contexts and audiences. Annexes 2 and 3 present a complete list of stakeholders consulted disaggregated by country. A summary of the data sources is represented in Table 2 below.

Table 2: Summary of data sources

Key informants interviewed	Global level	Country level
UNAIDS Secretariat	12	22
UNAIDS regions	6 Regions	-
Cosponsors	13	48
International partners	6	38
Government	-	31
Key population representatives	10	131
Total key informant interviews	47	270
Documents reviewed	Global level	Country level
	82	219

2.3 Data analysis, validation and synthesis

For all data collected through the methods described above, the evaluation employed a range of approaches to analyse, validate and synthesize the evidence, as follows:

- Analysis of secondary data and data from interviews: All raw data were collected in an evidence table based on the assumptions and evaluation questions. This ensured the analysis considered and triangulated all relevant secondary data collected, thereby reducing the risk of evaluation bias, and improving the robustness of findings.
- Compiling data on key population activities in a selection of countries for the years 2018-2020, gathered primarily from the JPMS website and data base.
- Quantitative analysis: Limited quantitative analysis for the available financial data on UBRAF funding, particularly for Country Envelopes.

- Country case study workshops: Country analysis workshops to discuss emerging country and global findings, issues and common threads. Participants included the Project Director of the evaluation (from the Euro Health Group (EHG)), the team leader and deputy team leader of the evaluation, the country team leaders and global key population network representatives.
- Cross-country and global analysis and synthesis: Analysis of evidence and findings within and across country case studies; and synthesis of global findings against the theory of change.
- A structured approach to assessing the strength of evidence of findings both for country studies and for the global analysis and synthesis work.

Ethical considerations

At all stages of the data collection and analysis, the evaluation team was cognisant of maintaining the highest levels of confidentiality and protection of study participants. All interview subjects and group participants participated voluntarily. As almost all interviews were conducted virtually, participants provided informed oral consent beforehand, including consent for the interview to be recorded. Participants were free to opt out of answering questions about which they felt uncomfortable. Care was taken in maintaining anonymity in reporting the results of interviews, including direct quotations. In those countries where approval for the interviews was necessary, applications were made to a local Institutional Review Board (IRB). The evaluation team abided by and were governed by United Nations Procedures on Ethical Standards in Research in the design, conduct and dissemination of the consultancy assignment. The transcripts and recordings of the interviews are being held by the evaluation team leaders and will be erased upon completion of the assignment.

2.4 Ethical considerations, limitations and constraints

The evaluation encountered some limitations and constraints, which are detailed in Table 3 below.

Table 3: Limitations encountered during the evaluation and responses

Limitations	Mitigation strategies
Limited number of case studies undertaken: Given the context-specific nature of HIV and national responses, having only six case studies and having diverse settings for key population responses limits and restricts the evaluation's ability to draw conclusions on how the findings may be applied to other settings.	Recognition of the context-specific nature of key population responses and identification of critical factors influencing responses in different contexts. Where possible, drawing out common themes across the case studies to ensure some degree of generalization
Data availability issues: Challenges accessing some country programme data and documentation occurred. Documentary evidence of UNAIDS Joint Programme results at the global and country levels was particularly limited in terms of independent country-level evaluations and reports detailing outcomes and results of Joint Programme interventions	Triangulation of information regarding Joint Programme interventions and the contribution to outcomes through country, regional and global interviews and through internet searches that identified some external evaluations and additional reports of Cosponsor initiatives and results
Limitations of the global review using JPMS data: Challenges with extracting and interpreting the data and information from the Joint Programme Monitoring system (JPMS), which limited the global analysis of Joint Programme activities and financial data.	Ensuring caveats were included in the analysis of the financial data and including in the global review of activities a more in-depth analysis of Joint Programme activities in 10 countries
Time restrictions and unavailability of some key stakeholders: Given the short time for data collection and the limited resources available for the evaluation, it was not possible to conduct a full range of interviews for example, key informant	Several follow-up requests were sent for interviews with some key informants before concluding they were not available for interview. Requests were also sent asking for responses by email and some information was gained, but again, responses were

Limitations	Mitigation strategies
interviews with regional-level key population networks were not included in the evaluation. In some countries and at the global and regional levels, setting up and securing interviews with all the key stakeholders was sometimes delayed and/or stakeholders were not available	low. Triangulation from other interviews was necessary
Limited time to analyse a large volume of information and to interview significant numbers of stakeholders: Given the time available for the data collection period, challenges reviewing large quantities of relevant documents and interviewing large numbers of key informants were noted	Prioritization of a sample of key informants for interview at the country level and of activities of strategic importance in the review and how these collectively contributed to the Joint Programme's work at the country and global levels and the evaluation questions. Points from regional interviews were followed up through requesting and reviewing additional documents
Limited availability of some key population representatives to participate in different aspects of the evaluation: In some cases, key population representatives contracted to support the evaluation teams were not available to participate as fully as expected	Conducting the key informant interviews without a key population representative but engaging them in other ways such as asking for reflections on a particular issue or triangulation on findings. Having a flexible approach was necessary given the representatives were often fully engaged through their other work
The effects of COVID-19: The ongoing pandemic affected most countries to various degrees – with some restrictions on face-to-face key informant interviews, small group discussions and site visits in most cases. All global and regional interviews and team discussions were held remotely. While key informants made themselves available and showed willingness to speak remotely, this does not replace the benefits of being able to meet face-to-face to discuss issues	Adopted a flexible approach, which inevitably meant having to accept changes to plans at short notice and time spent rescheduling. The number of key informant interviews scheduled per day was also limited, to prevent 'Zoom fatigue'. The country case study workshop was structured over 2.5 days to accommodate remote teams working across 12-hour time differences. Analysis was done remotely and regularly with the report writing team but this method of working does not replace a face-to-face workshop on findings that would be common practice. Team management entailed weekly meetings

3 UNAIDS Joint Programme at the country level: strategies and support for key populations

The Joint Programme's contribution to the Global AIDS Strategy 2021-2026 at the country level is operationalized through the Joint United Nations Team on AIDS (Joint Team), which comprises the UNAIDS Secretariat and Cosponsors (the Joint Programme). These teams develop, implement and report on jointly developed prioritized workplans, which may include interventions related to key populations. Additionally, Cosponsors may also be engaged in key population-related work outside of the joint workplans.

Funding for Joint Programme work on key populations at the country level is derived principally from core funds that are allocated to the Secretariat and Cosponsor agencies for the implementation of their functions and continued engagement, and Country Envelope funding, which is allocated to Cosponsor agencies and may be used for key population programming based on gaps and priorities. Additionally, Business Unusual Funds (BUF), part of Country Envelope funds, are available and allocated based on innovative proposals. Non-core funds, which are mobilized internally and externally by Cosponsor agencies may also be sources of funding used to prioritize and support key population work. The type of functions and interventions undertaken by the Joint Programme to

support the needs of key populations through the implementation of the 2016-2021 Strategy can be found in the theory of change in Annex 3 and in the findings (Section 4).

The roles and responsibilities of the UNAIDS Secretariat and Cosponsors are defined in the UNAIDS Joint Programme Division of Labour (DoL)^{9, 10}. Table 4 below details the Cosponsor lead agencies and the Cosponsor partner agencies in the Division of Labour.¹¹ Often the Division of Labour is tailored to the country context, which can result in fewer Cosponsor agencies being involved in delivering the joint plan and/or some agencies taking on different lead/partner roles due to varying country presence and the UNAIDS Secretariat. Country Joint Teams are supported in varying degrees by Joint Programme teams at the regional level and by the Secretariat and Cosponsors at the global level.

Table 4: Joint Programme lead and partner agencies in the Division of Labour

Division of Labour areas relevant to the evaluation	Lead agency	Partners
Investment and efficiency	UNDP/World Bank	UNICEF, WFP, UNFPA, WHO
HIV testing and treatment: Normative guidance and standards; strategic information; HIV testing and treatment; innovative testing strategies, access to treatment cascade, high-burden cities Fast-Track HIV services; and medicines and commodities	WHO	UNHCR, UNICEF, UNFPA, WFP, UNDP, UNODC, UN Women, ILO
HIV and universal health coverage, tuberculosis/HIV and other comorbidities and nutrition	WHO/World Bank	UNICEF, WFP, UNDP, UNFPA
HIV services in humanitarian emergencies	UNHCR/WFP	UNICEF, UNFPA, WHO
Decentralization and integration of sexual and reproductive health and rights (SRHR) and HIV services	UNFPA/WHO	UNICEF, WFP, UNDP, World Bank
HIV prevention among key populations: Gay men and other men who have sex with men, sex workers and transgender people	UNFPA/UNDP/UNODC	UNICEF, UNODC, ILO, UNESCO, WHO, World Bank
HIV prevention for young people: Combination prevention and youth health and education needs	UNICEF/ UNFPA/ UNESCO	All other Cosponsors
Harm reduction for people who inject drugs and people in prisons	UNODC	UNICEF, UNDP, WHO
Human rights, stigma and discrimination: Legal and policy reform; access to justice and rights; and HIV health-care discrimination eliminated	UNDP	UNHCR, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO
Gender inequalities and gender-based violence related to key populations	UN Women	All other Cosponsors
HIV sensitive social protection	WFP/ILO	UNHCR, UNICEF, UNDP, UNFPA, UNESCO, WHO, World Bank

Source: UNAIDS Joint Programme Division of Labour Guidance Note 2018

⁹ UNAIDS Joint Programme Division of Labour — Guidance Note 2018 | UNAIDS.

¹⁰ The Division of Labour has been updated to align with the new Strategy and can be found in the latest UBRAF. Most of the roles and responsibilities remain the same but two new responsibilities are in evidence: pandemic preparedness and the collective role of all Cosponsor agencies and the Secretariat in supporting community-led responses, thus ensuring communities are empowered to exert leadership and action in addressing the needs of “community-led responses”. Empowered communities have the capacities to exert leadership and take action in addressing the needs of people living with, at risk of, or affected by HIV, including key populations.

https://www.unaids.org/sites/default/files/media_asset/PCBSSOct_2022-2026_UBRAF_Framework_EN.pdf

¹¹ Agencies include: the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children’s Fund (UNICEF), the World Food Programme (WFP), United Nations Development Programme (UNDP), United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), United Nations Office on Drugs and Crime (UNODC), the United Nations United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), the International Labour Organization (ILO), the World Health Organization (WHO) and the World Bank.

4 Findings

Key Findings



While the evaluation is based principally on the findings from the six case study countries, the work of the Joint Programme at the country level is guided and informed by the global policy and directions of the UNAIDS Secretariat and Cosponsor agencies. The following sections present key findings arising from a review of Joint Programme global and regional documentation and key informant interviews carried out at the global and regional levels. Findings for the evaluation questions follow this section.

It should be noted that the period of this evaluation coincided with the implementation of the Fast-Track Strategy 2016-2021¹² and thus activities based on the Fast-Track strategy. Findings have been used to inform the recommendations, which will need to be implemented within the parameters of the Global AIDS Strategy 2021-2026.¹³

4.1 Contextual/situation findings from regional and global perspectives

High-level findings ¹⁴	The Global AIDS Strategy 2021-2026 references key populations but the Strategy's broad scope may not provide sufficient prioritization of key populations, given the contribution of key populations to incidence in most regions
	Advocacy is needed where it matters most – targeting resources to countries and key population groups where HIV transmission is not yet under control and where more specific and directed programme interventions are called for
	The Joint Programme plays a valuable role producing guidance, policy documents, key population data and technical advice, as well as advocating for resources. Collaboration with the Global Fund and PEPFAR have benefitted from this support and influenced their key population programming and strategies
	The Global Prevention Coalition (GPC) and the technical support mechanism (TSM) are both involved in key population responses. However, the Global Prevention Coalition could do more and the technical support mechanism is underutilized in some vital areas such as improving data, building capacity of key population organizations and networks and working towards sustainable financing
	All regions have included key populations as an important component of regional strategies with country programmes supporting key population issues to a greater or lesser extent, assisted by the regional support teams. An analysis of regional trends in key population programming over the past four years was limited by the shortcomings inherent in the Joint Program Monitoring System (JPMS).

¹² Launched on World AIDS Day 2014.

¹³ UNAIDS; Global AIDS Strategy 2021–2026 - End Inequalities, End AIDS; Geneva 2020

¹⁴ Strength of evidence for these findings was strong, with sources of evidence triangulated through multiple KII and documentary evidence.

4.1.1 Strategic and policy frameworks

The Global AIDS Strategy 2022-2026 references key populations in its result areas, however, the Strategy's broad scope may not allow sufficient prioritization of key populations, given the contribution of key populations to incidence in most regions.

The Fast-Track strategy had as its focus the achievement of the 90-90-90 targets by 2020 and 95-95-95 targets by 2030, “accelerating the delivery of high-impact HIV prevention and treatment services, using innovation to expand services, and focus on the locations and populations with the highest HIV burden”.¹⁵ In the name of efficiency and getting the most effective results, this meant a focus on the 30 countries that accounted for almost 90% of new HIV infections, 28 of which were low- and middle-income countries.¹⁶

The Global AIDS Strategy 2021-2026 has 10 result areas, of which the following mention key populations, alongside other priority population groups:

- Result Area 1: Primary HIV prevention for key populations, adolescents and other priority populations.
- Result Area 2: People living with HIV (PLHIV), especially key populations and other priority populations, know their status and are offered and retained in quality, integrated HIV treatment.
- Result Area 4: Fully recognized, empowered, resourced and integrated community-led HIV responses.
- Result Area 5: People living with HIV, key populations and people at risk of HIV enjoy human rights, equality and dignity, free of stigma and discrimination.

Arguably all the results areas have some relevance to different key population communities. For example, resource mobilization and allocation is critical for sustaining key population programmes (Result Area 8); social protection is particularly absent for unregistered and other key population groups operating within the informal economy (Result Area 9); and key populations require further tailored and nuanced responses within conflict and humanitarian settings (Result Area 10).

The Strategy is designed to be implemented as a comprehensive package, with equal importance given to biomedical interventions, enabling environments, community-led responses and the strengthening and resilience of systems for health. In addition, it outlines strategic actions to provide community-led and youth-led responses (including key population communities) with the resources and support they need to fulfil their role and potential as key partners in the HIV response.

There is strong evidence from multiple key informants at the global level that the Global AIDS Strategy 2021-2026 may not be prioritizing key population groups where HIV transmission is occurring, or distinguishing key populations from other vulnerable populations sufficiently, despite the very different needs of key population groups. The Strategy places emphasis on human rights and equity issues but in applying its direction across multiple Sustainable Development Goals (SDGs), the Strategy's comprehensive scope may be too diffuse to make a difference where it matters most – targeting resources to key populations and communities where HIV transmission has not yet been brought under control, and where specific and directed programme interventions are called for.

Despite Fast-Track targets being missed, the Joint Programme's support to advocacy and its generation of critical strategic information has contributed to greater recognition of, engagement with, and awareness of the need to address key population needs at both the global and country levels. Despite the challenges of the Fast-Track era and frustrations that not enough has been

¹⁵ UNAIDS: Understanding Fast-Track, Ending the Epidemic by 2030; accessed at https://www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_en.pdf.

¹⁶ Kenya, Cameroon and Ukraine were Fast-Track countries.

accomplished, there was agreement among a significant number of global key informants that the key population landscape has changed over the past five years, with an increased emphasis on, recognition of, and greater awareness of inclusivity of key population groups (both globally and in many individual countries). Examples include: representation of people living with HIV, key populations and other affected communities selected to join the multistakeholder task force for the high-level meeting on HIV, convened in 2021; and the situation in sub-Saharan Africa where key population programming (especially for people who inject drugs and for gay men and other men who have sex with men) was sporadic and is now more firmly established in many countries.¹⁷ The Joint Programme has contributed to this through advocacy and the production and dissemination of strategic information, including key population size estimates, modes of transmission studies and other key population analyses. These efforts have contributed to policy and programmatic shifts as greater consensus and acceptance of the need to address key populations have developed.

4.1.2 Programmatic and technical assistance

The Joint Programme plays a valuable role in producing guidance and policy documents, as well as in collecting and synthesizing global HIV data.

A strategic information team at UNAIDS HQ – collaborating with strategic information advisers at the country level – is responsible for the collection of data in the Global AIDS Monitoring system (GAM) as well as for updating the indicators for country reporting. Efforts have been made to expand the key population database, most recently with transgender people and prisoner indicators, as well as indicators for antiretroviral therapy (ART), stigma, hepatitis and sexually transmitted infections (STI).¹⁸ It was noted that ensuring data quality for population size estimates has been central to the Joint Programme’s work and has highlighted the poor or limited quality of data being submitted by countries.

The latest World AIDS Day Report¹⁹ estimates that more than 15 million people who would benefit from HIV prevention, care and treatment services are unaccounted for in countries reporting population size estimates and concludes that the total number of key populations “is probably double the current size estimates reflected in the HIV plans and strategies of these countries”.²⁰ If true, the widely quoted statistic that key populations and their sexual partners account for 65% of HIV infections worldwide in 2020 and 93% of infections outside of sub-Saharan Africa²¹ may be even higher. It is highly likely that, even if overall global AIDS Strategy targets are met by 2025 and 2030, key populations will still be overrepresented within the remaining new cases and untreated infections, with significantly less progress in HIV reduction than in broader populations.

The Communities Team, based in the UNAIDS Secretariat, and the network of community support advisers working at the regional and country levels aim to ensure that key populations are at the forefront of the global AIDS response. Key informants reported the strong role of UNAIDS Secretariat in creating space for key population groups, including young key populations and in facilitating greater engagement by some Cosponsor agencies with key population groups in areas of their work (for example, UN Women are now working both globally and in some individual countries with transgender people, UNDP is using Country Envelope funds to partner with key population organizations,²² and UNHCR is expanding its programming to support the health and protection needs of those selling or exchanging sex in humanitarian settings).

¹⁷ WHO conducted an analysis of recent national strategic plans in sub-Saharan Africa (unpublished) noting that more countries are now including sections on key populations in their national strategic plans (source – key informant)

¹⁸ KII information.

¹⁹ UNAIDS; World AIDS Day Report 2021; Geneva: Joint United Nations Programme on HIV/AIDS; 2021.

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²⁰ Ibid.

²¹ UNAIDS; Global AIDS Update 2021: Confronting Inequalities; Geneva 2021.

²² In 2020, UNDP supported 78 countries to advance access to HIV services for key populations, including through the UNDP Global Fund partnership. Under Global Fund programmes, UNDP supported countries in reaching key populations with

Key population representatives and/or organizations are represented on global technical review, management, and governing committees – cited by informants at all levels as evidence of work by the Joint Programme to increase the engagement of key populations and their inclusion in the policymaking, planning and implementation processes. However, despite these efforts, there is evidence that not all key population groups are engaged equally or consistently – people who inject drugs and transgender people are still underrepresented on some technical working groups and their representation on key population groups as staff in the UNAIDS Secretariat and across Cosponsor agencies remains limited (see Findings for Evaluation Question 4).

The Global HIV Prevention Coalition (GPC) has been a contributor to the HIV response for key populations but there is little evidence of marked progress in areas such as sufficient resourcing and scaling up of prevention services for key populations, human rights/legislation improvements, reductions in stigma or improvements in several key population indicators.

The Global Prevention Coalition, co-convened by UNAIDS and UNFPA, was established in 2017 and to date, 28 countries are members.²³ Global Prevention Coalition countries have made significant strides in implementing their national road maps, as summarized by the Global Prevention Coalition scorecards and posters on the Global Prevention Coalition website²⁴ and in progress reports. Global Prevention Coalition countries report on two indicators for key populations: key population size estimates being done, and a defined key population package of services in place. The lack of credible recent size estimates of various key population groups is cited in many countries as one of the main impediments to expanding and focusing key population interventions.

An evaluation of the Global Prevention Coalition carried out in 2020 noted that technical support had been utilized by most countries to strengthen their combination prevention activities, including guideline and tool development, regional workshops, webinars, consultant and other training and regular conference calls.²⁵ Additionally, the South-South Learning Network²⁶ has developed and used programme self-assessment tools in 10 sub-Saharan African countries for woman and girl sex workers and for gay men and other men who have sex with men. The learning network has helped establish a community of practice with national AIDS authorities in member countries and prevention stewardship. As co-conveners of the Global Prevention Coalition, UNFPA and the UNAIDS Secretariat worked with key population networks and the Global Prevention Working Group (2020) on a series of deep-dive discussions to inform the work of the Global Prevention Coalition and input into the development of the Global AIDS Strategy. It was noted that while guidelines and tools were available and accessible through the Global Prevention Coalition website, the Global Prevention Coalition has not done enough to make these resources widely known.^{27, 28}

The Global Prevention Coalition's influence on HIV prevention funding, in collaboration with the Global Fund, has been to modify funding request guidelines and technical review criteria to support primary HIV prevention (PHP) and targeted and costed proposals for the Global Prevention Coalition

tailored combination prevention packages, including 162 000 people who use drugs reached in five countries; 352 500 gay men and other men who have sex with men reached in 22 countries; 272 600 sex workers reached in 22 countries; and 5 900 transgender people reached in 13 countries. Sourced at [Organization Report](#)-

²³ Many of these are high burden HIV epidemic countries with more generalized epidemics, including within the key populations. There are key population epidemics in many countries that are not part of the GPC. There is an intent to broaden the GPC, noting that some countries (e.g. in EECA) have followed the road map approach albeit have not formally asked to join the coalition.

²⁴ <https://hivpreventioncoalition.unaids.org/global-dashboard-and-country-scorecards/>

²⁵ The Global HIV Prevention Working Group of the GPC has expanded to include UNODC, UNDP, UNESCO, UN Women and representation from all key population groups plus young key populations to help strengthen this area of work.

²⁶ GPC Annual Independent Progress Report, 2020.

²⁷ Ibid - The GPC focus on HIV high burden countries is another limiting factor, in terms of many key population epidemics being within low burden countries.

²⁸ Limited visibility of the extensive resources/library on key populations on the GPC website was directly noted by the evaluation team.

pillar interventions. While there is a reported uptake in planning, inclusion, and resourcing of primary HIV preventions, and increasing attention to key population groups in funding requests, major gaps remain against prevention targets agreed by United Nations members states, with prevention interventions often including untargeted, non-differentiated (by key population group) and low impact non-specific interventions.²⁹ While the Global Fund (and PEPFAR) have provided funding through strategic initiatives to incentivise investment in key populations and prevention programming, some informants considered this to be insufficient, particularly given the resourcing constraints as health systems struggle to respond to COVID-19.³⁰

The Global Prevention Coalition's work has highlighted gaps in available technical support in several areas, particularly regarding how to shift the structural barriers to prevention, especially for key populations.³¹ Further, Global Prevention Coalition attempts to change policy and legal barriers to prevention programming has shown limited success in influencing criminalization of same-sex conduct, sex work and illicit drug use, or combatting gender-based violence (GBV). This illustrates the most basic problem facing HIV prevention – cultural and legal barriers preventing access to those populations that are driving HIV epidemics. There was a view from global key informants that the Global Prevention Coalition had not focused sufficiently on key populations and could be doing much more to lead the prevention response for key populations.³² The initiation of the key populations community of practice is aimed, in time, at addressing these Global Prevention Coalition shortcomings. Further rollout of the Global Prevention Coalition to low burden HIV countries would also improve focus on key population programmes.

Technical support (TS), via the technical support mechanism, is supporting key population organizations and networks, both directly through inclusion in national strategic planning and indirectly through the improved programming and management that results from the technical support. However, the technical support mechanism remains underutilized in some essential areas of key population responses.

UNAIDS supports a technical support mechanism that provides technical support (namely consultancy services) to Joint Programme member countries. It is implemented jointly through Oxford Policy Management (OPM), based in the UK, and Genesis Analytics, based in South Africa. The technical support mechanism has managed 466 assignments from 2018 to December 2021.³³ All three of the technical support mechanism result areas emphasise community-led responses, rights, gender and populations left behind. The technical support mechanism supports broader activities that are relevant to key populations as well as key population-specific support, for example, size estimations and social contracting of key population civil society organizations (CSOs). Key population issues are part of many technical support assignments across the nine technical support mechanism programme domains.³⁴

Key population-related assignments under TSM in recent years include³⁵: the PLHIV Stigma Index 2.0, implemented with new methodology in over 40 countries; Gender assessments of the HIV response completed in 17 countries; development of NSPs and Global Fund applications (which increasingly include key population components); TS to inform responses to rights & gender-related impacts of COVID-19 on HIV prevention and treatment for key populations. Support to strategic information has

²⁹ 2020 Technical Review Panel Lessons Learned Report, May 2021.

https://www.theglobalfund.org/media/10974/bm45_07-2020-trp-lessons-learned_report_en.pdf

³⁰ GPC; External Review of The Global HIV Prevention Coalition and 2020 Road Map - Final Report; October 2020.

