

# Evaluation of the National HIV Prevention Program for Key Affected Populations, Migrant Workers and Prisoners

Final Report

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Institute for Population and Social Research  
Mahidol University



## EXECUTIVE SUMMARY

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The Institute for Population and Social Research (IPSR) of Mahidol University was selected by the National Committee for the Advancement of AIDS Prevention and the National AIDS Management Center (NAMc) to implement the *Evaluation of the National HIV Prevention Program among Key Affected Populations and Prisoners in Thailand* during 2010 – 2013. The second phase of the evaluation spanned the period from October 2011 – December 2012 and consisted of an in-depth study of program inputs, processes, and expected outcomes of the program. Among others, the **key research questions** for the evaluation include: whether interventions are being implemented as planned as an integrated, defined package of HIV prevention services and defined standards of quality; the extent of coverage of the delivery of the HIV prevention package to the target populations; and the results of the delivery of the package of prevention services in terms of the increase in the proportion of the population who know their own sero-status, the reduction of HIV risk behavior, the reduction of STIs, and increased access to ART and opportunistic infection (OI) treatment.

**Methods.** The NAMc evaluation study used both **qualitative and quantitative methods** to answer the research questions. The same study sites were used for both the service study and population study for FSWs, MSM and PWID. Systematic sampling using the probability proportionate to size (PPS) method was used to select three provinces for the FSW and MSM study and two provinces for the PWID study. **Quantitative surveys** were conducted using respondent driven sampling (RDS) in three sites for FSWs and MSM. The IBBS conducted by the Bureau of Epidemiology is used to present quantitative findings for PWID. A survey of a sample of prisoners was conducted in three prisons using handheld devices. The provinces selected are anonymized as the evaluation design was not intended to single out particular provinces, but to represent provinces with typical strengths and weaknesses. Bangkok, the capital city, was selected for all populations due to its large population size, and its uniqueness makes it not possible or beneficial to anonymize these results.

The **service component** of the study used conducted facility audits using in-depth interviews and document review; assessed routine monitoring data including the process of data collection, quality of data and role of the PCM; conducted a quality assessment by comparing service quality to international standards for HIV prevention programs; conducted observations of peer education service delivery; and assessed KAP satisfaction and participation through in-depth interviews.

**Results.** The quantitative surveys found that **coverage of key program components is lower than desired**. From 20-37% of venue-based FSWs were reached by **outreach** in the past year, but only 11-20% of non-venue-based FSWs. Among MSM, transgender (TG) (28-39%) and male sex workers (MSW) (18-70%) were reached by outreach at a higher rate than general population MSM (12-33%). By site, the MSM program in Province B and MSW in Bangkok were reached at a higher rate than others. For PWID, the results varied greatly by site, with 54% in Bangkok reached but only 27% in Province C. The prison outreach program showed good coverage although the results varied by prison; 1 of 3 inmates in the Bangkok prison were reached, but 2 of 3 in Province D and 3 of 4 in Province E.

**Drop-in centers** for FSWs and MSM had very low coverage (2-16%), and most respondents surveyed were not aware of the drop-in center in their community. The exception is MSW in Bangkok, where

41% reported visiting the drop-in center. Drop-in centers for PWID had higher coverage (28-53%), especially in Bangkok where more than half said they had been to the drop-in center in the past year. The information corner in the prison was visited by the majority of prisoners in Province D & E (61-66%) but only 27% of those in the Bangkok prison.

Coverage of the **condom, lubricant and safe injection equipment programs** was found to vary by site in the quantitative survey. From 70-87% of FSWs and MSM in Province B reported receiving a free condom in the past year, but only 31-60% in Province A and Bangkok. The exception is MSWs in Bangkok where 78% received a condom. The qualitative studies found that there was a mismatch of condom size supply and demand for both FSWs and MSMs. Both groups reported that the quality of the lubricant did not meet the standard. From 22-45% of PWID reported receiving a condom, but it should be noted that the low sex drive among some PWID affects demand for condoms. In the prisons, 24-38% of the inmates reported receiving condoms in the past year; some prisons do not officially allow condom distribution, and most condoms are targeted to TG and other MSM. Regarding safe injection equipment, 29% of PWID in Province A and 54% of those in Bangkok received it in the past year. The qualitative study found that safe injection equipment distribution and outreach are affected by law enforcement.

Rates of STI screening for FSWs and FSWs were found to be lower than the guideline for screening twice a year. Venue- and non-venue based FSWs were screened at about the same rate (39-52% screened in the past year). Coverage of STI screening for MSWs was low (6-18%). The qualitative studies found that outreach focuses on information communication rather than service promotion, and that the linkage between CSOs and government clinics is not operating effectively. The referral system from outreach to STI services is not being used. Some FSWs prefer the private sector for convenience and confidentiality. For both MSWs and FSWs, specialized and anonymous clinics are frequently used where available.

HCT coverage for the KAPs was found to be somewhat higher than that found by other studies. From 41-65% of FSWs reported being tested in the past year, and the rates for venue-based and non-venue based FSWs were the same. Coverage was lower for MSM (12-46%) with MSWs more likely to be tested than other MSM in Province B. More than half of PWID, both in Province C and Bangkok, reported using HCT services in the past year. The percentage of inmates requesting HCT was 23-39% in Province D & E; in Bangkok, the small percentage (4%) reflects shorter duration in the prison.

Regarding quality of services, the studies rated programs strongly in maintaining **clients' rights to services**. Both qualitative and quantitative evidence found few problems with stigmatization by service providers. The need for confidentiality was protected well by the KAP services, although anonymity is not possible at the government clinical services for STI screening and HCT. However, MSM and prisoners have not participated in services, and there have not yet been any client satisfaction assessments. There is some, but inadequate, participation of FSW and PWID in services.

Several aspects of the international standard for the service package for KAPs were found to be met by the program to a greater or lesser degree. These are **outreach to motivate and assist access** to services; that field staff are **knowledgeable** on prevention and services; that field staff are **mindful of a safe environment and maintain ethical and professional behavior**; that outreach services and HCT/STI services are offered at **convenient times**; and that prevention material resupply for the

populations is convenient. Other dimensions of service quality were found to fall short of international standards for KAP prevention programs. **No standard operating procedures (SOP) are available** for use by the programs, and there is **no regular monitoring of quality or indicators measuring quality**. For this reason, the programs were found to vary greatly from site to site. Also, there was a lack of standard informational resources for the programs, either as a reference for staff or in the form of behavior change communication tools. Other limited aspects of the program include that clients for the most part **do not receive risk assessments** and **there is little development of BCC media**.

With regard to monitoring, the FSW, MSM and PWID outreach programs have an operating UIC system but there is no linkage with the service provider system. Refresher training for field staff on monitoring and supervision of service quality is also implemented for the FSW, MSM and PWID outreach programs but not the prison peer education program. However, implementation is sporadic, and there is a lack of monitoring during actual implementation. By contrast, the HCT/STI providers have received in-service training on client monitoring.

Despite the qualitative components' conclusions that the outreach and clinical services are not well integrated, the quantitative results found a **positive relationship between contact with an outreach worker and health-seeking and HIV prevention behavior**. While not all populations at all sites are included in this finding, significant associations were found between exposure to the outreach program and consistent condom use among MSM, higher STI screening rates among FSWs and MSM, higher HCT service use among FSWs, MSM and prisoners, and lower injection equipment sharing among PWID. Outreach is also associated with higher levels of HIV knowledge in some study sites.

The finding that contact with an outreach worker is associated with higher use of services, while admittedly in a context of generally low coverage, provides additional evidence that the HIV prevention model providing a package of services has merit. The report also highlights some key differences between study sites, particularly in program management and in technical support. This evidence should guide the program in re-allocation of resources and refocusing the prevention effort.

## ACRONYMS AND ABBREVIATIONS

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ACHIEVED	Aligning Care and Comprehensive HIV-Prevention among Youth, MARPs, Children infected and affected by HIV/AIDS and other vulnerable children by Promoting Integrated Outreach and Networking with Government Decentralization to Achieve Coverage and Impact
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
BATS	Bureau of AIDS, TB and STI
BCC	Behavior Change Communication
BMA	Bangkok Metropolitan Authority
BoE	Bureau of Epidemiology
CCM	Country Coordinating Mechanism
CHAMPION	Comprehensive HIV-Prevention Among MARPs by Promoting Integrated Outreach and Networking
CSO	Civil Society Organization
DDC	Department of Disease Control, MOPH
DiC	Drop-in Center
DoC	Department of Corrections
ERB	Ethical Review Board
FHI	Family Health International
FSW	Female Sex Workers
FY	Fiscal year
GARPR	Global AIDS Response Progress Reporting
HCC	Health Counterparts Consulting
HCT	HIV Counseling and Testing
HIV/AIDS	Human immunodeficiency virus infection / acquired immunodeficiency syndrome
HIV+	HIV positive
HPMRG	Hard-to-Reach Population Methods Research Group
HPV	Human papillomavirus
IA	Implementing Agency
IBBS	Integrated Biological and Behavioral Survey
IPSR	Institute of Population and Social Research
KAP	Key Affected Population
MIS	Management Information System
MMT	Methadone Maintenance Treatment
MOPH	Ministry of Public Health
MSD	Medical Services Department, DoC
MSM	Men Who Have Sex With Men
MSW	Male sex worker
NAMc	National AIDS Management Center
NGO	Non-Governmental Organization
NHSO	National Health Security Office
OI	Opportunistic infection

OPD	Out-patient Department
PCM	Provincial Coordinating Mechanism
PCMO	Provincial Chief Medical Office
PCU	Primary care unit
PDA	Personal Digital Assistant
PHAMIT	Prevention of HIV/AIDS among Migrant Workers in Thailand
PLHIV	People living with HIV
PPAT	Planned Parenthood Association of Thailand
PPS	Probability proportionate to size
PR	Principal Recipient
PSI	Population Services International (Thailand)
PWID	People Who Inject Drugs
RDCO	Regional Disease Control Office
RDS	Respondent-Driven Sampling
RIHIS	Routine Integrated HIV Information system
RSAT	Rainbow Sky Association of Thailand
RTF	Raks Thai Foundation
S&D	Stigma and discrimination
SDP	Service delivery point
SOP	Standard Operating Procedures
SR	Sub-recipient
SSR	Sub-sub-recipient
STIs	Sexually Transmitted Infections
SWING	Service Workers in Group Foundation
TB	Tuberculosis
TDN	Thai Drug Users Network
TG	Transgender
TOT	Training of trainers
TRC	Thai Red Cross
TRP	Technical Review Panel
TTAG	Thai Treatment Action Group
TUC	Thailand MoPH – U.S. CDC Collaboration
UIC	Unique Identifier Code
UNAIDS	United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund

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# 1. INTRODUCTION

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## 1.1 Background

Thailand has achieved international recognition for being one of the few countries to reverse the HIV epidemic before its natural peak. However, in the past three to four years, there is mounting concern that HIV might be returning as a new threat in different forms than in the past, and in ways that may be even more difficult to control. For example, female commercial sex work has transitioned from venue-based establishments into indirect and free-lance interactions, which are much harder to intervene with and monitor. Results from HIV surveillance show that the prevalence of HIV among men who have sex with men (MSM) remains high. Also, intravenous drug use is evolving from heroin to other drugs such as methamphetamines without any reduction in risk from needle-sharing. Despite official denial, inmates in Thai prisons continue to have access to drug use by injection and there is unsafe anal sex between prisoners, regardless of sexual orientation.

In order to keep pace with the evolving risk environment, national HIV prevention strategies are emphasizing intensification of intervention programs for the key affected populations (KAP) with parallel programs to improve the prevention environment by reducing stigma among the general public and discrimination towards these populations. At the end of 2008, Thailand received support from the Global Fund Round 8 funding to expand HIV prevention for female sex workers, men who have sex with men, people who inject drugs, foreign migrant laborers and prisoners. The CHAMPION Project, which has been rebranded the ACHIEVED Project in Phase II, has as Principal Recipients (PRs) the Department of Disease Control (DDC) of the Ministry of Public Health (MOPH), Raks-Thai Foundation (RTF) and Population Services International (PSI). Additional support for interventions with KAP came from the National Committee for the Advancement of AIDS Prevention, USAID and the Thai-US Collaboration, among others. These programs were built upon community-based networks with support from local administrative organizations and Civil Society. International best practice experience in working with KAP such as these demonstrate that the most effective approach is to deliver an integrated package of services for those in need, conduct effective behavior change communication (BCC), increase access to condoms and lubricant, and provide harm reduction for people who inject drugs (PWID).

An integral part of this intensified prevention program is the evaluation of the inputs, processes, outputs and outcomes of the interventions. Thailand is well-known for its extensive collection of behavioral and biological data on the HIV epidemic and associated risk practices, and has independently developed innovative data collection tools to keep pace with the evolution of HIV spread. Wherever possible, Thailand involves local communities in the design and collection of data for these systems.

The Institute for Population and Social Research of Mahidol University was selected by the National Committee for the Advancement of AIDS Prevention and the National AIDS Management Center (NAMC) – on behalf of the Global Fund Country Coordinating Mechanism (CCM) – to implement the ***“Evaluation of the National HIV Prevention Program among Key Affected Populations and Prisoners in Thailand”*** during 2010 – 2012. The second phase of the evaluation spanned the period from August 2011 – October 2012 and consisted of an in-depth study of program inputs, processes, and expected outcomes of the program. The intention was to apply the results from the evaluation

to inform the implementation plan of the national program and to refine the prevention strategies. The data on inputs and processes that were collected from service providers can be used to define gaps in services and coverage, expose weaknesses and strengths of implementation (services and resource allocation), describe the extent of adherence to performance standards, and identify barriers to implementation. Data collected from the intended beneficiaries of the program can be used to forecast population impact as well.

## 1.2 Objectives of the evaluation

1. To evaluate the quality, coverage and efficiency of HIV prevention for KAP and prisoners.
2. To promote the use of the evaluation findings to inform the design of strategies, implementation and refinement of interventions supported by the Global Fund.

## 1.3 Research questions

This study attempted to answer the following evaluation questions as stipulated by the National Committee for the Advancement of AIDS Prevention:

1. Are all interventions being implemented as planned?
2. Are interventions reaching the intended and right clients?
3. Are interventions being implemented according to:
  - a. An integrated, defined package of HIV prevention services; and
  - b. defined standards/good quality (quality and intensity)?
  - c. If not what is missing and why?
4. To what extent do the key interventions appropriately address stigma and discrimination toward KAP?
5. To what extent is gender integrated into program planning, implementation, and capacity building of key interventions?
6. Are members of the target population satisfied with the interventions and services provided? How is the program design and actual service delivery informed by clients' needs and satisfaction?
7. What are appropriate tools and mechanisms, particularly the Provincial Coordinating Mechanism (PCM) for implementers to monitor regularly both the coverage and the behavior change reached through prevention services?
8. What is the extent of participatory involvement of KAP in planning and evaluating services?

9. What was the extent of coverage of the delivery of the HIV prevention package to the target population?
10. What were the results of the delivery of the package of prevention services in terms of the following:
  - a. Increase in the proportion of the population who know their own sero-status;
  - b. Reduction of HIV risk behavior;
  - c. Reduction of STI; and
  - d. Increased access to ART and opportunistic infection (OI) treatment.

The full “Request for Proposals” document may be found in Appendix 9.3.

#### **1.4 Benefits of the Evaluation**

In addition to being of direct benefit for the improvement and development of the national HIV prevention program implementation, the data from this evaluation study will be useful for the evaluation of the 5-year National AIDS Plan which began in 2012.

## 2. METHODOLOGY

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The evaluation study used both qualitative and quantitative methods to answer the research questions. The same study sites were used for both the service study and population study for female sex workers (FSWs), men who have sex with men (MSM) and people who inject drugs (PWID). For PWID, the timing of the fieldwork, the sites selected and the questionnaire were very close to that of the Bureau of Epidemiology (BoE) Integrated Biological and Behavioral Survey (IBBS). Because having two surveys of the same small population at the same time could have a negative impact on PWID, a mutual decision was made for IPSR to instead utilize the IBBS data for the evaluation. For prisoners, as described below three large male prisons were selected for the study and both the qualitative study and the quantitative survey were conducted in these sites. The migrant worker intervention is not covered in this report, as IPSR conducted a qualitative and quantitative evaluation of the Prevention of HIV/AIDS among Migrant Workers in Thailand (PHAMIT) project within the same time frame.

Because the research questions for the evaluation concerned the operations of the programs at the implementation (provincial) level, the study did not collect data from the central coordination unit (NAMc) or program management units (principal recipients (PRs), sub-recipients (SRs), or sub-sub-recipients (SSRs)). Both the qualitative and quantitative components focused intensively on a sample of provinces and Bangkok to evaluate the programs.

The methodology and study tools were reviewed intensively by the MOPH DDC's Ethical Review Board (ERB) and revisions were made according to their comments.

### 2.1 Selection of Study Sites for FSW, MSM and PWID Study

The sampling frame for the evaluation is the universe of provinces covered by the Global Fund HIV prevention program (a total of 45 provinces). While it is acknowledged that there are members of the KAP populations (particularly FSW and MSM) living in other provinces, this strategy reaches the majority of the targeted populations and is the appropriate sampling frame given that the focus of the study is on the package of services.

Because the study design is intensive—using a number of methodologies to gain a good understanding of the services and of the size and location of the populations within each province—IPSR selected a small number of provinces for the study. Two provinces were selected for PWID. Because MSM and FSW populations contain a great deal of overlap, these two populations were studied in the same provinces; three provinces were selected for MSM and FSW.

IPSR obtained monitoring data on the number of people reached by the HIV prevention program for FSW, MSM and PWID in 2011, and used provincial-level monitoring data as a proxy for population size (shown in Appendix 9.2, Table A2.1). The number reached by the program is an appropriate estimate for the population of the group because the objective of the study is to evaluate the program. Hence the sampling method gave greater weight to locations where a larger number of the population has been reached.

The probability proportional to size (PPS) sampling method was used to select three provinces for FSWs and MSM and two provinces for PWID. This is an appropriate method to use for this type of study where we want to learn about services available for a large number of population members (e.g. Bangkok), but also for medium and small size places. The method allows the larger provinces to have a higher probability of being selected in the first stage. By sampling exactly the same number of individuals (KAP) per province in the second stage, individuals in large provinces have a smaller probability of being sampled (shown in Table 2.4) (Babbie, 2011). Overall, the second stage compensates for the first stage, so that each individual in the population has the same probability of being sampled. Provinces were listed in the same order as was used for the monitoring data (regionally). A column with the cumulative sum of the population is calculated so that (using the example of FSWs) Bangkok is allocated number 1 through 6984, Nakhon Pathom number 6985 to 7319, etc. (see Appendix Table A2.1). The sampling interval is calculated by dividing the total population by the number of provinces to be selected. A random number between 1 and the sampling interval is then generated using a random number generator. This is used as the random starting point to select the first province. Subsequent provinces are selected by adding the sampling interval to the random starting point.

The results are shown in Table 2.1. The provinces selected are anonymized throughout the report as the evaluation design was not intended to single out particular provinces, but to represent provinces with typical strengths and weaknesses. Bangkok, the capital city, was selected in both samples due to its large population size, and its uniqueness makes it not possible or beneficial to anonymize these results.

**Table 2.1. Population study sites by key affected group**

FSWs & MSM	PWID
Capital City	Capital City
Province A	Province C
Province B	

## 2.2 Population Survey Research Design

### 2.2.1 Female Sex Workers (FSW) and Men Who Have Sex with Men (MSM)

#### **Sampling methodology**

One of the key objectives of the population survey is to estimate the coverage of the program among the key affected populations. For this purpose, it is important that a representative sample of each population should be reached, including “hidden populations”—such as non-venue based female and male sex workers, “underground” MSM, and PWID who are not visible—as well as more visible members of the populations. This is because it is important to see if services are reaching all of these sub-groups. Also, the sampling design must be systematic so that it is replicable in the case that a follow-up survey is conducted.

Respondent-driven sampling (RDS) is a systematic sampling method that has become increasingly used in recent years to survey hard-to-reach populations. The method takes advantage of the social networks that these populations have to recruit other members for the survey. Unlike snowball sampling, RDS techniques are designed to produce probability samples. Key features of RDS techniques include quotas on the number of respondents recruited by informants, an incentive

system to increase the likelihood of recruitment, and software that adjusts the resulting sample based on the social networks of the respondents. RDS has been used successfully in Thailand for previous surveys of key affected populations (Heckathorn, 1997; Johnston & Sabin, 2010; Whitehead et al., 2007; Yongvanitjit et al. 2010).

The RDS method begins by first recruiting “seeds” who give the first interviews and begin the recruitment process. Seeds were chosen who had strong social networks, were respected by their peers, and were supportive of the research (Johnston & Sabin, 2010). In addition, seeds were chosen who represented important sub-groups for the populations. From 5 to 10 seeds from each population group were recruited for each site. IPSR conducted small group discussions with potential seeds at the outset of the fieldwork to explain the objectives and logistics of the study, and to choose seeds who best fit the desired characteristics. IPSR also recruited additional seeds after the beginning of fieldwork if the initial seeds were not successful at recruitment. The characteristics of the seeds in each site are shown in Table 2.2.

Each seed was assigned an ID number and was given three coupons for them to recruit three other population members. Incentives for respondents were set at a level that was high enough to motivate them to participate in the study, but not too high as to attract people from outside of the population group to pose as group members. Seeds were paid 500 baht for their participation in the initial group discussion and their interview. All other respondents were given 350 baht for their interview. Seeds and subsequent respondents were also given 50 baht for each respondent they recruited who was eligible for the study and who completed an interview.

The first three respondents recruited by the seeds are called the first wave; the respondents recruited by the first wave are called the second wave, and so on. One of the key assumptions of the RDS methodology is that the greater the number of waves, the greater the amount of variation in the resulting sample. It is desirable for each seed to recruit at least four waves.

**Table 2.2. Characteristics of FSW and MSM seeds for three study sites**

Seed no.	Province A	Province B	Capital City
<b>Female sex workers</b>			
1	Age 32, meets clients at karaoke bar	Age 35, meets clients at karaoke bar	Age 43, works at a-go-go bar
2	Age 43, meets clients via the internet	Age 44, works at traditional massage	Age 33, meets clients at karaoke bar
3	Age 26, meets clients at karaoke bar	Age 33, works at traditional massage	Age 49, meets clients at a restaurant
4	Age 40, meets clients via the internet	Age 40, works at karaoke bar	Age 41, works in a karaoke bar
5	Age 38, works at massage parlor with rooms onsite	Age 27, works at karaoke bar	Age 24, meets clients via the internet
6		Age 38, works at massage parlor with rooms onsite	Age 23, meets clients on the street
7		Age 20, works at karaoke bar	Age 29, meets clients at public tourist site
8		Age 25, meets clients via the internet	Age 35, works at traditional massage
9			Age 39, meets clients on the street

Seed no.	Province A	Province B	Capital City
<b>Men who have sex with men</b>			
1	Age 19, student, self-identified gay man	Age 24, daily wage earner, transgender	Age 34, private employee in entertainment business, transgender sex worker
2	Age 22, not working or studying, transgender	Age 28, neither working nor studying, transgender	Age 21, service employee, self-identified gay man
3	Age 20, day laborer, transgender	Age 22, student, self-identified gay man	Age 41, service employee, attracted to both men and women, self-identified bisexual, male sex worker
4	Age 20, self-identified heterosexual, attracted to both men and women, male sex worker	Age 20, student, self-identified "tud", transgender	Age 51, service employee, transgender
5	Age 24, private employee, transgender	Age 26, private employee, self-identified bisexual, male sex worker	Age 21, self-identified gay man
6	Age 24, self-identified gay man, male sex worker	Age 26, transgender, male sex worker	Age 28, transgender
7	Age 36, self-identified "tud", transgender	Age 30, government official, transgender	Age 27, self-identified gay man, male sex worker
8	Age 27, works at private business, self-identified gay man		Age 20, student, self-identified gay man
9	Age 23, private employee, transgender		Age 37, professional, self-identified gay man
10			Age 20, student, self-identified gay man

During fieldwork, data from the screening survey (described below under "Survey Protocol") was entered into a spreadsheet and analyzed every week using RDSAT software (Volz et al., 2012). The software analyzes such factors as the number of waves recruited by each seed and homophily (the degree to which respondents are recruiting people who are similar to themselves). It also analyzes whether the sample has reached equilibrium, meaning that recruiting additional respondents will not change the composition of the sample according to key characteristics of interest. IPSR analyzed whether the FSW sample reached equilibrium for age and type of venue for recruiting clients; it analyzed the MSM sample for age, sexual identity, and sex worker status. Once the target sample size was reached in each site, fieldwork continued until equilibrium was reached.

### Sample size

Several considerations were taken into account to calculate the needed sample size for the study. First, the sample size should be sufficient to detect that the populations have reached national targets for the two key outcomes of interest (condom use with last non-regular/paid partner and knowledge of HIV status) by the time of the follow-up survey in 2014.<sup>1</sup> Minimum sample size was calculated using the standard formula, setting the significance level at 10%, 90% power and design effect of 2.0. Baseline estimates and targets for the two key behavioral indicators are shown in Table 2.3, drawn from the national program's baseline and target figures for 2014 for the National Strategic Plan.

**Table 2.3. Calculation of minimum sample size required for population groups to detect change over time with 90% power, 10% significance level and design effect of 2.0**

Baseline percent	Know status			Baseline percent	Condom use		
	2014 target	Minimum sample size	Proposed sample size		2014 target	Minimum sample size	Proposed sample size
36.0	55.0	89	1200	88.9 <sup>2</sup>	93.0	643	1200
21.3	32.5	204	1305	80.5 <sup>3</sup>	83.9	240	1305
59.7	91.2	23	715	30.8 <sup>4</sup>	43.8	181	715

The table shows both the minimum sampling size derived from the formula and the proposed sample size. All of the proposed samples are large enough to detect a change in the key indicators by 2014. By province, sample sizes by population are shown in Table 2.4. Following the PPS sampling design, an equal number of respondents were interviewed in each province.

**Table 2.4. Sample size for basic questionnaire by population and province**

	FSWs	MSMs
Capital City	400	435
Province A	400	435
Province B	400	435
<b>Total</b>	<b>1200</b>	<b>1305</b>

<sup>1</sup> At the time that sample size was calculated, a follow-up survey in 2014 was planned.

<sup>2</sup> Last client.

<sup>3</sup> Last anal sex

<sup>4</sup> Last sexual intercourse



***Survey protocol***

A site was rented for the FSW and MSM survey in each study province. Sites were chosen that were centrally and conveniently located. The sites were set up so that the coupon managers for the two surveys were the first to greet the respondents when they entered the site. After identifying the respondent as either an FSW or an MSM, the appropriate coupon manager received and noted the respondent's coupon number. He or she then screened the respondent for eligibility using the screening questionnaire (Appendix 9.1). The coupon manager also sometimes probed the respondent to make sure that the person was a legitimate member of the target population, to screen out those who were posing as a member to obtain the survey incentives.

If eligible, the respondent was then given a verbal explanation of the study and was given time to read a written information sheet. If the respondent chose to participate in the study, he or she read and signed the consent form. The coupon manager then continued the screening questionnaire, which included questions about their relationship with the person who recruited him or her. After completing the screening questionnaire, one of the field team then interviewed the respondent using the full questionnaire (Appendix 9.1). The full interview took about one hour. Once it was finished, the coupon manager interviewed the respondent about the size of his or her social network among other members of their population in the province. These post-interview questions (Appendix 9.1) are important for weighting the data according to the size of the social network, and for explaining the criteria for the respondents to be recruited. The coupon manager then gave the respondent three coupons, explained the recruiting process, and paid the respondent their incentive for participating.

***Network diagrams***

The results of the RDS sampling strategy are shown in Appendix 9.2, Figures A2.1-2.12. Diagrams are presented for each site and each population, color coded by age group, venue/non-venue status (for FSWs) and MSM group (for MSM). The diagrams show that the populations recruited other members across age groups and other subgroups; most seeds recruited at least four waves of respondents and some as many as twenty waves.

***2.2.2 Closed setting population***

To study closed setting populations, IPSR consulted closely with the Department of Corrections and the Thailand-U.S. Center for Disease Control Collaboration (TUC). TUC conducted a quantitative survey of 1,571 prisoners in three provinces (Chiang Rai, Udon Thani and Khon Kaen) in mid-2011 as a follow-up to one conducted in 2008. IPSR used the same sampling methodology that TUC had used, and a similar questionnaire. TUC also contributed the time of a programmer to set up the questionnaire on hand-held Personal Digital Assistants (PDAs), lent the PDAs to IPSR for the survey, provided training, and accompanied the survey team to the prisons.

***Sampling strategy and sample size***

The Department of Corrections and TUC advised IPSR to draw the sample from adult men's prisons rather than juvenile detention facilities, as juveniles tend to spend a shorter time in detention and might not be exposed to the HIV prevention program. Men only were surveyed, as they face multiple HIV risks when incarcerated (anal sex with other men and injecting drug use). Three large men's

prisons were selected from among those who participated in the GFATM HIV prevention program for prisoners, based on the size of the prison and whether prison administration officials gave permission for the survey. The selected prisons were located in the Capital City, Province D and Province E.

The total sample size and the subsample sizes for the three prisons were set using the same methodology as TUC had used for their survey. As shown in the shaded cells of Table 2.5, the sample size is set by calculating a proportion of the total prison population. For the Capital City and Province D, this is 20%; for Province E, 25% was used to assure a minimum sample size to detect a 10% difference in key indicators with  $\alpha=0.05$ , 80% power and a design effect of 2.0 (FHI, 2000:50). The target sample size is then inflated to allow for a 5% refusal rate.

**Table 2.5. Sample Goal and Completed Sample Size for Closed Setting Population Survey**

	Capital City	Province D	Province E	Total
Total male prisoner population	3,668	1,997	1,282	
Prison-specific survey sample sizes:				
10%	367	200	128	
15%	550	300	192	
20%	734	399	256	
25%	917	499	321	
Final target sample size adjusted for 5% refusal rate	771	419	337	1,527
<b>Completed sample size</b>	<b>778</b>	<b>421</b>	<b>344</b>	<b>1,543</b>

*Shaded squares represent selected sample size goal for each prison.*

Simple random sampling was used to select respondents from within the three prisons. This was done by obtaining a list of prisoners who had been in the current prison for at least six months. The list was obtained one or two days before the survey was conducted. The sample was selected from the list using a computer-based random number generator. The completed sample size for the closed population survey is shown in the last row of Table 2.5.

### **Survey protocol**

The survey was administered to the prisoners in groups of about 20-30, depending on the size of the space that was allocated for the survey administration. A group of prisoners who were selected for the survey were contacted by prison staff and brought to a central area where the survey was conducted. Survey staff gave a brief verbal overview of the survey objectives, method of administration and length to the group. Each respondent was given an information sheet and consent form and were given time to read them. Those who agreed to participate then signed the consent form with a member of the survey staff as witness. Any respondent who did not wish to participate simply waited for the rest of the prisoners to finish taking the survey and then returned to the main prison area with the rest of the group.

In the protocol for their previous cross-sectional survey, TUC outlined the reasons that PDAs are the most appropriate method for conducting a closed setting survey (TUC, 2010). These include that the

responses are likely to be more accurate, that prisoners are less uncomfortable and embarrassed when giving responses, and that the responses are kept completely confidential. IPSR was able to use this method for its survey through TUC's contribution of the programming time needed to revise the questionnaire and of the use of the PDAs for the survey.

The respondents took the survey at their own pace using the PDAs, seated in chairs with a bit of space between them. Respondents who finished first waited for the entire group to finish before returning to the main prison area. They were each given a token gift of a towel in appreciation for their participation.

## **2.3 Population Survey Data Analysis**

### ***2.3.1 FSW and MSM Surveys***

The RDS data was analyzed with RDS Analyst, software developed by a team of RDS experts that is still in beta version (HPMRG, 2012). The population estimates were produced using the Giles Successive Sampling estimation procedure (Gile, 2010; Tomas & Gile, 2011). This estimator uses a bootstrap procedure to correct for finite population effects. Tests for significant differences in key outcomes associated with the HIV prevention program were performed by examining whether the confidence intervals in the population estimates overlap.

### ***2.3.2 Prisoner Survey***

Data from the prisoner survey did not require data entry or cleaning since PDAs were used. The data was converted to SPSS for analysis. Chi-square tests were used to examine differences in key outcomes for those exposed or not exposed to the HIV prevention program.

## **2.4 Service Study Research Design and Data Analysis**

### ***2.4.1 Key processes***

The key processes in this study are outlined in Box 2.1 below. IPSR conducted the first activity while Health Counterparts Consulting (HCC) conducted activities 2, 3, and 4.

**Box 2.1: Key processes for the service study**

1. Service mapping (conducted by IPSR)
  - a. Listing
  - b. Schematic mapping
2. Facility audit
  - a. Program manager/provider structured interviews
  - b. Document review
3. Assessment of routine monitoring data
  - a. Review of monitoring data and procedures
  - b. Interview with M&E/program manager
  - c. Interview with PCM members involved with M&E quality control
4. Quality assessment
  - a. Quality checklist
  - b. Client-Provider observation (for outreach only)
  - c. Provider and client in-depth interviews

**2.4.2 Sample Frame**

Six provinces and their respective key affected populations (KAP) were sampled as seen in Table 2.6.

**Table 2.6: Service study sites by key affected group**

FSWs & MSM	PWID	Prisoners
Capital City	Capital City	Capital City
Province A	Province C	Province D
Province B		Province E

**2.4.3 Research methods**

Operational definitions for the service study are shown in Box 2.2

**Box 2.2: Operational definitions for services**

Service	One type of HIV prevention activity.
Facility/ Service delivery point (SDP)	One physical location that provides HIV prevention services. One facility or SDP may provide one or more services.
Package/ combination of services	Multiple services that a client may get at one time.
Coverage	The proportion of a population who have received at least one service in the past 12 months. Coverage may also be calculated for a combination/ package of services.
Quality of coverage	Quality standards are defined by the national program; if national standards do not exist, universal/international standards are used (Weir et al., 2011).

Service uptake	Use of a service by the population for which it is intended.
Adequacy of coverage	Coverage for a minimum proportion of the population for which services are intended. There is no pre-defined level for adequacy of coverage by the KAP HIV prevention program.

The following are the methods of data collection in the study.

*Facility audit:* This audit looks at services for KAP and whether they are implemented according to the program plan, including the management of services, supporting equipment and supplies, and standards of performance. In-depth interviews (IDI) were used with the key facility staff of all types of units under the SR/SSR operating in the province. The audit included review of existing documents. Service facilities were purposefully selected by HCC and IPSR from lists provided.

*Assessment of routine monitoring data:* This was conducted to assess the quality of the data and efficiency of the data system at the program level. The focus was on design of the database for service statistics, double counting, counts of service frequency by type of service and client. In addition, the evaluation team assessed the role of the PCM in program monitoring and their opinion of the data quality.

*Quality assessment:* This assessed quality of services against the Thai National Program’s standard operating procedures or, if none exist, then against international standards defined by UNAIDS, WHO, the Global Fund, and other international and civil society organizations (Weir et al, 2011).

Methods of services evaluation:

*In-depth interviews (IDI)* with service providers and clients from all types of facilities, public and private, including sub-sub-recipients (SSRs) and implementing agencies (IA). The focus was on units/clinics providing STI treatment, HIV counseling and testing (HCT), ART clinics, and outreach units. Ten to 15 KAP service clients were sampled per province.

*Observation* of field staff and volunteers conducting outreach to KAP. There was observation of interaction with two new KAP and one continuing KAP contact per volunteer

*Quality of Service Summary Tables:* Each KAP prevention program was given summary ratings for service quality using Universal Standards for Quality of Services as shown in Box 2.3.

### **Box 2.3. Universal Standards for Quality of Services**

#### **Standards for involving the key affected populations**

- The populations identified for targeted services are included in the needs assessment, planning, delivery and evaluation of the services.

#### **Standards for clients' rights**

- Clients are fully informed of the nature and content of the services as well as the risks and benefits to be expected;
- Confidentiality and privacy of clients is maintained at all times;
- Adherence to human rights; removal of legal barriers to access services; and
- Access to medical and legal assistance for people who experience sexual coercion or violence.

#### **Standards for providing comprehensive package of services**

- Ensure awareness and easy access to all components of the comprehensive package of services; and
- Ensure protocols for delivery of each component of the comprehensive package are updated periodically, disseminated to and adhered to by all service providers.

#### **Standards for staffing**

- Staff receives regular supervision by senior staff to maintain quality of service delivery; and
- Service providers are trained and sensitized to avoid discriminating against the key population

#### **Standards for the availability and accessibility of services**

- Services are accessible to all potential clients irrespective of age, ethnicity, sexual identity, citizenship, religion, employment status, health insurance status, substance use status;
- Services are considered easily accessible with regard to location, transportation options, travelling time and cost;
- Services are equitable and non-discriminatory; and
- Availability of safe virtual and physical spaces (e.g., telephone hotlines and drop-in centers, respectively) for the key population to obtain information and referrals for prevention, treatment and care services.

**Source:** Weir et al. 2011, p. 57.

### 2.4.4 Persons interviewed

A total of 235 persons provided data for this evaluation, drawn from nongovernmental organizations (NGOs), prisons, service facilities, the PCM, and the KAPs themselves, as seen in Table 2.7. The Team conducted 23 observations of outreach worker counseling: 8 for MSM, 5 for FSW, and 10 for PWID. Delays in study approval by the Bangkok ethical review committee resulted in a reduction of the number of interviews with staff there.

**Table 2.7: Number of persons interviewed by study site and type of service provider (number of facilities in parentheses)**

Province	NGO	Prison	Service facility	PCM	Beneficiaries (KAPs)
	Field coordinator, drop-in center (DiC) manager, field staff and volunteers		Program authority/ service coordinator/ health service provider		
Province A	22 (1)	-	18 (3)	2	MSM, FSW =16
Province B	11 (2)	-	6 (3)	1	MSM, FSW =16
Province C	7 (1)	-	6 (4)	1	PWID =8
Province D	-	4	1 (1)	1	prisoners =8
Province E	-	4	1 (1)	2	prisoners =8
Capital City	32 (7)	4	19 (4*)	-	MSM, FSW, PWID and prisoners =37
<b>Total</b>	72	12	51	7	93

**Remarks:** All facilities in Capital City are government except where marked with \* where two facilities are under NGO management.

## 2.5 Limitations of the study

Some limitations of the study methodology should be noted, both for the quantitative surveys and the qualitative methodology. First, it is important to note that the design of the study did not allow for impact evaluation; in other words, an analysis of cause and effect between the intervention and changes in KAP attitudes or behavior, or a comparison of what would have happened in the absence of the program (Ezemenari et al., 1999; Gertler et al., 2011). Instead, to examine the effects of the program, a comparison is made between KAP members who were exposed to program components and those who were not. In the future, multivariate analysis will be conducted to further control for individual characteristics which may be associated with program participation or effects.

Regarding the qualitative study, some other limitations should be noted. In observing the volunteer outreach, the evaluators could not always collect all of the planned data since some IAs did not allow observation. Sometimes it was hard to observe new client contacts since the number was few; thus there are more observations with continuing contacts. The study team was not able to observe more than one interaction with a given continuing contact. Some units did not want the evaluators to stand or sit too close to the client; thus, it was not always possible to hear the content of the

## 2 Methodology

interaction. Also, the time of data collection coincided with the end of the fiscal year and some IAs and halted field activities to await the next year's funding. Finally, the Bangkok Metropolitan Authority (BMA) did not accept the review by the MOPH ERB, instead requiring that the study also be reviewed by the BMA's own committee. This resulted in reductions of the number of interviews possible with staff there. This was especially problematic for the PWID evaluation which was concentrated in only two provinces, including Bangkok.



### 3. FEMALE SEX WORKERS

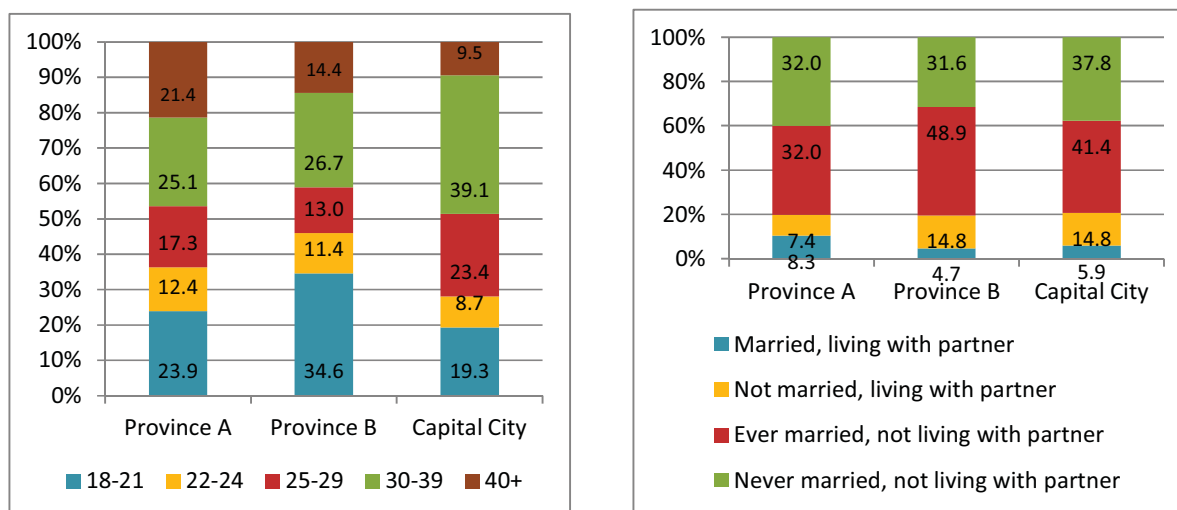
Most of the interventions for female sex workers in Thailand are funded by the ACHIEVED project with Global Fund support. The PR for this component is the Department of Disease Control of the MOPH and the Planned Parenthood Association of Thailand (PPAT) as the SR. The SR is responsible for management of the outreach programs implemented by SSRs, who are mostly civil society organizations (CSOs). These agencies collaborate with other network partners for referral for clinical services for STI screening and HCT services, which are public sector. There is no other funding source for these interventions other than the regular government budget, though some provinces have special projects funded by the TUC to improve standards for diagnosis and treatment of STIs in hospital settings.

The chapter presents synthesized findings of the service evaluation study and population surveys by topic. Characteristics of the FSW survey respondents are presented by site, with graphs showing results for venue/non-venue based FSWs and older/younger FSWs. A full set of tables for FSWs categorized by whether they are venue-based or not, and by age (< 25 or 25+), is found in Appendix 9.2, Section A3.

#### 3.1 Socio demographic and sex work profile

The sample of FSWs in the three sites features a broad range of ages (Figure 3.1). The sample in Province B is somewhat younger than that in Province A or the Capital City, where the median age is 29 (Table A3.1). Non-venue-based FSWs are younger than venue-based FSWs in each site. Few of the FSWs are currently married or living with a partner; fully 80% in all 3 sites are either never married or formerly married and not currently living with a partner (Figure 3.1).

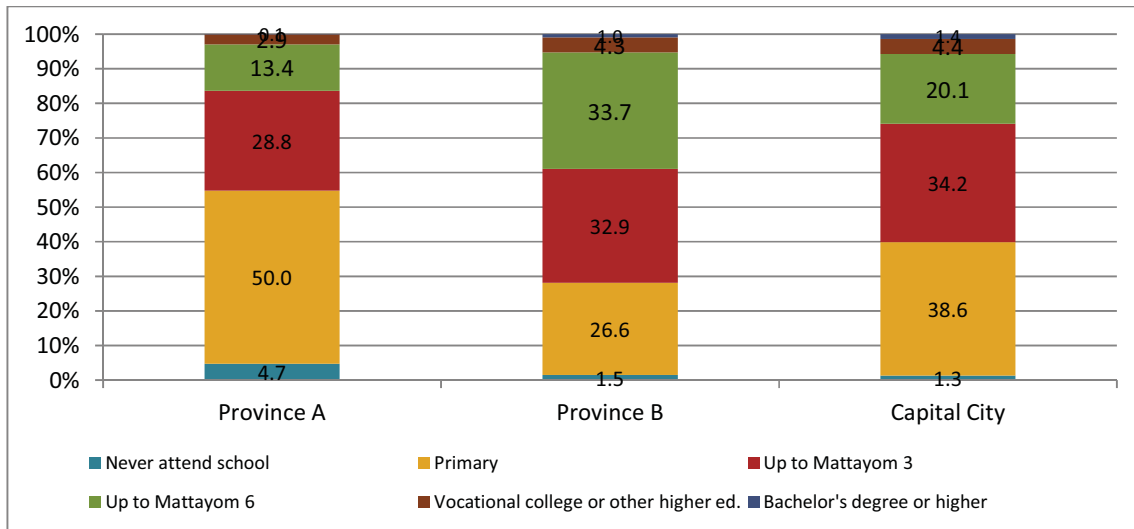
**Figure 3.1 Age distribution and marital status of FSW sample**



The findings for educational attainment show that most of the FSWs have reached Mattayom 3, but there are differences across the three sites (Figure 3.2). The Province A FSWs have the lowest level of education while in Province B about one out of three have a Mattayom 6 education. In Table A3.1

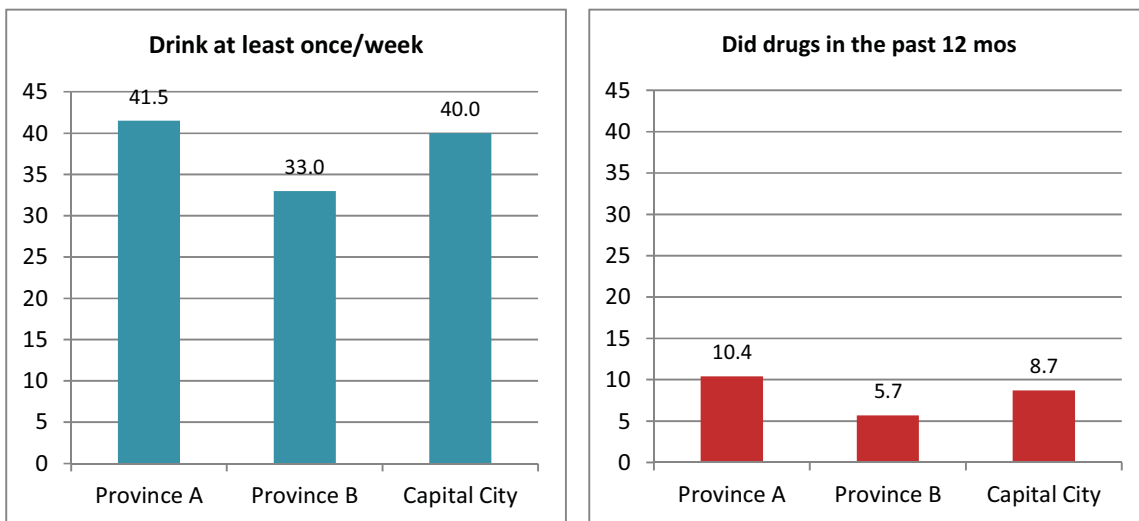
it is seen that venue-based FSWs tend to have higher educational attainment than non-venue based FSWs in Province A and Bangkok, while the opposite is true in Province B.