³¹ GPC; External Review of The Global HIV Prevention Coalition and 2020 Road Map - Final Report; October 2020.

³² Global level key informant.

³³ All data from the TSM SharePoint website, as well as a PowerPoint presentation summarizing the TSM April-September six-monthly report.

³⁴ Global Fund grant applications; national strategic plans and reviews; community and service delivery; strategic information; HIV and economics; human rights and gender; prevention; treatment and testing; and health system strengthening.

³⁵ All data from the TSM SharePoint website, as well as a PowerPoint presentation summarizing the TSM April-September six-monthly report

included: IBBS studies in 10 countries; drug use analyses; mapping and size estimations of key population communities. Support to financing and economics has included technical support to countries in the areas of social contracting of CSOs, integration into domestic mechanisms and abolition of user fees to enhance impact/sustainability (which would have implications for key population communities)³⁶. Work that involves key population-led organizations has included both their being part of the TA (data gathering and analysis as well as participating as informants) as well as specifically building their capacity to meaningfully engage.

With the increasing emphasis on community-led programming, more technical support is likely to be needed. Informants agreed that the Joint Programme can provide this to capacitate key population-led organizations in advocacy, management, financial systems, strategic planning, preparing proposals for funding and for supporting strategies and approaches to sustainability.

4.1.3 Global-level collaborations

The Joint Programme collaborates with its major donors through joint participation in committees and strategic planning and implementation at the global level. Additionally, the Joint Programme provides technical expertise in key population programming to the Global Fund.

The Joint Programme is seen by both PEPFAR and the Global Fund³⁷ as a source of data (size estimations, best practice information, the initiator of country case studies) as well as technical information to inform funding decisions. Participating on global technical working groups and panels, there is a “dialogue” on policies and priorities, and the Joint Programme agencies and the donors learn and take their cues from one another (although this varies as high-level decision-making changes within the agencies). All agencies agreed that they want to make funding decisions based on reliable data, and the Joint Programme is a prime source for this.

“The UNAIDS collaboration with CDC/PEPFAR and Global Fund means funders are in a better place to look at the validity, timeliness and robustness of data for program design. UNAIDS (has been) transformative in helping make KPs prominent and to have disaggregated data on KPs available— both have helped evolve Global Fund to how it can better contribute to advancing the HIV prevention agenda”³⁸

“PEPFAR wants countries to deal with the epidemic they have, not what they think they have”³⁹

Both PEPFAR and the Global Fund have recently increased their funding for key population interventions, and both the Joint Programme and the Global Prevention Coalition⁴⁰ feel that they contributed to this policy shift through their provision of data evidence and lobbying efforts (at both the national and global levels) to effect this change. Key informants from the Global Fund and PEPFAR confirmed the importance of the Joint Programme as a source of data and policy advice that has informed the development and alignment of their new/forthcoming strategies with the Global AIDS Strategy 2021-2026.⁴¹

PEPFAR’s new strategy, Vision 2025,⁴² is notable for specifically including key populations within several of its strategic goals. The strategy also explicitly states that it “will be greatly informed by and closely

³⁶ A review of TSM projects shows that key population-related assignments to date have been carried out in all UN regions in Africa, Asia, Latin America and Eastern Europe.

³⁷ All evidence in the following paragraphs and quotes is based on KIIs with GF and PEPFAR representatives, as well as Joint Programme interviewees.

³⁸ *ibid*

³⁹ *ibid*

⁴⁰ *ibid*

⁴¹ *ibid*

⁴² https://www.state.gov/wp-content/uploads/2021/09/DRAFT-Overview-PEPFAR-Strategy-Vision-2025_Version-2.0-2.pdf

coordinated with the Global AIDS Strategy 2021-2026 and the post-2022 Global Fund Strategy to optimize complementarity, value for money, and impact.”⁴³

4.1.4 Regional support for key population programming

All Joint Programme regions have included key populations as an important component of the regional strategy, with country programmes supporting key population issues to a greater or lesser extent, assisted by the regional support teams. However, an analysis of regional trends in key population programming over the past three years was limited by the shortcomings inherent in the Joint Programme Monitoring System (JPMS).

The evaluation team conducted an analysis of available data at the country and regional levels. The analysis was carried out based primarily on JPMS data from the past three years from 63 selected countries. Interviews were conducted with representatives from each Joint Programme regional support team to gather a perspective on the main issues and trends in the regions.

Analysing trends in key population programming at either a regional or a country level from the JPMS summary regional and country reports was problematic for several reasons. The reports demonstrated a lack of standardization of reporting, a frequent lack of attribution to agencies of planned/executed activities, and a lack of differentiation by key population for each activity (see also information on findings for Evaluation Question 4).

In general, countries in the Asia Pacific (AP) and Eastern Europe and Central Asia (EECA) regions had better quality reporting. The reports from West and Central Africa (WCA) and East and Southern Africa (ESA) regions made less mention of key populations, which may be an example of underreporting, either at the national level or in the JPMS reporting process. Standardization of reporting for the JPMS occurred in 2020, which may result in improved quality of reporting.

The regional reports vary in detail and length but do show that all regions prioritize key populations. However, because of the substantial variations in the nature of the epidemic between and within regions, due to both the local epidemiology and different national governments’ appreciation and acceptance of key population issues, it is difficult to make generalizations on a regional level. That said, trends in programming are somewhat more evident in regions where the epidemic is primarily in certain populations. For example, EECA and the Middle East and North Africa region (MENA) have prioritized people who inject drugs and prison programming, while the Latin America and Caribbean region’s (LAC) focus is more on transgender people and gay men and other men who have sex with men. Trends are more difficult to discern in the WCA and ESA regions, where the epidemic is more generalized (but with concentrated epidemics occurring in specific populations) and where there are institutional and cultural impediments to acknowledging and programming for key populations.

Latin America and the Caribbean region⁴⁴

IBBS data from five countries surveyed in the JPMS show high rates of infection among transgender women and gay men and other men who have sex with men and, to a lesser extent, woman and girl sex workers. Some countries, for example, Ecuador, Guatemala and Peru, appear to have a coherent three-tier approach with successful initiatives in policy influencing, operational changes and engagement with civil society, but are not specific about key population activities.

The LAC regional JPMS reports for 2019 and 2020 list several activities carried out in the region over the past three years for key and vulnerable populations,⁴⁵ including: preparing guidelines for “Out of

⁴³ *ibid*

⁴⁴ Data in the following sections includes a combination of material from the JPMS reports, supplemented by findings from conference calls with members of the various regional support teams.

⁴⁵ It is a feature of most of the regional reports that the term “key and vulnerable populations” is used to describe activities, without distinguishing which key or vulnerable population is being targeted by the activity. In many cases, it appears that

School Sexuality Education” (UNFPA); working on lesbian, gay, bisexual, transexual, intersexual, queer and other non-binary persons’ (LGBTIQ+) issues such as stigma and discrimination and human rights (Caribbean); supporting pilot pre-exposure prophylaxis (PrEP) demonstration projects; supporting the largest regional sex workers network, REDTRASEX (UNDP); supporting activities in many countries⁴⁶ for refugees and asylum seekers (HIV testing, prevention, treatment and care services) that included attention to key populations (UNHCR); strengthening health information systems in the areas of HIV/sexually transmitted infections and services for key populations and developing key population prevention cascades and HIV estimates for key populations (Pan American Health Organization (PAHO)).

The Middle East and North Africa region

Rising new infections, criminalization and punitive laws are the biggest issues affecting services. There is variability within the region, with Morocco and Algeria addressing key populations, including engagement in Global Fund funding process (Morocco). There have been some policy breakthroughs (for example, PrEP, Egypt adopting human rights policies for people who inject drugs and implementing opioid substitution therapy (OST)) but little evidence of activities or success in influencing policy or awareness raising at the government level. In humanitarian settings the hostile security environment makes reaching key populations difficult and, in general, key populations are underprioritized. The reduced resources available (decreased Country Envelope resources to MENA) have limited the amount of activity possible. Key populations who received the most attention and focus by the Joint Programme were people who inject drugs, prison populations and gay men and other men who have sex with men, with very little reporting on woman and girl sex workers.

The MENA regional JPMS reports for 2019 and 2020 list several activities conducted in the member countries, some of which include: a UNODC-initiated prisons project (Egypt, Morocco, Tunisia), a regional workshop on guidelines of HIV prevention, treatment, care and support for people who use stimulant drugs (UNODC); support to scale up/initiate PrEP programmes for key populations in priority countries; and HIV services for key populations during COVID-19 in Sudan, Djibouti, Morocco, and Tunisia (UNAIDS) to utilize Global Fund flexibilities to sustain HIV services during COVID-19 with a focus on key populations and support for development of national strategic plans (UNDP – Tunisia).

The West and Central Africa region

JPMS reporting on key populations is scant. There is little evidence of coherent government-led programming for any specific group of key populations; where mentioned, key populations appear to be an afterthought. Some countries (for example, Benin) make no mention of key populations in their reporting and even countries with large key populations (for example, Nigeria) report limited programming.

However, the WCA regional JPMS reports for 2019-2020 list a number of activities supported at the regional level for key and vulnerable populations, including: developing a regional strategy for HIV, tuberculosis (TB), Hepatitis B and C and SRHR among key populations launched in 2020 through the West Africa Health Organization (WHO/UNAIDS/ the Economic Community of West African States (ECOWAS)); a workshop to support the piloting of the Stigma Index 2.0 methodology in six countries; a bio-behavioural survey across six countries to better understand the situation of people with disabilities; and the launching of the Hello Ado app using multimedia edutainment and gamification to educate adolescents and young people on prevention of HIV and other sexually transmitted infections, prevention of early and unintended pregnancy, and gender-based violence, among other issues.⁴⁷

the activity is actually aimed at the general community, with key or vulnerable populations being just one of the beneficiaries, and not necessarily the primary recipient of the intervention.

⁴⁶ Chile, Costa Rica, Colombia, Ecuador, Guatemala, Guyana, Mexico, Peru and Venezuela.

⁴⁷ Presumably these last two would include key populations among their sample.

East and Southern Africa region

The ESA region demonstrates targeted key population responses by the Joint Programme. A regional HIV prevention technical working group has been established with quarterly meetings and a scorecard on key populations programming modelled on the Global Prevention Coalition scorecard. Swedish international Development Cooperation (SIDA) has supported the regional team with key population programming implementation. Key population networks such as AIDS and Rights Alliance for Southern Africa (ARASA) have been involved in the South African Development Community (SADC) Strategy development for key populations. Changes noted in the past five years in the region include an enhanced focus on key populations, with more guidance in place for key population programming and nationally owned packages of programmes, with more acceptance, more data, and better targeting, monitoring and tracking. This does not apply to all key population communities, with more activities happening around sex workers and gay men and other men who have sex with men, and less on people who inject drugs and transgender people.

The JPMS reports do not clearly differentiate between key population groups, and some activities are lumped together with adolescent girls and young people.⁴⁸ There is little mention of gay men and other men who have sex with men and little or no mention of transgender people, suggesting that inclusion into programmes or specific programming for those populations are still under-supported. Awareness-raising is more prominent at the civil society level while people who inject drugs and prisoners are overlooked in most reports with a couple of exceptions for example, Namibia.

The ESA regional JPMS reports for 2019 and 2020 list several regionally sponsored activities, including: developing guidance documents;⁴⁹ monitoring the implementation of the SADC key populations strategy; conducting regional workshops to accelerate HIV prevention with representatives of government, priority populations and civil society; assessing minimum standard compliance for prisoners in 10 countries (UNODC); developing country road maps to influence the supportive legal environments for all populations; supporting a regional conference for LGBTIQ+ activists from SADC member states focused on assessing and mitigating the social, economic, and political impact of COVID-19; and documenting innovations from seven countries, including multi-month dispensing of PrEP, home delivery of condoms and lubricants, and mobile clinics to serve sex workers and underserved populations.

Asia Pacific region

In many countries in the region, increasing conservatism in both the legal and political environment has made programming difficult with the limited resources available, especially in terms of supporting advocacy. However, the JPMS country reports suggest broad and generally comprehensive programmes for most categories of key populations. Policy change and/or legal framework amendments have occurred in relation to specific key populations in several countries including India and China.

The AP regional JPMS reports for 2019 and 2020 list a large number of activities supported by the regional team, a few of which include: comprehensive HIV/sexually transmitted infection prevention services in 11 Pacific countries (UNDP, Global Fund funded); integration of HIV surveillance into routine programming in nine countries in partnership with health ministries and local civil society organizations (UNDP); regional discussions on PrEP in 18 countries (UNAIDS/WHO); small grants provision to regional networks to strengthen the capacity and leadership of LGBTIQ+ youth networks to advocate for rights and inclusion at the national and regional levels; establishment of the Asia-Pacific Expert Advisory Group (EAG) on compulsory facilities for people who use drugs (UNAIDS/UNODC); the launch of an inter-agency task team (IATT) on the Young Key Populations

⁴⁸ Adolescent girls and young people, to include young men as well.

⁴⁹ Such as Minimum Key Population SRHR Protection Standards for Parliamentarians and a key population technical guide for programme scale-up.

website; and support to livelihoods initiatives for LGBTIQ+ sex workers, women and girls in Cambodia, Nepal, Pakistan, Thailand and Vietnam.

Eastern Europe and Central Asia region

More progress is being made in eastern Europe than in central Asia. PrEP has been integrated into programming, there is good scale-up of self-testing, and domestic funding is increasing through different models. Social contracting pilots are still not at scale. The response to COVID-19 and home dosing of opioid substitution therapy are also positive shifts and demonstrate good progress on differentiated service delivery models. Regional networks have strengthened capacity to work on treatment and care for key populations, and the UNAIDS Secretariat has been ensuring these networks are supported. However, there is mixed progress on the enabling environment with legal barriers worsening and criminalization of HIV requiring more advocacy.

The reports suggest that the Joint Programme supports key population services particularly for people who inject drugs and incarcerated populations. There is evidence of a range of options for services to other key populations supported by the Joint Programme in several countries for example, chat-bots for confidential services for transgender people and gay men and other men who have sex with men. Woman and girl sex workers receive little mention as a separate group and no evidence of specific Joint Programme programming for woman and girl sex workers was noted.

The EECA regional JPMS reports for 2019 and 2020 list a number of activities targeting key populations, including: building the capacity of four regional networks to operationalize tools in service delivery, to develop a strategic plan for young gay men and other men who have sex with men (UNFPA); addressing drug use and people who inject drugs (UNODC); building capacity of prison staff (UNODC); working with young key populations in Kazakhstan, Kyrgyzstan and Ukraine (UNESCO/UNAIDS); convening a regional judge's forum (UNDP); and establishing a regional hotline for people living with HIV and key populations (UNFPA).

4.2 Evaluation question findings

4.2.1 EQ 1 (relevance) and EQ 3 (harmonization and alignment)

EQ 1: How relevant are Joint Programme activities for addressing the needs and priorities of each key population group?	
EQ 3: To what extent are the activities of the Joint Programme harmonized and aligned internally and externally with other actors' interventions in the country?	
High-level findings	<ul style="list-style-type: none"> ■ Key population groups are not systematically involved in Joint Programme strategic annual planning processes and strategic assessments of country key population needs do not always guide the prioritization of Joint Programme activities. ■ There is a greater focus on broader programming activities with varying degrees of relevance for key populations than on activities for specific key population groups. There is evidence that the prioritization of activities in support of key populations could be tightened up. ■ The mix of activities does not necessarily reflect the leveraging of the comparative advantage of Cosponsor agency expertise but reflects the capacity levels of agencies to support key population programming. ■ There is a stronger focus of support to systems and services for key populations and the enabling environment and less support to sustainable financing, which is necessary for ongoing key population programming.
Theory of change	The theory of change assumes that the meaningful engagement of key population groups is central to the Joint Programme's work, including the planning and design of relevant activities for the key populations the Joint Programme is expected to serve. There is an assumption that the Joint Programme annual plans are based on epidemiological data and an assessment of

the needs of different key population groups in the national response, thus ensuring Joint Programme support is highly relevant and targeted. **Summary assessment:** There is mixed evidence from the case studies for these assumptions holding true – meaningful engagement of different key population groups in *annual planning processes* is not consistent across the countries and activities are not always based on strategic assessments of needs. The evidence indicates that other factors, such as short UBRAF planning and funding cycles, resourcing constraints, and the strategic repositioning of Cosponsor agency HIV and key population work, shape and have implications for the relevance, coherence, and likely impact of key population-related activities.

Joint Programme activities have been significant in moving the key population response forward in the case study countries. Case study evidence indicates that the activities undertaken by the Joint Programme over time have helped position and establish the Joint Programme as a leader in advocating and setting the agenda for key population responses with national authorities and wider partners. As is the case at the global level, the Joint Programme is widely recognized by national stakeholders as a neutral and trusted partner mandated to defend human rights, and recognized for its work in generating strategic information, policy, and programmatic technical advice, convening and brokering partnerships and technical support, and supporting the capacity of key population groups, including their participation in national planning processes.

There is evidence for the catalytic nature of Joint Programme activities, which, for example, have brokered and scaled up prevention and treatment interventions such as PrEP in Thailand and Ukraine and medically assisted therapy (MAT)⁵⁰ for people who inject drugs in Kenya. There is also evidence of the Joint Programme supporting innovation, such as an App for the protection of sex workers in Tunisia, or technical support by WHO to accelerate differentiated service delivery mechanisms during the COVID-19 pandemic that benefit some key population groups - for example, the transition of facility-based opioid substitution therapy for people who inject drugs to take and administer at home in Ukraine. There is strong evidence for Joint Programme collaboration and partnerships with a broad range of entities that have been mobilized for HIV and key population activities and this is widely recognized by many of the stakeholders consulted in case study countries (more details on these activities and their results can be found in Evaluation Question 8 and case study reports).

In case study countries there was weaker evidence for meaningful engagement of key population groups and other government and international partners in *annual planning processes* of Joint Programme activities for key populations. UBRAF guidance⁵¹ emphasises the importance of developing Joint Programme plans that are evidence-based and involve consultations with key population groups and national and international partners to ensure the Joint Programme support is relevant to the country context and coherent with the HIV response, including the work of other partners/funders.

Although Joint Programme plans are generally said to be aligned with national strategic plans and priorities, with the exception of Thailand, there was weaker evidence that joint annual planning processes had engaged key population groups and national and international partners. In Peru, Kenya, and Tunisia, some key population groups consulted for the evaluation were not involved or were unaware of the work of some Cosponsors and of their work in relation to key populations, or of the priorities of the Joint Programme in their country. In Ukraine, key informants including government stakeholders, non-governmental organizations (NGOs), key population representatives and donors indicated that recent Joint Team planning processes have been less participatory, with

⁵⁰ Medical assisted therapy clinics are supported by PEPFAR in Kenya and offer integrated services for people who inject drugs, including opioid substitution (methadone) therapy; HIV testing services; ART; condom distribution; vaccination, diagnosis, and management of viral hepatitis; prevention and treatment of tuberculosis; and overdose prevention and treatment. The therapy centres on harm reduction, which comprises a range of services that mitigate the adverse consequences of drug use and protects public health.

⁵¹ https://www.unaids.org/sites/default/files/media_asset/20151103_UNAIDS_UBRAF_PCB37_15-19_EN.pdf
https://www.unaids.org/en/resources/documents/2021/PCBSS_2022-2026_UBRAF_Framework

limited involvement. Reasons cited in the countries where this was evidenced include limited time available for planning and the small budgets involved. This supports similar findings from the Review of the Implementation of the Joint Programme's Action Plan and Revised Operating Model Interim Report,⁵² which also highlights inconsistencies with engaging key stakeholders in annual planning processes, including inconsistencies caused by time limitations.

The examples of Thailand and Kenya highlight engagement in Joint Programme planning processes with implications for the positioning and relevance of the Joint Programmes work and activities in support of different key population groups. More details can be found in the case study reports.

Thailand

The Joint Programme is positioned to play a brokering role, which brings together different partners and technical support to support its work. This positioning is strategic and responds to the realities of staffing constraints in Thailand. The Joint Programme annual plan is developed through a participatory process involving the UNAIDS Secretariat, Cosponsors, and consultations with national partners including key population organizations and international donor partners. The plan is informed by epidemiological and national programme data, which is the basis for addressing identified needs of certain key population groups. This has helped prioritize the Joint Programme work with people who inject drugs (the most under-performing area of national HIV response) and transgender people (targeting persistently high HIV prevalence rates). The priorities of the Government and other partners are considered to ensure alignment with national needs. For example, priority was not accorded to sex workers, except for LGBTIQ+ sex workers due to low HIV prevalence rates and high programme coverage rates compared to other key population groups, or to gay men and other men who have sex with men, as this key population group is supported through PEPFAR funding.

Kenya

Over the past decade, the Joint Programme has played a key role in supporting key population responses under the Ministry of Health leadership and significant progress has been made with key population programmes, initially led by women and girl sex worker-led organizations and gay men and other men who have sex with men. Key population programming is peer-led with key population-led organizations involved in programme design and implementation of prevention and treatment services, as well as influencing policy and becoming equal partners in the HIV response. Key population groups have not been involved in Joint Team annual planning processes. There is a perception by key informants that, as the key population response has strengthened, the Joint Programme's role and work with key populations has become less visible and clear. Key informants have suggested that in the Kenya context, where government and key population groups are doing most of the programming, engaging with key population groups and wider partners in annual planning processes may help identify and strengthen the position, prioritization and relevance of the Joint Programme's work.

There is less evidence in the case study countries that Joint Programme annual plans and activities are based on recent strategic assessments of different key population group needs and that these assessments guide the prioritization of activities. Joint Programme annual planning documents and UBRAF strategic priorities tend to reference key populations in relation to other populations, such as "vulnerable populations and key populations" and "young people and adolescents and key populations" with little distinction between the groups. Further, 'key populations' are also rarely disaggregated by key population group. There is also less evidence that the activities programmed under these priorities are based on recent strategic assessments of the needs of different key

⁵²https://www.unaids.org/sites/default/files/Evaluation%20of%20the%20Joint%20Programme%20Action%20Plan%20_%20Review%20Report.pdf

populations. Thus, the degree to which Joint Programme activities clearly ‘map to’ and address identified gaps and priorities of different key population groups at the country level is difficult to determine.

Related to this point, there is strong evidence from the case studies that annual plans are derived from a collection of individual Cosponsor agency activities, rather than guided by an overarching country key population strategy for the Joint Programmes work. There is also very limited evidence that the key population-related activities undertaken are supported by a theory of change that would explain how and why the planned activities intend to bring about change. Not using a theory of change for Joint Programme work, including for key populations, is widely considered a weakness by the key informants interviewed for this evaluation.

Multiple factors influence the choice, relevance and coherence of the Joint Programme country plans for key populations. Short planning periods and UBRAF funding and disbursement cycles (12 months or less) can affect the strategic vision for the Joint Programme’s work, resulting in activities that could not be implemented in the time frame available. Additionally, the mobilization of resources beyond UBRAF core funding, that is, from other donors, is perceived by key informants, including Cosponsor informants, to influence the coherence of Joint Programme activities, resulting in plans that reflect more of a ‘project-by-project’ approach. Additionally, when Cosponsors receive donor funds and the share of UBRAF funding is minor in comparison, this can influence the allocation and availability of Cosponsor staff vis-à-vis the implementation of other Joint Programme activities (see also findings for Evaluation Question 4).

There is evidence in the case study countries of a need to strengthen coordination and collaboration of Joint Teams; coordination and collaboration with external partners is strong.

Evidence from all the case studies suggests that coordination and collaboration of Joint Teams could be strengthened, and this in turn would improve the coherence of country workplans including for key populations. Areas commonly cited in the countries include: Joint Team members not always aware of what each other is doing; uneven levels of Joint Team collaboration and commitment to working on key populations; a tendency for Joint Team meetings to focus on the reporting of activities and/or individual agency Country Envelope proposals, with less focus on joint strategy; and Country Envelope proposals not being used as strategically as they could be, resulting in a collection of individual projects, linked in varying degrees to the UBRAF strategic priority in the Joint Plan (see also findings for Evaluation Question 4).

“That is a gap, I think. It is a gap that I see is strong and yet to overcome. Because I think that if we were working together better for the same goal better, we would suddenly have more achievements. It would even be excellent for the four agencies to go to the ministry to speak on the same issue than to go on their own with their separate agenda and projects. I think that is one of the main gaps.” (Key informant, Joint Team)

The degree of collaboration with country partners working in the key population space is reported to be good. Strong and close relationships with international partners (principally the Global Fund and PEPFAR) and national partners, both key population-led organizations and government ministries, are evident, particularly for the implementation of activities. The Joint Programme is actively involved in the key elements of HIV programming, including the preparation of the Global Fund funding requests, PEPFAR country operating plan (COP) discussions, and the development of national AIDS programmes/strategies. One of the key functions of the Joint Programme is to convene and/or coordinate the work of technical working groups and facilitate key population consultations and engagement in the preparation of these documents and decision-making processes. This role is evident in the case study countries with key population groups frequently engaged in such processes (see findings on Evaluation Question 6 for more detail).