**Figure 3.2 Educational attainment of the FSW sample**



The survey asked FSWs about alcohol and drug use in the past 12 and 3 months. As seen in Figure 3.4, from 30-45% of FSWs said that they drink at least once a week, with a lower proportion of drinkers in Province B. Less than 10% of the FSWs said that they used illegal drugs in the past year. The most frequently mentioned drugs used were amphetamines and methamphetamines. Only one or two respondents in each site said that they had injected drugs in the past 12 months.

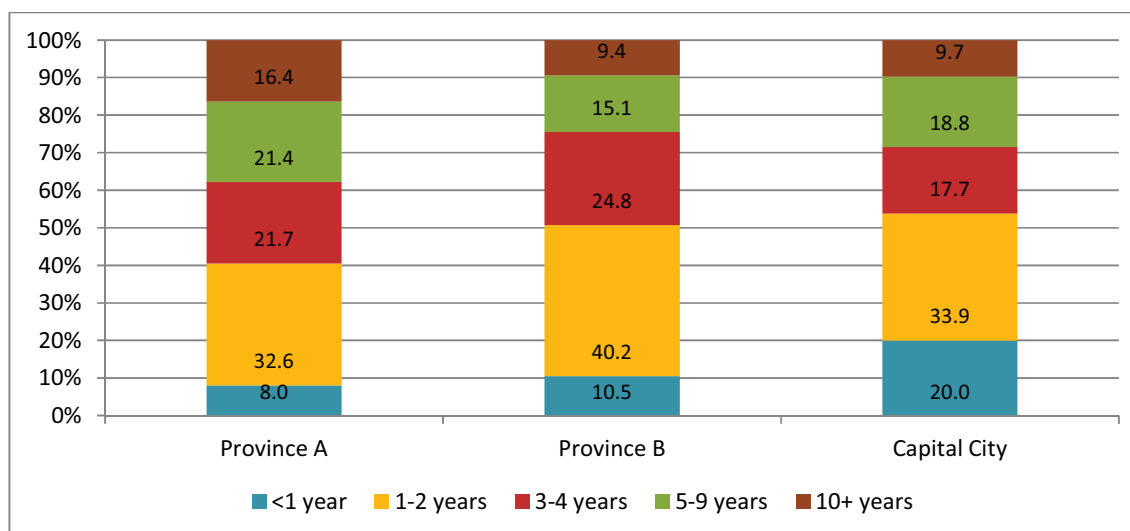
**Figure 3.4 Alcohol and drug use among FSWs surveyed**



The survey also asked the FSWs about some of the details of their work as sex workers. While only about 10% of those surveyed in the provinces were new to sex work, in Bangkok 20% had done sex

work for less than a year (Figure 3.5). Some proportion of the FSWs had worked for 10 years or more in the profession, particularly in Province A where the sample included many older FSWs.

**Figure 3.5 Length of time working as a sex worker**



The FSWs were asked “Where do you usually meet your clients?” as a way to classify the type of sex work that they do. As seen in Table 3.1, the sample is about evenly split between venue-based and non-venue-based FSWs in all three sites. Within each site however, the mix by type of venue or method of meeting clients varies. The Province B sample includes a larger proportion of massage parlor-based FSWs. In Bangkok almost no FSWs who work through a pimp were interviewed. The Bangkok sample also has a larger proportion of street-based FSWs. All sites had a substantial proportion of free-lance FSWs who work through the internet or mobile phone (from 19-37%).

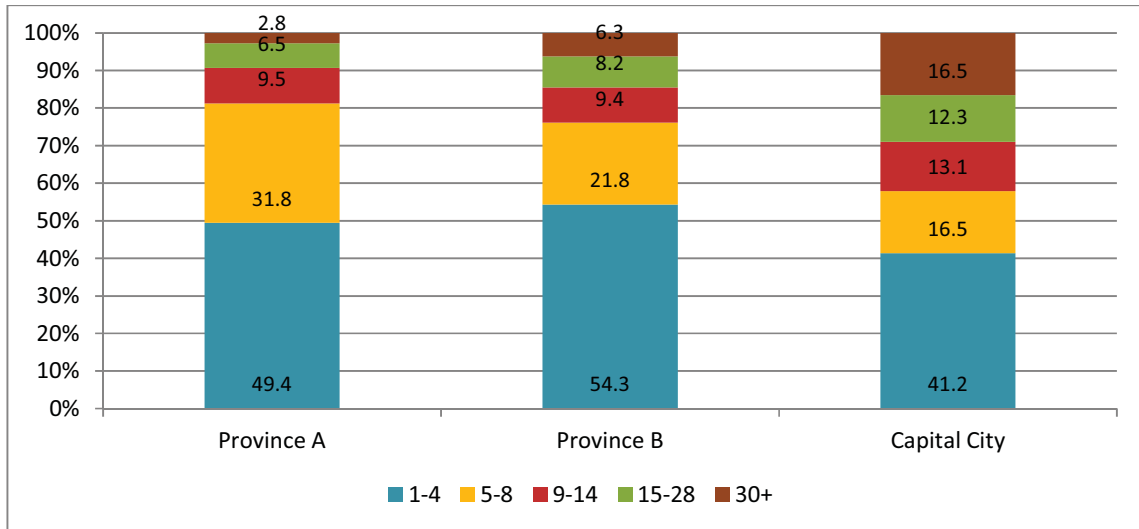
**Table 3.1 FSW venue or method for meeting clients**

	Province A	Province B	Capital City
<b>Venue based</b>			
Massage with rooms/no rooms onsite	4.5	26.4	6.3
Entertainment venue (bar, karaoke, etc.)	46.4	19.5	48.5
<i>Total venue-based</i>	<i>50.9</i>	<i>45.9</i>	<i>54.8</i>
<b>Non-venue based</b>			
Public place (street, canal etc.)	0.6	0.7	24.9
Through a pimp	23.8	16.1	0.9
Freelance (telephone, internet)	23.2	37.4	19.4
Other	0.6	0.0	0.0
<i>Total non-venue-based</i>	<i>49.1</i>	<i>54.1</i>	<i>45.2</i>
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
<b>(N)</b>	<b>(418)</b>	<b>(412)</b>	<b>(430)</b>

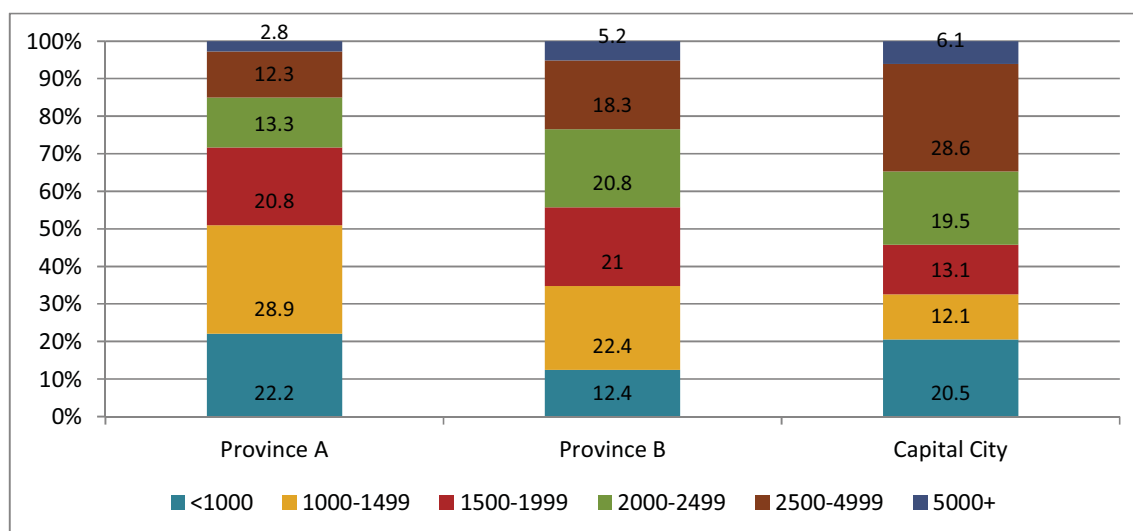
As seen in Figure 3.6, many of the FSWs surveyed have only a few clients per month. Bangkok had a higher proportion of FSWs who had at least 15 clients per month. There is a wide range of prices for the FSWs surveyed (Figure 3.7); the median price in each site (Table A3.2) is highest in Bangkok and

lowest in Province A. While non-venue based FSWs make more money on average in Province A and Province B, the venue-based FSWs make more in Bangkok (Table A3.2). This is likely because there is a large proportion of street-based FSWs in Bangkok. The price pattern for older and younger FSWs is also different in Bangkok; while in Province A and Province B those under 25 obtain a higher price, the opposite is true in Bangkok (1425 baht for under 25 vs. 2000 for 25+. This is likely due to differential distribution in age by type of venue.

**Figure 3.6 Number of clients in the past month**



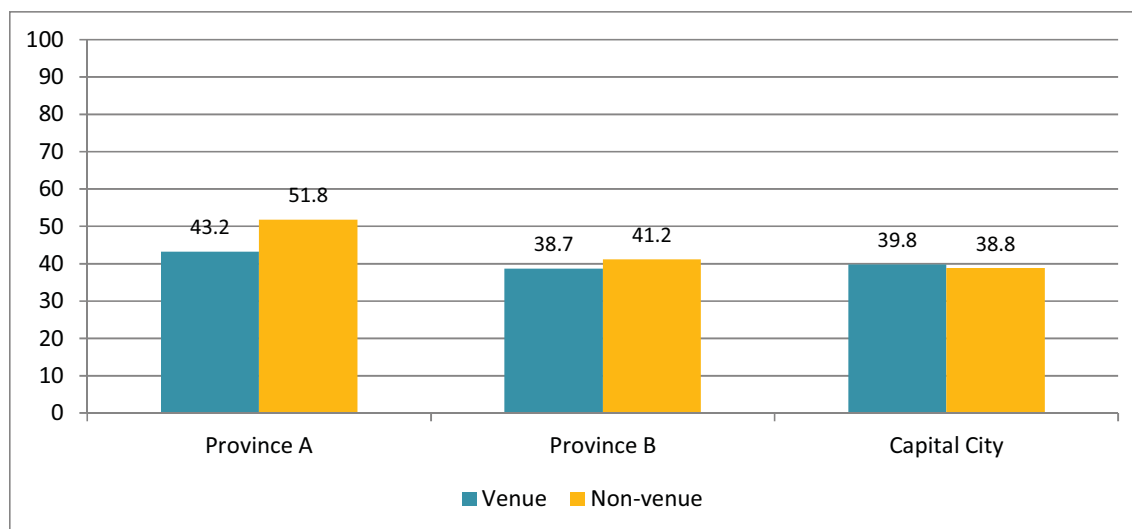
**Figure 3.7 Price paid by the last client (in baht)**

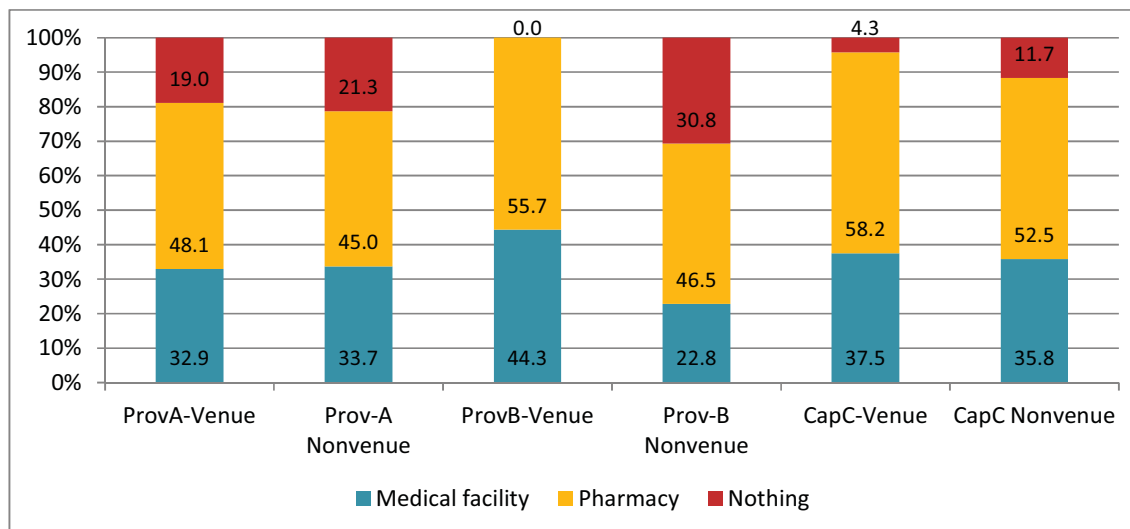


### 3.2 STI knowledge and experience with STI symptoms and treatment

As shown in Tables A3.4 and A3.5, the majority of FSW in Province B and Bangkok can spontaneously name at least one symptom of STIs in women; in Province A less than 50% can do so. When asked whether they experienced any symptoms of STIs in the past 12 months, about 40% said yes across sites (Figure 3.8). About half of the FSWs who had symptoms said that they went to a pharmacy for medication, while about one-third said that they went to a doctor or other medical facility (Figure 3.9). In each site the proportion who said they did “nothing” was higher among non-venue FSWs.

**Figure 3.8 Proportion of FSWs who reported experiencing STI symptoms in the past 12 months**



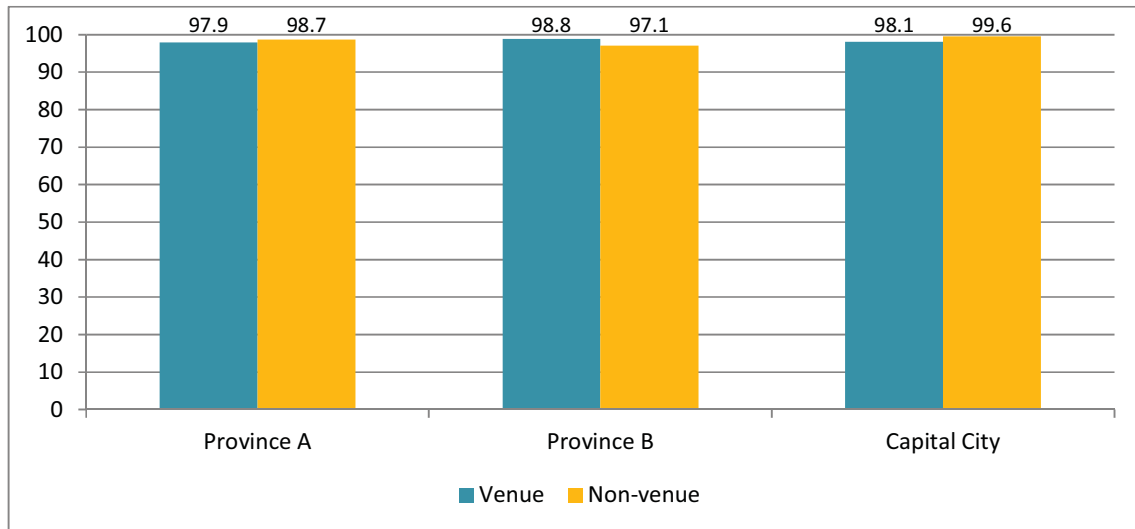
**Figure 3.9 FSW response to STI symptoms (among those who had symptoms)**

### 3.3 HIV knowledge, risks and prevention behavior

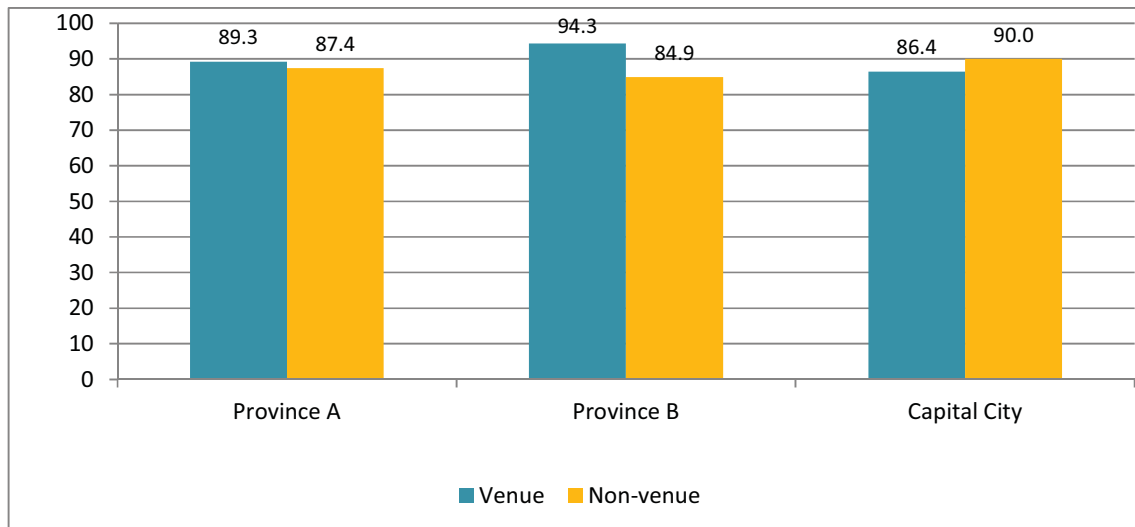
As seen in Tables A3.6 and A3.7, all FSWs sampled were able to answer at least one of the five knowledge questions prescribed by the Global AIDS Response Progress Report (GARPR) correctly. These are answers to the following true/false statements: (1) Using a condom during sex can prevent HIV; (2) Sex between two mutually faithful monogamous partners can prevent HIV; (3) HIV cannot be spread by mosquito bites; (4) HIV cannot be spread by eating with an infected person; and (5) Someone who looks healthy can still have HIV infection. From 22-31% were able to answer all five questions. In Bangkok, non-venue-based FSWs had significantly lower knowledge about HIV.

Tables A3.8 and A3.9, as well as the figures below, present results on FSW risks and preventive behavior. As seen in Figure 3.10, reported condom use with last client is nearly universal for both venue and non-venue based FSWs in all three sites. When asking about the frequency of condom use, we asked a follow-up question to those who said that they used a condom “every time”. When asked, “Was there any time in the past six months that you didn’t use a condom with clients?” about 12-15% of those who answered “every time” said yes. This follow-up question was used to revise the results on frequency of condom use to a more accurate figure. In Figure 3.11, it is seen that reports of consistent condom use with clients are just under 90% for the three study sites. In Province B, non-venue based FSWs were significantly less likely to say that they used condoms consistently with clients. As seen in Figure 3.12, older FSWs were also more likely to report consistent condom use with clients than those under age 25 in Province B and Bangkok

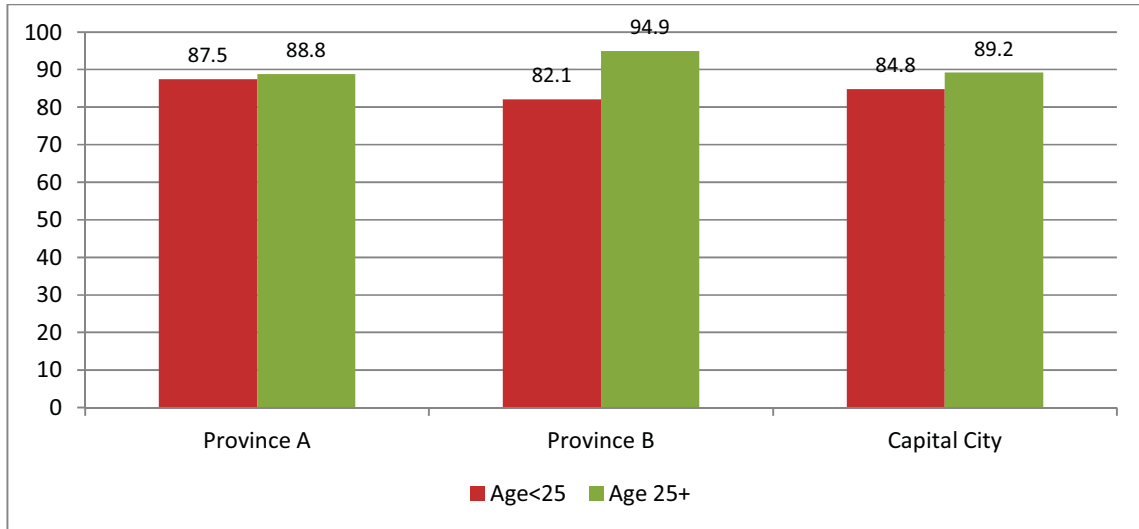
**Figure 3.10 Percentage of venue- and non-venue based FSWs reporting that they used a condom with their last client**



**Figure 3.11 Percentage of venue- and non-venue based FSWs reporting that they use condoms every time with clients**

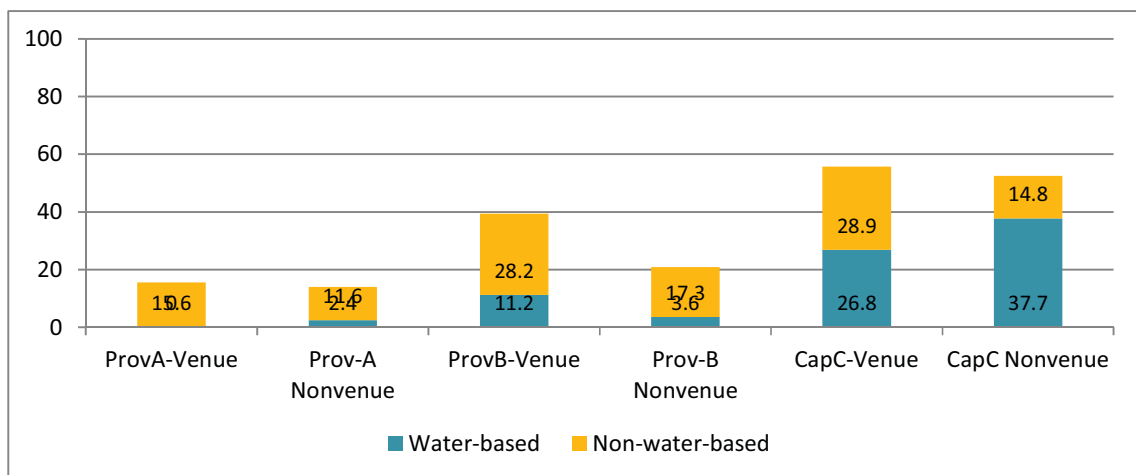


**Figure 3.12 Percentage of FSWs aged under 25 and aged 25 or older reporting that they use condoms every time with clients**



FSWs were also asked if they used lubricants with clients and if so the type of lubricant. As seen in Table A3.8 and Figure 3.13, lubricant use varied widely by study site. Very few FSWs reported lubricant use in Province A, while about 40% of venue-based and 20% of non-venue based FSWs did so in Province B. In Bangkok, the majority of FSWs said that they used lubricant with their last client, though use was about twice as frequent for venue-based FSWs. Moreover, water-based lubricant use was extremely low outside Bangkok, with most FSWs using lotion, oil or other substances that can damage condoms.

**Figure 3.13 Lubricant use by type with last client by venue- and non-venue-based FSWs**



FSWs were asked about how many non-paying partners they had in the past month and their relationship with their last non-paying partner. A large proportion of FSWs (about 45%) reported no



non-paying partners in the past month; most who had a partner reported that he was a regular partner or spouse. As is common in FSW research, most FSWs did not use condoms consistently with their non-client partners, although a majority of Province B FSWs said that they did so last time (Table A3.8 & A3.9). About one-third said that they used condoms consistently with non-clients.

UNFPA had a program in recent years that promoted the female condom to FSWs in a number of provinces outside Bangkok. The study found that about 6% in Province A and Province B had ever used the female condom.

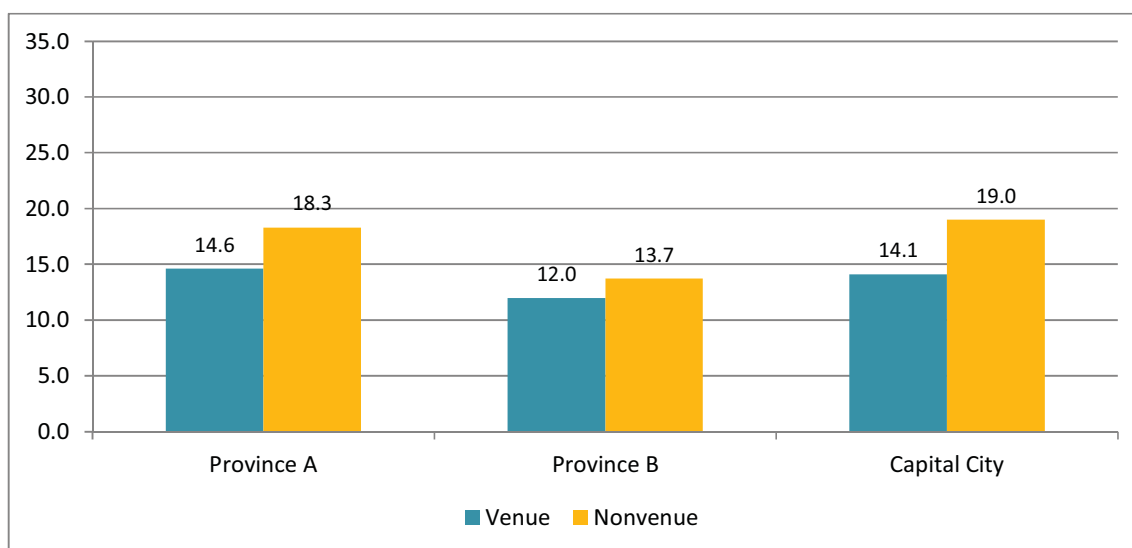
### 3.4 Stigma and discrimination towards FSWs in daily life

Thailand’s National HIV/AIDS Strategy includes the vision of “getting to zero” stigma and discrimination (S&D) towards key affected groups. Two goals that will contribute to this vision are 1) that human rights and gender-specific needs are addressed in all HIV responses; and 2) that stigma and discrimination towards people living with HIV (PLHIV) and key affected populations (KAPs) is reduced by half. These two types of stigma and discrimination are examined separately in this chapter: findings on S&D experienced at HIV prevention services from the service study and the quantitative survey is discussed within the sections on individual services, whereas findings on S&D experienced by FSWs in daily life as reported in the FSW survey is discussed here.

#### Difficulties experienced due to FSW status

FSWs were asked if they face difficulties in their daily life due to their FSW status. Less than 20% of the FSWs surveyed said that this was the case (Figure 3.14); surprisingly, non-venue based FSWs had slightly higher positive responses in all sites. When asked what type of difficulties they faced, being called names, ridicule and not being treated with respect was the most frequently given answer.

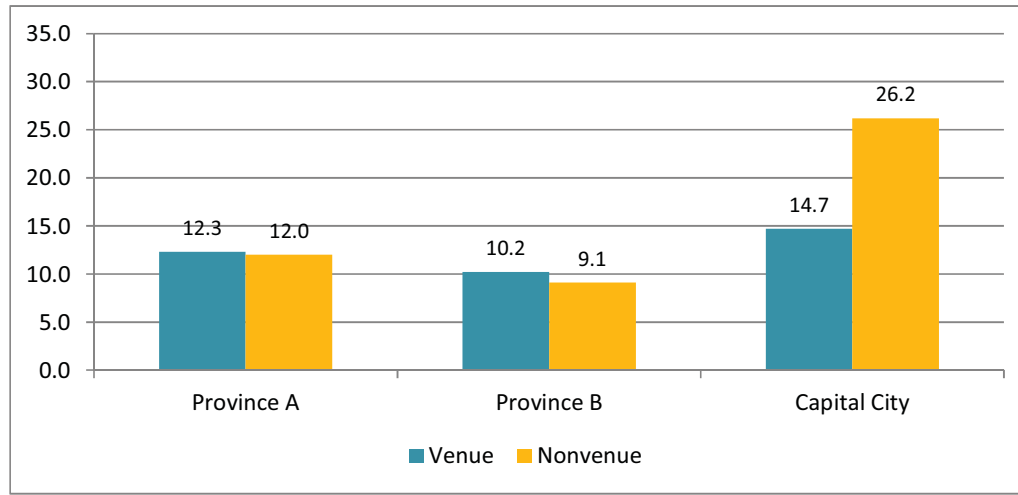
**Figure 3.14 Percentage of FSWs saying that they face difficulties in daily life due to their FSW status, by venue/non-venue status**



**Violence and forced sex**

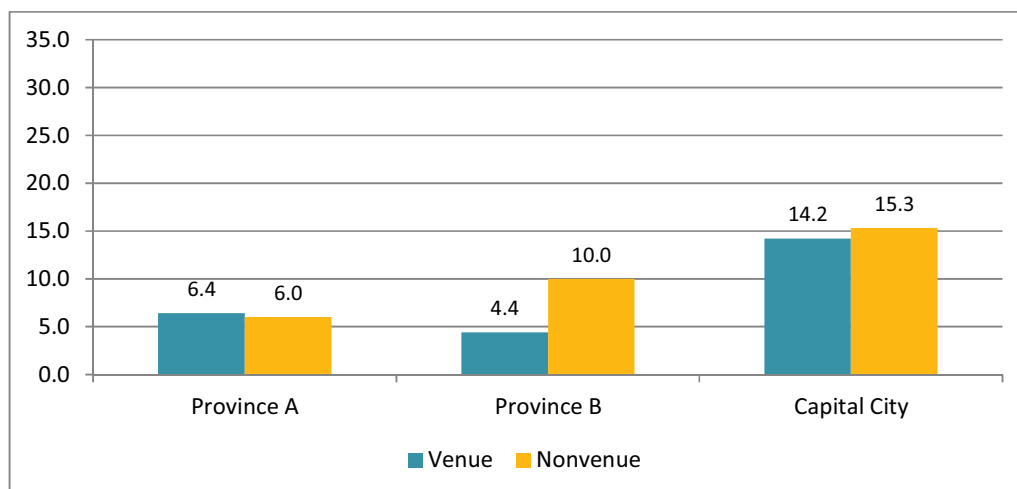
FSWs were asked if they had been the victim of violence by a client in the past 12 months and separately whether they had been forced to have sex by anyone in the past 12 months. In Province A and B, from 9-12% reported violence by a client and there was little difference between venue and non-venue FSWs (Figure 3.15). In Bangkok however, 14% of venue-based FSWs and 26% of non-venue based FSWs reported violence. In the latter case, street-based FSWs reported much higher rates of violence by clients.

**Figure 3.15 Percentage reporting being the victim of violence by a client in the last 12 months**



The same pattern is found for reports of forced sex (by anyone) in the past 12 months; Bangkok has a higher rate of such reports although there is little difference by venue status (Figure 3.16). When asked who perpetrated the forced sex, nearly all said that a client was responsible; only a few mentioned another sexual partner, a pimp, military or police.

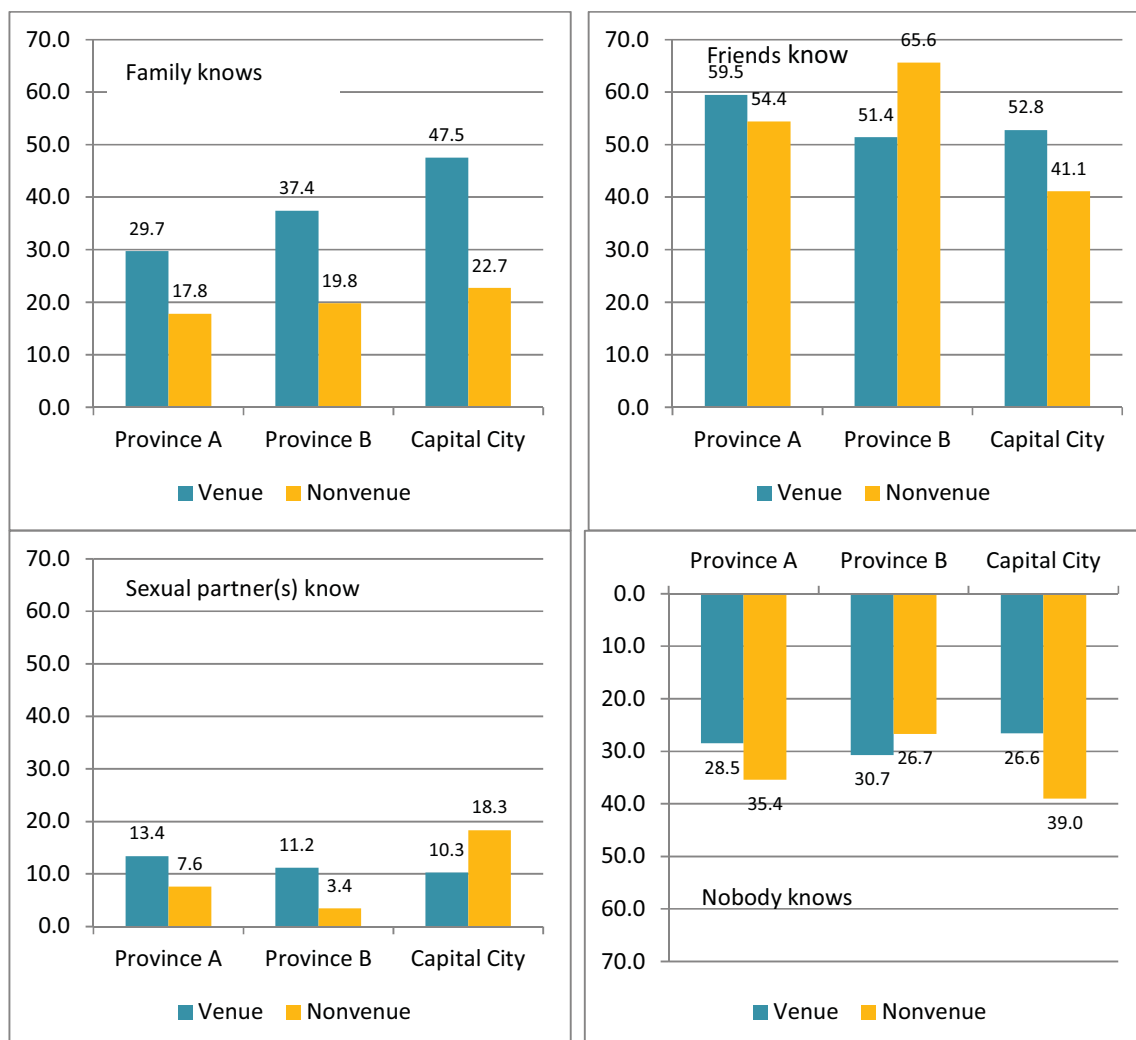
**Figure 3.16 Percentage of FSWs reporting being forced to have sex against her will in the past 12 months**



***Hiding FSW status***

The survey also asked whether the respondents hid their FSW status from their family, friends, sexual partners and others. For venue-based FSWs, the percentage whose family knows about their status increases by size of place; only 30% of Province A FSWs say that their family knows while half of those in Bangkok say so (Figure 3.17). Only about 20% of non-venue based FSWs say that their families know across sites. From 40-65% say that their friends know, while very few (3-18%) say that their other sexual partners know. Across sites, from 27-35% (about one-third) reported that nobody else knows that they are an FSW (aside from co-workers).

**Figure 3.17 Whether family, friends, sexual partners or “nobody” knows that respondent is a sex worker**



The findings on stigma highlight the risks that FSWs face in their daily lives. The Avahan project in India has recognized that violence is a barrier to FSWs’ participation in HIV prevention efforts and have incorporated participatory anti-violence activities into their programs (Beattie et al., 2010). These results indicate that Thailand could both reduce violence and increase HIV prevention program effectiveness by following this model.

### 3.5 Services available to FSWs

Table 3.2 summarizes the services tailored to FSW that were included in the service listing for each study site, including drop-in centers (DiC), STI screening facilities and HIV counseling and testing (HCT) centers. In addition to these services that specialized in serving FSWs, all sites also had a number of non-specialized services available that FSWs may use. Province A’s population is about half that of Province B; the number of STI services available are proportionate in the two provinces, but Province A has very few HCT sites in comparison to Province B. Bangkok’s number of services is about the same as Province B, though the population is much larger. Part of the difference lies in the

fact that six government hospitals in Province B provide specialized STI and HCT services for FSWs. Province B also has a mobile clinic that provides STI and HCT services for FSWs.

**Table 3.2 Number and type of services available to FSW by study site**

	Province A	Province B	Capital City
Drop-in centers	1 DiC	1 DiC	1 DiC
Office of Disease Prevention & Control	1 STI/HCT		1 STI/HCT
Government hospitals	2 STI/HCT	6 STI/HCT	1 STI/HCT
Bangkok Health Center			9 STI/HCT
Private hospitals		2 STI/HCT	1 STI/HCT
Private clinics	2 STI	2 STI/HCT	1 STI/HCT
Mobile clinics		1 STI/HCT	
<b>Total</b>	<b>1 DiC, 5 STI, 3 HCT</b>	<b>1 DiC, 11 STI, 11 HCT</b>	<b>1 DiC, 13 STI, 13 HCT</b>

### 3.6 Outreach program evaluation and coverage

#### 3.6.1 Management and staffing of the outreach program

The implementation structure for FSW outreach at the provincial level is parallel for each of the SR/SSR combinations and the IA. The personnel structure consists of three responsible staff for each IA: a field manager, field coordinator and drop-in center manager. There are two cadres of field staff: volunteers and peer support groups. The number in each differs according to the size of the FSW population in the location, ranging from 8 to 69 field staff.

The role of the volunteers and the peer educators is similar: to increase motivation for prevention, to provide referral for STI screening and HCT, and to distribute condoms and lubricant. Volunteers are recruited from FSWs in entertainment establishments (except for a few sites in Bangkok which include experienced women in non-FSW occupations). Potential candidates are first given a general training in human rights, rights to treatment, reduction of stigma, among other topics. Participants who seem to have the qualities of a good volunteer are screened. They should have the trust of their peers, good human relations skills, a volunteer mind-set, understand and can communicate with other FSWs, and have time to attend routine meetings at the coordination center. The selected candidates are then given additional training in counseling and accessing the FSWs.

The peer support groups do not receive financial compensation. The evaluation found that the workload of the peer educators is less than that of the volunteers, and that some peers are unmotivated. One IA suggested revisiting the compensation policy, or to just use one group (volunteers or peer support groups). Compensation for the volunteers differs among IA. Some give a lump sum of 2,500 baht a month per person; others 1,000 baht with a requirement of 10 work days a month, per capita payments of 100-120 baht for new contacts, and 120-250 baht for a HCT referral. However, compensation cannot exceed 2,500 baht per volunteer in any given month.

The evaluation found key differences in management and coordination among the three sites. The IA for Province B had been working with FSWs for some years before the beginning of the Global Fund project, whereas the IA in Province A was working with this population for the first time. The IA in Province B reported that they received a great deal of support from the SR, including regular

meetings, while the IA in Province A had not. The PCM in Province B was also perceived as playing a strong role, whereas the PCM in Province A was perceived as distant and not integrally involved with the program.

In Bangkok, one of the IAs providing outreach for FSWs from the beginning of the Global Fund program was no longer part of the program at the time of the service study fieldwork. The agency named to replace this IA also ceased operating just before the evaluation fieldwork. Another IA, which implements a drop-in center for both MSWs and FSWs, continued to provide outreach; however, it focused on certain geographic areas only.

Province A experienced high turnover of IA staff and volunteers during the nearly three years of implementation, especially among the younger volunteers. This is due to the occupational need of FSW to rotate locations and establishments, project work demands, and inadequate compensation. Due to annual budget cuts, replacement recruits did not receive the full training that the original cohort did. This increased the burden on the experienced volunteers and field staff. Province B's outreach staff and volunteers did not suffer this high degree of turnover.

A factor affecting all of the sites is that the project budget was not allocated strategically in proportion to need and context; and it was not clear why the budget was the same for all IAs across settings. Over the course of the project the IAs have experienced disruptions of budget flow between quarters and fiscal years (FYs). Smaller IAs did not have enough reserve to maintain activities during these funding gaps, as there was not enough budget for staff supervision of volunteers.

### ***3.6.2 Capacity building and quality control***

The SSR have plans for an annual training of trainers (TOT) to refresh skills in FSW education and training of volunteers. They are supposed to review members of the service network and the referral sites for HCT and STI. The plan includes semi-annual capacity building for volunteers. This evaluation found that staff who have been working in this area for many years feel that the training is always the same, though the Year 3 training emphasized the data system because of new forms being used. All staff complained of the lack of technical assistance visits from SR/SSR staff. Some did receive training in data management from the PR.

To build capacity of the volunteers, PPAT has prepared a training curriculum but some IAs have not fully implemented the training. It is not clear if there has been any assessment of the knowledge levels of the volunteers. Nor has there been any needs assessment of staff needs for more knowledge and skills. IA staff have too many demands on their time to fully conduct the refresher training for volunteers or to provide on-site mentoring. Most interaction is by phone to arrange condom resupply.

There are 11 PPAT/partner handbooks for the following: Staff; Training and Activities; Peer-based Information Dissemination; Health Services; and the set of 7 CHAMPION project handbooks. This evaluation did not find any handbook content on gender differences and related stigma, though this topic may be integrated into the routine training. Almost all of the volunteers said they had no operations handbook or guidelines for conducting activities. The field staff said they did not have operational handbooks specific to their role either. Thus, implementation is not uniform.

### **3.6.3 Peer education**

Volunteers interact both with FSW individuals and groups of FSW under IA staff leadership. The group interactions occur at the worksite or drop-in center (DiC). Each volunteer has an outreach target of about 50 peers per year, with each having a zone covering about ten establishments. They need to have at least three interactions with each targeted FSW, and cover the quota of knowledge content areas. Personal information of the FSW is recorded and, in some sites, the national ID card number is used as a unique identifier code (UIC). Some FSW refused to cooperate and did not want to give the personal information.

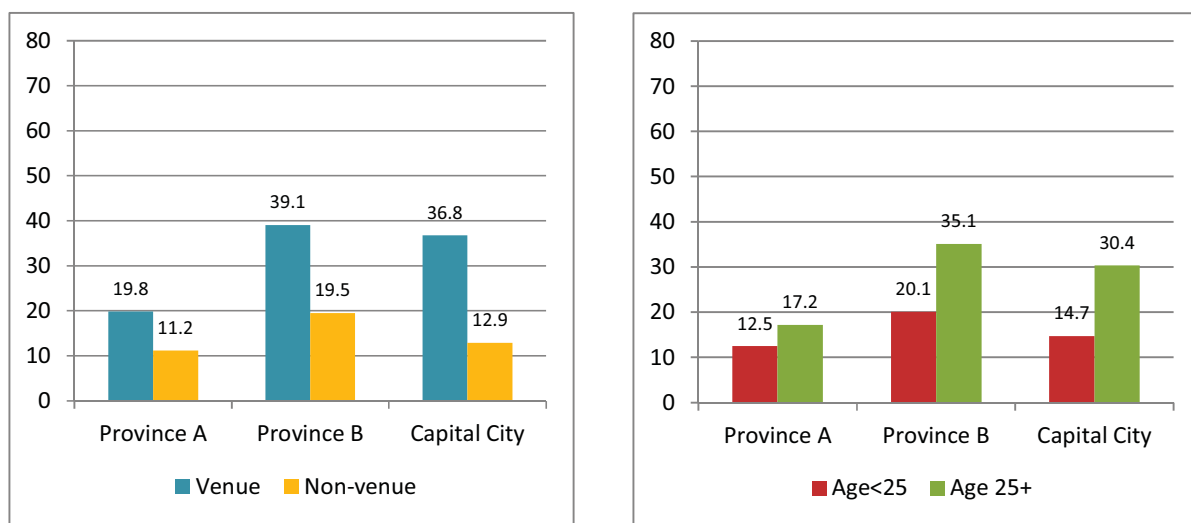
From the observations of peer educators conducted for this evaluation, we found that the interaction between the volunteers and FSWs rarely exceeded 10-20 minutes. For the most part, the exchanges were not in-depth and mostly involved one-way communication of information from the volunteers to the FSW. There was little skills building for, say, condom negotiation. Volunteers informed FSW of referral sites but did not spend much time on building motivation for risk behavior reduction or in promoting STI screening and HCT services. Some volunteers only conducted condom distribution.

In project Year 3, the reporting of the volunteer activities was the same as in previous years, but the method of counting contacts was restricted to just new contacts and reduction of duplicate counts by use of a Unique Identifier Code (UIC) system. Also, compensation was based on new contacts rather than continuing contacts. One SSR introduced a points system for FSW clients, and issued cards which would be stamped for each encounter with the project field team. Later, prizes would be awarded for a given number of stamps. Stamps were color-coded by type of contact activity. Others had a coupon system to distinguish between new and continuing contacts. Thus, counting systems were not necessarily uniform across IA.

Generally, IA did not have problems achieving the numeric targets of contacts. But successful referrals for HCT and STI screenings were below target. This is perhaps attributable to a decline in intensity of outreach and lack of risk assessment and motivation to seek these services. All of the outreach worker respondents observed that there was no field operations manual. Some volunteers complained they did not receive mentoring from the IA staff.