The Joint Programme's key population work in the case study countries includes an extensive range of activities, with varying degrees of relevance and focus on specific key population groups. The evaluation observed a number of points drawn from the case studies.

Activities undertaken by the Joint Programme related to key populations tend to fall into several categories:

- Activities that have a significant key population focus. Some of these activities apply to all key population groups (for example, unit cost of key population civil society organization services), although most activities focus on one key population group, such as sex workers or people who inject drugs.
- Broader programmatic activities that are relevant to key populations but also other populations. Such activities may include PrEP, or human rights, stigma and discrimination work and may or may not include a targeted key population group.
- Activities where the primary focus is on other populations, with a lesser focus on key populations. This might include work on adolescent girls and young women or other youth, but from which young key populations might benefit.

Joint Programme activities implemented in case study countries are a mix of these categories with activities that have a broader programmatic focus forming a larger proportion of a country's portfolio of activities than those activities with a significant focus on key population groups. While many of these broader activities may be relevant for an effective key population response, they do not always have a stated focus on key population groups, nor are they always designed with key population groups as the primary beneficiary of support. The relevance of these broader programmatic activities will depend on the activity itself and the epidemic context. For example, in Thailand, support to PrEP is a broader programmatic activity that, in this context, is relevant to the strategic needs of key populations.

The case studies also show that the Joint Programme is, to a varying extent, funding activities that have a focus on the general population and/or other populations, such as youth and adolescents, with lesser reach to key populations. The issue is not whether there is a need for this type of programming but whether it is appropriate for limited donor and UBRAF funding to be allocated to these activities without more specificity and targeting of key population groups. The evidence suggests there is scope for Joint Programme resources and activities to be further prioritized and focused on key population groups.

The activities undertaken by the Joint Programme in the case study countries largely map to the activity areas identified in the theory of change, with most activities potentially contributing to intermediate outcomes 1 and 2 - increased provision of service packages targeting key populations; and policy changes related to the removal of criminal and discriminatory laws and stigma and discrimination. There has been less focus on intermediate outcome 3, which is focused on developing and implementing financing mechanisms to ensure key population programming is sustained (see also findings from Evaluation Question 8 for how activities are contributing to outcomes).

The mix of activities is not necessarily the result of leveraging the comparative advantage of Cosponsor agencies in the Division of Labour, but reflects different levels of capacity across the Joint Programme to support key population programming. Significant UBRAF budget cuts in 2016 have been a driver in the reorganization of Cosponsor agency HIV programmes and this has affected the capacity to undertake key population programming (see also findings for Evaluation Question 4). In the case study countries, it was notable that fewer Cosponsor agencies are working on key population responses. Evidence suggests this is due to:

- Budget reductions, which have resulted in some Cosponsor agencies having less resources and capacity (human and financial resources) to fulfil the roles and responsibilities assigned to them through the Division of Labour. This diminishes the intent of the Division of Labour, which is designed to leverage the comparative advantage of different agency expertise.
- Some Joint Programme agencies, such as UNICEF, UNFPA, UNESCO, WHO and World Bank, have strategically repositioned their HIV work - evident through their global strategies - and are focusing on their traditional core work and integrating or linking HIV to this work. This has implications for key population programming, which is less explicit. For example, the World Bank is integrating HIV into broader health agendas, particularly universal health coverage and health system strengthening, and through efforts to address key non-health factors that significantly affect HIV outcomes including gender (for example, gender-based violence and economic empowerment). In the case study countries, there is evidence of modified programming. For example, in Thailand, UNICEF has, in recent years, been phasing out from HIV work and is now focusing on integrated health services for adolescents, which includes sexual and reproductive health, teenage pregnancy, mental health and adolescent nutrition.

There are arguments that integrating HIV with a broader focus on health, the Sustainable Development Goals and leaving no one behind, has the potential to continue to focus on key populations such as sex workers through greater integration of HIV services with a full range of sexual and reproductive health and/or other relevant services such as sexually transmitted infections and viral hepatitis. There is also an argument that integrated approaches can address the structural determinants of inequality that hamper key population access to services in the longer term. However, evidence suggests there are potential trade-offs to these approaches, including a danger that Joint Programme responses lose their focus on key populations at a time when the scale-up of key population-specific programming is needed to reverse the increases in the percentage of new HIV infections among key populations and their sexual partners.

There is strong evidence for the Joint Programme’s work in generating global and regional key population-related tools and guidance aimed at developing relevant evidence-based plans and activities, but less evidence for use of these products in case study countries. The generation of evidence-based tools and guidance to aid key population programming is a significant activity for the Joint Programme and a raft of technical guidance, good practice papers based on global and regional experience, and toolkits exist to address the specific needs of different key population groups.

Joint Programme agencies in collaboration with global key population networks have developed key population-specific implementation tools for sex workers, people who inject drugs, transgender people⁵³ and gay men and other men who have sex with men that are considered by some key informants outside the Joint Programme to be ‘best practice’. For example, UNDP has produced a good practice guide for the management of transgender prisoners, which includes recommendations on the provision of HIV services and represents one of the few products addressing the intersectional needs of these populations. UNICEF in collaboration with UNDP, UNFPA and UNAIDS also produced a toolkit in 2018 addressing HIV prevention programming in young key populations, specifically targeting young sex workers, transgender people, people who inject drugs and gay men and other men who have sex with men.

While there is strong evidence for the use of UNAIDS key population guidance informing Global Fund and PEPFAR work and uptake and use of WHO technical guidelines, there is less evidence of use and uptake of key population-related tools to inform programming in the evaluation country case studies. Findings indicate that the UNAIDS Secretariat plays a role in disseminating guidance and tools, but there is patchy evidence for collective responsibility across the Joint Programme to

⁵³ Ref: <https://www.nswp.org/resource/international-guidelines/sex-worker-implementation-tool-kit>
<https://hivpreventioncoalition.unaids.org/resources/>

promote and use the products. Some key informants cited funding constraints as a reason why the awareness and use of products is not promoted or used to maximal effect by the Joint Programme. Evidence from Tunisia indicates that tools developed at the regional level are not systematically used because they are too generic for such a diverse range of countries in the eastern Mediterranean regional office region, which points to the importance of involving local stakeholders and key population communities in the development of such tools.

4.2.2 EQ 2 (human rights and gender equality)

EQ 2: To what extent has the Joint Programme considered the human rights, gender equality and more vulnerable key population groups in the design of the Joint Programme's activities? ⁵⁴	
High-level findings	<ul style="list-style-type: none"> Human rights and gender equality considerations are very evident in the design of Joint Programme activities and include key population-specific human rights work and broader enabling environment programming that often goes beyond HIV. While all key population groups are marginalized, young key populations, transgender people and prisoners receive less attention as per evaluation case study countries. Current definitions of key population groups do not adequately reflect the diversity of key populations or the intersectional vulnerabilities and needs across and within key population groups. This has implications for relevance and effectiveness of the Joint Programme's work with key population groups.
Theory of change	<p>The theory of change assumes that Joint Programme activities in human rights and gender equality programming for key populations, and the work on reducing legal, policy and societal barriers to accessing services, will in theory catalyse legal and policy change and support shifts in societal behaviours and attitudes. Summary assessment: Evidence from the case studies suggests this assumption is correct and that the activities undertaken are a critical component of successful key population responses, but evidence indicates these activities have yet to yield significant progress in changing the enabling environment that hinders access to and provision of health services for key populations. The evaluation also finds that some key populations are not being addressed as much as others and that the current key population definitions are narrow and do not adequately reflect the diversity of key populations or the intersectional nature of their needs and this has implications for provision and uptake of people-centred services (intermediate outcome 1).</p>

The evidence from case studies indicates that Joint Programme interventions in relation to key populations are designed with human rights and gender equality considerations. Addressing human rights issues and promoting gender equality is included in strategic priorities identified for 2018-2021 in Joint Team plans across the six case study countries. However, the degree to which human rights, gender and enabling environment activities focus on key population groups is variable. Activities include a combination that targets key population groups as well as focusing on broader policy and enabling environment work, which often go beyond HIV. UNDP, UNODC and the UNAIDS Secretariat have played prominent roles in the case study countries supporting human rights work, often in collaboration with key population-led organizations, but also with ministries, parliamentary committees, and law enforcement agencies, as appropriate to the context.

Activities addressing gender equality issues, as they relate to key population groups, is less evident in the case studies although there are some examples from Tunisia of UN Women having supported sex workers and people who inject drugs (however, this was curtailed as UN Women stopped working in Tunisia), and from Cameroon where annual reports on gender-based violence against the LGBTIQ+ community have been produced. Gender equality is being promoted by UNAIDS Secretariat and addressed through other Cosponsors' work (UNHCR, UNICEF, UNDP, UNFPA, UNODC, UN Women, and WHO) as a mainstreamed approach, not necessarily specific to HIV or key populations. For example, in Ukraine, the UNDP Gender Equality Strategy 2019-2022 provides a road map to elevate

⁵⁴ Evidence to support the findings in this section are derived from global and country case study key informant interviews and documentary sources. The data and documentation sources are of good quality, but there is less evidence available to address all the assumptions related to this evaluation question.

and integrate gender equality into all aspects of UNDP work. In Cameroon, much of the UN Women budget is for the promotion of gender equality in broad terms - women's economic governance, leadership and political participation.

Progress has been made to recognize and address the needs of marginalized key population groups but significant programming gaps remain, notably for young key populations, transgender people and prisoners who are being left behind to varying degrees in case study countries. There is strong evidence that the Joint Programme has made efforts to address more marginalized key population groups, for example, through generating strategic information for existing or previously unaddressed key population groups (such as for transgender people in Tunisia and Thailand), through advocacy to support the integration of key populations in national planning and funding documents (for example, the inclusion of woman and girl sex workers for the first time in the 2021 Global Fund funding request in Peru), through the promotion of rights of prisoners in Ukraine, and through addressing the rights of transgender people and people who inject drugs in Cameroon.

However, in most case studies there is evidence that some key populations are less addressed than others, and this is also visible in Joint Programme programming in case study countries with notably less attention being paid to young key populations, prisoners, and transgender people. The focus on some key population groups and not others is contextual, as seen in the example of Kenya, where Joint Programme activities for key populations have largely targeted people who inject drugs, in part because UNODC is receiving USA funding for the implementation of the medical assisted treatment project. Other key populations, such as young key populations, have received less attention from the Joint Programme despite being identified as a high priority group in the national strategic plan. While receiving donor funding for a specific key population project is a critical way to support and scale Cosponsor agency programming and implementation, there are potential trade-offs with the overall coherence of the Joint Programme portfolio of activities and it can drive or sometimes distort the prioritization of different key population groups.

Table 5: Example of human rights activities related to key populations

Activity areas of the theory of change	Human rights activities in 2018-2021 Joint Plans in the case studies countries
Generation of strategic information for key population groups	<ul style="list-style-type: none"> ■ Tunisia: Data concerning transgender people are very limited. The UNFPA transgender mapping exercise, implemented by the Positive Prevention Association (ATP+) was the first of its kind to identify transgender people's needs. Findings indicated low condom use and extremely high rates of sexually transmitted infections in this key population group. The evidence, supported by advocacy from the UNAIDS Secretariat and UNFPA, has enabled the integration of transgender-focused interventions in the national strategy 2021-2025 including a specific target of 95% of transgender populations in all their diversity to be allowed to access and benefit from the combined prevention service package according to national standards based on their needs and specifics and for this service to be sensitive to gender.
Addressing barriers to services for key populations	<ul style="list-style-type: none"> ■ Thailand: The status and progress of activities to reduce stigma and discrimination in health care settings was monitored using measurable targets, standardized indicators and data collected. ■ Kenya: UNODC is addressing the human rights of people who inject drugs through supporting a walk-in system for women to facilitate greater access to services offered in MAT clinics. This also includes discussions for establishing a specific day for women to access services and timings for woman and girl sex workers. Support is also being provided to MEWA, a civil society organization working with women who inject drugs to start a woman's shelter to ensure safety for woman and girl sex workers who use drugs and experience violence.

There is evidence of Joint Programme involvement in operationalizing global partnerships and initiatives in human rights in two case study countries but there is limited detail for how these initiatives are being implemented and sustained. Cameroon's work on stigma and discrimination has taken place in the context of the Global Partnership of Action for the Elimination of All Forms of Stigma and Discrimination through which trainings, workshops and panels have been organized by the Joint Programme (UNAIDS Secretariat, UNICEF, UN Women, ILO) for health facility staff, security forces and magistrates in Yaoundé and Douala and community leaders (chiefdoms, clergy) and government bodies, reaching over 300 people.

The case study indicates that the Joint Programme is adopting a stepwise approach towards supporting the enabling environment for key populations including through their work on stigma reduction and human rights. The work focuses on changes in advocacy and partnerships with the government and framing human rights and access to health issues of transgender people and people who inject drugs in the context of the 2030 Agenda. This is reported to have established traction and is changing the human rights landscape affecting key population groups.

Tunisia reported on support to the Global Fund's Breaking Down Barriers (BDB) Initiative baseline study conducted in 2018. The report was instrumental in creating a national strategy on human rights and HIV and mobilized Global Fund catalytic funding for human rights interventions. This resulted in subcontracting Avocats Sans Frontières (ASF) to provide legal support to key population groups and the appointment of a Global Fund human rights and HIV project coordinator. Case study evidence of the role of the Joint Programme in supporting the Breaking Down Barriers Initiative is limited, but much of the Joint Programme's work in Tunisia has been aimed at improving the environment and protecting the rights of the key populations through policy papers to advocate for key population rights, a legal assessment supported by UNDP, and further studies on human rights and HIV. It is unclear how impactful these outputs have been (see also findings for Evaluation Question 8).

Addressing the intersectional needs of different key population groups does not feature prominently in Joint Programme technical and programming guidance at the global level, which is also reflected at the country level. There is only limited evidence of intersectionality work in the case study countries, the most developed being in Thailand. Global key population informants and documentary evidence suggest that addressing the intersectional needs and vulnerabilities of different key population groups is an important area that is already happening in community-led programming but is not prominent or adequately addressed by Joint Programme documents, strategies and guidance. However, there is evidence that this is developing: for example, UNDP has produced guidance on transgender HIV prisoner needs (see example of Thailand below) and WHO has a working group on 'gender affirming' health care with key population engagement including young key population representation. Additionally, there seems to be different understandings of what 'intersectionality' means in the context of the needs of different key population groups and related service provision, and in relation to other vulnerable populations. For example, the Global AIDS Strategy 20210-2026 refers to intersectional *inequalities*, but it does not differentiate those inequalities relating to key populations from those inequalities faced by a broader range of populations mentioned (for example, priority adolescents and young people, women, and girls).

The findings from the case studies indicate that, for the most part, key population programming is still largely organized using the Joint Programme's key population categories used for this evaluation – sex workers (rarely disaggregated by gender), people who inject drugs, gay men and other men who have sex with men, transgender people and prisoners. Global documents and key informant evidence confirms the limited progress made in breaking down these silos, and the challenge of generating relevant data to address key population intersectional needs when there are still significant data gaps for the groups mentioned above, including transgender persons. Further, the evidence suggests a need for the Joint Programme to evolve its understanding of key populations, in all their diversity, in order to increase the relevance of support to the populations the Joint

Programme is expected to serve. To some extent this is beginning to happen, with global AIDS monitoring data now being collected for transgender people, separate from gay men and other men who have sex with men. There is also some, but limited, evidence from the case studies of intersectional programming approaches being implemented, although this varies considerably between countries and is most developed in Thailand.

Thailand: A significant number of activities have taken an intersectional approach, with and for people who inject drugs being predominant, in line with the Joint Programme's prioritization of this key population group. These include multiple activities for women and girls, the LGBTQI+ community, prisoners, young key populations, sex workers who use drugs and gay men and other men who have sex with men. This is relevant and appropriate as drug use is common among all key population groups. Some transgender-focused activities have also adopted an intersectional approach for example guidance on practices for transgender sex workers and transgender prisoners - with guidance on practices produced by UNDP.

4.2.3 EQ 4 (capacity and resources)

EQ 4: To what extent are the capacities and resources of the Joint Programme appropriate for work with and for key populations?⁵⁵

High-level findings

- Funding cuts have accelerated the repositioning of HIV and key population programming in agency strategies and work programmes, arguably with a lesser focus on key populations.
- Raising resources beyond UBRAF funding for key populations is difficult due to the nature of the work. External funding can promote a project-by-project approach with implications for the strategic direction and coherence of global and country plans for key populations.
- There is limited guidance and direction for the prioritization of UBRAF resources in relation to delivering the strategic priorities of the Global AIDS Strategy 2021-2026.
- Notable Joint Programme gaps in capacity and expertise identified include: HIV prevention, gender and sexuality issues, not enough staff working on data, not enough key population staff, including transgender people and young key populations, few staff at country level with key population expertise.
- The Joint Programme's monitoring system cannot be used for strategic programming. Getting a sense of the volume of investment for key populations, the activities and results of the Joint Programme's work is difficult and this poses a threat for future funding contributions.

Theory of change

The theory of change assumes that in undertaking its activities, the Joint Programme's allocation of resources (staffing presence and financial resources) and capacities are sufficient to ensure technical leadership and engagement to respond to key population needs.

Summary assessment: This assumption is weakened by the evaluation evidence, which outlines the challenges and impacts of the Joint Programme's resourcing situation in relation to key population programming. As such, the Joint Programme has lost significant positioning, investment and ability to provide support to key population responses and this has impacted on the delivery of the Fast-Track strategy and will affect progress towards the new strategy's strategic priority outcomes.

The Joint Programme has been subject to significant funding cuts. These cuts have driven the reorganization and strategic repositioning of HIV and key population responses and have had impacts on staffing and the Joint Programme's capacity to undertake key population work. Joint Programme capacity and staffing levels dedicated to key population programming are limited. Evidence indicates that, since the end of the Millennium Development Goals and the transition to the

⁵⁵ Findings are based on strong evidence from multiple and triangulated sources, which include key informant interviews at global level with Cosponsor agencies, donors, global key population networks, and country case study key informants. Further sources of data include recent evaluations of UNAIDS Joint Programme, of the UNFPA HIV response, reviews of the Country Envelope allocation model, UNAIDS and Cosponsor progress reports. Additionally, capacity findings were cross checked informally with the team undertaking the UNAIDS Capacity Assessment and the evaluation findings were supportive of their assessment findings.

Sustainable Development Goal era, HIV has been increasingly affected by reduced resources from the Joint Programme. In addition, the reductions in HIV programming capacity have been accelerated by the UBRAF funding cuts in 2016, which drastically reduced resource allocations and cut staffing levels dedicated to HIV and key population responses across the Joint Programme, with Cosponsor agencies particularly impacted.

For example, and according to key informants, during the Fast-Track period, the UNICEF HIV-related UBRAF budget decreased by 80%, which led to a reorganization of the HIV response. UNFPA also saw HIV-related budget reductions with UBRAF core funds declining from United States dollars (US\$) 10.5m to US\$ 2m (excluding the Country Envelope funds) in 2016 and a 29% reduction in the level of regional and country staff allocated to the HIV response between 2016-2019. Over 50% of full-time positions dedicated to HIV at UNFPA Headquarters were cut, resulting in the merger of the HIV/AIDS Branch and Sexual and Reproductive Health unit. As noted for UNDP below, UNFPA country-level focal points have shared responsibilities often for youth populations and SRHR.

Funding cuts with impacts on the staffing and the prioritization of HIV were also reported by UNDP, UNODC and UNESCO. UNDP no longer has dedicated HIV focal points in each country and staff time is often shared with responsibilities for youth and gender. This is not conducive to key population programming, which is challenging, given the need to work with governments when key populations are criminalized in most countries, and given the fact that staff may not have the capacity, expertise, or interest in taking on these responsibilities.

Shrinking budgets and human resources and the reduced capacity for HIV work by several Cosponsors are widely seen by evaluation informants both at the global and country levels to have diminished the overall capacity of the Joint Programme to undertake key population-relevant programming. Fewer expert staff and staff specifically focusing on key populations has affected the Joint Programme's capacity to provide technical leadership in countries and programming at scale and to deliver on the Fast-Track strategy. Capacity gaps identified during this evaluation include a greater need for expertise in HIV prevention; increased understanding of the needs of different key population groups ("not all lumped together"); gender and sexuality issues; and increased representation of key populations on staff, including from key population groups still establishing their voice and visibility, such as transgender people and young key populations, and reduced key population expertise at country levels. There are limited data on the diversity of Joint Programme staff (see Box 2 below). These data relate to UNAIDS Secretariat staff only. At the time of writing, data on the diversity of Cosponsor agency staff was unavailable.

Box 2: UNAIDS Global staff survey results

In November 2020, the first benchmarked UNAIDS Global Staff Survey⁵⁶ in more than a decade was conducted, which included five demographic questions. Respondents were invited to self-identify their gender identity, race/ethnicity, HIV serostatus, sexual orientation and whether they had a disability. A total of 523 out of 815 staff members and affiliate personnel (64%) responded to the survey, 2.5% of whom identified themselves as gender non-conforming, transgender, gender nonbinary, gender-fluid or other, and 8.4% of whom preferred not to say.

Source: People of UNAIDS 2020

The impact of resource constraints is felt acutely at the country level. In Peru, Thailand, and Tunisia the UNAIDS Secretariat is often the Country Director, sometimes with an extra staff member to undertake all the roles entrusted to the Secretariat. This is somewhat ameliorated through part time technical support provided by Secretariat and Cosponsor staff based in regional offices (see below) or with additional temporary contract staff. Regional staff have multiple demands and this is reported to affect the availability and capacity to support country key population programming. Further, where dedicated HIV specialists have been let go, the role of HIV focal points has often been taken on by generalists or specialists in other fields on a part time basis. For example:

⁵⁶ https://www.unaids.org/sites/default/files/media_asset/People%20of%20UNAIDS%202020%20_single%20pages.pdf

- The Peru UNAIDS Country Director receives 10% level of effort from UNHCR regional office for human rights; supplemented by three temporary specialists working in areas relevant to key populations.
- Thailand receives up to 30% level of effort from the regional support team in Asia Pacific for PrEP, human rights and law.
- Tunisia receives between 5-20% level of effort from five regional Cosponsor offices (WFP, UNDP, UNFPA, UNODC and WHO).

The scaling back of Cosponsor staff and presence has meant that already stretched UNAIDS country offices or agencies that are still present, may absorb technical responsibilities of other Cosponsors to the extent feasible. This has been reported in Thailand where staff reductions in WHO have resulted in the UNAIDS Secretariat taking on much of the work that would normally be done by the WHO country office; similarly, ongoing work to address sustainable financing of key population services has been taken up by the UNAIDS Secretariat, in place of the World Bank, which has reduced its HIV work in Thailand due to its upper middle-income status. In Peru, UNFPA has taken on the role of lead agency for human rights, in the absence of UNDP. While there is an argument that taking on the responsibilities of other agencies demonstrates flexibility with the Division of Labour, there is strong evidence from key informants at the global and country levels that this has diminished the intent of the Division of Labour with impacts on the technical expertise available for key population programming.

Another aspect of this is what some informants termed a “critical flaw” of the United Nations approach in relation to key populations. By focusing on low and lower middle-income countries and reducing support once countries reach upper middle-income status, the United Nations is ignoring the reality of inequalities in all countries, leaving behind those key populations where HIV incidence is still occurring but who are now no longer within the purview of United Nations support. Providing a solution to this dilemma is beyond the terms of this evaluation.

In Kenya and Ukraine, Joint Programme membership and in-country presence is larger. Kenya has 12 Cosponsor agencies (19 staff) and the UNAIDS Secretariat has seven staff; Ukraine has 10 Cosponsors (17 staff) and the UNAIDS Secretariat has five staff. While Cosponsor personnel in both countries are assigned to HIV issues, for the most part, these staff are not working exclusively on HIV or key populations; only Ukraine appears to have a full-time dedicated staff member working on key population responses.

Evidence from the case studies suggests that while capacity and staffing levels are an overall constraining force, the positioning of the Joint Programme is important in overcoming these challenges. The case study of Thailand provides evidence of a focused and strategic key population response despite low staffing levels. In this case, a technical assistance-based model, strongly aligned to identified needs of prioritized key populations has been central to the Joint Programme’s approach.

The Joint Programme faces critical challenges with generating and prioritizing the resources available for key population programming. The Independent Evaluation of the United Nations System Response to AIDS 2016-2019 highlighted the disconnect between the ambitious actions defined in the UBRAF 2016-2021 and the available resources to achieve those actions, as well as the challenges of mobilizing core funding for the Joint Programme, in part due to an inability to link funding to results. The Independent Evaluation also emphasised the lack of UBRAF guidance on the prioritization of strategic results areas or activities which, if strengthened, could support more strategic allocation of resources for activities that directly benefit key population groups.