The FSW survey was not able to distinguish between the different types of outreach workers, such as peer support and volunteers, since the FSW respondents were not likely to know the difference between them. Instead they were asked whether someone approached them to talk about HIV/AIDS in the past 12 months. As seen in Figure 3.18, the results varied by site, by whether the FSW was venue-based and her age. Over 30% of venue-based and older FSWs in Province B and Bangkok were reached by an outreach worker, while coverage for non-venue based and younger FSWs was much lower. One explanation for this could be the higher turnover among outreach workers in Province A, in contrast with the consistence and experience of program staff in Province B.

**Figure 3.18 Coverage of FSW outreach worker program (outreach worker, peer educator or volunteer) by venue/non-venue and age group**



### 3.6.4 Drop-in Centers (DiCs)

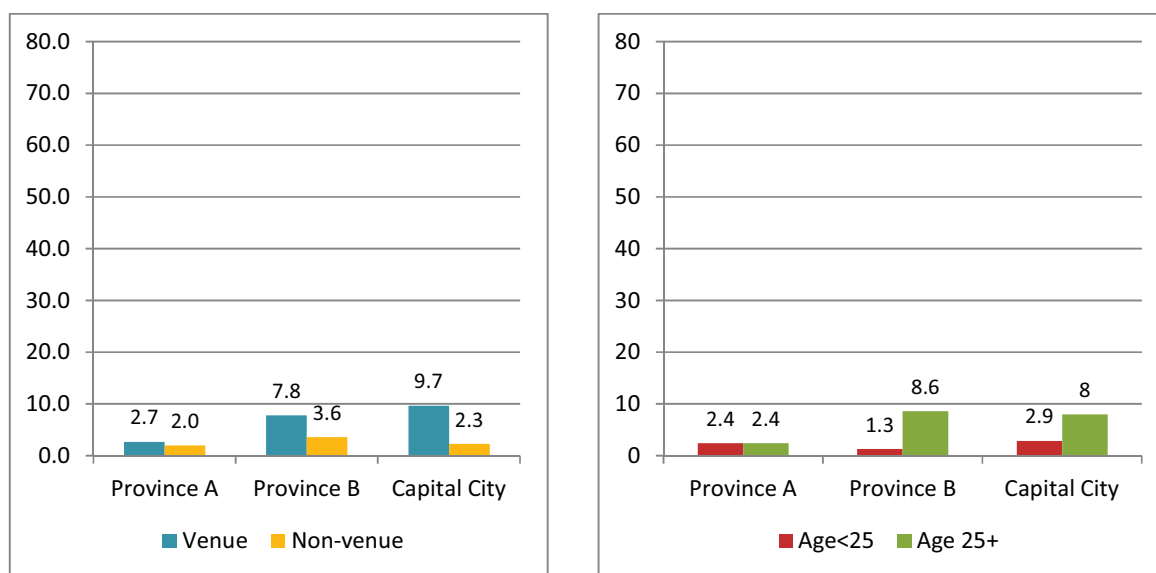
The project stipulates one drop-in center per province without regard to the local context or the size of the FSW population. In Province A, the DiC is located in an area remote from the FSW worksites in most of the study sites; in Province B and in Bangkok the DiC is located in the heart of entertainment hot-spots. Each DiC the team visited was more of a coordination center than a service site. Some were structured with office space, with others left unstructured to accommodate group activities. Each DiC had supplies of educational media, condoms and lubricant. The media varied by site. There was no separate counseling room. Mostly, the DiC were used meetings between staff, volunteers, and network members. Most counseling in the DiC is by phone; walk-in cases are few. Most visitors want condom resupply. Participants in group activities at the DiC are few. Some IA have expanded the function of the DiC outside the project specifications by using counterpart funding to conduct adult learning, language lessons, and hiring a nurse to provide services twice a week. This had increased FSW utilization of the DiC. One DiC manager said these activities better met the needs of the FSW than just talking about HIV and STIs all the time.

The DiCs have working hours that are consistent with the lifestyle of the FSW. Most visitors come during 1:00 – 6:00 p.m. Some DiC are open from 9:00 a.m. to midnight. Mobile outreach is from 5 – 8 p.m. It should be noted that over half of the FSW interviewed for this evaluation were not aware of the existence of the local DiC or had never visited it to receive services.

In line with the findings of the service study, the FSW survey found that few respondents had ever been to a drop-in center in their province (Figure 3.19). While venue-based and older FSWs were more likely to have visited a DiC, the results were not significant. When asked why they had never been to a drop-in center, nearly all said that they did not know about the drop-in center.



**Figure 3.19 Coverage of FSW drop-in center program by venue/non-venue and age group**



### 3.6.5 Behavior change communication materials

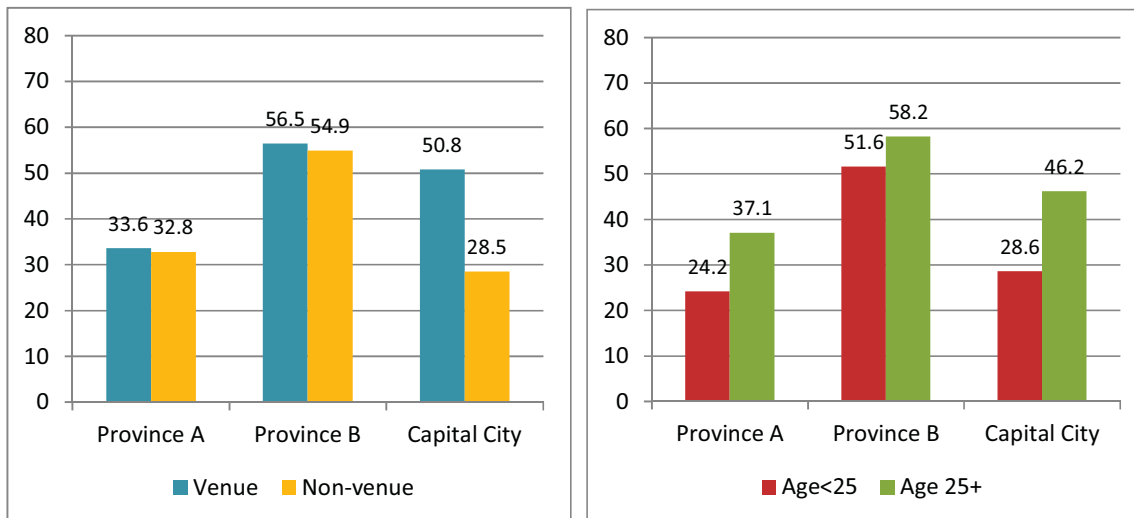
Behavior change communication (BCC) materials for HIV prevention among FSWs are distributed through four channels: (1) Volunteers; (2) Worksites; (3) Clinics and hospitals; and (4) the DiC. While all the IAs have distribution data for condoms and lubricant, this evaluation did not find any distribution data for educational media. Most are provided by central offices like the Bureau of AIDS, TB and STI (BATS). There was no new production of media after Year 2, and IA and FSW did not participate in media development, though some were asked for their reactions to existing media. But products are still much the same as before. Also, there has been a decline in resupply of copies of media. Leaflets have to be requested from the local Provincial Chief Medical Office (PCMO) or Regional Disease Control Office (RDCO). Some IA developed their own media such as pens, key chains, coasters, water cups, T-shirts, etc, with messages or slogans.

Most of the BCC provided by the IAs to the evaluation team are about basic HIV/STI facts and places for services. The team found them to be limited in scope and not attention-getting. Some respondents in this evaluation said the media were inappropriate for the FSW. The materials were too information-based and did not reflect the diversity of the FSW. There was one media item produced specifically for Karaoke FSW (by BATS with UNFPA support), but this item is out of stock. The IAs have ideas about producing FSW-specific media for the local context, but no budget to produce these.

When asked if they had ever seen a brochure or poster produced for FSWs, the results were much higher than that for exposure to outreach workers or DiCs (Figure 3.20). Note however that the question referred to “ever” seeing these materials, rather than seeing them in the past 12 months. More than half the FSWs in Province B had seen these materials, as did venue-based FSWs in Bangkok. The percentages for Province A, for younger FSWs and for non-venue based FSWs in Bangkok were much lower. Since the written materials could have been seen at a medical facility as

well as at the DiC or through outreach, this finding may correspond to higher levels of STI screening and/or HCT among these groups.

**Figure 3.20 Coverage of written behavior change communication materials for FSWs by venue/non-venue and age group (percentage who ever saw BCC materials)**



### 3.6.6 Enabling environment for HIV prevention

As discussed above, program efforts for HIV prevention are more effective when they are conducted in the context of a supportive environment at the workplace. The IA in Province B conducted “Workshop in a Bar” events to improve understanding and acceptance of PLHIV among worksite owners and the surrounding community. This resulted in the formation of the Network Center for Friends of Female Sex Workers. It is not clear whether this activity improved project outcomes; respondents said that the results were less than optimal, and that there is still stigma and discrimination against HIV+ FSW. This contributes to some FSWs avoiding HIV testing if possible to save their job.

### 3.6.7 Summary of outreach program quality and coverage

In sum, the Team has the following findings of quality of the outreach program:

- ◆ Program targets and the compensation structure emphasize providing outreach to new contacts. This is having the effect of reducing the ability to reinforce educational messages for continuing contacts. Several respondents said that the quality of outreach has declined over time.
- ◆ There is a lack of monitoring and mentoring of volunteers because of the heavy workload of the field supervisors. There is not enough budget for field supervision. Progress review, trouble shooting and continuing education is done through group meetings of the volunteers.

- ◆ Some groups, for example non-venue based FSWs, are being overlooked. There is no planning for full coverage of the FSW population and outreach activities are centered on entertainment establishments.
- ◆ Activities of volunteers are not standard across sites due to the lack of a field operations manual as a reference. Also, the volunteers do not have tools for behavior risk assessment or anatomical models to demonstrate proper condom use. Most observations of the peer educators for this evaluation did not include risk reduction counseling or motivation for seeking HIV prevention services such as STI screening or HCT.
- ◆ There is not sufficient budget to establish full-service drop-in centers in convenient locations for the FSWs. For this reason the DiCs have for the most part become coordination centers for the IAs.
- ◆ Little priority or budget has been dedicated to the production of BCC materials or of maintaining their availability throughout the life of the project. FSWs have not participated in their production. Innovative forms of media have not been utilized.

The population survey saw low levels of coverage for the outreach program, although coverage varied by site. As seen in Table 3.3, only about 1 out of 7 FSWs in Province A said they had talked to an outreach worker in the past year while about 1 out of 4 did so in Province B and the Capital. This quantitative finding is in line with the service study's observation that Province B's outreach program is run more systematically and with greater support from the SSR and PCM. Very few FSWs surveyed had been to the drop-in center, and the majority of FSWs did not know about the drop-in center. The percentage who said they had ever seen written materials for FSWs was much higher; these could have been seen at an entertainment venue or medical facility as well as been distributed by an outreach worker.

**Table 3.3: Summary table for coverage by the outreach program**

	Province A	Province B	Capital City
Talked to a peer educator/outreach worker	15.6	28.5	26.0
Visited a drop-in center	1.6	4.3	5.7
Saw a brochure or poster for FSWs	33.3	55.7	41.9

### 3.7 Distribution of condoms and lubricant

Condoms and lubricant sachets are distributed free by the outreach workers and standing facilities. The DiC prominently display condoms and lubricant, and these are easy for FSWs to take. Volunteers also take a supply of condoms and lubricant with them on worksite visits. They see this as their most important service to the FSWs. They also provide a supply of the commodities to worksite owners/managers, and IAs distribute them during campaigns, festivals and other public events. Service outlets provide free condoms to FSWs but not all provide lubricant. Finally, community health outlets such as village health volunteers distribute condoms to FSW.

All the condoms distributed are male condoms (with the exception of one IA which includes female condoms supplied by UNFPA). But all IAs have samples of the female condom for educational

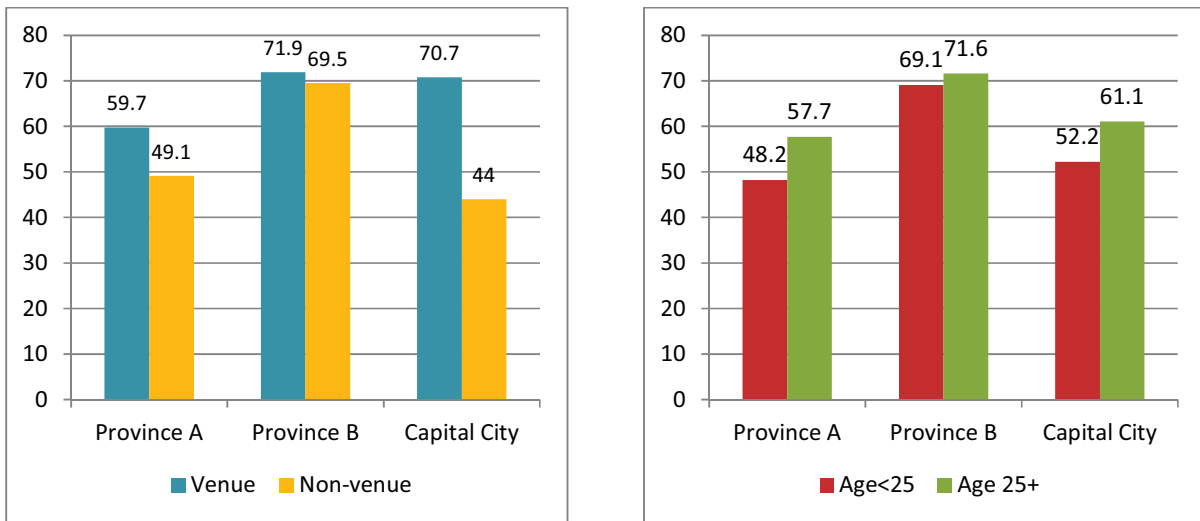
purposes. Generally the FSWs prefer the male condom; they resort to female condoms if the client refuses to use a male condom.

All of the IAs received condoms and lubricant from the SR (procured by BATS). But delivery is slow and there are stock shortages across all IAs, including in the past 12 months. Some IAs borrow stock from other agencies to fill temporary shortages. Additionally, the size of the condoms does not always match the need. Condoms distributed by hospitals are provided by the National Health Security Office (NHSO). They do not experience stock-outs and resupply the FSW in their area.

All IA, staff and volunteers fill out condom supply and distribution forms by location and type of activity. This information is used to balance the stock card data and report up to the SSR/SR. There is no specification if the recipient is a new or continuing contact or number of supply per contact. Number of supply is reported for bulk distribution to worksites or other equivalent. All IA know the principles of proper stock storage but the lack budget to arrange proper storage facilities.

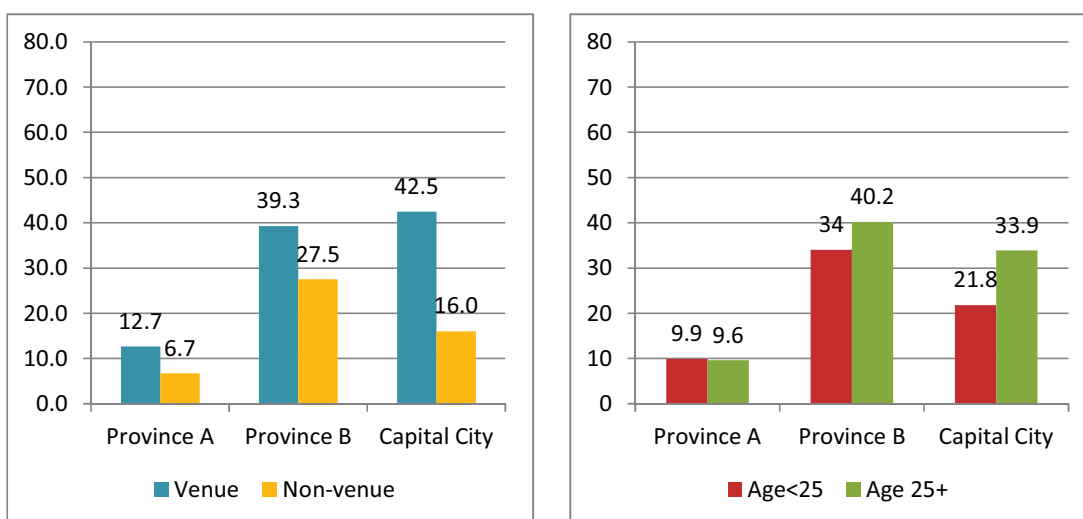
Over half of the FSWs surveyed said that they had received a free condom in the past year in all three sites (Figure 3.21). In Province B and Bangkok, venue-based FSWs were significantly more likely to say they had received a free condom.

**Figure 3.21: Coverage of condom distribution for FSWs by venue/non-venue and age group**



The results for receiving free lubricant were considerably lower, as would be expected from the qualitative findings (Figure 3.22). Coverage was particularly low in Province A, and was significantly higher for venue-based and older FSWs in Province B and the Capital City.

**Figure 3.22: Coverage of lubricant distribution for FSWs by venue/non-venue and age group**



Summary findings for condom and lubricant distribution are seen in Table 3.4.

**Table 3.4: Summary table for coverage by the condom and lubricant distribution program**

	Province A	Province B	Capital City
Received a free condom in the past 12 mos.	54.5	70.5	58.6
Received free lubricant in the past 12 mos.	9.7	37.5	30.5

### 3.8 STI screening and HCT program evaluation and coverage

The public outlets that provide STI and HCT services include the primary care unit (PCU), community hospital, regional hospital, and STI clinics under the MOPH (see Table 3.2). HCT and STI services require an extra level of collaboration among partners in the public sector. At the beginning most participating agencies at all levels had limited awareness and participation in the system design for the FSW. When the PCM came into prominence in the past three years, the outreach and service agencies were more involved through meetings and referral system development – especially for HCT and STI. This helped to create more client-friendly services. The PCM in Province B arranged for mobile outreach services and study tours to government outlets to improve understanding of services.

Most of the government service providers have had the opportunity for refresher training in counseling, referral, gender, stigma/discrimination, and STI case management by the MOPH. Staff at the PCU said that they feel they need more training and lack confidence due to low caseloads and lack of practice. Physicians outside of Bangkok expressed the need for more technical training in STI case management. What is more, none of the government hospitals have a specific STI clinic (except for the RDCO); women with STI have to go to the OB-GYN department.

FSW who are found to be HIV+ are referred to the ARV clinic, just as the general public is. There is no clear division of labor in the project for following up the HIV+ FSW for assistance and positive

prevention. However, staff involved directly in HIV/AIDS are well-informed about issues of gender and sexuality.

### **3.8.1 Referral to STI screening and HCT services**

One of the components of the outreach service package is for outreach workers to motivate FSW to use STI screening and HCT services, and to give clients a referral form to present at the service outlets. Outreach staff fill out the referral form and, with the volunteer, accompany the FSW to the service. But some FSW go for services without the referral form even though it is known that they received advice from outreach workers to go for STI screening or HCT. In some cases, the service provider notes this as a referral. But not all outlets do this; thus the count of referrals is underestimated. All of the HCT and STI outlets in all the provinces said that they face the experience of very few FSW clients who are referred.

Follow-up of cases is rare, and is it not always known why some FSW did not follow the referral advice. Also, some outreach staff prefer to respect the confidentiality of the FSW by not following up. There is more active follow-up when the service outlet has un-claimed test results and asks the IA to help track the FSW.

The FSW survey found very few FSWs who said that they got a referral for STI screening or HCT (Table 3.5). While most of these referrals were from a DiC or outreach worker, a few were from employers or another medical facility.

**Table 3.5 FSWs who got STI screening through referral in the past 12 mos. (of those who received the service)**

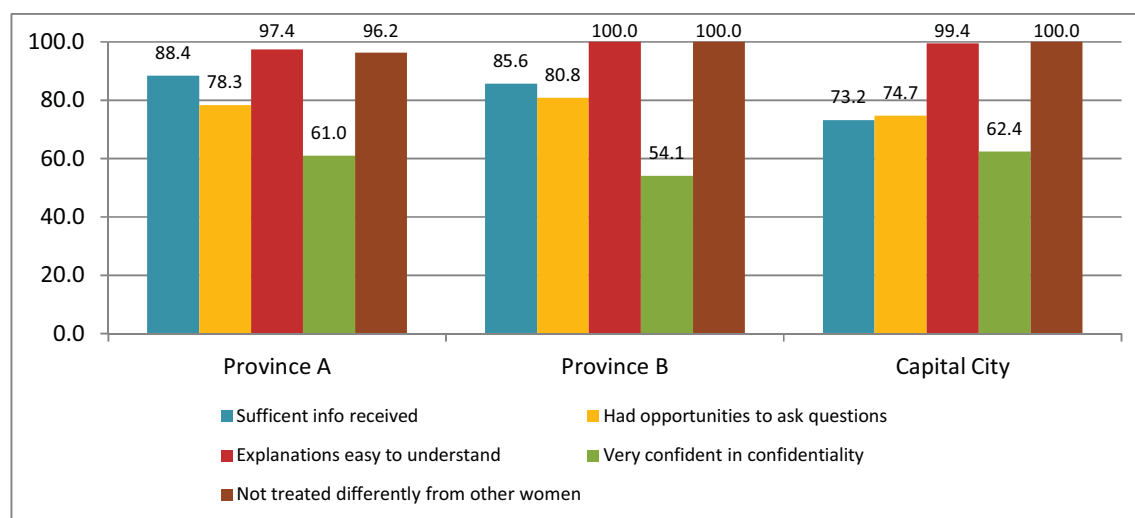
	Province A	Province B	Capital City
<b>STI screening</b>			
Outreach worker/DiC	2.2	3.9	1.4
Employer/medical	2.0	0.0	1.1
No referral	95.9	96.1	97.5
Total	100.0	100.0	100.0
(N)	(220)	(73)	(227)
<b>HCT</b>			
Outreach worker/DiC	2.8	2.0	2.8
Employer/medical	0.0	0.0	0.4
No referral	97.2	98.0	96.8
Total	100.0	100.0	100.0
(N)	(198)	(245)	(273)

### **3.8.2 FSW satisfaction with services and reports of stigma & discrimination**

Clients and volunteers reported that they are satisfied with the treatment and attitude of the clinicians providing the services and that they are generally client-friendly. The exception is that some admission and screening staff at hospitals have negative attitudes toward FSWs. The program does not provide any assessment of client satisfaction with the exception of the STI clinic of the DDC. But providers estimate that client satisfaction is over 85%, and FSW interviews confirm that.

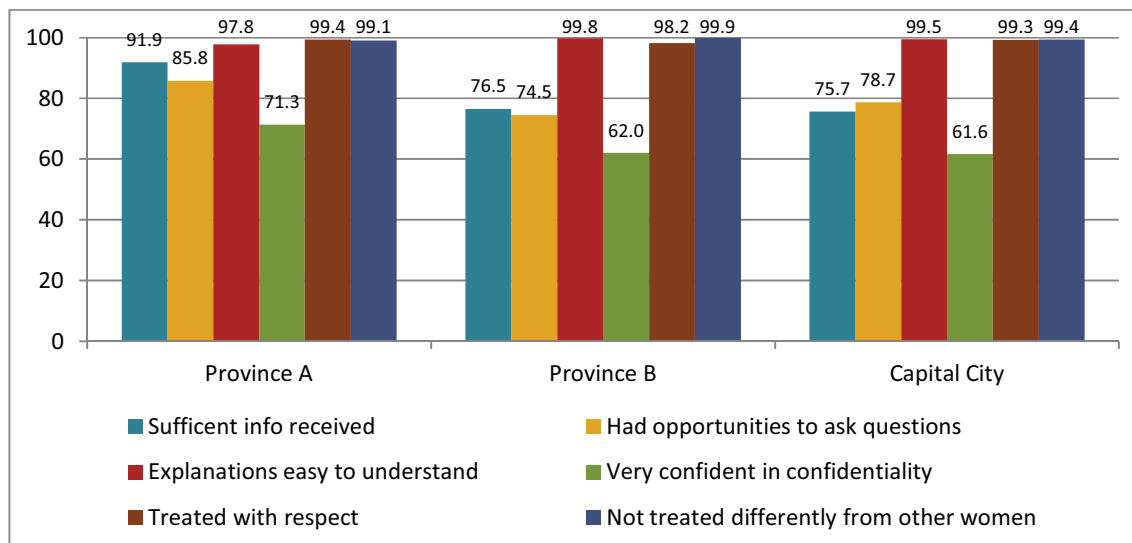
The survey asked FSWs who had been screened for STIs in the past 12 months a number of questions about their satisfaction with the service. As seen in Figure 3.23, FSWs were for the most part satisfied with the services. Almost no FSWs reported feeling like they were treated differently from other women. Most felt that they were given sufficient information about STIs and that the explanations were easy to understand. The lowest percentage response on the satisfaction questions were with regard to whether the FSW felt that her confidentiality was maintained; only 55-60% said that they felt “very confident” about this.

**Figure 3.23 Satisfaction with STI screening services**



FSWs who had gone for HCT in the past 12 months also generally had positive experiences (Figure 3.24). Nearly all said that they were treated with respect and were not treated differently from other women. However, confidence that confidentiality would be maintained was about 70% in Province A and 60% in Province B and Bangkok. It should be noted also that fear of stigmatization and a lack of confidential may continue to be a barrier to service uptake, even though those who do use them have mainly positive experiences.

**Figure 3.24 Satisfaction with HCT services**



**3.8.3 STI screening coverage**

Program monitoring data reports show low numbers of FSWs who were referred for STI screening. Program targets were not met, despite the existence of FSW-friendly services. Although the government outlets did not have separate clinics for FSW, they had facilitators in the Community Medicine Department to provide special assistance to FSW so that they would not have to go through the out-patient department (OPD). The screening and treatment process cuts across a number of units including OB-GYN, Community Medicine, and the HIV and ART clinics if appropriate.

The service package includes checks for Hepatitis B and Pap smear but this differs among facilities. There is no SOP for STI screening for FSW. Actual standards of practice differ, even though the facilities asset that they use the MOPH guidelines. The project also lacks indicators and motivation for improving service quality. Some clients are reluctant to go to government facilities if they have to show their Thai ID card in order to obtain free/subsidized services, because they are concerned about confidentiality. FSW who go to the STI clinic of the Department for Disease Control (DDC) receive anonymous service since they have budget to cover it without involving the NHSO. Also, all government outlets identify STI and HIV clients by a UIC to protect confidentiality. Post-test results are only provided in person, not by phone.

At the same time, some of these facilities do not have flexible hours to suit the FSW, and only provide service on certain days of the week. Some FSW complain that government workers do not understand their life-style in which they work late and get up late; a more convenient time for them to seek services is in the afternoon. Also, often if venue-based FSW go for testing it is due to their employer’s requirement to have quarterly testing, and the FSW needs to produce evidence of negative results. Their continuing employment depends on being tested. Some facilities are not located conveniently for the FSW, and the wait times can be long. Thus, some FSWs choose to use the private sector.

The FSW survey found that coverage for STI screening was nearly 50% in Province A and Bangkok, but very low in Province B (16%) (Table 3.6). There were also sharp differences in where the FSWs



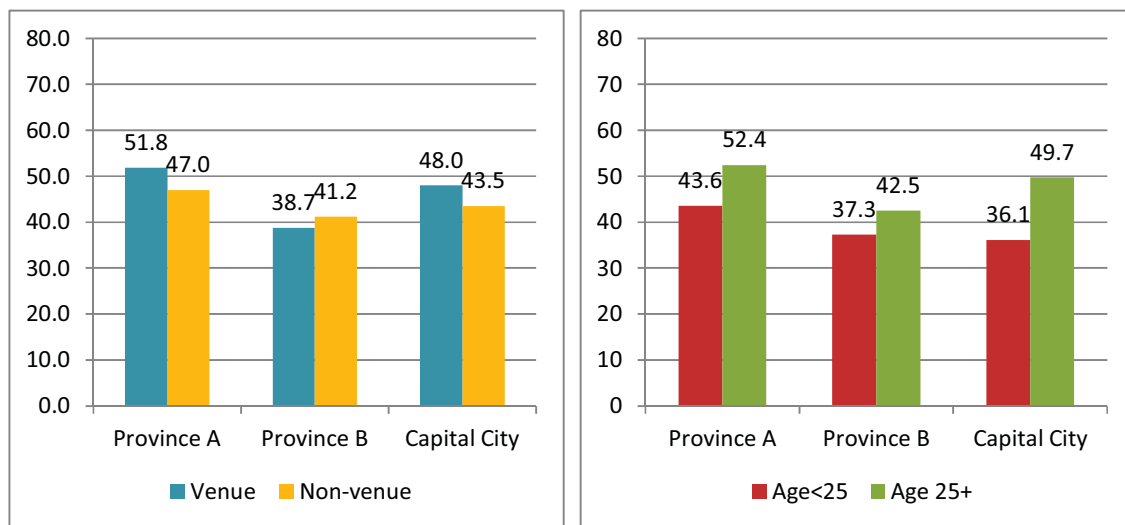
reported receiving services. In Province A, nearly all FSW reported attending the government services, corresponding to the fact that most services in that province are government sector (Table 3.2). The same was true of the (low) percentage who were screened in Province B, though a higher percentage went to FSW-centered services such as the mobile clinic. In Bangkok, nearly half of those who went for screening sought it in the private sector, and less than 5% went to a special FSW clinic.

**Table 3.6: Summary table for coverage of the STI screening program**

	Province A	Province B	Capital City
<b>Received STI screening in the past 12 mos.</b>	<b>49.4</b>	<b>16.4</b>	<b>45.9</b>
Government services	42.1	10.3	13.4
Specialized FSW services	1.8	3.3	4.3
Private sector services	5.4	2.8	28.3

No significant difference was found in STI coverage by whether the FSW was venue-based or non-venue-based, which is an unexpected finding since many venue-based FSWs are required to get screenings by their employer. Older women were significantly more likely to be screened however (Figure 3.25).

**Figure 3.25: Coverage of STI screening for FSWs by venue/non-venue and age**



Best practices for HIV prevention for FSWs include periodic STI screening, and many venue-based FSWs are required by their employer to be screened regularly. As seen in Table 3.7, more than half of the FSWs in Province A and in Bangkok who reported getting STI screening were screened more than once in the past 12 months. The same is true of Province B, although screening rates are considerably lower.

**Table 3.7 Number of times screened for STIs in the past 12 months for venue-based and non-venue based FSWs**

	Province A			Province B			Capital City		
	Venue	Non-Venue	Total	Venue	Non-Venue	Total	Venue	Non-Venue	Total
<b>Number of times</b>									
None	48.3	53.2	50.7	72.9	93.0	83.9	52.0	56.6	54.1
Once	21.5	20.3	20.9	10.5	3.9	6.9	14.2	21.6	17.5
Twice	16.6	11.2	14.0	7.5	2.2	4.6	12.1	12.9	12.5
3-5 times	11.2	6.3	8.8	4.6	0.2	2.2	10.4	5.9	8.4
6-12 times	2.3	8.9	5.5	4.5	0.7	2.4	10.1	2.3	6.6
13+ times	0.1	0.3	0.2	0	0	0	1.3	0.8	1.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<b>(N)</b>	<b>(220)</b>	<b>(198)</b>	<b>(418)</b>	<b>(219)</b>	<b>(193)</b>	<b>(412)</b>	<b>(88)</b>	<b>(69)</b>	<b>(157)</b>

When asked why they had not gone for STI screening in the past 12 months, a variety of reasons were given. The most frequent responses were time inconvenience (9-29%, especially in Bangkok), that she does self-care (8-25%, especially in Province B) and that she does not feel that she is at risk (9-12%, especially in Province A).

### 3.8.4 HCT program evaluation and coverage

Since Year 2, there have been mobile HCT units including rapid testing (by IA involved in special projects) and this has increased up-take. The staff and volunteers announce up-coming mobile unit visits to the FSW and make appointments. However, only a few of the government static units use rapid testing. The limitations of the mobile service include lack of a regular plan by the government outlet to deploy the unit, or lack budget to make visits as planned. As noted, FSW who do go for HCT may be compelled to by their worksite. They said they receive pre and post-test counseling, and the process takes about 20 minutes. The mobile units report caseloads of from ten to 100 clients. But staff observed that the larger the caseload the less time for counseling, and quality of counseling probably declines in those situations.

The FSW survey found that HCT coverage was higher than that for STI screening. In Province B and Bangkok, about 57% of FSWs reported getting HCT, while in Province A the percentage is 43% (Table 3.8). As it was for STI screening, most FSWs in Province A used government services for HCT. In Province B, the percentage is evenly split between government services and specialized FSW services; a large proportion of the latter group said that they went to a mobile clinic. In Bangkok 10% went to specialized FSW services, with 25% going to the private sector and 22% to government services.

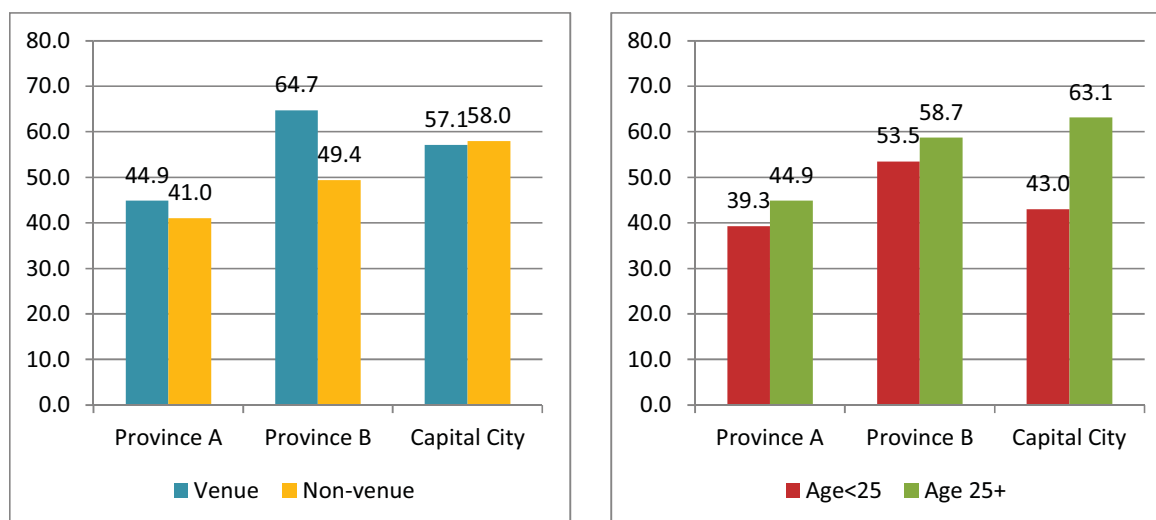
**Table 3.8 Summary table for coverage of the HCT program**

	Province A	Province B	Capital City
<b>Received HCT in the past 12 mos.</b>	<b>43.0</b>	<b>56.5</b>	<b>56.7</b>
Government services	33.2	25.1	22.2
Specialized FSW services	1.1	26.1	10.0
Private sector services	8.7	5.3	24.5

The reason for HCT coverage being higher than that for STI screening may be due to the nature of the process. HCT does not require disrobing or a physical examination; therefore mobile clinics can perform the test without needing a private room. FSWs are likely to see the process as easier and quicker and thus may be more likely to use HCT services for that reason.

In Province A and Bangkok, venue and non-venue based FSWs attended HCT in about equal proportions though in Province B venue-based FSWs were significantly more likely to be tested (Figure 3.26). In Bangkok older women were significantly more likely to be tested than those under age 25.

**Figure 3.26 Coverage of HCT for FSWs by venue/non-venue and age group**



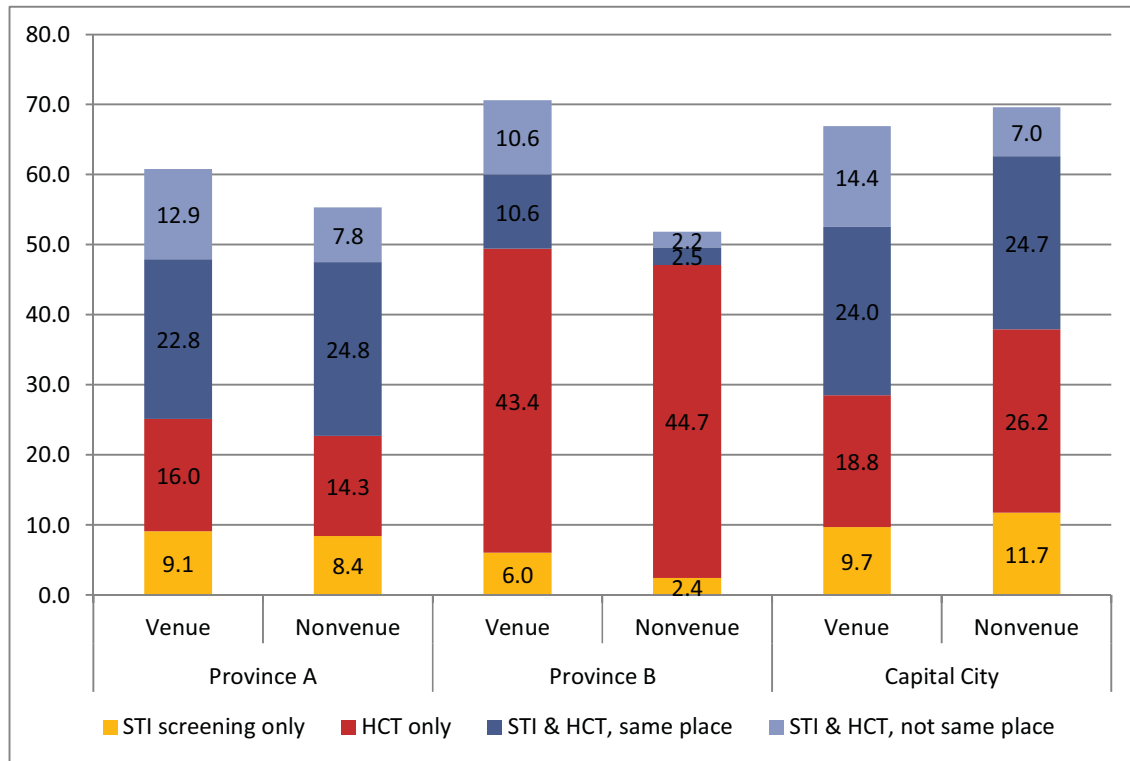
It should be noted that, as seen in Tables A3.10 and A3.11, virtually all of those who went to HCT also received the results of their test.

When asked why they had not used HCT services in the past 12 months, the main answers given were time inconvenience (18-44%), not feeling at risk (10-22%) and being afraid of the results (14-30%). All of these reasons may be addressed through having specialized services for FSWs and providing counseling that includes risk assessment and promoting the benefits of knowing one’s status.

### 3.8.4 Coverage of STI screening and HCT at the same service site

Figure 3.27 gives a comprehensive picture of the percentage of FSWs who used STI screening services, HCT services, or both. It also examines whether the respondent went for HCT and STI screening at the same service site. In Province A and in Bangkok, a large proportion of FSWs (about 1 in 4) received both services at the same site, and the percentage receiving both services at the same site is greater than the percentage who used only a single service. This finding implies that providing both services at the same location is very attractive to FSWs and lends support to the effectiveness of providing a package of HIV prevention services, discussed further below.

**Figure 3.27 Coverage of STI screening only, HCT only, and both STI screening and HCT (at the same or at different service sites) by venue/non-venue FSWs**

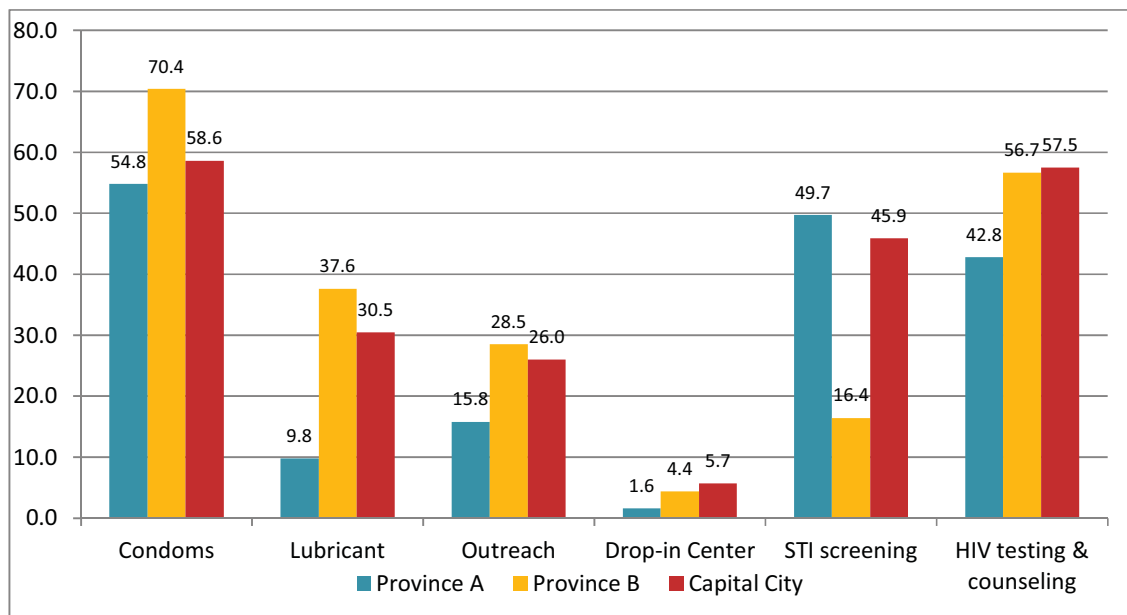


### 3.9 Package of services

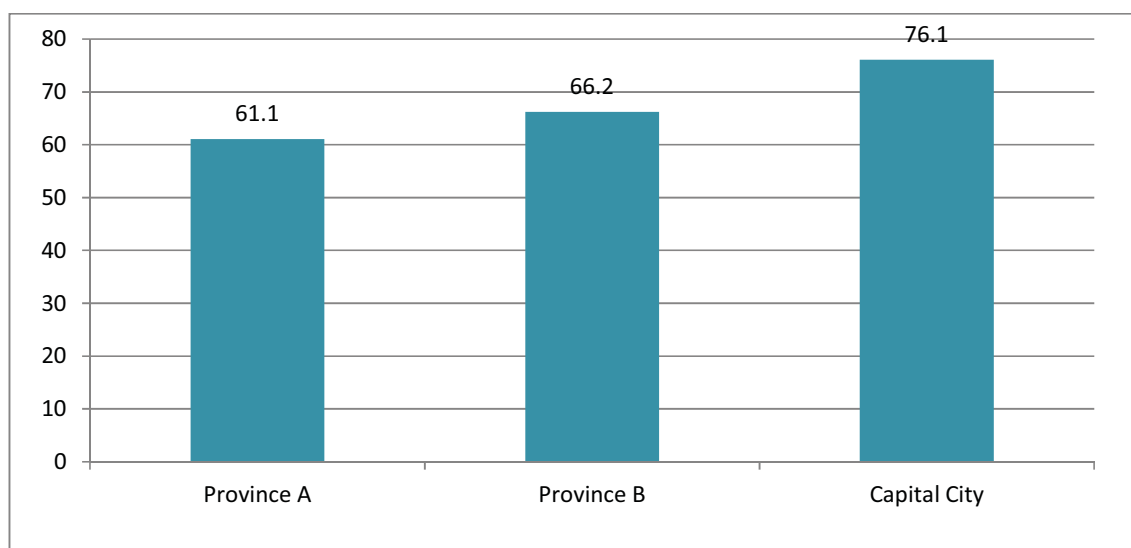
The Round 8 HIV prevention program was designed to provide a package of services to KAPs, as global research has found that this approach is the most effective for HIV prevention. A summary of coverage for single services is found in Tables A3.10-11 and in Figure 3.28. Condom distribution and secondly HCT had the highest coverage figures.

Figure 3.29 looks at the percentage of FSWs who received at least one service from outreach, drop-in, STI screening and HCT (not counting condom or lubricant distribution). Looking at coverage this way, 76% of Bangkok FSWs were reached by the program followed by 66% in Province B and 61% in Province C.

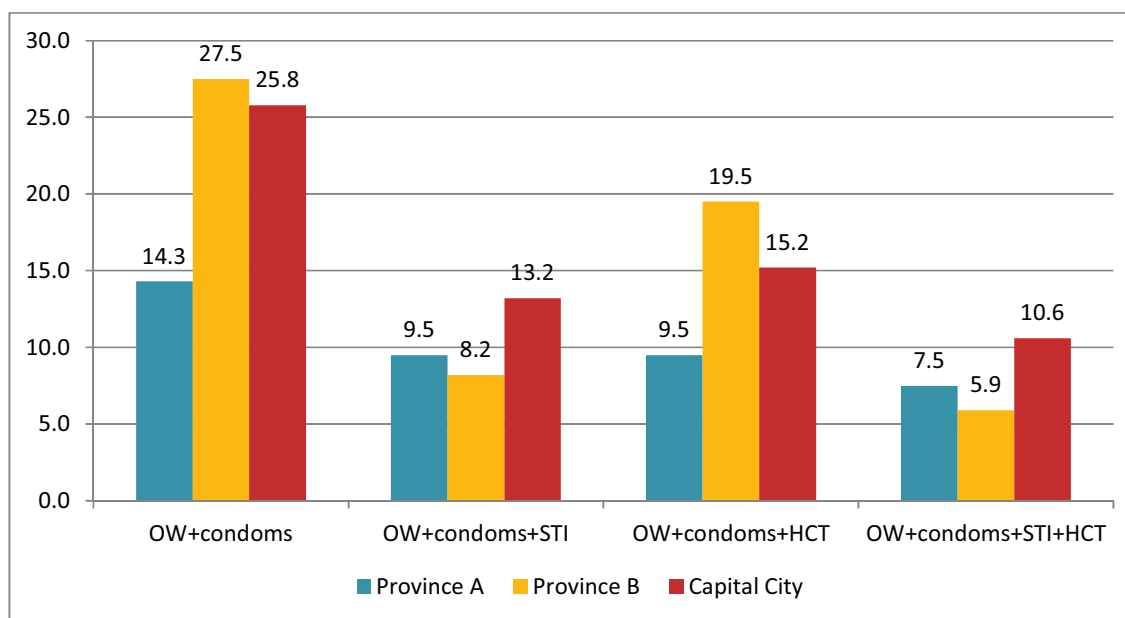
**Figure 3.28 Coverage by single services for FSWs**



**Figure 3.29 Percentage of FSWs reached by any service (at least one from outreach, drop-in center, STI screening and HCT)**



Finally Figure 3.30 examines the percentage reached by multiple services. Coverage by a package of services for FSWs is low in all study sites. The highest proportions are found in Province B and Bangkok where about 27% both met with an outreach worker and received free condoms.