Evidence from this evaluation supports these findings and notes the continued challenges facing the Joint Programme to generate and prioritize resources for key population programming. While UBRAF core budgets provide predictable funding and some prioritization of HIV, when distributed across seven regions and multiple countries, the resulting budgets can be small. Cosponsor agencies have generated resources over and above their core allocations but the ability to do so varies from agency to agency and raising funds specifically for key populations is difficult. Seeking additional funding can also have implications for the coherence of the Joint Programme (as explained in findings for evaluation questions 1 and 3) and can create potential competition among agencies for small amounts of resources. This also has implications for key population-led networks and organizations, as there are limited donors for rights-based key population work.

“Since the UBRAF funding cuts, Cosponsors are knocking on the same doors as everyone else, raising money for specific projects rather than playing ball with the Joint Programme, and this affects the overall coherence of the Programme” Global-level key informant

From the case studies, it seems the availability of staff reflects the availability of resources and can vary. In Ukraine, the WHO office has grown substantially since receiving additional donor funding, whereas UNODC has reduced its size, following the end of a donor-funded grant. From the donor’s perspective, this approach to staffing is appropriate as increased numbers of staff may be required commensurate to the scope and size of the project, but in terms of fulfilling core functions and responsibilities to the Division of Labour, agencies may continue to be under-resourced (for example, UNODC in Ukraine with two staff at 50%).

Country Envelope funding from UNAIDS (approximately US\$ 22 million globally *per annum*) is made available to Cosponsors at the country level based on a funding allocation model that prioritizes Fast-Track countries (like Cameroon, Kenya, Ukraine) as well as providing funds for other priority countries. Findings from the case studies show that Country Envelope funds range from US\$ 150 000 in Thailand and Peru, US\$ 300 000 in Ukraine, US\$ 350 000 in Cameroon to US\$ 600 000 in Kenya in 2018-2019 (there was no Country Envelope funding for Tunisia in 2018-2019) and that these figures have remained fairly constant over the evaluation period, with the exception of Tunisia, which received Country Envelope funding in 2020 (US\$ 97 800).

The process of allocating Country Envelope funding to Cosponsor agencies within a country has been difficult to determine and varies among countries. For example, the distribution of Country Envelope allocation across the agencies in Ukraine suggests it is allocated systematically across several Cosponsor agencies. Key informants at the global and country levels have reported on the challenges of using Country Envelope funds: they are small in volume and come with considerable reporting responsibilities, which can act as a disincentive for using these funds. This contrasts with the Business Unusual Funds, which appear more flexible and have also been used for key population-specific activities in Thailand and in Tunisia (100% of BUF budget; 45% of BUF budget respectively).⁵⁷ However, without stronger guidance on how UBRAF funds should be prioritized, resources for key population-specific funding are likely to continue to be insufficient.

The analysis below of UNAIDS financial data at the global and country levels has focused on Country Envelope budgets (not expenditures) as per accessibility of data⁵⁸. The analysis has raised questions

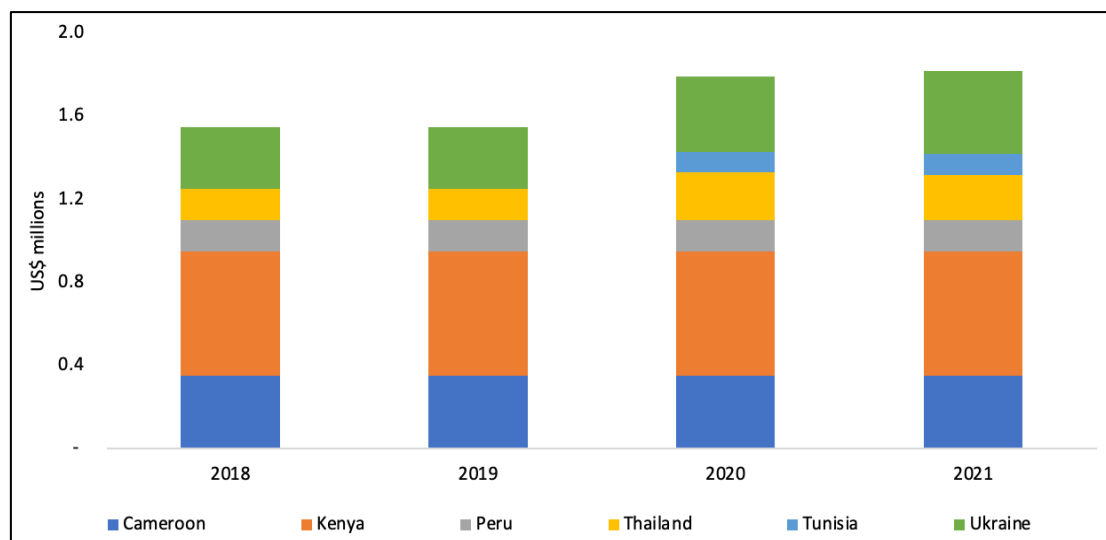
⁵⁷ For 2022-2023, there is no separate funding labelled “Business Unusual Fund”. The US\$ 3 million, which used to be referred to as BUF in the 2020-2021 biennium has been subsumed into the Country Envelope, which has increased to US\$ 25m. The allocation of the entire Country Envelope is reported to be based on the innovative and successful principles of BUF - merit-based proposals for time-limited, innovative, potentially high-risk and high-impact country initiatives and/or leveraging of resources that accelerate reaching the 2025 targets.

⁵⁸ The evaluation analysed budgets tagged only against Outputs 4.1 and 4.2, which relate to key populations (see below). Going beyond these outputs is potentially problematic as other outputs, such as 6.1, 6.2 and 6.3 for human rights, stigma and discrimination, will have benefitted key populations, but not exclusively. Output 4.1: Evidence-based HIV services for key populations implemented; Output 4.2: Comprehensive packages of harm reduction services established for people who inject drugs.

as to the quality and validity of the data both in terms of the completeness of budgetary data and in relation to the coding of activities within the Country Envelope. As such, the analysis and any findings derived from it should be interpreted with caution. Nonetheless, some overall observations can be drawn from the data for the period 2018 to 2021.

Finding 1: The budget for Cosponsor Country Envelope across all strategic results areas (SRA) has remained fairly consistent over time at the global level (*circa* US\$ 22 million per year) with some increases in case study countries. As shown in Figure 4, the Country Envelope budgets increased in some countries with the addition of the Business Unusual Fund.

Figure 4: Country Envelope budgets by case study country (2018-2021) ⁵⁹

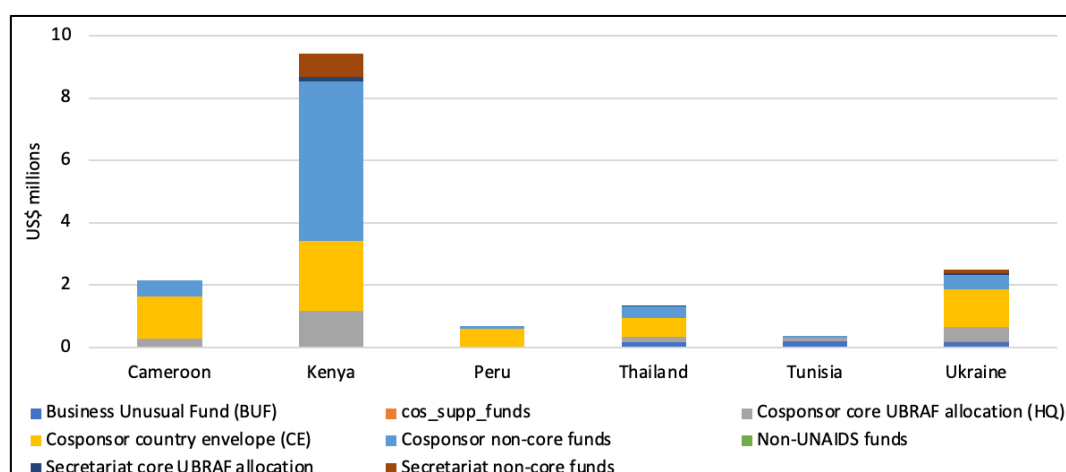


Source: Country Envelope databases shared by UNAIDS

Finding 2: The Country Envelope appears to comprise a substantial but varying proportion of total budgets (90% in Peru; 55% in Ukraine; 24% in Kenya). Figure 5 presents the total budget by funding source across all SRAs and agencies/cosponsors between 2018 and 2021. The variation in budget across categories, notably cosponsor non-core funds, over time suggests the data is incomplete. Unfortunately, it is not possible to disaggregate key population-related funding in non-core funds and this is a weakness in that it is difficult to get a sense of volume of investment in key population work across different sources of funding used by the Joint Programme. The high levels of non-core funds for Kenya can probably be attributed to the USAID project funding UNODC's MAT clinic for people who inject drugs.

⁵⁹ Includes Business Unusual Fund (BUF) budget in 2020 and 2021.

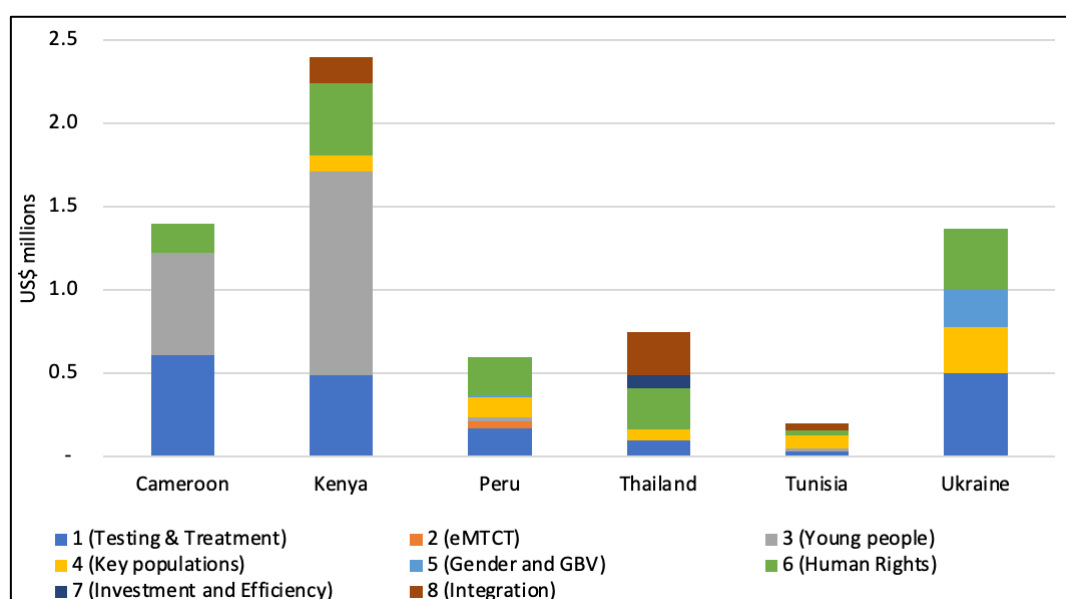
Figure 5: Total budget for case study countries by funding source (2018-2021)



Source: Download from JPMS, September 2021

Finding 3: The budget for SRA 4 (Key Populations) comprises 11% of the global budget for all SRAs, although this varies between countries, for instance from 0% in Cameroon to 39% in Tunisia. As shown in Figure 6 between 2018-2021 for the case study countries only, SRA1 (testing and treatment) has the largest budget (37%), followed by SRA 6 (human rights 27%), SRA 4 (key populations 21%), and SRA 5 (gender and GBV 16%). It is quite likely that other SRAs will include budgeted activities that are relevant or have a specific focus on some key population groups (such as SRA 6) but currently these are not captured in key population budget data.

Figure 6: Country Envelope budget for case study countries by strategic results areas (2018-2021) ⁶⁰

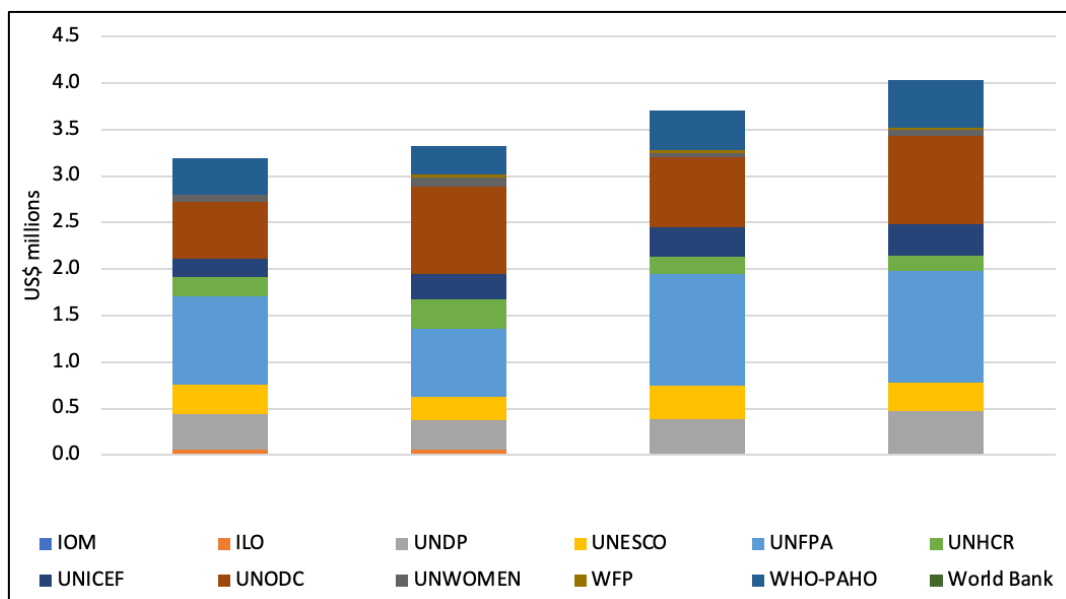


Source: Country Envelope databases shared by UNAIDS

Finding 4: The Cosponsors with the largest Country Envelope budget for Strategic Result Area 4 (key populations) globally for 2018-2021 are UNFPA (29%) and UNODC (23%), followed by WHO/PAHO (12%) and UNDP (11%) (Figure 7).

⁶⁰ Includes Business Unusual Fund (BUF) budget in 2020 and 2021.

Figure 7: Country Envelope budget for Strategic Results Area 4 by Cosponsor (2018-2021) ⁶¹



Source: Country Envelope databases shared by UNAIDS

The evidence suggests that the JPMS system is problematic in determining the investment, progress, and results of the Joint Programme’s work with key populations and this might have implications for Joint Programme funding. The evaluation used the JPMS as a key data source for understanding the content of the Joint Programme’s plans, activities and results at the country level, as well as for wider global and regional analysis (see Box 3). UBRAF output indicators are tied to national targets and are ‘distinct’ from Joint Programme activities, and thus identifying and capturing the contribution of the activities to country level change is problematic.

Related to this point, the weak quality of Joint Programme reporting and data in the JPMS makes it difficult to systematically identify, monitor and report on the level of investments and results of key population programming undertaken at the country level, thereby limiting the extent to which the key population data can be used for strategic analysis and programming. Key informants at the global and country levels raised significant concerns regarding the current system. They suggested that outputs and results could be developed in order to more closely reflect the work undertaken and in order to ensure there is a more identifiable ‘line of sight’ between investments (with appropriate and focused tagging) and outputs, and they also suggested that results for key populations could be strengthened. Having greater capacity to demonstrate results has been flagged as an important issue for keeping HIV on donor agendas, and for mobilization of resources.

⁶¹ Includes Business Unusual Fund (BUF) budget in 2020 and 2021.

Box 3: Challenges and issues with the current Joint Programme reporting system

- **The country reports are not comprehensive in relation to the respective work plans and result areas.** In some cases, a funded activity is listed with the funding amount and the relevant strategic result area. However, in many cases the lack of reference to specific numbered activities makes it difficult to correlate the extent to which key population activities were fully programmed and completed.
- **In most of these countries, there were examples of planned budgeted activities not being reported.** This applied to advocacy and awareness-raising activities and mentions of desired outcomes or granular detail around advocacy were absent.
- **For many countries it is unclear which populations are considered primary prioritized key populations** for specific countries or regions and the corresponding reasons why these populations are included in the JPMS are also unclear. There are examples of key population-allocated funding supporting refugees or displaced populations without an explanation or justification as to why those populations were deemed to be recipients of key population funding.
- The weakness of the “achievements, challenges, key future actions” format for reporting is the lack of space for analysis around why planned key population activities were either not programmed or not well reported, or why activities not included in the workplan were carried out.
- There appears to be a lack of quality control or oversight of the content being reported in the JPMS.

Additionally, evidence from the global and country levels highlight the role for more independent evaluation of the Joint Programme’s work in key populations and the need for greater use of theories of change. There is evidence of more frequent evaluations commissioned at the global level for example, the UNDP-commissioned evaluation of the Global Commission on HIV and the Law;⁶² the UNFPA evaluation of its work in HIV,⁶³ plus others. However, more regular country-based evaluation of Joint Programme interventions targeting key populations would help ensure that activities are relevant and impactful. Having greater key population representation in the development of Joint Programme plans, as per the findings, and in the design of activities – particularly for human rights and enabling environment interventions – may help strengthen monitoring, evaluation and accountability.

Related to this point, the more systematic use of theories of change that can also be used for monitoring and evaluation (M&E) purposes was cited as important by a diverse range of global stakeholders, particularly in relation to ‘translating’ the Global AIDS Strategy 2022-2026 into workable key population strategies and interventions.

4.2.4 EQ 6 (mobilizing and empowering key population organizations)

EQ 6: How effective is the Joint Programme in mobilizing and empowering key population-led organizations and networks in the monitoring and accountability of policies and programmes and the implementation of services?⁶⁴

High-level findings

- The Joint Programme has successfully convened and brokered relationships between governments and some key population groups and has supported engagement of these groups in national consultations, strategy and coordination processes and decision-making forums.
- However, the Joint Programme’s role in capacity-building of key organizations varies considerably in case study countries and is invariably small scale due to limited funding, with bilateral and multilateral donors and other funders doing much more.
- Challenges remain in ensuring key population engagement is influential in national planning and Global Fund funding requests, particularly for the prioritization of resources and ensuring planned allocations (for example, in funding requests) are translating into actual budgets for key population programming.

⁶² <https://erc.undp.org/evaluation/evaluations/detail/9380>

⁶³ <https://www.unfpa.org/admin-resource/evaluation-unfpa-support-hiv-response-2016-2019>

⁶⁴ Findings are based on strong evidence from multiple and triangulated sources, which include key informant interviews at the global level with Cosponsor agencies, donors, global key population networks, and country case study key informants.

Theory of change	The theory of change assumes that capacity-building of community networks and organizations enables meaningful engagement as equals in HIV and health governance, policy, planning and funding mechanisms. Having the capacity to advocate and lead the design and implementation of key population targeted services and societal enablers supports the implementation of people-centred services and should encourage greater access and uptake by key population groups. Joint Programme activities to strengthen the capacity of communities to monitor responses through the collection and use of their data should enable them to hold decision-makers and service providers accountable for their HIV commitments, helping to improve the quality, responsiveness, and uptake of services. Summary assessment: Evidence from the case studies suggests this assumption holds to some extent in that Joint Programme brokering of the involvement of key population-led organizations in HIV and health governance, policy, planning and funding mechanisms is in evidence, but the Joint Programme's role in capacity-building is less than assumed, with a significant degree of variance among countries in the extent to which the Joint Programme is engaged in supporting the mobilization and empowerment of key population-led organizations and the effectiveness of those efforts, also due in part to the small volume of funds available for such activities.
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The most common area of Joint Programme support for key population-led organizations across the case study countries is exercising the United Nations' convening power to broker their engagement in national programme consultation, coordination, and decision-making processes.

This brokering has been undertaken with government ministries, service providers and other partners in strategy and policy development, new or enhanced areas of programming, monitoring service implementation and consideration of law reforms. In countries with more mature key population programming, such as Kenya, some well capacitated and long-standing key population-led civil society organizations for sex workers and gay men and other men who have sex with men that have benefitted from long-term capacity-building by the Joint Programme and other partners are now no longer reliant on the Joint Programme's convening power to secure a seat at the table. This, however, is not the case for newer civil society organizations in Kenya, particularly those representing transgender people and people who inject drugs. There is some evidence of increased Cosponsor engagement with key population groups not previously or only minimally supported, for example, transgender people in Tunisia and young key populations in Thailand, while in other countries there is minimal Joint Programme support for some key population-led civil society organizations for example, transgender people and people who inject drugs in Cameroon.

There is limited evidence of Joint Team members in-country playing a role in alerting governments and key population civil society organizations to emerging issues. These issues might not have been considered in as timely a fashion if it were not for the United Nations' intervention and initiative. An example of this responding timely is the gender-sensitive management of transgender prisoners in Thailand. More generally, the adoption of a rights-based approach to HIV programming, albeit with differing levels of impact across the case study countries, can be seen to be a result of effective mobilization and advocacy by key population-led organizations, with the support of the Joint Programme.

The one key population group in the case study countries that has benefitted less from Joint Programme efforts in mobilizing and empowerment is prisoners, as deprivation of their liberties and the constraints of correctional systems mean that there are no key population-led organizations to work with.⁶⁵ UNODC has been doing work with prisoners in many countries, including the case study countries, and there is some evidence of the Joint Programme undertaking, in some countries, assessments of HIV-related needs of prisoners through situational assessments. These assessments have resulted in services to meet needs, for example, in Tunisia and Thailand, as well as the establishment of the UNODC civil society organization working group for prisoners.

⁶⁵ Although work could be done through support groups in many countries for former inmates now back in society.

There is variability in the extent to which Cosponsor agencies support the mobilization and empowerment of key populations. Across the case study countries, the Cosponsor agencies most commonly supporting key population groups were UNAIDS Secretariat and UNDP and to a lesser extent UNODC and UNFPA, with the amount of support varying by country. For example, in Peru, only the UNAIDS Secretariat and UNFPA have been providing support for the empowerment of key population-led organizations. In Kenya, key population organizations (representing sex workers and gay men and other men who have sex with men) did not feel they were adequately involved in the Joint Programme work, but perhaps did not appreciate that UNFPA supports and works through the Ministry of Health programme for sex workers as well as supporting a subregional sex worker programme. Key informants at the country and global levels were critical of Cosponsors that were not seen as fulfilling their obligations in the Division of Labour, with UNFPA being mentioned by many as not engaging with sex workers sufficiently, although this is variable by country. For example, in Tunisia UNFPA has been supporting organizational and programmatic capacity development of a civil society organization for sex workers.⁶⁶

Capacity-building of key population-led civil society organizations for service delivery is not routinely part of most country Joint Programme activities and is primarily supported and undertaken by major donors such as PEPFAR and the Global Fund. In these countries, the Joint Programme's work, often supported through regional catalytic funds, is related more to brokering and leveraging its convening power to secure a seat at the decision-making table for key population-led organizations.

However, in Thailand and Ukraine, the Joint Programme has complemented the service delivery-related capacity-building of donors by undertaking activities to promote the sustainability of the service delivery role of key population-led organizations (see findings for Evaluation Questions 8 and 10).

The extent to which the Joint Programme has effectively mobilized and empowered key population organizations is highly variable among countries, as is the capacity of key population organizations. Factors that appear to affect this are maturity of the epidemic (Thailand, Ukraine and Kenya would be examples of this), the extent to which Joint Team members have the resources and capacity to prioritize work with key populations and the overall capacity and prioritization of key population work by the Joint Programme, as well as the country's level of development. However, an assessment of the contribution of the Joint Programme to the mobilization and empowerment of key population-led organizations is complex, as capacity-building is often a long-term exercise and results are often the product of the combined efforts of different development partners.

⁶⁶ The variability in levels of support is perhaps the issue here. Although there is little support for sex workers in the case study countries, UNFPA has active and extensive support for sex workers in Bangladesh, Bhutan, Brazil, Ecuador, Georgia, Kyrgyzstan, India, Indonesia, Iran, Myanmar, Turkey, South Africa and Zimbabwe.

The **Ukraine and Thailand** case studies found Joint Programme capacity building efforts over many years have been effective in the development of strong and vocal key population organizations that are present on all relevant national coordination mechanisms and contribute meaningfully to the planning and implementation of the HIV response. This reflects the maturity of the HIV response in both countries and long-standing support for key population-led organizations from the Joint Programme and donors within a political and legal environment that does not prevent the capacity-building activities.

The **Kenya** case study found that apart from UNODC, Joint Programme capacity strengthening was ad hoc and lacking a plan or long-term vision. The focus of the Joint Programme has primarily been on people living with HIV rather than key population-specific networks. In contrast, UNODC has involved people who inject drugs and harm reduction networks in the design of opioid substitution therapy interventions and mentored some people who inject drugs to take on a leadership role.