**Figure 3.30 Percentage of FSWs reached by a package of services**

### 3.10 Data System and Data Quality

PPAT has developed tools for data collection by the outreach IA. There are seven forms and one logbook. Only two of these have data that are entered into a spreadsheet with electronic transmission to other offices. The staff are trained in the use of the forms and data entry. Troubleshooting is done by phone. But staff and volunteers complained that the forms were modified often, and this wasted their time. To protect FSW anonymity, files are locked and the system uses the UIC code. Most IAs do not have a back-up system for the data, since they have confidence in the ability to retrieve the e-mail attachments. All staff said there was no user's handbook for the data system.

The following describes the data collection tools:

1. Preliminary client information form: This records the first contact by place of contact, knowledge of the DiC, type of service, worksite, and general background of the FSW. A UIC is generated. Activities conducted are classified into four categories: AIDS education, STI education, condom supply, and lubricant supply.
2. Expanded activity report: This records the educational content given within and outside the DiC at each contact.
3. Technical support activity form: This reports the core activities.
4. Registration Log of project participants: This records data on persons participating in project activities, whether new or continuing contact, including name, worksite, phone contact, date of birth, and signature.
5. Form for Resupply of project Materials: This is a daily activity log with monthly summaries to track the number of supplies reimbursed, distributed and the balance on hand.

6. Condom report form: This includes the stock by type of condom and activities. It records redistribution of condoms and lubricant, and serves as a stock card.
7. Project Activity Service Form: This summarizes the number of FSWs who participate in an activity. Data are extracted from the volunteer activity recording form.
8. Referral Form: This is for referrals to clinical care. Each form has three copies: 1 for the IA, 1 kept in the form book, and 1 given to the clinic.

Only two forms are used for data entry: # 4 and #7. But there is a lack of uniformity across IAs since some IAs have added data items on their own. Staff are also not clear on what use the data are; so staff and volunteers see the system as a burden.

Client data are recorded for site of service, DiC, knowledge exchange, condom resupply, DiC service, and referral. Volunteers report service encounters monthly, counting only new contacts. Activities with continuing contact are recorded in the activity log. Visits for condom resupply are not recorded as a contact. Service units that report FSW who come for service are counted as a referral, even if they did not take the referral form.

Duplicate counts can be edited out by cross-tabulations by UIC, birth data and worksite. The computer software has a guard against duplicate entry as well. HCT clients are recounted as new if there is at least a three-month interval. Individuals and HCT visits can be tabulated separately. Volunteers can distinguish between new and continuing contacts since they are familiar with the workforce. Errors in recording birth date can result in duplication if different UIC are assigned to the same individual. All IA staff understand and give importance to data editing and accuracy and completeness. But data quality control methods differ among IA. Some do manual cross-checks or volunteer and summary forms. Some use simple spreadsheet consistency checks. Some re-check the paper forms with the computerized data before submitting reports. When PPAT receives the reports, if they spot small errors, they will call the IA. If there are larger problems they will send the file back to the IA to correct.

Generally, the IAs do not use the data from the forms or computer reports for monitoring or improving implementation. The PCM review progress by looking at IA reports and sometimes have ad hoc requests for certain types of data. But the government and project data systems are not linked. The PR/SR need to devote more effort to standardizing the data system across IA, and promote greater use of the data at the field level to improve implementation.

### **3.11 Summary of service quality**

The evaluation team has summarized the quality of services in comparison with the following six service standards: rights, quality control, service access, participation of the target group, service package, and monitoring. As noted above, the standards come from UNAIDS and other international agencies (Weir, 2011). The summary is shown in Table 3.9.

**Table 3.9 Summary of service quality for the FSW program**

Standard	FSW program	Rating
<b>All HIV Prevention Services</b>		
<b>1.1. Rights to Service</b>		
1.1.1. Clients are fully informed about the service, the risks and expected benefits.	The volunteers did not provide much information about the services; just superficial. They did not try to motivate to seek services.	+
1.1.2. Confidentiality is protected, and client privacy is respected throughout.	The outreach workers and service sites understand the rights of clients and some outlets are anonymous. But use of the NHSO insurance requires that real names are used from the Thai ID card. Outreach and service facility providers understand the need for confidentiality; the UIC system helps protect anonymity Privacy of service area is problematic in some places; such as lack of separate counseling rooms. But protection of privacy is handled well.	++
1.1.3. Equal service for all (absent of stigma or discrimination)	Service is equal and unbiased; client-friendly. (Exception: Admission and screening section staff of clinical facilities are not always client-friendly.)	+++
<b>1.2 Quality Control</b>		
1.2.1. All core services have written SOP that is accessible as a reference at any time.	No equivalent written SOP found. Some have written procedures for their own unit.	+
1.2.2. Staff receive regular monitoring and inspection from supervisors for quality control.	There is little monitoring and mentoring for volunteers on a regular basis. Some volunteers and staff have not received any monitoring visits.	—
1.2.3. Service providers have been trained to be sensitive to issues of stigma and discrimination, to prevent this from happening to FSW.	All staff and volunteers have been trained by the project/IA in this area.	+++
<b>1.3 Access to Services</b>		
1.3.1. Access to services is universal without discrimination according to age, sex, ethnicity, gender, nationality, religion, occupation, health insurance coverage, or drug use.	No discrimination against FSW. No stigma. All FSW have rights to services. But there is lack of motivation to seek services.	+++
1.3.2. Access is convenient by location, travel, travel time, and cost of travel.	DiC are not conveniently located without a variety of needed services to draw in clients. Project partners have increased client-friendly outlets. FSW have more options.	+ ++



Standard	FSW program	Rating
1.3.3. Safe atmosphere (Internet chat option, hot line, peer support group) for the FSW to obtain information and referral.	Not yet implemented, except in Bangkok.	—
1.3.4. No stock-outs of essential equipment for services, including HIV tests, condoms, lubricant, and clean needles/syringes, in the prior 12 months.	External re-supply is irregular, resulting in shortages of condoms and lubricant.	—
<b>2. Services for the FSW</b>		
<b>2.1. Participation of FSW</b>		
2.1.1. The FSW participate in needs assessment of their peers, planning, services and evaluation.	There is participation of FSW at some levels, such as the PCM.	++
<b>2.2. Service Package</b>		
2.2.1. There is outreach to motivate and increase access to services; covering a range of areas; to ease access of FSW to services, information, referral and prevention supplies.	The outreach has a service package for information, referral and prevention supplies. The quality of information about HCT and STI services is inadequate.	++
2.2.2. Field staff have correct knowledge about HIV prevention and provided services.	Staff and volunteers understand the services well. Some staff and volunteers are new and are not yet fluent in BCC. Volunteers need more education on STI.	++
2.2.3. Field staff understanding the need to protect the client during service encounters. They must have ethics and professionalism	Field staff and volunteers understand well about this. They use the UIC system to protect the confidentiality of the clients.	++
2.2.4. Outreach, HCT, and STI services are available for the FSW in particular and at convenient times for them.	There are efforts to provide mobile HCT to improve FSW access and at convenient times. But the service is irregular. - The STI service is still not convenient for FSW. There is a lack of an examining table and lab at some sites.	++ —
2.2.5. Condoms and lubricant, clean needles, etc. are provided in sites near where the FSW congregate at a convenient time.	Prevention supplies are distributed through the DiC, volunteers, work sites, service facilities, and community health outposts.	+++
2.2.6. The clients have risk assessments as part of the HIV prevention communication.	Risk assessment is done in a group, and mostly by the outreach staff, not the volunteers. There is limited time for activities when conducted in the worksites.	+
2.2.7. There is monitoring of the outreach to see if the FSW received STI screening or HIV HCT.	There is no system for monitoring the FSW as to whether they go for HCT or STI after being referred. Recently, the procedure has been changed to have the field staff accompany the FSW for referral.	+

Standard	FSW program	Rating
2.2.8. Educational media are developed for behavior change, with participation by the FSW. The media are distributed/communicated to the FSW through appropriate channels.	Education media are minimal. There is limited budget for media development. Thus, only the cheapest materials are reproduced. These are not popular with the FSW; the FSW did not participate in media development.	+
<b>2.3 Monitoring</b>		
2.3.1. Clients have a UIC, and the monitoring system can track these individuals by UIC. Or, there is an alternate system for monitoring client receipt of services.	The UIC is only used in the GF-supported outreach activities. It is still not possible to track all service clients or link client movement between the outreach and clinical facilities.	—
2.3.2. Field staff receive refresher training, mentoring and supervision on service quality (including HCT and STI).	- Volunteers receive refresher training occasionally. But there is little monitoring and supervision from supervisors. Most service providers for HCT and STI have opportunities for in-service training on counseling and STI. But they only receive minimal monitoring and supervision for quality control. There are no indicators for improving quality of services.	+ ++

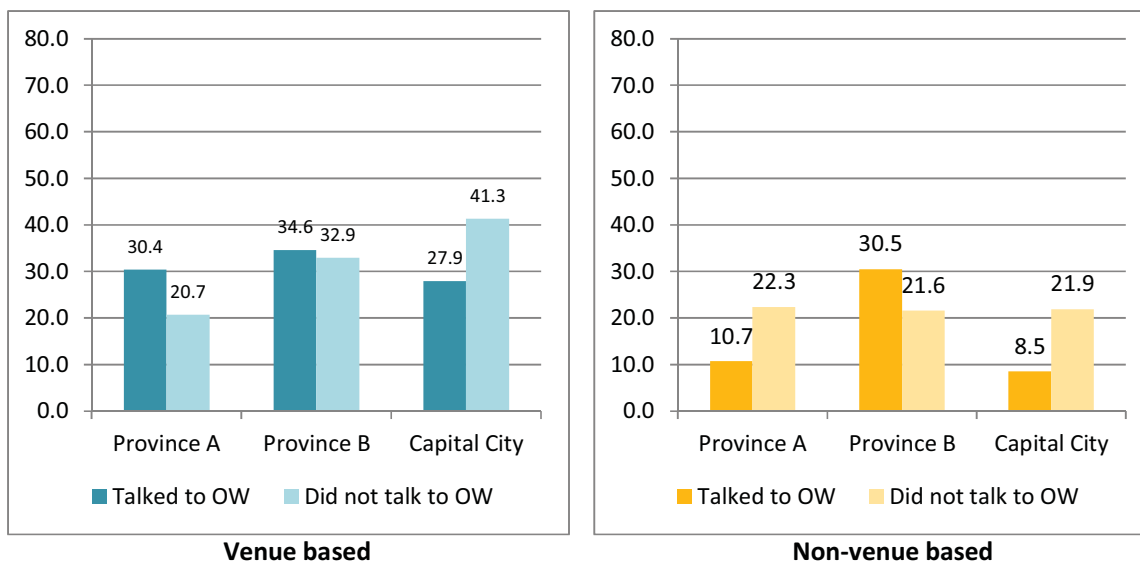
**Remarks:** +++ denotes good, ++ denotes fair, + denotes poor, - denotes no implementation

### 3.12 Effect of the program on HIV knowledge and prevention behavior

Finally we look at whether exposure to the HIV prevention program is associated with higher HIV knowledge or more frequent HIV prevention behavior. As discussed in the methodology chapter, no causality between program exposure and differences in knowledge or prevention behavior can be concluded, as the data is cross-sectional.

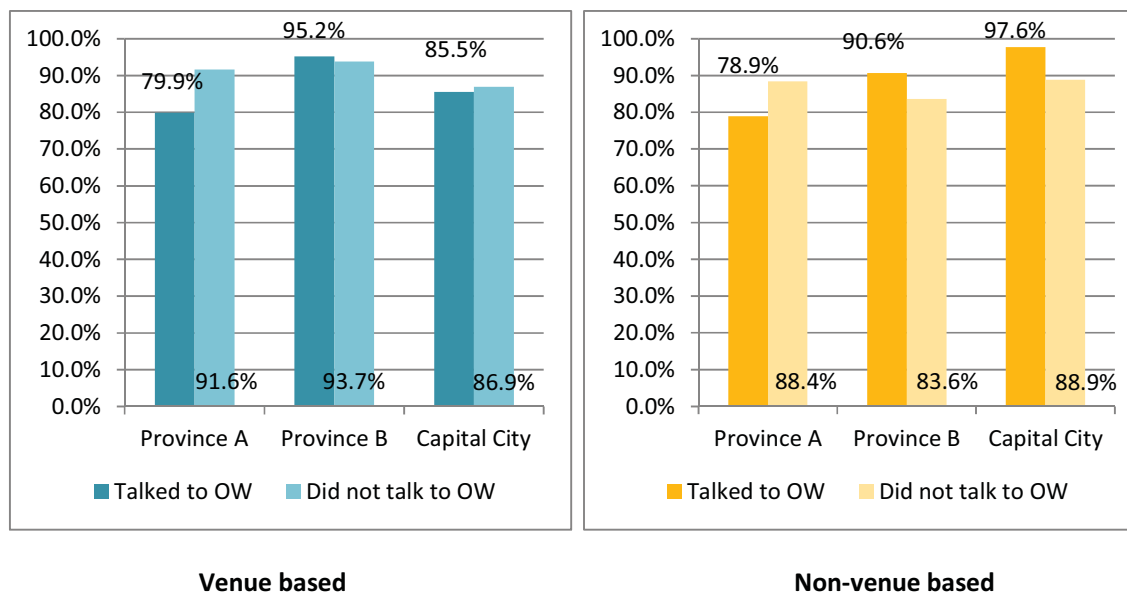
As seen in Figure 3.32, there is no significant difference in knowledge about HIV, as measured by the percentage who got all five GARPR questions correct, by whether the FSW had talked to an outreach worker. In some groups, knowledge was higher among those who did not talk to an OW.

**Figure 3.31 Correct answer on 5 GARPR questions measuring HIV knowledge by whether talked to an outreach worker in the past 12 months**

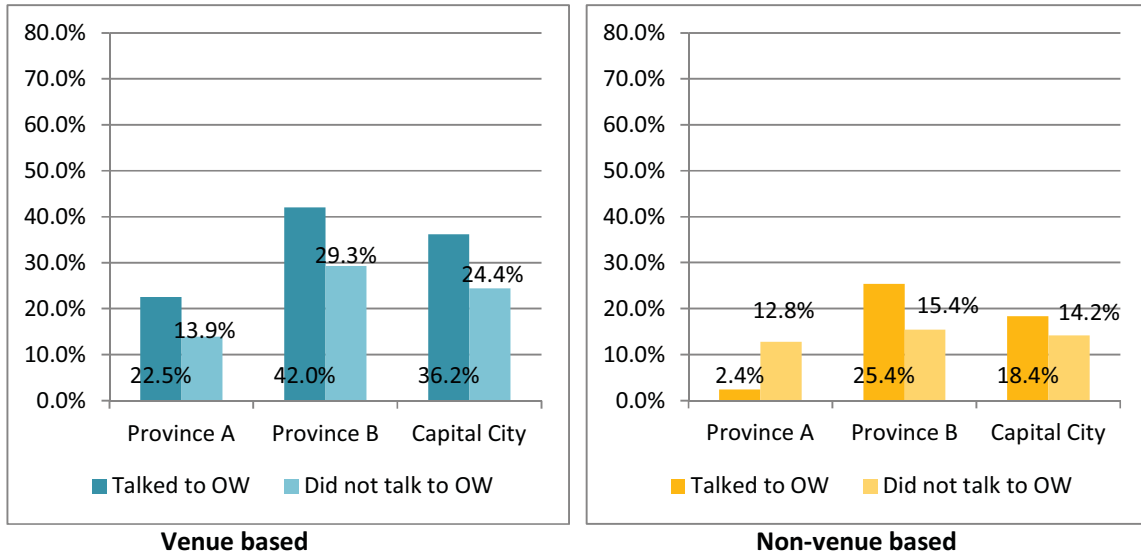


Consistent condom use with clients is at a very high level, and there is no difference between FSWs who talked to an outreach worker and those who did not (Figure 3.32). Regarding the use of water-based lubricant however (Figure 3.33), across sites and for venue- and non-venue based FSWs, use is nearly always significantly higher for those who had talked to an outreach worker. The exception is for non-venue based FSWs in Province A, where use is higher for those who did not talk to an outreach worker.

**Figure 3.32 Consistent condom use with clients in the past 12 months for those who talked to an outreach worker and those who did not (venue and non-venue based FSWs)**

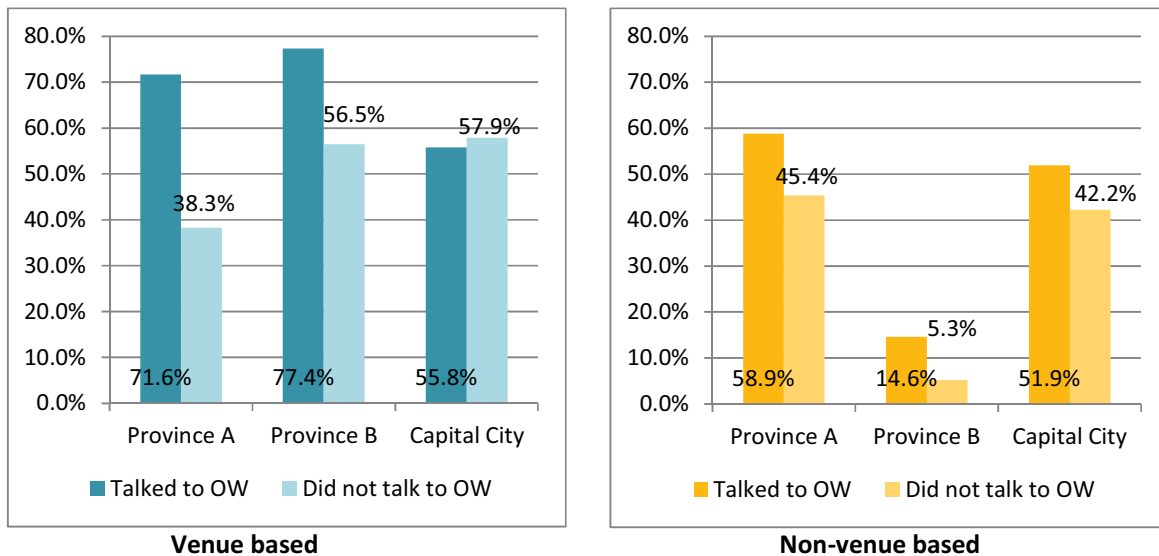


**Figure 3.33 Water-based lubricant use with clients in the past 12 months for those who talked to an outreach worker and those who did not (venue and non-venue based FSWs)**



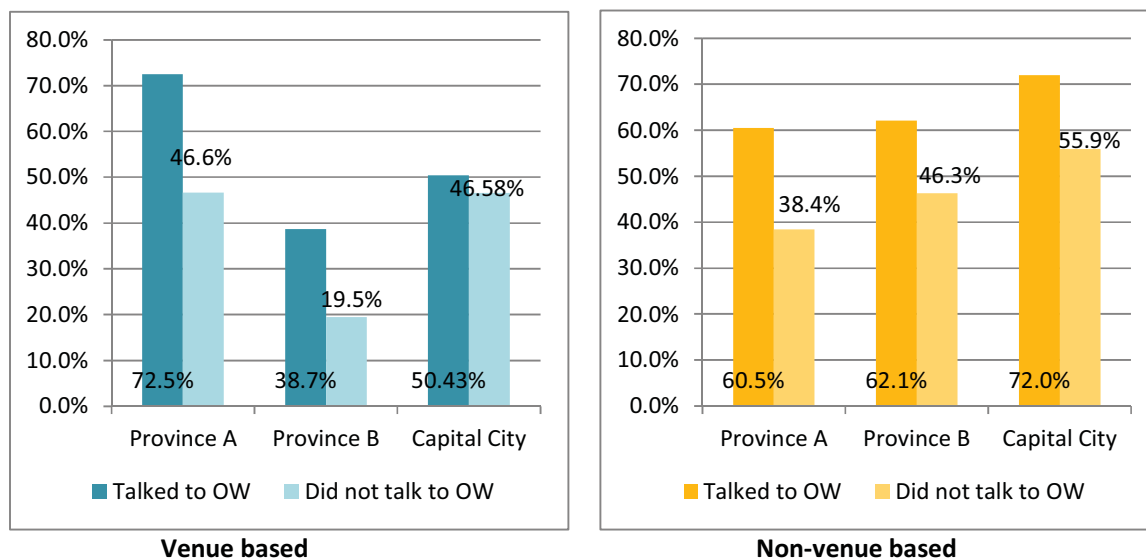
The study finds that attendance at STI screening was higher for FSWs who talked to an outreach worker (Figure 3.34). However, the difference is significant only for venue-based FSWs in Province A and non-venue-based FSWs in Province B.

**Figure 3.34 STI screening in the past 12 months for those who talked to an outreach worker and those who did not (venue and non-venue based FSWs)**



Both venue- and non-venue-based FSWs who talked to an outreach worker were more likely to attend HCT services (Figure 3.35). The difference is significant for all groups except for venue-based FSWs in Bangkok.

**Figure 3.35 HCT attendance in the past 12 months for those who talked to an outreach worker and those who did not (venue and non-venue based FSWs)**



The quantitative finding that FSWs who talked to an outreach worker were more likely to use HCT services may seemingly contradict those of the qualitative (service) study, which found that the peer educators were more focused on giving HIV/AIDS information than on promoting services or counseling on risk assessment. Some alternative explanations include that the break-down in the referral system noted earlier has led to underestimates of how many FSWs do seek HCT after meeting with an outreach worker. In Province B, outreach workers work closely with the mobile clinic and often arrange appointments and accompany FSWs for these services. In other areas, outreach workers also sometimes accompany FSWs to the services. Another explanation could be that there are characteristics of FSWs that are associated with seeking both types of HIV prevention services without a causal link. For example, an FSW who is worried about her HIV status may be more interested in talking to an outreach worker, and to use HCT services. These factors will be explored further through multivariate analysis.