The **Peru** case study concluded that, while key population-led organizations are actively involved in implementing services, they are not sufficiently capacitated to develop evidence-based advocacy strategies. Despite some Joint Programme capacity-building efforts, the participation of key population-led civil society organizations in planning, monitoring and evaluation has been largely absent.

Key population representatives are members of the country coordinating mechanism in all six case study countries and the Joint Programme's support for these key population members is the main form of assistance used for developing and then monitoring programmes. The Joint Programme commonly supports the participation of key populations in ongoing monitoring, especially in relation to their inputs to Global Fund application design and implementation. In most case study countries key populations are represented on the country coordinating mechanism in some capacity, including on oversight committees. For example: in Peru, representation on the country coordinating mechanism includes one woman sex worker, one transgender woman and one representative of indigenous people; in Ukraine, all five key population groups, including prisoners, are represented; in Tunisia, there is one sex worker and one representative of people who inject drugs and there is a vacant position for representation from gay men or other men who have sex with men. Little evidence was gathered on whether there are any mechanisms for feedback to the Joint Programme on the effectiveness of key population representation on country coordinating mechanisms, but respondents from Kenya suggest that the active presence of key population representation on the country coordinating mechanism has been beneficial to the process.

In **Tunisia**, the case study found that the Joint Programme has been effective in ensuring the participation of a range of key population-led civil society organizations in policy and programme planning exercises. However, the outcomes of the capacity-building are variable. While larger civil society organizations have the capacity to work with key populations, the capacity of community and local key population groups was found to be low, particularly in terms of integrating new knowledge approaches to their work. Cosponsors and civil society organizations described the potential for key population groups to leverage new knowledge for transformational changes, and to integrate it as part of their own community-based activities as very low. The more socioeconomically vulnerable the group is (such as people who inject drugs), the lower the return has been on capacity-building and empowerment.

The Joint Programme in **Cameroon** has championed the introduction of key population interventions in the national strategy and fostered the growing, albeit weak, participation of key population-led civil society organizations in service design and implementation. The Joint Programme has prioritized technical support aimed at improving the effectiveness of service delivery to the detriment of strengthening the organizational capacity of civil society organizations. Overall, there is an insufficient number of key population-led civil society organizations, which has limited the availability of community-level services. Notable limitations impacting on the effectiveness of the Joint Programme's support for key population-led organizations are the low number of civil society organizations mobilized, the very short time frame for funding and the low levels of funding, coupled with weak community-based organizational capacity.

However, there is little evidence of key population representation beyond Global Fund funding requests design, specifically, during the grant-making period. While grant-making should follow the fidelity of the plans in the Global Fund funding request, there are often changes made at this stage of the process, including with the trajectories of funding for specific key population activities or groups, or changes of grant sub-recipients.⁶⁷ The lack of key population presence in grant-making reduces grant accountability to key populations and has implications for grant implementation, with the potential to reduce the scale and impact of the key population response.

The Joint Programme support for key population representatives who sit on other national coordination mechanisms also contributes to empowering key population-led monitoring of programmes. For example, in Thailand, key population representatives and representatives of people living with HIV are involved in the committee monitoring the health sector's stigma and discrimination reduction efforts. The Joint Programme also commonly supports people living with HIV and key population groups in the conduct of Stigma Index surveys,⁶⁸ including capacity-building in survey planning, administration and analysis.

Evidence from the case study countries indicates that community-led monitoring, in the form of surveys of key populations and people living with HIV service users, is primarily being supported by PEPFAR and the Global Fund, with little involvement by the Joint Programme. However, there are examples from other countries (for example, Tanzania and Mozambique) where UNAIDS was

⁶⁷ The Global Fund Prospective Country Evaluation Synthesis Report for 2021 provides evidence of this, with budgets in the areas of human rights and gender equality declining in six of eight Country Envelope countries during the grant making process. HIV grant budgets mostly declined, particularly for prevention among key populations with budget declines for people who inject drugs, prisoners and gay men and other men who have sex with men.

https://www.theglobalfund.org/media/11081/terg_2021-pce-synthesis_report_en.pdf

⁶⁸ The stigma index focuses on the stigma experienced by people living with HIV - including additional layers of stigma experienced by key populations living with HIV. However, recent work piloting the Stigma Index 2.0 has paid more attention to the stigma and discrimination that exacerbates the vulnerability of key populations not living with HIV. Work on this is ongoing.

involved as a technical partner and supported by PEPFAR to conduct scoping assessments on community-based and community-led monitoring, as well as piloting and promoting more user-friendly community-led monitoring data collection, but these activities are not universal. In the case study countries, the evaluation did not find evidence of the Joint Programme complementing the work of others on community-led monitoring. There was no evidence it worked with governments and key population civil society organizations to incorporate community-led monitoring data into national monitoring and evaluation systems. Nor was there evidence it supported the use of community-led monitoring data in programming improvements. There was also no evidence of the Joint Programme addressing the sustainability of community-led monitoring in anticipation of donor exit by building the skills of selected regional key population networks to provide ongoing community-led monitoring technical support for civil society organizations at the country level.

4.2.5 EQ 7 (humanitarian settings and COVID-19)

EQ 7: How effective has the Joint Programme been in responding to key population needs in humanitarian settings and the COVID-19 pandemic ⁶⁹	
High-level findings	<ul style="list-style-type: none"> ■ The Joint Programme has been proactive in responding to the COVID-19 pandemic and initiatives have focused on mitigating the impact of the pandemic on key population groups. Flexible reprogramming of UBRAF funds and support to mobilize funds has facilitated action. ■ Available case study data for how the Joint Programme has responded to key population needs in humanitarian settings is very limited. It is therefore difficult to determine the extent to which key population groups, as defined for the purposes of this evaluation, are being targeted and addressed through the Joint Programme's humanitarian work. ■ There are concerns that the Joint Programme's strategic pivot to addressing the dual pandemics of HIV and COVID-19 and pandemic preparedness will reduce attention to HIV and specifically key population programming at a time when this should be scaled up.
Theory of change	<p>The theory of change assumes that Joint Programme responses to the COVID-19 pandemic mobilize emergency funding to limit the impact on services targeting different key population groups and support community-led innovations. In theory, the centrality of community-adapted innovations supports the strengthening and resilience of community health through flexible and responsive approaches that enable access to services for different key population groups. Summary assessment: The evaluation finds evidence for the Joint Programme's role in mobilizing emergency funding, some of which has been used to alleviate the impacts of COVID-19 through cash transfers. There is also some evidence for Joint Programme support to more flexible service delivery models and social protection systems, which could benefit key population groups. However, as with other evidence for this evaluation, it is difficult to determine the true extent to which different key population groups are supported through Joint Programme work, as interventions for COVID-19 responses have been a combination of general support to the health system (such as personal protective equipment (PPE)), key populations and other vulnerable populations.</p>

The evidence from the country case studies indicate that the Joint Programme has been proactive and flexible in addressing COVID-19-related challenges affecting HIV and key populations. There is strong evidence that the Secretariat and Cosponsor agencies have been proactive in developing and implementing activities, often with key population groups, aimed at mitigating the impacts of the pandemic on HIV programming, key populations, migrant populations (particularly Peru), and internally displaced people (particularly Cameroon). The UNAIDS Secretariat has played an important role in rapidly mobilizing and coordinating Joint Programme COVID-19 advocacy and technical

⁶⁹ Evidence for findings in this section on COVID-19 is strong - derived from global key informant interviews (all the main global key population networks, Cosponsor agencies and UNAIDS Secretariat staff); global documentary evidence including all the resources on the Global Prevention Coalition website pertaining to COVID-19; Global AIDS Strategy 2022-2026; Global AIDS Report 2021. Country-based evidence is derived from key informant interviews (national authorities, key population networks, Joint team members and partners) and COVID-19 relevant documentation. Available evidence for Joint Programme work in humanitarian settings regarding key population is considerably less.

support efforts. Cosponsor agencies have also mobilized to address emerging issues: with UNICEF, UNFPA, and UN Women purchasing 47 000 doses of dolutegravir (DTG) 50 mg. This emergency procurement is reported to have assisted key populations living with HIV; UNFPA and WHO funded personal protective equipment (PPE), which was distributed to the National AIDS Programme and civil society organization personnel in Tunisia; UNAIDS Secretariat and UNICEF have raised awareness and communicated COVID-19-related issues to key population groups in Kenya, Thailand and Peru; WHO has supported the development of technical guidance and the acceleration of flexible service delivery approaches in Ukraine and Thailand; and UNAIDS has supported research, data generation and lessons learned on the impacts of the pandemic on specific key population groups, such as sex workers in Thailand.⁷⁰

Case study evidence points to the role and contribution of the Joint Programme's COVID-19 responses in generating resources. These range from reprogramming UBRAF funds and use of Business Unusual Funds and supporting efforts to access emergency international funding, some of which has been directed to ensure continuation of key population services and welfare support. In this regard, the Joint Programme provided technical support to national authorities to access Global Fund pandemic emergency funding in Ukraine, Peru, and Kenya. For example, in Tunisia, US\$ 1.5m was secured from the Global Fund for 2021 for emergency support to COVID-19, in addition to the US\$ 235 000 in 2020.

While support has largely focused on addressing the more immediate impacts of the pandemic, the Joint Programme plays a role in supporting systems that could, in time, contribute to sustaining key population responses. Examples of these supporting systems include: strengthening community delivery and support systems through key population involvement in COVID-19 service delivery initiatives; providing support to emergency social protection systems that are inclusive of key populations, and have the potential to be absorbed by national authorities; and generating data and related advocacy on the impacts of COVID-19 on key populations, as mentioned below in Thailand. More details of these examples are provided in the boxes below.

Joint Programme social protection initiatives have been extended to include key populations. Existing Joint Programme funds have been reprogrammed to provide essential welfare support to key population groups whose livelihoods have been heavily impacted by COVID-19. These programmes have often been implemented by key population groups as observed in Peru and Thailand.

In **Peru**, there has been a strong key population focus to the United Nations' COVID-19 response, which has been led and coordinated by WFP and builds on WFP social protection work targeting migrants. WFP and the UNAIDS Secretariat developed a new care initiative for migrants through cash transfers, which has been extended and tailored to address transgender women, women and girl sex workers and gay men and other men who have sex with men (current phase is reportedly reaching 1 800 people from these key population groups). Support from Global Fund and USAID has enabled scale-up. WFP is advocating for the programme to be added to the Ministry of Social Inclusion's existing social protection programme.

In **Thailand** reprogramming of UBRAF funds allocated to UNDP and UNODC enabled UNDP to provide small grants of approximately US\$ 10 000 each to four sex worker and LGBTIQ+ organizations in Bangkok, and three provinces, to procure food, water and PPE over a short term (three-month) period for 3 200 LGBTIQ+ people and sex workers.

⁷⁰ Service Workers In Group Foundation (SWING) and UNAIDS Thailand, A Community-Led Rapid Assessment of the Impact of COVID-19 on Sex Workers (Thailand). 2020 and also featured on UNAIDS website. <https://www.unaids.org/en/keywords/thailand>. The study seems to have informed related articles and documents, for example. [file:///C:/Users/Clare/Downloads/seajph2020v9n2p100-eng%20\(1\).pdf](file:///C:/Users/Clare/Downloads/seajph2020v9n2p100-eng%20(1).pdf)

Technical support for the development of COVID-19-related guidelines and for the promotion of differentiated service delivery models such as multi month dispensing (MMD) has been accelerated in Ukraine, Kenya, and Thailand. However, there is limited data available regarding the number of key population beneficiaries reached.

WHO **Ukraine** has supported the development of COVID-19-related guidance for service providers, including the transition of OST patients to take-home administration, delivery of ART by mail, extension of ART prescription, and decentralization of clinical and laboratory services. In Kenya, in partnership with NASCOP, civil society organizations and Kenya Red Cross, UNODC developed a mobile van service to dispense methadone to MAT clients close to their home during curfew and other COVID-19-related restrictions on mobility. UNODC advocacy supported the development of a standard operating procedure (SOP) for home dosing (5 days' medicine in pre-packed containers). Advocacy is being done with the Pharmacies and Poisons Board (PBB) to consider scale-up to address barriers related to distance to the clinic and daily dosing. Some of the advocacy by UNODC and civil society organizations has not been successful due to lack of resources or other policy issues.

At the global level, there is strong documentary and key informant evidence for the significant investment by the Joint Programme in supporting COVID-19 responses through leveraging global and national HIV responses and infrastructure and through the promotion and development of human rights-based strategies. Lessons learned documents and programmatic guidance related to or targeting key populations in the COVID-19 era also exists (available for sex workers, prisoners and people who inject drugs) some of which have been developed in collaboration with global key population networks.⁷¹ The focus of the Global AIDS Strategy 2022-2026 on addressing inequalities and the latest World AIDS Day report 2021 provide evidence of a pivot in the Joint Programme's strategic orientation towards addressing the inequalities of the dual HIV and COVID-19 pandemics and increasing pandemic preparedness and response, by focusing on building health systems' resilience and community-led responses, and by strengthening local data and surveillance systems. While there is a strong logic to the approach, key informants have expressed concerns about the 'drift' in direction towards COVID-19 and pandemic preparedness, in relation to the core mandate of the Joint Programme suggesting that a rebalance is needed to ensure HIV and targeted key population responses remain 'in focus'.

The evaluation's evidence for Joint Programme responses to key population needs in humanitarian settings is very limited and is discussed largely in relation to responses to COVID-19. Joint Programme responses to addressing key population needs in humanitarian settings is most prominent in the Peru case study where the Joint Programme has responded to a request from the Government to address the health needs of migrants – considered to be a key population in Peru. Within this context there is evidence of UNHCR, the International Organization for Migration (IOM) and WFP supporting the linking and access of migrant populations from Venezuela to HIV/sexual and reproductive health services. In Kenya, there is also some limited evidence of UNHCR supporting HIV testing for 250 LGBTIQ+ people in Kakuma refugee camp. However, from the case study data, it is difficult to determine the extent to which key population groups, as defined for the purposes of this evaluation, are being targeted and addressed through the Joint Programme.

⁷¹ 20200909_Lessons-HIV-COVID19.pdf; UNAIDS Rights in the time of COVID-19, 2020; World AIDS Day 2020 Prevailing Against Pandemics (UNAIDS, Dec 2020); World AIDS Day 2021 Unequal, Unprepared, Under Threat (UNAIDS, Dec 2021); <https://hivpreventioncoalition.unaids.org/resource/strategic-considerations-for-mitigating-the-impact-of-covid-19-on-key-population-focused-hiv-programs-may-2020/>; <https://hivpreventioncoalition.unaids.org/resource/covid-19-hiv-prevention-treatment-care-and-support-for-people-who-use-drugs> and many more Cosponsor reports and information sheets housed on Cosponsor websites and GPC website (resources page).

4.2.6 EQ 5 (achieving outputs/areas for strengthening) and EQ 8 (contribution to services, promotion of human rights, gender equality and decriminalization, and sustainable financing)

EQ 5: How well is the Joint Programme implementing activities for key populations and achieving the UBRAF outputs? Which areas require further strengthening and why?

EQ 8: How effective is the Joint Programme in contributing to: 1) provision of comprehensive services for key population groups, including the most vulnerable groups; 2) promotion of human rights, gender equality and the removal/reduction of criminal and discriminatory laws and stigma and discrimination; and 3) sustainable financing and programming mechanisms for key population groups?⁷²

High-level findings	<ul style="list-style-type: none"> Overall, data and evidence for the Joint Programme's activities is available; data and evidence for the results and achievements of the Joint Programme's work is significantly more challenging. There is evidence that Joint Programme activities have updated and integrated evidence into policies, guidance and implementation models and this is contributing to the enhanced service delivery approaches or increased provision of services for key populations. Joint Programme activities have increased legal and policy literacy among key population organizations, which has helped with advocacy and community mobilization in support of policy and legislative change. Human rights work is informing HIV strategy and policy documents but progress in law reform and significant policy change in the enabling environment has been slow. Compared to intermediate outcomes 2 and 3, and with the exception of Thailand and Ukraine, fewer activities have focused on developing and implementing sustainable financing and programming mechanisms for key population groups, representing a strategic gap.
Theory of change	<p>Comprehensive service packages: The theory of change assumes that the generation of strengthened and disaggregated key population-related data will inform strategic planning processes and, coupled with advocacy, this will in theory lead to the increased funding of and support to scale up of comprehensive and integrated services packages for key populations.</p> <p>Summary assessment: Evidence from the case studies suggest this assumption is correct although not on the scale needed to meet coverage targets nor sufficiently comprehensive to meet both broader needs common to all key population groups and key population-specific needs. While there is evidence of disaggregated key population data informing planning, more disaggregated data is needed.</p> <p>Enabling environment: The theory of change assumes that Joint Programme activities in human rights and gender equality programming for key populations, and the work on reducing legal, policy and societal barriers to accessing services, will in theory catalyse legal and policy change and support shifts in societal behaviours and attitudes.</p> <p>Summary assessment: The evaluation finds this assumption is correct and that the activities undertaken are a critical component of successful key population responses but evidence indicates they have yet to yield significant progress in changing the enabling environment that hinders access to and provision of health services for key populations. Furthermore, the 'input' nature of some activities (workshops, training) presents additional challenges for sustainability.</p> <p>Sustainability: The theory of change assumes that Joint Programme support to sustainability planning will enable stable and equitable funding of key population programmes.</p> <p>Summary assessment: Evidence from country case studies indicates that the assumption does not hold true as most countries have not undertaken substantive financial sustainability activities, with the exceptions of Thailand and Ukraine, where the assumption appears to hold.</p>

⁷² Evidence to support the findings in this section are derived from country case study key informant interviews and documentary sources. The data and documentation sources are generally of good quality. There is, however, some variance in the strength of evidence for the Joint Programmes contribution to intermediate outcomes in instances where a range of partners have been undertaking similar or complementary activities and intermediate outcomes may have resulted from various outputs. In these instances, it is plausible that the Joint Programme has made a contribution to achievement of an intermediate outcome, but a definitive link cannot be established.

The evaluation examined the effectiveness of the Joint Programme at the country level in implementing activities for key populations and achieving outputs and contributing to intermediate outcomes, as defined by the theory of change (see Figure 3). The three tables below set out examples of activities from Joint Programme country plans and their contributions to the three intermediate outcomes in the theory of change:

1. Increased provision of comprehensive and integrated service packages for key populations, including the most vulnerable key population groups.
2. Policy changes enacted, criminal and discriminatory laws repealed and stigma and discrimination reduced.
3. Sustainable financing and programming mechanisms for key populations.

Data in these tables are drawn from the six country case studies. The selection of activities includes the more significant outputs and contributions to intermediate outcomes, while also, within the limitations of space, presenting a somewhat illustrative range of activity types.^{73, 74}

There is evidence for the catalytic nature of Joint Programme activities that have contributed directly or plausibly to the achievement of intermediate outcomes. However, it should be noted that the selection of examples was mostly oriented towards activities that have contributed to intermediate outcomes and therefore presents the overall achievements of the Joint Programme in a more positive way than is the case. As noted in the findings for Evaluation Question 4, there is much less evidence for the results of the Joint Programme's work or for the use of theories of change that could have explained how planned activities intended to bring about change. This may impact negatively on the effective design of activities to catalyse change and may also account for the difficulty some Joint Team members across case study countries had in articulating their agencies' contribution to intermediate outcomes. Similarly, the extent to which activities such as trainings and workshops contribute to intermediate outcomes is questionable.

⁷³ A core activity of the Joint Programme is advocacy, which in theory generates political will, sustained engagement and conditions that support Joint Programme outputs, thereby contributing towards intermediate outcomes. As advocacy is a cross-cutting activity that can contribute to all three of the Joint Programme's intermediate outcomes, it is not shown in the Joint Programme activity boxes in each of the tables in this section.

⁷⁴ Findings in relation to capacity-building of key population networks are outlined in Section 5.4 on mobilization and empowerment of key population-led organizations.

Increased provision of comprehensive and integrated service packages for key populations, including the most vulnerable key population groups (refer to the theory of change in Figure 3, orange boxes)

Joint Programme activities	Joint Programme outputs	Joint Programme contributions (to intermediate outcomes)
Generation of key population-related data: size estimates; disaggregated data by sex and age; gender analysis of key populations; specific studies, baselines and assessments	Data informs strategic planning processes, which support investment in high impact health and enabling strategies and interventions targeting high burden key population groups and locations	Increased provision of comprehensive and integrated service packages targeting key populations including young key populations in user-friendly/safe settings
Activity	Outputs	Intermediate outcomes
Thailand: PrEP scale up <ul style="list-style-type: none"> UNAIDS Secretariat initiated study to estimate the number of people who would benefit from PrEP UNAIDS Secretariat supported development of a national PrEP M&E framework for use in a national pilot and provided technical support for the pilot UNICEF supported PrEP pilot for adolescents 	<ul style="list-style-type: none"> Study found that 148 500 people would benefit from PrEP – more than seven times the number enrolled in 2020 M&E data demonstrated that the PrEP pilot was successfully implemented with no adverse findings PrEP was demonstrated to be suitable and feasible for adolescents by the pilot project 	<ul style="list-style-type: none"> Estimation study was influential in demonstrating the need for PrEP scale-up Successful pilot resulted in national adoption of PrEP and inclusion in universal health coverage benefits package, with scale up to 150 health facilities with no cap on enrollees PrEP for adolescents included in national guidelines, with no requirement for parental consent
Tunisia: Generation of transgender strategic info <ul style="list-style-type: none"> UNFPA support for mapping of transgender populations Advocacy by UNAIDS country office and UNFPA using data from the mapping study 	<ul style="list-style-type: none"> Data generated on transgender population, including behavioural data and identification of service needs 	<ul style="list-style-type: none"> Mapping study facilitated inclusion of transgender-focused interventions in the National AIDS Strategy, with a coverage target
Systems and services including for young key populations and prisoners Capacity-building; policy, guidance, tools, evidence, road maps; comprehensive key population service packages, linked/integrated with other services; innovative service delivery models	People-centred comprehensive service packages established and innovative service delivery models. Linkages to other health/social services	Increased provision of comprehensive and integrated service packages targeting key populations including young key populations in user-friendly/safe settings
Activity	Outputs	Intermediate outcomes
Thailand: Bangkok Fast-Track cities - UNAIDS Secretariat, UNICEF and UNODC technical support, in collaboration with PEPFAR, key population civil society organizations and other partners, to enhance city council HIV health services, with a focus on key populations	<ul style="list-style-type: none"> Optimized HIV testing and treatment services and PrEP uptake in city council health clinics 	<ul style="list-style-type: none"> Significant improvement in performance against the 90-90-90 targets. Integration of HIV testing into all Bangkok Metropolitan Administration primary health clinics with a 90% uptake rate for same day ART initiation. Integration of antiretrovirals into selected primary health care clinics to improve access. Higher HIV testing and PrEP. Uptake rates in key population civil society organization services, including for young key populations

Ukraine: optimization of testing, treatment & PrEP- WHO advocacy and technical support on HIV testing, treatment and PrEP. UNDP support for cost-effective ARV procurement	<ul style="list-style-type: none"> Revised national HIV testing and treatment protocol including a simplified HIV testing algorithm, test and start, an ART adherence standard, ART optimization, and a PrEP service standard 	<ul style="list-style-type: none"> Median time from HIV testing to ART initiation decreased from three months to two weeks. Significant cost savings achieved from ART optimization Cost savings of 89% in ARV procurement
Kenya: OST/MAT scale up - UNODC technical support to national and county governments, civil society organizations and the Pharmacy and Poisons Board (PPB) for scale up of MAT	<ul style="list-style-type: none"> National and county MAT guidelines, standard operating procedures and training manuals for health facilities and prisons developed Enabling environment for MAT clinics at the county level established PPB regulation of methadone promulgated Minimum standards for methadone dispensing pharmacies established 	<ul style="list-style-type: none"> Establishment of six MAT clinics, including one prison clinic, and enrolled 60% of all MAT clients nationwide Government scale-up of MAT clinics in other counties Enrolment of 26% of the estimated total population of people who inject drugs in MAT achieved National management of methadone through PPB national guidance and regulation strengthened
Tunisia: expansion of integrated services for prisoners - UNODC rapid situation assessment of HIV, STIs, hepatitis and TB in prisons and technical support to the Ministry of Justice on strategy and services development	<ul style="list-style-type: none"> Ministry of Justice national strategy for drug and HIV prevention, testing and treatment and care in prisons developed UNODC capacity-building of civil society organizations to deliver integrated services to prison inmates on release 	<ul style="list-style-type: none"> Voluntary HIV testing and treatment services available in 12 prisons Reintegration, harm reduction, HIV, hepatitis, TB and substance use services provided to inmates post-release
Cameroon: improvements in HIV service delivery - Joint Programme technical support to Global Fund and PEPFAR funded health services	<ul style="list-style-type: none"> Improvement in HIV service packages for key populations 	<ul style="list-style-type: none"> The Joint Programme has plausibly contributed to improvements in test and treat, ongoing tracking of people living with HIV on ART, differentiated service delivery, integration of HIV, TB, STI, hepatitis and SRH services, with increased key population community participation
Ukraine: Integration of HIV in gender-based violence services - UNFPA technical support for integration of HIV testing into gender-based violence services	<ul style="list-style-type: none"> Intervention design, piloting and guideline development 	<ul style="list-style-type: none"> UNFPA technical support directly contributed to integration of HIV testing into gender-based violence services at the local level
Peru: improving access to ART - WHO technical support on decentralization of ART	<ul style="list-style-type: none"> Expansion of ART prescribing and management to primary health care facilities 	<ul style="list-style-type: none"> WHO catalysed improved access to ART through expansion to primary health care facilities, with multi month dispensing
Ukraine: scale-up of services for drug users - UNODC technical support on needs of new psychoactive substance users and advocacy to MoH on OST scale up	<ul style="list-style-type: none"> Detailed assessment of the service needs of new psychoactive substance users, intervention development and piloting by UNODC 	<ul style="list-style-type: none"> Access to treatment services for new psychoactive substance users improved OST scale-up in the community and introduction to prisons

There is strong evidence across the case studies that Joint Programme activities in relation to data collection and analysis, including disaggregated key population data, has informed planning processes and supported investment in key population-focused or relevant health services.

Examples in the table above include the PrEP data collection in Thailand, which contributed to national scale-up and the inclusion of transgender-focused interventions in the Tunisia National AIDS Strategy following a UNFPA-supported mapping exercise. There is also evidence from the case studies (not included in the table) of disaggregated key population data informing priorities in Global Fund funding requests. For example, a Joint Programme-supported integrated biological and behavioural study of people who inject drugs in Thailand was used by the UNAIDS Secretariat to broker a significant scale-up of Global Fund activities, including community-led programming.

There is strong evidence of the Joint Programme contributing to the updating and integration of evidence in policies, guidance and implementation models, which is contributing to enhanced service delivery approaches and/or increased provision of services. Examples from the table above include broader programming of relevance to key populations such as revised testing and treatment guidelines, decentralization of care and treatment to primary care and improving HIV testing and PrEP uptake rates. As noted in a high-level finding on the relevance and coherence of the Joint Programme's work, a higher proportion of Joint Programme activities in case study countries focus on broader programming that is relevant to key populations compared to programming that targets the needs of specific key population groups. There is evidence from the country case studies that a better balance between these two types of programming is needed to comprehensively address the needs of key populations. For example, young key population programming is mostly under-resourced, despite evidence from some countries (for example, Thailand) that this group accounts for a high proportion of new infections. Another example is that *comprehensive* harm reduction programming for people who inject drugs is often absent or not taken to scale due to political sensitivities. There is, however, an increase in programming to meet the specific needs of transgender people, who are no longer lumped in with programming for gay men and other men who have sex with men.

Policy changes enacted, criminal and discriminatory laws repealed and stigma and discrimination reduced⁷⁵ (refer to the theory of change in Figure 3 orange boxes)

Joint Programme activities	Joint Programme outputs	Joint Programme contributions (to Intermediate outcomes)
Addressing societal barriers for key populations including young key populations: Stigma Index 2.0; settings-based training; monitoring of discriminatory laws and policies; human rights violation mechanisms; access to justice initiatives	Legal and policy reforms catalysed and capacity for legal literacy and access to justice expanded. Constituencies mobilized to eliminate stigma and discrimination in different settings	Policy changes enacted; removal of criminal and discriminatory laws; stigma and discrimination reduced
Activities	Outputs	Intermediate outcomes
Thailand: development of strategic information - Multiple UNDP-commissioned studies: national survey on experiences of discrimination and social attitudes towards LGBTIQ+ people, qualitative research on stigma and discrimination against transgender people in accessing	Strong evidence that these studies have increased legal and policy literacy among key population groups who have used findings in development of legislative and policy proposals (for example, legal gender recognition) and advocacy	No intermediate outcomes achieved to date – work in progress. Strong evidence of UNDP support for mobilization of LGBTIQ+ groups in support of findings and recommendations that are being considered by government agencies and parliamentary committees

⁷⁵ Information on the design of the Joint Programme's activities in relation to human rights, gender equality and more vulnerable key population groups is in Section 4.2.2.

health care; and a legal and policy review of legal gender recognition		
Ukraine: human rights protection - Promotion of human rights for key populations by Joint Programme in collaboration with key population groups	<ul style="list-style-type: none"> ■ Advocacy on human rights issues by Joint Programme ■ Human rights-related capacity-building by UNDP ■ Advocacy to mainstream human rights in national policy development and local Fast-Track cities programming ■ Assessment of policies and laws 	Joint Programme advocacy has been instrumental in the prioritization of human rights principles and stigma reduction in key programmatic documents and an overall improvement in the enabling environment. Joint Programme advocacy plausibly contributed to the Government's adoption of the Strategy for a Comprehensive Response to Human Rights-Related Barriers to Accessing HIV and TB Services, including incorporation of priority actions recommended by the Global HIV Prevention Coalition
Kenya: stigma and discrimination reduction - The Joint Programme, particularly UNDP, has been engaged in stigma and discrimination reduction advocacy activities with key population networks and other partners for a number of years	Joint Programme support has plausibly catalysed progress in stigma and reduction activities and contributed to mobilization of key population communities on this issue	The Joint Programme has plausibly contributed to the Kenya Stigma Index survey finding of a reduction in the overall index for people living with HIV and key populations from 45% in 2014 to 23% in 2021, although other partners have also contributed
Cameroon: Promotion of human rights - Joint Programme activities to promote removal of punitive laws, policies, practices, and stigma and discrimination reduction	Joint Programme advocacy, training, and data dissemination	Punitive laws, policies and practices remain in place, but Joint Programme activities have plausibly contributed to improved social tolerance of key populations and a reduction in stigma and discrimination

There is strong evidence that Joint Programme activities have increased legal and policy literacy among key population organizations. This increase in literacy has been used as a foundation for advocacy and community mobilization in support of policy and legislative change. While there is evidence from case study countries of human rights informing HIV strategy and policy documents, progress in law reform and significant policy change in the broader enabling environment (that is, non-HIV-specific) has been slow due to hostile social and political environments.

Joint Programme activities to promote human rights in the case study countries have primarily focused on generation of strategic information (for example, research reports), related advocacy, curriculum development for trainings, workshops and consultations aimed at policy and law changes. UNAIDS Secretariat and UNDP in Thailand have played an important convening and brokering role to ensure a seat at the table for key population organizations to advocate for reform agendas to governments. This has been particularly important for smaller civil society organizations and those representing more marginalized groups, such as transgender people and people who inject drugs, and, in some countries, for sex workers and gay men and other men who have sex with men.

Joint Programme support for activities to reduce stigma and discrimination has taken place in each of the case study countries. While some country case studies report reductions in stigma and discrimination, this varies from incremental to more substantive. Stigma and discrimination are seen by many key informants across case study countries as the most significant barriers to key populations accessing services. Global key population network representatives observe that Joint Programme stigma and discrimination activities at the country level are primarily focused on people

living with HIV and HIV-related stigma, with a lesser focus on stigma related to key population groups such as homophobia.

Sustainable financing and programming mechanisms for key populations (refer to the theory of change in Figure 3 orange boxes)

Joint Programme activities	Joint Programme outputs	Joint Programme contributions (to Intermediate outcomes)
Supporting resource generation for key population responses: National strategic plans/Global Fund/PEPFAR planning; resource mobilization strategies; sustainable financing; social contracting mechanisms; integration with universal health coverage, health insurance and social welfare systems; emergency COVID-19 funding for key populations	Domestic and external resources mobilized based on national strategic plans and/or sustainable financing mechanisms for health and other social sectors	Sustainable financing mechanisms and integrated key population services implemented
Activity	Outputs	Intermediate outcomes
Thailand: sustainable programme mechanisms for key population-led civil society organizations - UNAIDS Secretariat brokered a study on international best practices for government certification of civil society organization community health workers (CHWs) as a component of government accreditation of HIV civil society organizations, coupled with advocacy to the Ministry of Public Health (MoPH)	Agreement by the MoPH to establish HIV civil society organization accreditation and community health worker certification mechanisms as prerequisites to enable universal health coverage funding of civil society organizations	<ul style="list-style-type: none"> MoPH regulation for accreditation of civil society organizations as providers of select clinical services, including HIV screening and dispensing of PrEP and ART prescribed by a physician MoPH community health worker certification implementation guide issued
Thailand: Universal health coverage funding of civil society organization services - World Bank commissioned studies on social contracting models for HIV civil society organization service delivery and a cost analysis of civil society organization services for key populations	Studies published and used as a platform for discussions between the Joint Programme and government officials on a sustainable model for funding HIV civil society organization services under universal health coverage	Agreement in principle by government officials with the social contracting of civil society organizations under universal health coverage. Ongoing work being undertaken
Ukraine: Domestic resources mobilized - Advocacy by UNAIDS country office and civil society organizations to increase government HIV budget, including for prevention programming <ul style="list-style-type: none"> UNAIDS country office technical support to Government on prevention programming mechanisms 	Funding procedures, service packages and quality criteria established (with UNAIDS country office technical assistance) for government-funded prevention programming	<ul style="list-style-type: none"> Government of Ukraine commitment in 2018 to increase funding of HIV prevention by 80% over three years Government of Ukraine HIV budget increased from US\$ 12.5 million in 2016 to US\$ 32 million in 2020 Social contracting mechanism for a basic package of civil society organization prevention services for key populations established by MoPH in 2019
Kenya: Global Fund supported key population programming scaled up - Joint Programme	Global Fund funding request reflects key population programming priorities	Kenya's current Global Fund grant includes US\$ 23 million for key population programming, enabling

technical inputs, consultant support and facilitation of the involvement of all key population groups in developing the most recent Global Fund funding request		scale-up of services in existing counties and expansion of key population coverage to 11 additional counties, with all of Kenya's 47 counties now providing key population services
Tunisia: Global Fund transition strategy - Joint Programme brokered technical support for the country coordinating mechanism for a sustainability risk analysis and development of a Global Fund transition strategy	Transition strategy for Global Fund exit developed	Feasibility of the transition strategy is uncertain as the Government's commitment to investing in HIV programming and key populations is weak

Across the case study countries there has been significantly less work by the Joint Programme related to intermediate outcome 3 on developing and implementing sustainable financing and programming mechanisms for key population groups, compared to the level of effort on intermediate outcomes 1 and 2.

In Cameroon, Kenya and Peru there is no evidence of the Joint Programme undertaking substantive work to address sustainable financing for key population programming or more broadly, with the exception of the WFP in Peru, which is seeking to leverage government adoption of its key population social protection programme. Of the case studies, the Joint Programme has only made significant progress in Thailand and Ukraine in relation to sustainable programming and financing mechanisms for key populations (see Evaluation Question 10).

There is strong evidence in all case study countries of the Joint Programme's involvement in the development of Global Fund funding requests that in several countries has resulted in the mobilization of significant levels of resources for key population programming where government funding has been at a low or non-existent level (for example, Thailand for people who inject drugs and Kenya for transgender people and people who inject drugs). Depending on Global Fund transition timelines, this may only represent a short-term fix as external donor funding is in essence not sustainable.

The overall low level of prioritization for sustainable financing and programming mechanisms across most of the six country case study countries represents a significant strategic gap.

4.2.7 EQ 9 (contextual factors) and EQ 10 (sustainability)

EQ 9: How well is the Joint Programme responding to influential contextual factors?	
EQ 10: How sustainable are the results of the Joint Programme's work, particularly for key population-led organizations and responses?⁷⁶	
High-level findings	<ul style="list-style-type: none"> ■ Global and country evidence for how the Joint Programme is responding to contextual factors is limited but in the more mature key population epidemics, the Joint Programme is responding to issues concerning the sustainability of the key population programming. ■ Although sustainable financing and programming mechanisms to support key population-led responses is recognized globally as essential, this has not been a priority area of work for Joint Teams in the countries studied. ■ Many transition strategies have not worked due to limited government ownership and are therefore aspirational in nature and unlikely to result in sustainability. ■ For key population programming there is a need to: i) sustain donor support for key population programming; ii) advocate for a greater domestic share of key population programming from domestic allocations; and iii) support efforts to integrate key population programmes and costs in universal health coverage.
Theory of change	<p>Sustainability: The theory of change assumes that Joint Programme activities to strengthen strategic and sustainability planning will result in more stable and sustainable financing and programming mechanisms for key population services. Summary assessment: As before, evidence from country case studies indicates that the assumption falls short as most countries have not undertaken substantive financial sustainability activities, with the exceptions of Thailand and Ukraine where the assumption appears to hold. Also, there is limited evidence for transition strategies generating sufficient political priority and ownership by governments. Understanding the political economy and why the underlying assumptions for change are not happening will be important going forward.</p>

There are limited findings from the global-level evidence and case studies that specifically explore how the Joint Programme is responding to influential contextual factors in relation to key populations. In the more mature key population epidemics of Thailand and Ukraine, responses have focused on specific challenges to ensuring that progress towards 2030 remains on track and to the sustainability of the key population programme – particularly sustainable financing.

Although sustainable financing and programming mechanisms to support key population-led responses is recognized globally as essential, this has not been a priority area of work for Joint Programme teams in most country case study countries.⁷⁷ In most country case study countries, the level of government resourcing for key population programming is low - particularly funding for key population-led civil society organizations prevention responses that are primarily dependent on the Global Fund, PEPFAR and other bilateral donors. Where governments have increased domestic funding for the HIV response, this has often been for treatment and rarely for prevention (although Ukraine is an exception). The Global Prevention Coalition has been working to address this. Although sustainable domestic financing is a long-standing challenge, it has not been a priority for the Joint Programme, which has placed significantly lesser emphasis on sustainable financing than on other areas of work in some of the case study countries. Notable exceptions to this are Thailand and Ukraine.

The Joint Programme in Thailand has undertaken a substantial body of work in relation to sustainable financing mechanisms for key population programming. Notably, this work seeks to ensure sustainable programming mechanisms for key populations by funding key population civil society organization service delivery through social contracting, using a universal health coverage funding

⁷⁶ Evidence to support the findings in this section are derived from country case study key informant interviews and documentary sources. The data and documentation sources are generally of good quality.

⁷⁷ See previous findings for Evaluation Question 8 on the effectiveness of the Joint Programme in contributing to sustainable financing and programming mechanisms for key population groups for additional information on sustainability.

mechanism. As such, this model of funding seeks to maintain key population-led services rather than mainstreaming or incorporating key population services within government-provided health services. The system of HIV civil society organization accreditation and certification of their community health workers is further evidence of a systematic approach to programming mechanisms that goes beyond just financing. Currently, civil society organizations are delivering services for sex workers, people who inject drugs and gay men and other men who have sex with men.

In Ukraine, the Secretariat and UNDP have made significant contributions towards sustainable financing through their work to support the introduction of social contracting with civil society organizations for a basic package of key population civil society organization prevention services. The Joint Programme's successful advocacy for increased government investments in key population prevention programming is notable given that in most countries increased domestic resources for HIV are exclusively for treatment.

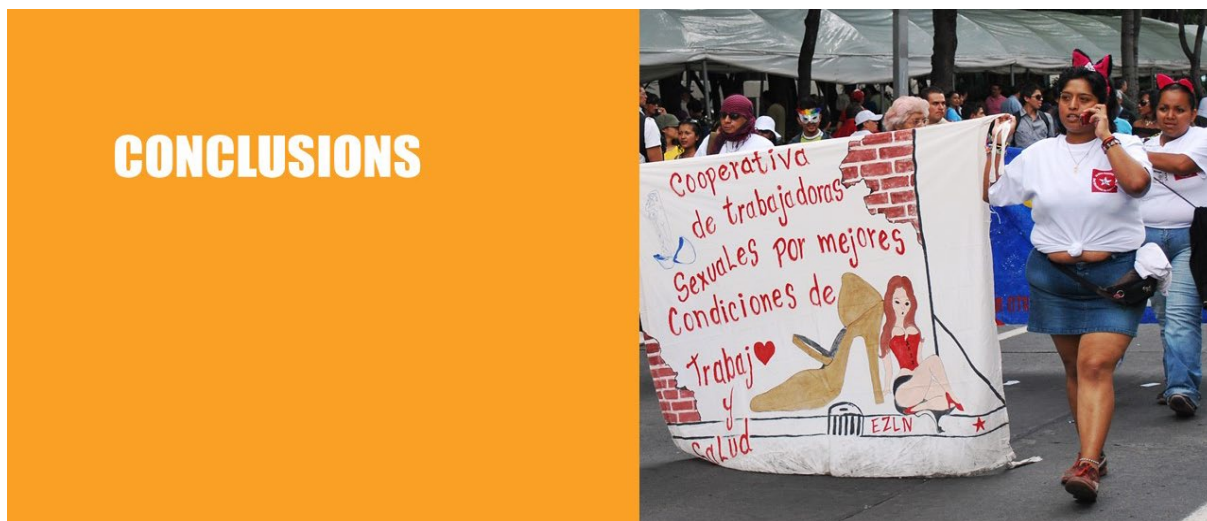
Country transition strategies to address the exit of the Global Fund and other donors frequently fail to deliver government ownership of the sustainable financing agenda. The development of transition strategies to support countries' plans for the exit of the Global Fund and other donors provides a vehicle for mobilizing domestic funding for key population and other HIV programming and for addressing sustainable programming mechanisms for key populations. The UNAIDS Secretariat commonly provides external consultant support for the development of transition strategies and is involved in technical working groups overseeing this process. While transition strategies are developed in consultation with governments, this frequently fails to achieve government ownership of the need to step up their funding commitments. For example, in Tunisia, the Joint Programme has supported the development of a Global Fund transition strategy, but this is unlikely to be implemented due to a weak commitment by the Government to investing in HIV programming, particularly for key populations.

Additionally, developing transition strategies for a specific disease programme is somewhat out of kilter with the universal health coverage agenda, for which many countries are striving. As such, many transition strategies are often aspirational in nature and unlikely to result in sustainable domestic financing. A limitation of transition strategies is that they are often developed by consultant teams over a short period of time. The challenging process of developing government commitment to sustainable financing requires multifaceted strategizing over a considerably longer period.

The increasingly conservative political environment in many countries, particularly in those countries where some key populations are criminalized, makes it increasingly challenging to achieve government commitment to sustainable funding for key population-led organizations and services. This points to the need for the Joint Programme and key population networks, concurrent with their sustainable domestic financing work, to continue to advocate for at least a maintenance of international funding for key population-led organizations and networks.

The Joint Programme's country teams need additional technical support in sustainable financing. Sustainable financing is a complex technical area that appears not to be well represented within the skill set of Joint Programme staff, which is primarily oriented towards technical support in the areas of evidence-based service packages and promotion of human rights. However, there is the opportunity for greater WHO and World Bank involvement through the universal health coverage agenda. The UNAIDS Secretariat and Cosponsors, such as the World Bank, could also enhance their global and regional technical support on sustainable financing to Joint Programme country teams, including guidance documents. At the country level, there could also be more efforts made to enable key population groups and networks to engage with universal health coverage discussions.

5 Conclusions



The key findings of the evaluation, which cut across the countries studied, and are drawn from global and regional informants and supporting literature, lend themselves to the following conclusions, most of which are not standalone, but have relevance and bearing on one another:

- 1. The Joint Programme is a well-respected body that has been instrumental in developing and supporting key population responses, but its role as an advocate for human rights and related legislative change is perceived to have reduced.**

The Joint Programme is a key stakeholder in countries and one whose neutrality gives it the authority to convene meetings, bringing government and civil society to the table. However, as the champion for supporting key population rights and HIV responses, there is a strong perception that this neutral voice is not being used powerfully enough, and that the Joint Programme has been less visible and proactive in advocating for all key population groups in recent years.

In the context of the latest data, where at least 65% of new HIV infections are found within key population groups, and the increasingly conservative contexts in which the Joint Programme operates, there is an urgent need to intensify advocacy efforts. The Joint Programme, in collaboration with key population groups, is well positioned to step up its advocacy for change in punitive legal environments, to campaign for greater efforts to reduce stigma and discrimination targeting these populations, and to defend rights to access services.

- 2. The increase in new infections occurring among key populations and the Global AIDS Strategy focus on tackling inequalities both combine to present a strong case for strengthening the prioritization and focusing of key population programming.**

HIV programming has been strategically repositioned in some Cosponsor agencies with increased integration of HIV and key population programming mainstreamed into core work, resulting in trade-offs in the relevance of such activities for key populations. Funding cuts have impacted significantly on human and financial resources across the Joint Programme, affecting most agencies' capacity to sustain the same level of support to HIV and key population programming.

However, data on new infections among key population groups, and the focus on addressing inequalities in the Global AIDS Strategy 2021-2026, necessitate a stronger prioritization and focus on key populations in the Joint Programme's work. This prioritization must be done, with the evidence showing that high incidence among key populations is occurring not just in the high priority countries (Fast-Track countries and members of the Global Prevention Coalition) but also in small countries

that do not have a high overall HIV burden, and in middle-income countries that are no longer eligible for, or are transitioning from, donor support.

3. There is scope to increase the relevance and impact of the Joint Programme's work for key populations through inclusive planning processes and through having a more explicit focus on specific key population groups in Joint Programme interventions.

There is scope to increase the relevance, accountability and potential results of Joint Programme support through consultations with key population communities in Joint Team annual planning processes and through ensuring that updated strategic assessments of country needs drive the prioritization of Joint Programme resources. Additionally, Joint Programme plans, strategies documents, systems, and mechanisms (such as the JPMS and technical support mechanism) do not always go far enough in differentiating between key population groups and other priority and vulnerable populations. Lack of clear definitions and adherence to definitions of key populations, particularly in relation to other 'priority vulnerable populations', can dilute funding allocations to key population groups, giving the impression that more work is focused on key population groups than perhaps is the case. In operationalizing the Strategy, it will be important to rebalance plans and increase the share of activities that explicitly address key population groups while also strengthening the focus on key population groups in broader programming work.

Further disaggregation is also needed between key population groups. The current labelling of key population groups fails to recognize and understand the complexity of individual and community identities and the need to address the intersectional needs and vulnerabilities within and across key population groups. This will be important for scaling up the delivery and use of 'people-centred' services that are tailored accordingly.

4. The Joint Programme's interventions have focused more on supporting key population services and addressing structural barriers that undermine access to services with a lesser emphasis on the programmatic and financial sustainability of key population responses.

The evaluation evidence makes a case for a balance of investments both for continued and scaled up HIV-specific key population programming and for the integration of HIV services including within universal health coverage (UHC) frameworks - with an enhanced and tailored focus on key populations. However, Joint Programme key population programming and strategic direction in many countries have yet to adjust to new initiatives towards universal health coverage with HIV and key population communities infrequently engaging or 'being at the universal health coverage table'.

The effects of the COVID-19 pandemic are likely to affect the achievements of the Global AIDS Strategy. While synergies exist among the HIV and the COVID-19 responses, the Joint Programme should prioritize its mandate to ensure that HIV and targeted key population responses remain 'in focus' in the wider pandemic response.

5. In many contexts, community-led responses and programming have yet to be embedded or taken to scale in country HIV responses. Involvement of key population organizations in the planning and implementation of Joint Programme activities and in national planning and funding mobilization processes varies and should not be considered as achieving the goal of community-led programming.

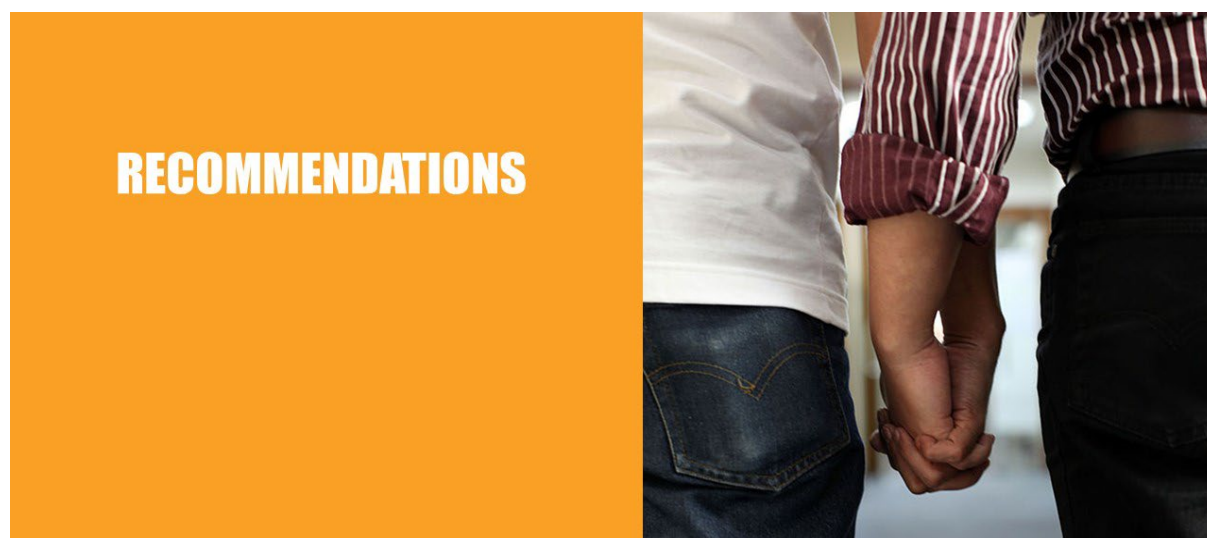
While Joint Programme members have helped establish and mobilize key population organizations and networks and their engagement in national decision-making processes, the case studies reveal large differences in the degree of key population engagement in these endeavours. Challenges remain in ensuring that key population participation in country coordination mechanisms or in national strategy and Global Fund funding processes is influential and translates into the meaningful prioritization of resources and budgets necessary for community-led service delivery at scale.

The Global AIDS Strategy 2021-2026 sets an ambitious target for the delivery of HIV prevention services for key populations by community-led organizations. The increased demands on community-led organizations come at a time when the trend is one of decreasing support for these groups. Yet in order for key population-led organizations to play a greater role in leading responses they will need sufficient resources (human and financial) and strengthened management capacity. The revised Division of Labour in the UBRAF 2022-2026 tasks the Secretariat and all Cosponsor agencies with the responsibility of empowering community-led organizations. Understanding what this means for the Joint Programme and how this will be realized and reflected in responsibilities across Cosponsors will be a priority as the necessary next step to progress the implementation of the Global AIDS Strategy 2021-2026.

6. The JPMS does not adequately reflect key population activities. Overall resources have reduced and it is difficult to ascertain the level of investment in key populations, and corresponding results.

Much of the reporting, both in the JPMS and in country budgets and plans, does not distinguish between key population groups, but discusses them as a homogenous entity, all equally at risk. Weak quality of monitoring and reporting data, partial reporting of investments for key population work across funding sources and outputs that are 'distinct' from the Joint Programme's work, all make it difficult to systematically identify, monitor and report on the results of the Joint Programme's work for key populations. At a time when HIV is competing to stay on donor agendas and there is a need to retain international funding for key population work, challenges in articulating results could lead to further reductions in financial contributions to the Joint Programme, with a negative impact on HIV and key population responses at a time when more action is needed if the Global AIDS Strategy 2021-2026 targets are to be met.

6 Recommendations



The following recommendations aim to support the positioning of work for and with key populations to ensure key population programming becomes a central plank of the Joint Programme's work for the 2021-2026 strategic period. Much of the success of the Joint Programme's work will depend on the willingness of Joint Programme agencies to collaborate and the ability of the Joint Programme to close the gap between commitments and policies developed at the global level and implementation support to key population groups at the country level.

Recommendation 1: Urgently increase the prioritization and strategic focus of the work for and with key populations (*UNAIDS Secretariat and Cosponsor agencies*)

- 1.1 Prioritize a set of countries for accelerated action for key population programming based on where infections are happening and align resources and capacity. Devise and test a relevant set of outputs and indicators for measuring progress with the Joint Programme's work in these countries.
- 1.2 Systematically engage all key population groups equally in Joint Programme work, including representatives from more neglected communities – transgender people, people who inject drugs, and young key populations – and develop different strategies to engage prisoners.
- 1.3 Develop and agree a clear definition across the Joint Programme, and with funding partners, for the differentiation of key populations from 'other vulnerable populations'. Additionally, systematically differentiate between key population groups. Act on this differentiation - strategies, plans, programming, and reporting at all levels of the Joint Programme - and work with partners to ensure consistency.
- 1.4 Increase the prioritization of key population funding in UBRAF guidance and strengthen oversight mechanisms for coherence of country plans. Ensure the allocation of funds are based on data-informed strategic assessments of country needs. Prioritize key population-led organizations as partners in the planning, monitoring and implementation of the Joint Programme activities, including for Country Envelope funds.
- 1.5 Scale up advocacy for key populations and be a proactive and outspoken defender of the rights of key populations in all settings, strongly advocating for decriminalization, gender identity and diversity, funding for prevention services, community-led responses and use of data to drive programming. Work as equal partners with key population groups to devise and implement advocacy strategies.

Recommendation 2: Strengthen support to community-led programming (*UNAIDS Secretariat, Cosponsor agencies*)

- 2.1 Develop clear guidance, internal policies and oversight mechanisms to ensure responsibilities for community-led programming across the Joint Programme, including at the regional and country levels, are understood and programming is aligned to the Global AIDS Strategy 2021-2026 and related targets.
- 2.2 Formulate guidance that better addresses the diversity of key population groups and the intersectional needs within and between these groups and support staff understanding on gender and sexuality.
- 2.3 Broaden engagement with, and scale up technical support, for community-led implementors to strengthen capacity to deliver services, and for community-led research, monitoring and data generation/use in national systems.
- 2.4 Increase accountability to key populations through monitoring community engagement and influence in national strategic planning and Global Fund funding request prioritization processes, from funding request through to grant making, in order to ensure limited HIV resources target high impact key population programming and planned allocations are translated into budgets.

Recommendation 3: Intensify support to ensure financial and programmatic sustainability of key population responses *(UNAIDS Secretariat, Cosponsor agencies)*

- 3.1 Increase involvement and dialogue with universal health coverage stakeholders, platforms, and forums. Support consultations with key population groups and the meaningful engagement of different key population groups and networks in such forums.
- 3.2 Strengthen guidance to, and support for, ways in which universal coverage mechanisms and social contracting models can address access to community-led services tailored to different key population groups in a range of different settings.
- 3.3 Increase technical support directed to assisting countries to plan for sustainable financing that addresses reliance on external funding for key population services.
- 3.4 Embed and sustain effective systems and services developed and implemented during the COVID-19 epidemic and explore opportunities to improve the sustainability of programmes.

Recommendation 4: Accelerate data generation for key population programming including through the JPMS *(UNAIDS Secretariat and Cosponsor agencies)*

- 4.1 Urgently expand programme data by identifying and filling key population data gaps, including size estimates for people who inject drugs, transgender people, diverse groups of young key populations, and prisoners, all differentiated by gender and age.
- 4.2 Overhaul the JPMS monitoring system for key population programming and strengthen assurance of data quality and reporting.
- 4.3 Implement a system for tagging key population investments across funding streams.
- 4.4 Promote the use and adaptation of the reconstructed theory of change as a model to operationalize and monitor the implementation and results of key population programming by country teams, key population groups and other partners.

Recommendation 5: Enhance the operational effectiveness of the work of the Joint Programme for and with key populations *(UNAIDS Secretariat and Cosponsor agencies)*

- 5.1 Lengthen the UBRAF planning and disbursement cycle from one year to two years, with the intention of enabling more strategic planning and programming of funding.
- 5.2 Track the use and uptake of guidance produced by the Joint Programme for key population programming in order to ensure relevance and added value of Joint Programme products and outputs.
- 5.3 Enhance and increase the monitoring and learning function of the Joint Programme including through:
 - Increasing evidence for Joint Programme results on work with different key population groups, and how these have catalysed change.
 - Supporting partners such as the Global Fund with more in-depth joint learning.

Annex 1: Global key informants

Global KIIs

Name	Organization
UNAIDS Secretariat	
Luisa Cabal	Human Rights Team
Mianko Ramaroson	As above
Simone Salem	As above
Laurel Sprague	Community Response Team
Jane Batte Cleiton Euzebio de Lima David Chipanta Alicia Sanchez Jacek Tyszkoi Elani Nassif	As above
Hege Wagan	HIV Prevention Team
Clemens Benedikt	As Above
Keith Sabin	Strategic Info advisor
UNAIDS Regions	
ESA	UNAIDS
WCA	UNAIDS
MENA	UNAIDS
AP	UNAIDS
EECA	UNAIDS
Cosponsors	
Tim Sladden	UNFPA
Chewe Luo	UNICEF
Damilola Walker	UNICEF
Su Myat Lwin	UNICEF
Mandeep Dhaliwal	UNDP
Boyan Konstantinov	UNDP
Deena Patel	UNDP
Katharine Ward Marelize Gorgens Nejma Cheikh	World Bank
Chris Castle Ariana Stahmer	UNESCO
Annette Verster Rachel Baggley	WHO
Ehab Salah	UNODC
Nazneen Damji	UN Women
Elena Kudravtseva	UN Women
Donors	
Ed Ngoskin	Global Fund
Susie McClean	Global Fund
Ralf Jurgens	Global Fund
Gina Dalabetta	Bill and Melinda Gates Foundation
Parvizez Hussein	PEPFAR-OGAC

Name	Organization
Tisha Wheeler	USAID
Global KP Networks	
Maria Phelan	Robert Carr Foundation
Wame Jallow	ITPC
Tinashe Rufurwadzo	Global Network of YP living with HIV
Erica Castenillos	GATE
Max Appenroth	GATE
Judy Chang	INPUD
Joanne Keatley	IRGT
Ruth Morgan Thomas	NSWP
Andrew Spieldenner	Mpactglobal
Jessica Whitbread	Y+
Primrose Matambanadzo Frances Cowan	CESSHAR Zimbabwe
Matteo Cassolato	Frontline AIDS

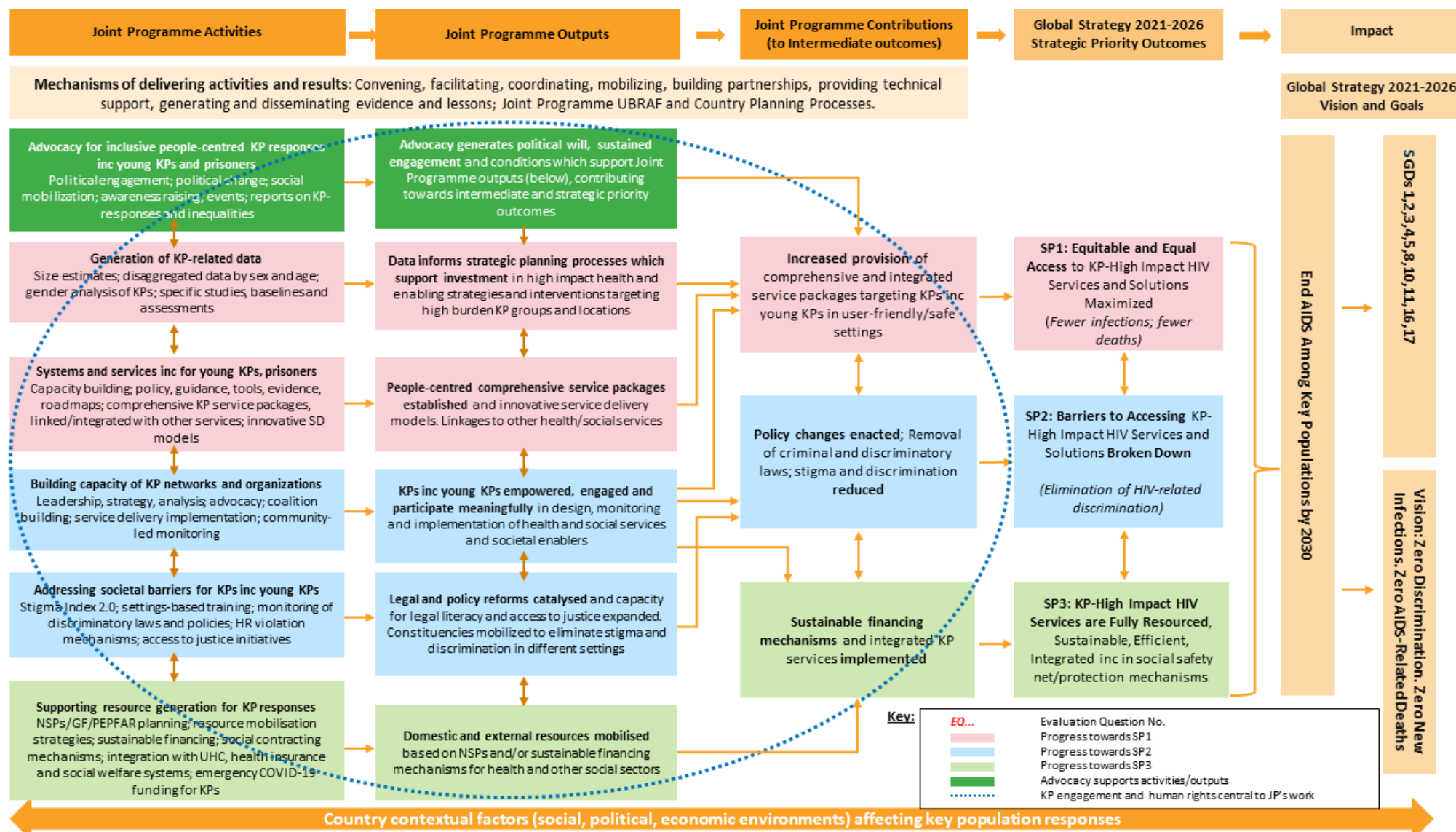
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- Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs (**IDUIT**). Practical guidance for collaborative interventions. UNODC, INPUD, UNAIDS, UNDP, UNFPA, WHO, USAIDS, PEPFAR ([http://www.unodc.org/documents/hiv-aids/publications/Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs PRACTICAL GUIDANCE_Country_Envelope_FOR_COLLABORATIVE_INTERVENTIONS.pdf](http://www.unodc.org/documents/hiv-aids/publications/Implementing_Comprehensive_HIV_and_HCV_Programmes_with_People_Who_Inject_Drugs_PRACTICAL_GUIDANCE_Country_Envelope_FOR_COLLABORATIVE_INTERVENTIONS.pdf))
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Annex 3: Revised Theory of Change – informed by the evaluation



Revised Theory of Change for how UNAIDS Joint Programme contributes to Ending AIDS Among Key Populations by 2030 – informed by findings from the evaluation.

The overarching theory for how UNAIDS Joint Programme contributes to the 2021-2026 Strategic Priorities⁷⁸ and accelerates progress towards realising the vision of zero new infections, zero discrimination and zero AIDS-related death and the goal of ending AIDS among key populations by 2030 is outlined below and accompanies the Theory of Change (TOC) graphic. The ToC recognises the interconnected and mutually reinforcing nature of the work of the Joint Programme at the country level (the focus of the ToC is the country level) and depicts the central role played by KP engagement. ***Findings from the evaluation underscore the importance of understanding the interconnected and mutually reinforcing nature of the Joint Programme's work.***

Theory of Change

Contextual factors (social, political, economic) affecting country key population responses are those factors in the wider context which are not part of the Joint Programme's work or support to key populations, yet they interact, influence, help or hinder UNAIDS contribution to key population responses, including ability to contribute to intermediate outcomes and Strategic Priorities/outcomes. **No change.**

Intermediate outcomes, outcomes (Strategic Priorities) and impact. For this ToC, three intermediate outcomes have been included which represent expected changes because of the support of Joint Programme's interventions and outputs. Other partner inputs also contribute to these intermediate outcomes. The three intermediate outcomes are expected to contribute to the achievement of the three Strategic Priorities/outcomes, which in turn support progress towards the goal of ending AIDS in key populations by 2030, the vision of achieving the Three Zeros and various SDGs. **No change to relevance of these intermediate outcomes, however, the timeline of the Global Strategy 2022-2026 will make it extremely challenging to demonstrate Joint Programme contribution to these outcomes, as will the Joint Programme reporting system.**

Mechanisms: The ToC has highlighted key 'activity or intervention' areas that the Joint Programme is involved in, to support key population responses. Mechanisms have also been defined and are the Joint Programme's primary functions and delivery processes which operate in particular contexts to generate outputs and outcomes of interest, for example, partnership development, convening and coordinating, disseminating lessons learned. **No change. Although future iterations of the TOC could include assumptions related to Joint Programme capabilities (strategy and systems) and Practices (Leadership and Transparency)**

Activities to outputs, contributing to progress towards intermediate and strategic priority outcomes

- The Joint Programme **leads, advocates, and mobilises action at all levels to ensure an inclusive key population response** which engages and responds to the needs of all key population groups. In theory, the Joint Programme's leadership and advocacy generates political will that recognises all key population groups in the HIV response **in equal measure**, and acts on inequalities that prevent access to services, including human rights and gender inequalities. In theory, advocacy and mobilisation creates space, resources, and capacity for community-led responses to address the programming needs and barriers faced by different key population groups. Joint Programme advocacy supports all the activity areas and outputs and supports conditions necessary to accelerate progress towards intermediate and strategic priority outcomes, and ultimately, the goal to end AIDS among key populations by 2030. **Minor change to the theory.**

⁷⁸ Strategic Priority 1: maximise equitable and equal access to HIV services and solutions (target – 95% coverage of a core set of evidence-based HIV services for ; Strategic Priority 2: break down barriers to achieving health outcomes; and Strategic Priority 3: fully resource and sustain efficient HIV responses and integrate them into systems for health, social protection and humanitarian settings and pandemic responses.

In undertaking advocacy activities, it is assumed that the Joint Programme designs and implements the right things and has sufficient capacity, skills, and traction to influence to enable change. **Major challenge to the assumption in that evaluation evidence indicates that the Joint Programme is not sufficiently resourced to undertake the many activities depicted in the TOC. A more appropriate assumption would be: the Joint Programme is positioned appropriately to enable it to design, implement the right interventions to enable change.**

- The Joint Programme supports country capacity to **generate and analyse data** related to key population groups, their needs and the inequalities that hamper access to services. In theory, the availability and use of better quality and granular data (disaggregated by population, sex, and age, and builds on gender analysis of KPs) enables country stakeholders to identify programme gaps and inequalities, and data informs resource allocation, programme priorities and investment strategies. Strategic planning processes use data to leverage and prioritise resources for high impact health and enabling strategies which target high burden populations and locations. In theory, data-driven investments contribute towards the scale up of comprehensive packages of HIV services tailored to each key population group, the intensification of actions addressing barriers to accessing services, and more efficient responses, thereby contributing towards the achievement of intermediate and strategic priority outcomes. **No change to the theory.**

It is assumed that health systems have sufficient capacity to collect and analyse key population related data to accurately determine key population needs, gaps and inequalities. It is also assumed that sufficient capacity, **resources and incentives** exists within the Joint Programme to support the use and analysis of data and ensure such data is used to inform transparent resource allocation and prioritisation processes and implementation decisions which enable increased provision of KP HIV service packages, **at national programme level and for Joint Programme planning. Assumption remains valid but amended based on evidence from the evaluation.**

- The Joint Programme supports development of **systems and HIV services for key populations through development of normative and operational guidance**, related tools, policies, roadmaps, and through Joint Programme support to innovative and integrated service delivery models. In theory, evidence-based guidance is rapidly translated into action, enabling comprehensive packages of HIV services for key populations to be established and scaled up based on latest evidence. The Joint Programme's support to innovative and integrated service delivery models in theory enables services to respond better to the context and needs of key population groups, and this facilitates greater provision of services, access, and uptake of services, and contributes to the achievement of the intermediate outcomes and strategic priorities. **No change to the theory.**

It is assumed that sufficient health systems capacity exists to deliver broader health services, integrated or linked with KP services packages, and integrated services are functional and effective and deliver programme efficiencies. It is assumed that UNAIDS generated evidence **influences and supports** implementation. **Minor change to the assumption.**

- A key activity area for the Joint Programme is **strengthening the capacity of key population community networks and organisations**. In theory, enhancing the capacity and skills of community networks and organisations empowers communities to engage meaningfully, as equals, in HIV and health governance, policy, planning and funding mechanisms. In theory, having the capacity to advocate and lead the design and implementation of key population targeted services and societal enablers, ensures appropriate people-centred services can be implemented. In theory, this should encourage key population groups to access and use these services more. Additionally, Joint Programme activities to strengthen the capacity of communities to monitor responses for key populations through the collection and use of their data, should enable communities to hold decision-makers and service providers accountable for their HIV commitments, and will help improve the quality, responsiveness, and uptake of services. These in turn contribute to progress towards the achievement of the intermediate outcomes, strategic

priorities, and ultimately the global goal of ending AIDS in key populations by 2030. **No change to the theory.**

It is assumed that Joint Programme support to key population networks and community organisations is appropriate to the epidemic and the response and is effective in capacitating the leadership of such organisations **such that they can advocate and influence the provision of comprehensive services, the enabling environment and sustainable financing for KP services.** **Change to assumption.**

- Joint Programme advocacy and championing of HIV human rights programming and societal enablers by focusing on the **removal of legal and policy barriers, addressing stigma and discrimination, violence, and human rights violations** against key populations, in theory catalyses legal and policy change and supports shifts in societal behaviours and attitudes. Additionally, community-led monitoring, and data generation (such as Stigma Index monitoring) are important sources of strategic information which can inform evidence-based investments and precision programming. In theory these changes improve the enabling environment whereby key populations can enjoy their rights to health, without fear, thereby supporting greater access and uptake of services, and thus contribute to the achievement of intermediate and strategic priority outcomes. **No change to the theory.**

It is assumed that legal and policy reforms **are informed by** technical support provided by the Joint Programme, and this supports **contributes to improving** access to services and the breaking down of barriers. **Challenge to the assumption. Evaluation evidence suggests original assumption was ambitious.**

The Joint Programme **mobilises resources for efficient and sustainable key population responses** and supports the inclusion of key population needs in UHC-related platforms, social protection and other social welfare mechanisms.

The Joint Programme's support to transition plans and sustainable financing mechanisms, in theory enables the continued, stable, and equitable funding of key population programmes, necessary for the scale up of services and societal enablers and to ensure progress towards ending the epidemic. Additionally, meaningful engagement of key populations in national UHC and social welfare platforms will, in theory, facilitate the inclusion key population needs in sustainable and equitable health care financing strategies and systems, thus contributing to the achievement of intermediate and strategic priority outcomes. **No change to theory.**

The theory assumes that the Joint Programme has sufficient capacity and will to engage in the development of sustainable financing strategies for key populations, including through UHC platforms and other social sector mechanisms (social protection, social contracting) and that sustainable financing strategies are implemented. **No change to assumption.**

- Finally, Joint Programme **responses to the COVID-19 pandemic** mobilise emergency funding to limit the impact on services targeting key populations and support community-led innovations. In theory, the centrality of community-adapted innovations targeting key populations supports the strengthening and resilience of community health through flexible and responsive approaches, and enabling access to services for key populations. **No change to theory.**

Some changes to the TOC graphic are also recommended following the findings from the evaluation. These include:

- Greater depiction of role and contribution of KP engagement to sustainable financing.
- Addition of role of Joint Programme planning and UBRAF processes in Mechanisms.
- Depiction is made in the final TOC of the centrality of rights-based considerations in Joint Programme work, representing a finding from the evaluation.

Annex 4: Evaluation framework

Evaluation Criteria: Relevance and coherence: These questions are concerned with the design of the Joint Programme’s workplans and activities for KPs and whether the Joint Programme is ‘doing the right things’ and how well the activities complement and support other actors’ interventions targeting KPs.

Evaluation question 1: How relevant are the Joint Programme activities for addressing the needs and priorities of each KP group? Are activities strategic/catalytic? Is support provided in the right mix?

Rationale: This question focuses on the design and relevance of Joint Programme activities (the nature and mix of activities and relevance to epidemiological, social, economic, and political context).

Key Assumptions	Indicators	Sources of Evidence
<p>1.1 Joint Programme activities are designed with the involvement of KPs and based on an assessment of epidemiology, priority gaps and needs of different Key Population groups.</p> <p>1.2 Activities are strategic, catalytic and leverage more substantial change and effect for KP responses, relative to the size of the Joint Programme’s investment.</p> <p>1.3 Joint Programme mandate leverages the comparative advantage of each Cosponsor agency to deliver a mix of activities which respond to the needs of different KP groups at country level.</p> <p>1.4 Global/regional Joint Programme KP-related tools and evidence inform design and choice of country activities.</p>	<ul style="list-style-type: none"> ■ Evidence of meaningful KP involvement by group in Joint Programme meetings, strategic planning committees, reference groups, technical working groups, country coordination mechanisms (CCMs), etc. ■ Evidence of KP priorities reflected in the outcome documents, minutes, funding/program decisions. ■ Evidence of Joint Programme activities being implemented or modified to address emerging issues in KP programming. ■ Evidence of assessment, consultations, analysis of data to understand the needs and priorities of KPs. ■ Examples of Joint Programme activities that catalysed or influenced changes in KP programming or response, relative to the resources available to do the work. ■ Extent to which UBRAF core funding leverages the expertise and comparative advantages of the Joint Programme including linkages beyond HIV (cross ref to question 3 and 4). ■ Examples of partnerships established within or outside the UN system that respond to KP programming needs. ■ Evidence of knowledge and application of global implementation tools, assessment tools (like programme self-assessment tools) for KP programmes among the Joint programme teams. 	<p><u>Data and document review</u></p> <ul style="list-style-type: none"> ■ Joint Programme strategy and policy documents and reports on HIV and KPs. ■ Joint Programme resourcing frameworks/country envelopes, workplans, results reports. ■ National strategy and guidance documents, minutes, reports relating to NSP development, COP development, Global Fund, including technical support plans (if in existence) to demonstrate shared and coordinated agendas. ■ Examples in reports of Joint Programme leverage and catalytic actions. ■ UN Division of Labour document and local customizations. ■ Reports from international KP networks. ■ Joint Programme related tools and lessons learned reports <p><u>Interviews, group discussion</u></p> <ul style="list-style-type: none"> ■ UNAIDS Secretariat and Joint Programme staff. ■ National and sub-national health authorities/National AIDS programmes. ■ National HIV Commission. ■ Other relevant Ministries – Education, Social Welfare, Justice etc ■ Relevant CCM members and/Principal Recipients ■ Multilateral/bilateral partners supporting KPs. ■ KP networks and organisations – global and national level.

Key Assumptions	Indicators	Sources of Evidence
Evaluation question 2: To what extent has the Joint Programme considered human rights, gender quality and more vulnerable KP groups in the design of the Joint Programme activities?		
Rationale: This question is concerned with the extent to which the most vulnerable KPs, human rights and gender issues and equality (as related to KP groups) have been considered in the design of Joint Programme's activities.		
Key assumptions	Indicators	Sources of Evidence
<p>2.1 Joint Programme activities prioritise the most vulnerable KP groups including identifying intersectionality within KP groups.</p> <p>2.2 Joint Programme activities are informed by gender, age, gender equality and human rights analysis.</p> <p>2.3 The concept of equity and how to operationalise an equity-based approach is well understood within the Joint Programme and among other stakeholders.</p>	<ul style="list-style-type: none"> ■ Evidence of KP data being generated that disaggregates by age, gender, KP group and identifies intersectionality among different KP group (e.g. transgender people and gay men and other men who have sex with men who are sex workers or use drugs) other intersecting factors as relevant to the context. ■ Evidence of KP Joint Programme budgets being allocated according to need and vulnerability. ■ Evidence of Joint Programme addressing issues of inequity and its consequences like violation of human rights, violence, stigma and discrimination. ■ Evidence of joint programme engaging with wider and diverse stakeholders beyond the HIV landscape, i.e.: human rights council, gender minority organisations, human rights organisations, government bodies/ministries beyond health (i.e.: ministry of justice and human rights, ministry of children protection and women empowerment, etc.) ■ Evidence of guidelines or training for Joint Programme staff on the meaning of equity/ equity-based approach in the context of implementing the 2016-2021 Strategy. 	<p><u>Data and document review</u></p> <ul style="list-style-type: none"> ■ Data generated on KPs by Joint Programme. ■ National programme data on KPs. ■ Joint Programme policy documents, guidance and reports on HIV, KPs, equity. ■ Joint Programme workplans, results reports, training reports. ■ Strategy and guidance documents, minutes, reports relating to NSP development, country operating plan (COP) development, Global Fund funding applications and which include financial/resource allocation data. ■ Examples in reports of Joint Programme leverage. ■ Reports from international KP networks. <p><u>Interviews, group discussion</u></p> <ul style="list-style-type: none"> ■ UNAIDS Secretariat and Joint Programme staff. ■ National and sub-national health authorities/National AIDS Programmes. ■ National HIV Commissions. ■ Dept of Justice, Legal, Social Welfare, Education. ■ Relevant CCM members and Principal Recipients. ■ Multilateral/bilateral partners supporting KPs. ■ KP networks and organisations – global and national level.
Evaluation question 3: To what extent are the activities of the Joint Programme harmonised and aligned <i>internally</i> within the Joint Programme, and harmonised and aligned <i>externally</i> , with other actors' interventions in the country		
Rationale: This question addresses the coherent planning and delivery of Joint Programme activities.		

Key assumptions	Indicators	Sources of Evidence
<p>3.1 Cosponsor leadership and plans demonstrate commitment to KP programming and interventions.</p> <p>3.2 Joint Programme workplans demonstrate agreed priorities and actions for different KP groups; activities are delivered in alignment with the UNAIDS Division of Labour and without duplication between agencies or fragmenting responses for KP groups.</p> <p>3.3 Joint Programme and key partners (such as Civil society organisations, PEPFAR, the Global Fund and bilateral partners working in the HIV space) coordinate and collaborate on their programming and technical support to ensure complementary and harmonised approaches and interventions.</p> <p>3.4 Collaborations at global, regional and country level developed by the Joint Programme support priority programming for KP groups at country level.</p>	<ul style="list-style-type: none"> ■ Evidence of shared ‘positions’ and actions between Secretariat and Cosponsor agencies on KP priorities and interventions. ■ Timelines of activities and evidence of coordination efforts (within the Joint Programme; between the Joint Programme and external partners such as Global Fund and/or PEPFAR). ■ Evidence of use of guidance, standards and tools of Joint Programme being used by partners such as PEPFAR and Global Fund to align investment of partners (shifts in NSP priorities, other strategies, investments following Joint Programme activities or outputs). ■ Evidence of formal mechanisms of coordination between Joint Programme (ideally with clear roles for UNAIDS Sec/Joint Team Cosponsors described)/ and PEPFAR and Global Fund (and/or other partners). ■ Staff versus HIV and health country stakeholders, KPs and funding partners’ experience and views on the positioning and leveraging potential of the Joint Programme; the degree of harmonisation within the workplan and with external partners. 	<p><u>Data and document review</u></p> <ul style="list-style-type: none"> ■ Joint Programme policy documents and reports on HIV and KPs. ■ Joint Programme workplans, results reports. ■ Joint Programme minutes of meetings ■ Joint Programme ToRs for technical support. ■ Strategy and guidance documents, minutes, reports relating to NSP development, COP development, Global Fund, including technical support plans (if in existence) to demonstrate shared and coordinated agendas. ■ UN Division of Labour document. ■ Minutes of meetings between Joint Programme and PEPFAR and/or Global Fund and other partners. <p><u>Interviews, group discussion</u></p> <ul style="list-style-type: none"> ■ UNAIDS Secretariat and Joint Programme staff/RCO. ■ National and sub-national health authorities/National AIDS Programmes ■ National HIV Commission. ■ Relevant CCM members and Principal Recipients; representatives of other health sector coordination platforms. ■ Multilateral/bilateral partners supporting KPs. ■ KP networks and organisations a global and country level.
<p>Evaluation question 4: To what extent are the capacities and resources of the Joint Programme appropriate for work with and for KPs?</p> <p>Rationale: This evaluation question also relates to relevance and coherence in that it explores whether the Joint Programme has the breadth and depth of skills/capacities necessary to design and deliver on KP issues.</p>		
Key assumptions	Indicators	Sources of Evidence
<p>4.1 The Joint Programme’s allocation of resources (staffing presence and financial resources) and capacities ensure sufficient technical leadership and engagement to respond to KP needs; and enable Cosponsor agencies to play roles of Co-convenor and partner in Joint Programme responses for KPs.</p>	<ul style="list-style-type: none"> ■ Staffing levels and in-house skills to undertake HIV-related KP, gender and human rights work in Joint Programme and across Cosponsor agencies. ■ Joint Programme financial resources on the work with and for KP work. ■ Evidence of the Joint Programme working with national programme to define technical support needs. 	<p><u>Data and documents</u></p> <ul style="list-style-type: none"> ■ Joint Programme workplan, monitoring and results reporting. ■ Joint Programme country envelope data. ■ Minutes of meetings, other documents demonstrating role of Joint Programme. ■ Independent evaluations of UNAIDS Joint Programme. ■ Technical support plans for KPs. ■ Minutes, ToRs for technical support, feedback forms.

Key assumptions	Indicators	Sources of Evidence
4.2 Joint Programme financial resources including the resource allocation to key populations (in total and as a proportion of the Joint Programme budget) is appropriate to enable the implementation of the activities.	<ul style="list-style-type: none"> ■ Evidence of national programmes seeking and receiving technical support from UNAIDS Secretariat/Country Office and Cosponsors. ■ Evidence of Joint Programmes having the capacity to rapidly response to technical support needs of the country. ■ Stakeholder perspectives on UNAIDS skills and capacities, and degree of traction/leverage Joint Programme staff hold and why. 	<ul style="list-style-type: none"> ■ Budgeting and staffing data (Secretariat and Cosponsors) in case study countries <p><u>Interviews, group discussion</u></p> <ul style="list-style-type: none"> ■ KP networks and organisations. ■ UNAIDS Secretariat and Joint Programme staff. ■ National and sub-national health authorities/National AIDS Programmes. ■ National HIV Commission. ■ Multilateral/bilateral partners supporting KPs.

Evaluation Criteria: Efficiency and Effectiveness: These questions are concerned with the implementation of the Joint Programme's activities, specifically whether they have been implemented in an efficient and timely way, and the extent to which they have achieved their results (outputs) and contributed to 'upstream' outcomes.

Evaluation question 5: How well is the Joint Programme implementing the activities for KPs and achieving the UBRAF outputs? Which areas require further strengthening and why?

Rationale: This question is concerned with the implementation of the activities, specifically the efficiency of implementation of planned activities and will explore *what* the Joint Programme has implemented (against the workplan) including by KP group and activity area (e.g., types of guidance and tools developed with KPs) and *how well* activities have been implemented including the scale of support.

Key Assumptions	Indicators	Sources of Evidence
<p>1.1 Joint Programme activities and technical support provision for KP groups are implemented as planned (on time; on budget; and as intended) and achieve intended outputs/results.</p> <p>1.2 Country stakeholders and partners are motivated and have the capacity to engage in the implementation of Joint Programme activities and initiatives.</p>	<ul style="list-style-type: none"> ■ Frequency and attendance of Joint Programme partners in work planning and review meetings. ■ Extent to which activities have been completed against the joint workplan; scale of interventions/country and KPs coverage; budget allocations spent; and results reported for KP groups. ■ Stakeholder and partner perspectives on sequencing, timing, scale of activities and if implemented as planned. ■ Degree of involvement of KP groups and other stakeholders and partners in Joint Programme implementation. ■ See also indicators above for addressing country technical support needs in relation to KPs. 	<p><u>Data and documents</u></p> <ul style="list-style-type: none"> ■ Joint Programme workplans from 2018-present, activity reports, allocation and expenditure reports. ■ Joint Programme results and achievement reports since 2018. ■ ToR of commissioned technical support. ■ Minutes from meetings, activity reports, participant reports. ■ Output documents arising as a result of technical support e.g. prevention roadmaps/KPs component if supported by UNAIDS resources. <p><u>Interviews, group discussion</u></p> <ul style="list-style-type: none"> ■ Secretariat and Cosponsor staff. ■ Recipients/beneficiaries of Joint Programme technical support. ■ KP and other partners such as PEPFAR.

Evaluation question 6: How effective is the Joint Programme in mobilising and empowering KP networks and organisations in the monitoring and accountability of policies and programmes and the implementation of services?

Key Assumptions	Indicators	Sources of Evidence
Rationale: This question specifically focuses on the Joint Programme's results with respect to strengthening the leadership of KP networks and organisations and their involvement in the design and delivery of services.		
Assumptions	Indicators	Sources of Evidence
<p>6.1 KP-led organisations, groups and networks have the capacity and tools to meaningfully engage in governance, strategic planning, programme monitoring mechanisms and decision-making platforms (including Global Fund access to funding and grant implementation, PEPFAR COP processes and other national/sub-national mechanisms related to HIV responses).</p> <p>6.2 Joint Programme activities have been effective in supporting service delivery and community monitoring efforts led by Key Population groups.</p> <p>6.3 Relationships between KP groups and government have improved because of Joint Programme actions.</p>	<ul style="list-style-type: none"> ■ Evidence of KP networks and organisations leading in the policy level, planning, programme, monitoring or decision-making. ■ KP involvement in broader health and social sector planning, universal health care (UHC forums, health and social welfare platforms, sustainable financing forums) ■ Evidence of Joint Programme support for training and capacity-building of KP networks and organisations and/or training of individuals (e.g. in technical and implementation areas, but also capacity in leadership, including design, resource mobilisation, service delivery, monitoring and evaluation). ■ Evidence of KP networks and organisations initiating and implementing programmes or interventions at the country level. ■ Evidence of KP networks and organisations using their own or local data to monitor KP services and/or evidence of a formal and established community monitoring process in the country. ■ Evidence of research and publications initiated and executed by KP networks and organisations. ■ Stakeholder and partner perspectives on nature and extent of engagement of KP networks and organisations. ■ Evidence on joint programme supporting the development of policies and guidelines that support and recognise community/KP-led organisations ■ Evidence on joint programme advancing community/KP-led research and KP-generated data that is used to inform decision-making ■ Evidence of Joint Programme allocation of funds to KP led organizations and advocacy for governmental and other donors funding for these organizations 	<p><u>Data and documents</u></p> <ul style="list-style-type: none"> ■ Joint Programme workplan, monitoring and results reporting. ■ Joint Programme country envelope data. ■ National programme HIV and health reviews, documents, reports, guidance. ■ Minutes of meetings, other documents demonstrating role KP representation in key decision-making platforms. ■ Independent evaluations of UNAIDS Joint Programme. ■ Training and capacity-building reports from KP networks, CDC-UNAIDS CoAg evaluation and Fast-Track Cities evaluation and joint VAWG evaluation. ■ KP network-generated data and monitoring reports. ■ PEPFAR and Global Fund documents and guidance e.g. on Community-led monitoring. ■ Other programme documents related to community-led work and monitoring ■ COP related documents <p><u>Interviews, group discussion</u></p> <ul style="list-style-type: none"> ■ KP networks and organisations and other community representatives. ■ UNAIDS Secretariat and Joint Programme staff. ■ National and sub-national health authorities/National AIDS Programmes. ■ National HIV Commissions. ■ Other related Ministries (Education, Social Welfare) ■ Relevant CCM members and Principal Recipients; representatives of other health coordination platforms. ■ Multilateral/bilateral partners supporting KPs. <p><u>Site visits</u></p> <ul style="list-style-type: none"> ■ Where possible, to observe KP network-led services and programmes.

Assumptions	Indicators	Sources of Evidence
	<ul style="list-style-type: none"> ■ Evidence of coordination of KP responses at the national, district, site level. ■ Perceptions of stakeholders of the role and contribution of UNAIDS Joint Programme interventions to higher level results over past five years. 	
Evaluation question 7: How effective has the Joint Programme been in responding to a) KP needs in humanitarian settings b) KP needs during the COVID-19 pandemic?		
Rationale: Humanitarian disasters and civil conflicts to create increased risks for KPs, and the COVID-19 pandemic has emphasised this. This question explores how the Joint Programme has responded to addressing KP needs in humanitarian settings; and how the Joint Programme is supporting efforts for dealing with the continuing and long-term effects of the COVID-19 pandemic.		
Assumptions	Indicators	Sources of Evidence
7.1 Joint Programme support in humanitarian settings enables continued access and availability of services for KP groups. 7.2 Joint Programme support to COVID-19 responses address acute needs, leverage funds and enable continued access and availability of HIV and COVID-19 services for KP groups. 7.3 The Joint Programme maximises lessons learned from the HIV response to support resilient systems for health for COVID-19 and future pandemic responses.	<ul style="list-style-type: none"> ■ Evidence of KP needs being considered in disaster and humanitarian planning (e.g. for migrants). ■ Evidence of country COVID-19 contingency plans including a section on KP issues that need to be considered (e.g., access to PPE for KP frontline workers, COVID-19 diagnosis and vaccine, social safety net. ■ Evidence of KP representatives being part of the national response planning for COVID-19. ■ Joint Programme generation and dissemination of lessons from HIV for supporting the COVID-19 response. ■ Global Fund emergency response funding applications indicate Joint Programme and KP involvement. ■ Evidence of resources received by KP- led organisations to mitigate the impacts of the Covid-19 pandemic ■ Stakeholder and partner perspective on support received. 	<u>Data and documents</u> <ul style="list-style-type: none"> ■ National level COVID-19 policy statements and plans. ■ National level documents from recent humanitarian disasters (wars, natural disasters). ■ Joint Programme reports on lessons learned from HIV for Covid-19. ■ Minutes of meetings and Global Fund funding requests for emergency funding. ■ Grant documents/agreements for emergency funding. <u>Interviews, group discussions</u> <ul style="list-style-type: none"> ■ UNAIDS Secretariat and Joint Programme staff. ■ National and sub-national health authorities/National AIDS Programmes. ■ Dept of Emergency Planning/Humanitarian action. ■ National HIV Commission. ■ CCM representatives and Principal Recipients. ■ KP networks and organisations.
Evaluation question 8: How effective is the Joint Programme in contributing to i) scaled up provision of comprehensive services for KP groups, including the most vulnerable KP groups ii) the promotion of human rights, gender equality, and removal or reduction of criminal and discriminatory laws and stigma and discrimination iii) sustainable financing and programming mechanisms for KP groups (intermediate outcomes)?		
Rationale: This question explores how the actions and results of the Joint Programme are being acted upon and contribute to the achievement of intermediate outcomes necessary for progress towards the strategic priority outcomes.		

Assumptions	Indicators	Sources of Evidence
<p>Joint Programme work is high quality and acted on:</p> <p>8.1 Strengthened and disaggregated KP-data drives strategic planning and resource allocation processes and leverages funding for KP responses. This enables programmes to increase the provision of KP HIV service packages including for the most vulnerable KP groups.</p> <p>8.2 Countries update and integrate evidence in policies, guidance and tools and implementation models which contributes to updated high impact KP HIV service packages, including linked/integrated services (TB/HIV; SRH; STIs; Hep B/C; NCDs)</p> <p>8.3 Joint Programme support to strengthened KP organisations, human rights and gender equality, and traction in changing the enabling environment contributes to the enactment of policies and laws and a reduction in stigma and discrimination.</p> <p>8.4 Strengthened strategic and sustainability planning supports implementation of sustainable financing and programming mechanisms for KP groups.</p>	<ul style="list-style-type: none"> ■ National programme data since 2018 used to indicate changes in provision and coverage of comprehensive KP services. ■ Evidence that Joint Programme-supported data is being used to scale up the provision of comprehensive services for and by KP groups, including the most vulnerable KP groups. ■ Evidence that Joint Programme advocacy with donors and funders is systematic and prioritises provision and coverage of KP services where the estimates are high. ■ Evidence at the country level of increased emphasis and resource allocations across for KP groups and within groups based on intersecting factors such as sex, age, income., other between the previous and current National HIV/AIDS Strategic Plans. ■ Evidence that the scaled-up provision of comprehensive services includes linkages/integrated services with other health and social services and innovate delivery models. ■ Changes in social and gender norms, policies, laws, regulatory environments reflect Joint Programme advocacy and technical support. ■ Evidence of more comprehensive human rights interventions supporting KP health services (access to justice, documentation, and redress) ■ Sustainable financing and programming mechanism/s implemented reflect Joint Programme advocacy and technical support. 	<p><u>Data and documents</u></p> <ul style="list-style-type: none"> ■ National programme data on provision and coverage of KP service packages. ■ Available studies (inc seroprevalence data, behavioural data, size estimations, disaggregated data in different forms). ■ National HIV/AIDS Strategic Plans. ■ Global Fund funding requests and TRP reports; PEPFAR plans and reports. ■ MOH policy and planning updates (for timing and implementation of scaled up services, integrated services and use of differentiated service delivery models. ■ Health and HIV programme reviews. ■ Legal and policy documents, press releases, political statements regarding enabling environment. ■ Measurement data and documents demonstrating improvements to access to justice and systems of redress ■ Minutes of meetings with donors and funders demonstrating advocacy for KPs. ■ Documents and data related to HIV-sensitive social protection and social contracting mechanisms being established. <p><u>Interviews, group discussion, site visits</u></p> <ul style="list-style-type: none"> ■ UNAIDS Sec and Cosponsors including World Bank. ■ National and sub-national health authorities. ■ National HIV Commissions. ■ Ministry of Finance. ■ Prison Committees. ■ Ministry of Justice, Police, Social Welfare and other enabling environment related Departments. ■ Multilateral/bilateral partners supporting HIV prevention, societal enablers, KPs. ■ KP networks and community organisations. <p><u>Site visits/observation</u> of comprehensive and integrated services targeted to different KP groups.</p>

Assumptions	Indicators	Sources of Evidence
Evaluation question 9: How well is the Joint Programme responding to influential contextual factors which impact on KP programming (such as increasingly conservative political environments, decreasing resources for HIV, other)?		
Assumptions	Indicators	Sources of Evidence
<p>9.1 The Joint Programme demonstrates flexibility and modifies actions to respond to the changing context/landscape and emerging issues of different KP groups (e.g. through changes in advocacy, champions, partnerships, nature of engagement).</p> <p>9.2 The Joint Programme actions have traction and are impactful in changing the human rights and health landscape affecting KP groups.</p>	<ul style="list-style-type: none"> ■ Evidence of modifications in Joint Programme activities and strategies to gain traction with governments over difficult issues associated with KP groups – evidenced through changes in advocacy, champions, partnerships, leadership tactics and nature of engagement. ■ Stakeholder and partner perspectives on Joint Programme responses to uncomfortable issues, and the effectiveness of those responses. 	<p><u>Data and documents</u></p> <ul style="list-style-type: none"> ■ Joint Programme documents, reports, and minutes of meetings ■ Print and social media interventions ■ Political statements regarding enabling environment ■ Shifts in national policy and strategies <p><u>Interviews, group discussions, site visits</u></p> <ul style="list-style-type: none"> ■ Multilateral/bilateral partners supporting HIV prevention, societal enablers, KPs. ■ KP networks and community organisations. ■ Independent consultants, academia ■ Selected government officials – MOH/NAP/NAC.
Evaluation Criteria: Sustainability: This question is concerned with how enduring the benefits of the Joint Programme's support for KPs are or are likely to be.		
Evaluation question 10: How sustainable are the results of the Joint Programme's work, particularly for KP-led organisations and responses?		
This question explores the extent to which the Joint Programme's activities and results have the potential to be sustained over the medium-longer term (5-7 years) and factors affecting the sustainability of the Joint Programme's results and higher-level outcomes.		
Assumptions	Indicators	Sources of Evidence
<p>10.1 Joint Programme activities and results are influential (e.g. on partners' strategies and implementation) and leverage resources to sustain Key Population-led organisations and responses.</p> <p>10.2 Sufficient political will, country health systems capacity and resource availability exist to continue the required level of programmatic implementation such that outcomes are sustained in the medium-longer term.</p>	<ul style="list-style-type: none"> ■ Changes in strategies, investment and implementation approaches of multilateral and bilateral partners reflect Joint Programme advocacy and interventions that promote sustainable KP-led responses and service delivery. ■ Joint programme support to more sustainable programming mechanisms such social contracting mechanisms between Governments and NGOs and Joint Programme support to capacity building of KP organisations to meet social contracting requirements. ■ Improved trends in domestic investment in relation to KP responses (amounts, sources, allocation). 	<p><u>Data and documents</u></p> <ul style="list-style-type: none"> ■ Joint Programme documents, bi-and multilateral strategies, plans and reports. ■ Domestic and international funding data found in NSPs, Global Fund and PEPFAR documents. ■ National Health Accounts on HIV allocations and spend. ■ ToR on technical support for financing and sustainability including costing exercises. ■ Policy statements/Press reports regarding shifts in awareness and funding for KPs. ■ Domestic resource mobilisation strategies for HIV; UHC health care financing strategies.

Assumptions	Indicators	Sources of Evidence
	<ul style="list-style-type: none"> ■ Integration of HIV budgeting and resource allocations into national efforts to leave no one behind e.g., such as the development of national health insurance schemes and social protection programmes. ■ Perceptions of stakeholders of the sustainability of UNAIDS Joint Programme interventions and the contribution to sustaining KP responses. 	<p><u>Interviews, group discussion, site visits</u></p> <ul style="list-style-type: none"> ■ KP networks and community organisations. ■ UNAIDS Sec and Cosponsors including World Bank. ■ National and sub-national health authorities/National AIDS programmes. ■ National HIV Commissions. ■ Ministry of Finance; Ministries of Social Welfare. ■ Multilateral/bilateral partners supporting HIV prevention, societal enablers, KPs. ■ CCM representatives; representatives from other health sector coordination platforms.



20 Avenue Appia
1211 Geneva 27
Switzerland

+41 22 791 3666
distribution@unaids.org

unaids.org