## 4. RESULTS: MEN WHO HAVE SEX WITH MEN

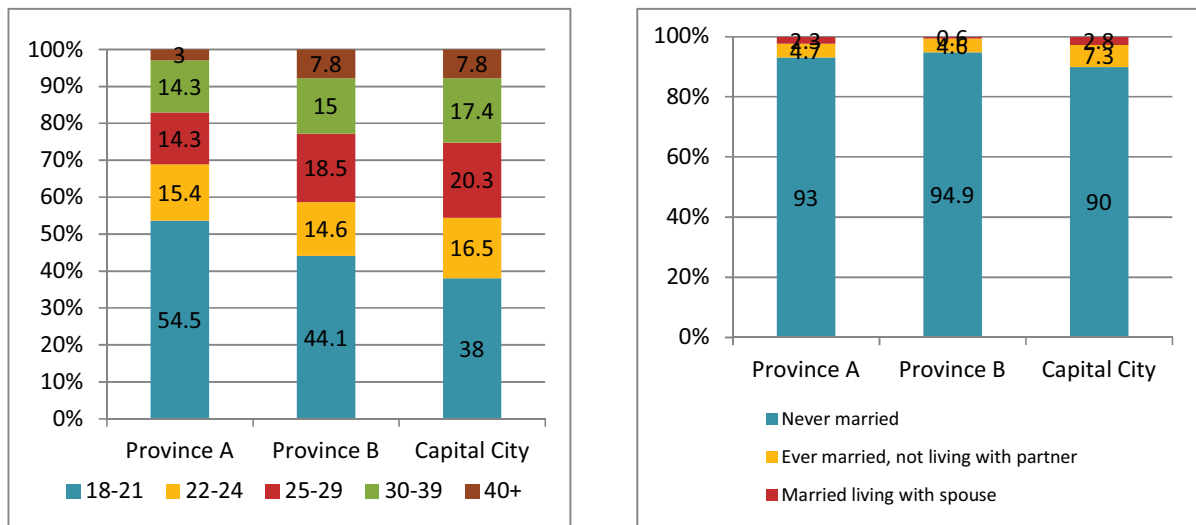
Services for MSM include ACHIEVED project interventions, activities funded by the Thailand MOPH – U.S. CDC Collaboration (TUC), and public sector clinical facilities, which draw upon routine government budget to support services. Interventions for MSM in the first two years of ACHIEVED were implemented by the SR Rainbow Sky Association of Thailand (RSAT). In Year 3, the Planned Parenthood Association of Thailand (PPAT) became the SR with RSAT as the SSR.

The chapter presents synthesized findings of the service evaluation study and population surveys by topic. Characteristics of the MSM survey respondents are presented by study site, with graphs showing results for MSMs in three groups (general population MSM, transgender (TG) or male sex workers (MSW)) and by age (< 25 or 25+). A full set of tables for MSMs categorized in three groups and by older/younger age is found in Appendix 9.2, Section A4.

### 4.1 Sociodemographic profile of MSM

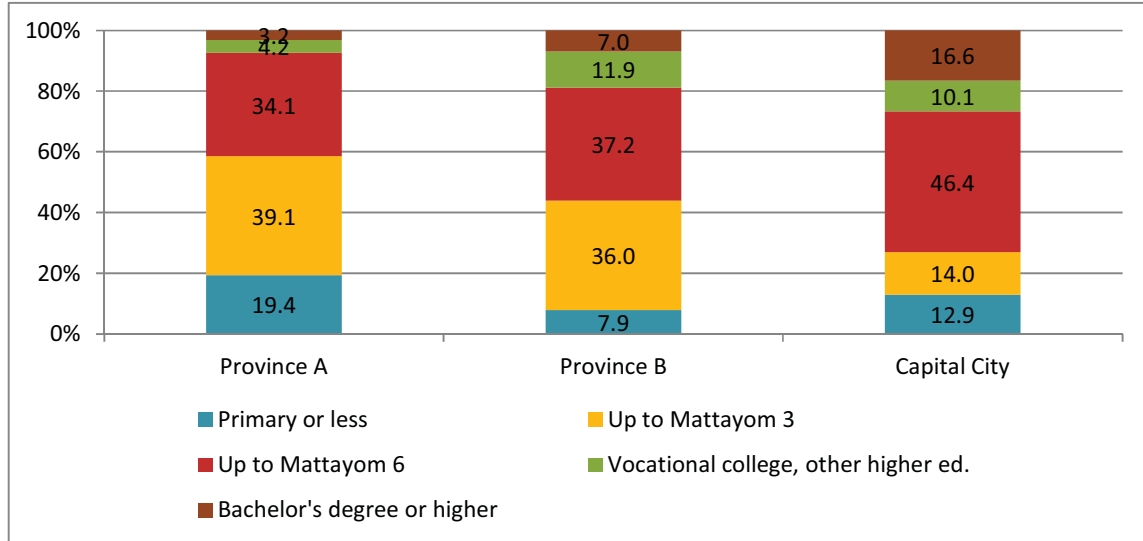
The age of the MSM in the samples varied by site, with Province A having the greatest proportion of MSM under the age of 25 and Bangkok the smallest (Figure 4.1). At least 90% of the sample in each site had never been married; only a few were currently married.

**Figure 4.1 Age distribution and marital status of MSM sample**



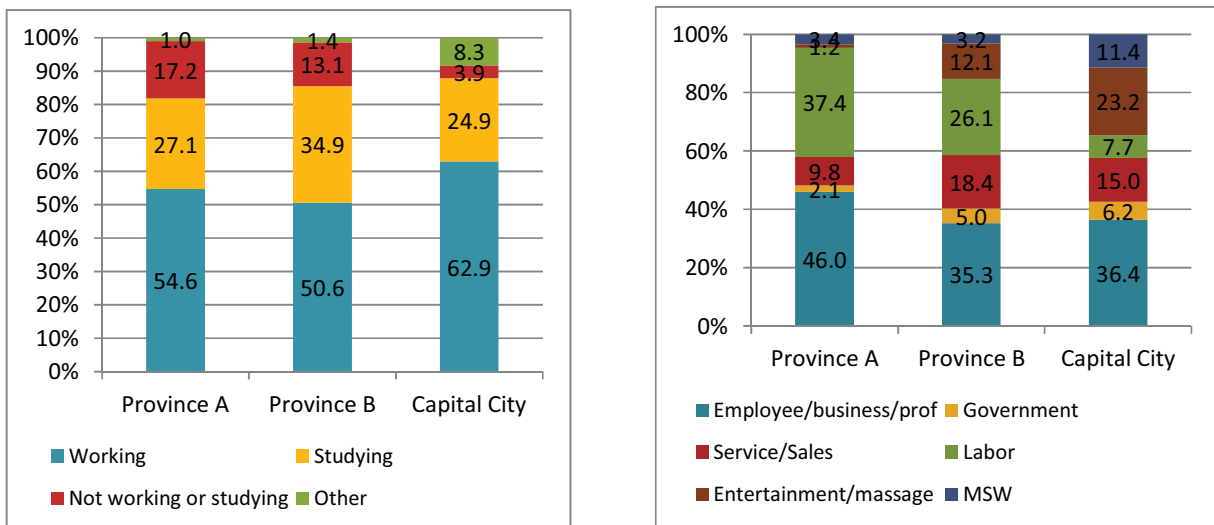
Educational attainment of MSM is fairly high (Figure 4.2); 40% of those in Province A have more than Mattayom 3, with 56% and 73% exceeding this level in Province B and the Capital City respectively. Fully 16% of MSM in Bangkok have a bachelor's degree or higher.

**Figure 4.2 Educational attainment of the MSM sample**



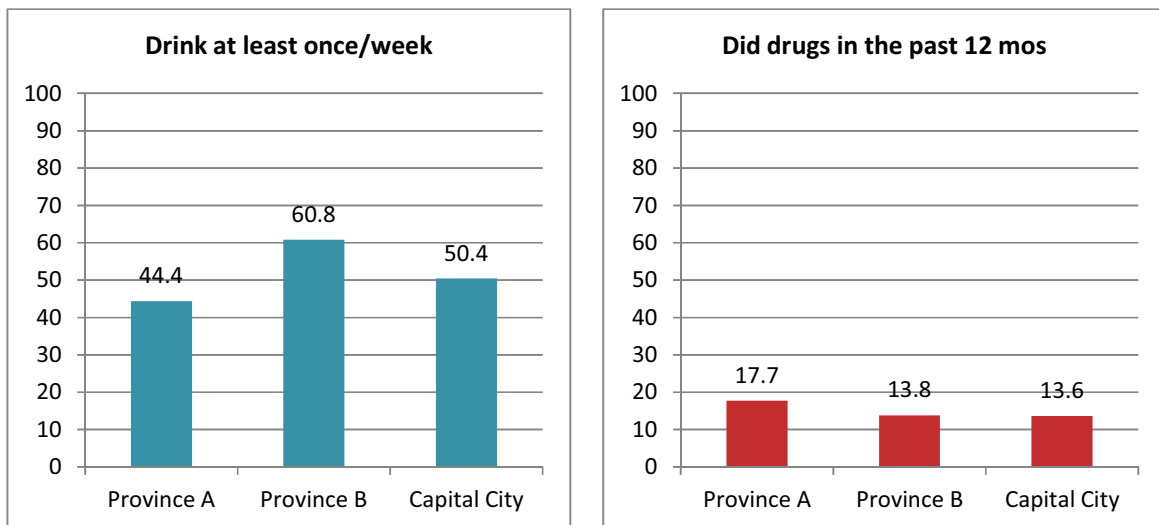
Related to the age composition of the sample, only about 50-55% of respondents in Province A & B were working at the time of the survey, with about 60% in Bangkok (Figure 4.3). From one-quarter to one-third of the MSM were students. Of those that are working, a wide variety of occupations were listed by the respondents. In Bangkok, about one-third of the working MSM were working in the entertainment or massage business, or as a male sex worker.

**Figure 4.3 Work status and occupation of the MSM sample**



Alcohol and drug use among the MSM sampled was not reported as high (Figure 4.4). From 44% to 61% said that they drink alcohol at least once a week. Less than 20% said that they had taken an illegal drug in the past year. The most frequently reported drugs taken were amphetamine and methamphetamine, and MSWs had the highest use of these drugs. Methamphetamine was mentioned by 17% of MSWs in Bangkok and by 24% in Province B. Only one respondent said that he had injected drugs in the past three months.

**Figure 4.4 Alcohol and drug use among MSMs surveyed**

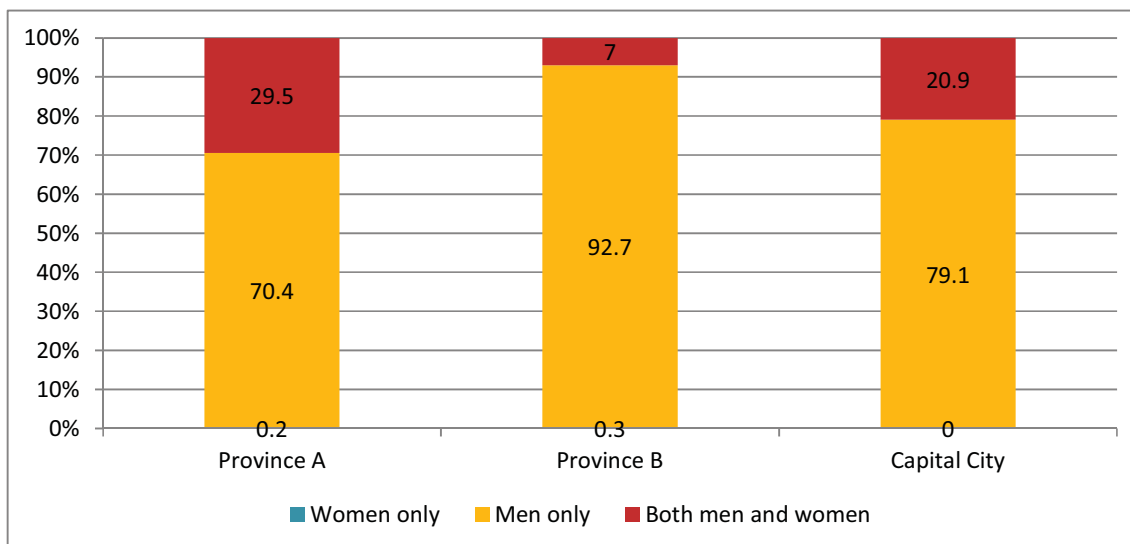


## 4.2 Self-reported sexual identity

Respondents were asked whether they were attracted to men only, to women only or to both. As seen in Figure 4.5, only a very few said they were attracted to women only. From a very small percent in Province B (7%) to 21-30% in Province A and Bangkok said they were attracted to both men and women, with the remainder attracted to men only.

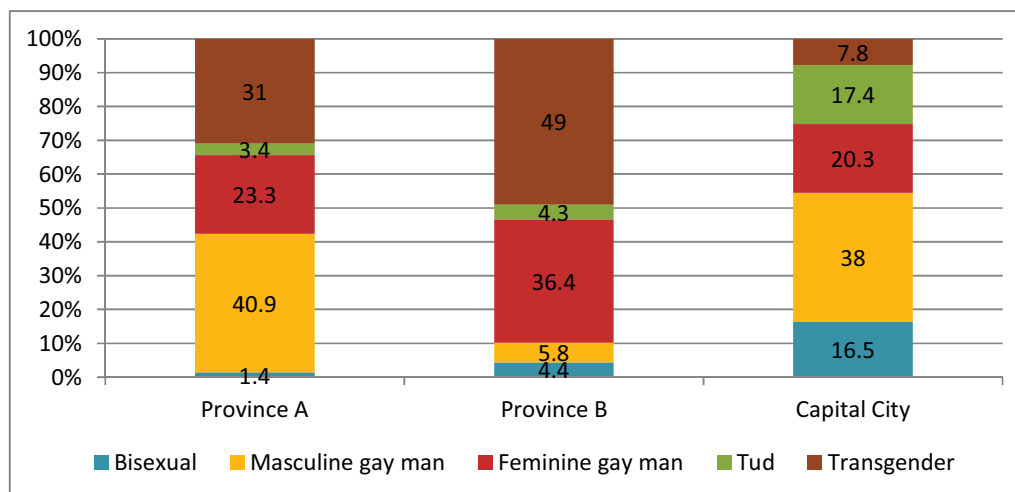


**Figure 4.5: Proportion of MSM who say they are attracted to men only, women only or both**



The survey also asked respondents whether they thought of themselves as bisexual, a masculine gay man (“real man”), a feminine gay man (“gay”), a *tud* (who sometimes dresses as a woman but may spend most of the time living as a man) or finally transgender. As seen in Figure 4.6, the distribution by MSM group is very different by site. Bangkok is the only site with a substantial proportion of bisexual men (17%) and has a much lower proportion of transgender (8%) than Province A (31%) and Province B (49%). The greater variety of MSM sub-groups in Bangkok is likely a reflection of the greater freedom to be open about sexuality in the capital, as well as the fact that many MSM gravitate to Bangkok from other provinces.

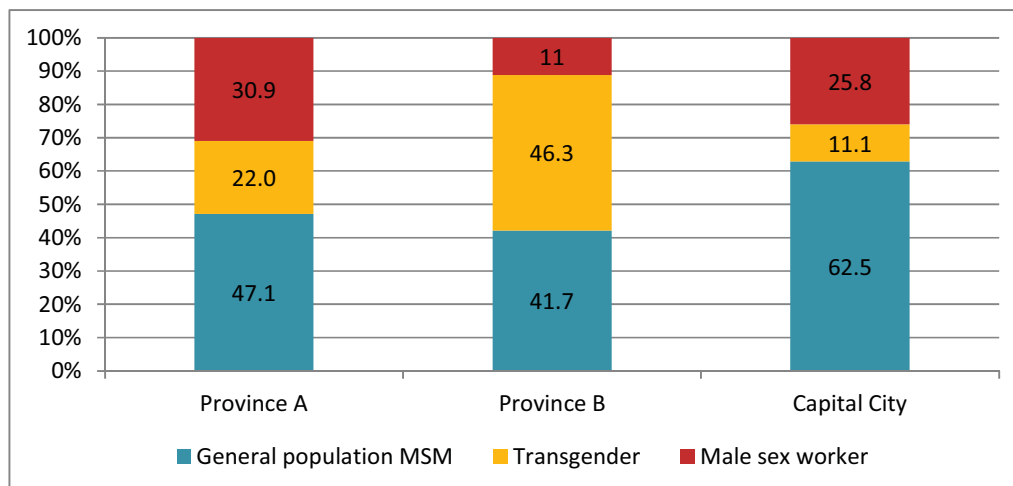
**Figure 4.6: Self-reported sexual identity of MSM**



For the remainder of the chapter, the MSM are classified into the three groups shown in Figure 4.7: male sex workers (who may be transgender or not); transgender (not sex workers) and general

population MSM (who are not transgender or sex workers). These subgroups are used in the figures and in the tables in Appendix 9.2, Section A4.

**Figure 4.7: Proportion of MSM who are general population MSM, transgender and male sex workers by study site**



### 4.3 Sex work profile of MSWs

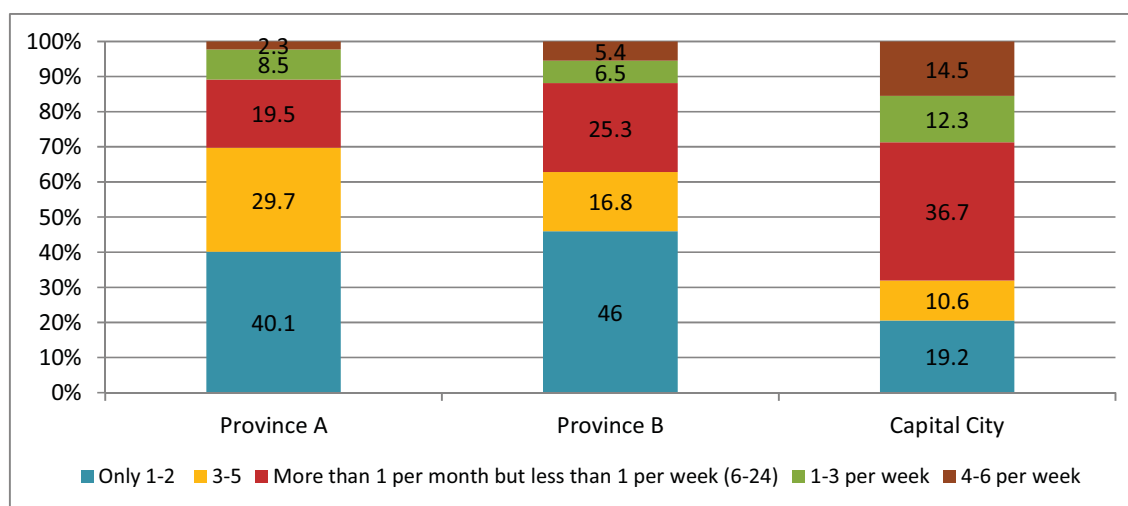
MSM who said that they had received money for sex in the past six months were asked a series of questions about their work as sex workers. As seen in Table 4.1, the results varied greatly by site. About one-third of MSWs in Bangkok said that they met their clients at a massage/sauna, though no MSWs gave this response in Province A or Province B. Provincial MSM are more likely to meet their clients in a public place. Many MSW listed more than one place or method for meeting clients, and as seen in Table A4.3 many of them meet clients at both at venues and through non-venue methods.

**Table 4.1 MSMs' venue or method for meeting clients (multiple response possible)**

	Province A	Province B	Capital City
<b>Venue based</b>			
Massage/Sauna venue	0.0	0.0	35.1
Entertainment venue (bar, karaoke, etc.)	14.3	10.7	45.7
Restaurant	38.9	2.8	1.7
Other venue	2.3	8.0	0.8
<b>Non-venue based</b>			
Public place (street, canal etc.)	25.3	26.4	2.4
Through a pimp	4.8	1.0	5.7
Freelance (telephone, internet)	45.8	60.6	32.3
Other	8.3	8.4	4.0
	(137)	(55)	(136)

A large proportion of the MSWs in Province A and Province B (40-46%) said that they only had one or two clients in the past six months (Figure 4.8). In Bangkok however only 20% have so few clients. In fact less than 15% of the MSWs in the provincial sites had one client per week or more, whereas in Bangkok 27% were in this category. As seen in Table A4.3, transgender MSWs had fewer clients than those who were not transgender. There is little difference by age in the number of clients (Table A4.4).

**Figure 4.8 Number of clients in the past six months for MSW**



#### 4.4 STI knowledge and experience with STI symptoms and treatment

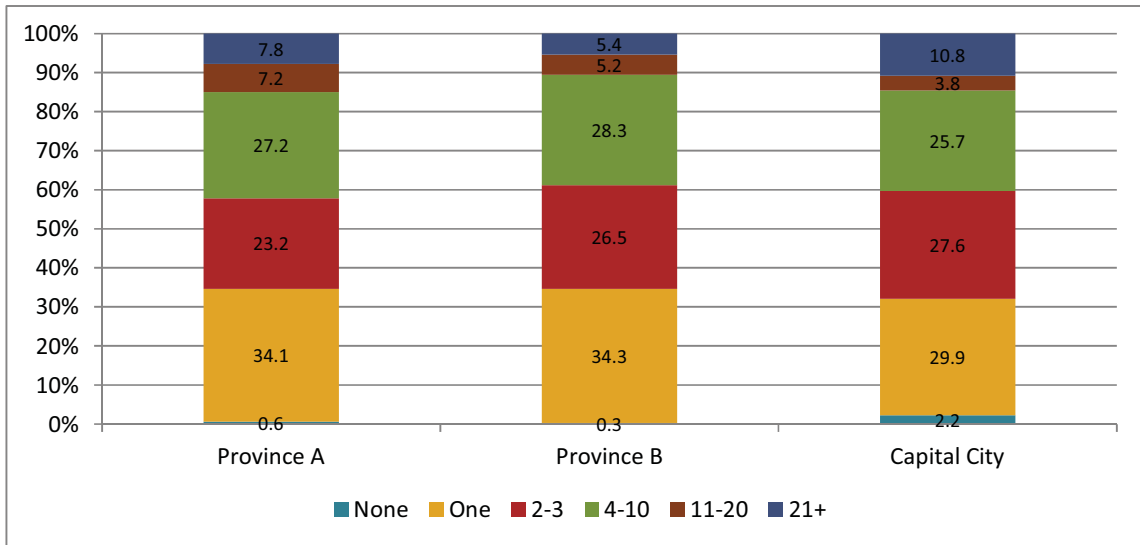
As shown in Tables A4.5 and A4.6, the majority of MSM in Province B and Bangkok can spontaneously name at least one symptom of STIs in men; in Province A less than 50% can do so. This is similar to the findings for FSW in Province A. Older MSMs are more knowledgeable about STI symptoms across sites, but there is no discernible pattern by MSM group. When asked whether they experienced any symptoms of STIs in the past 12 months, from 7% in Province A to 19% in Province B said yes, with 15% in Bangkok. Male sex workers were more likely to have symptoms across sites, as were younger MSMs. MSM in Province A were much more likely to say that they went to a medical facility for treatment, whereas those in Province B and Bangkok who had symptoms were more likely to say that they went to a pharmacy for medication.

#### 4.5 HIV knowledge, risks and prevention behavior

As seen in Tables A4.7 and A4.8, all MSM sampled were able to answer at least one of the GARPR standard knowledge questions correctly. These are answers to the following true/false statements: (1) Using a condom during sex can prevent HIV; (2) Sex between two mutually faithful monogamous partners can prevent HIV; (3) HIV cannot be spread by mosquito bites; (4) HIV cannot be spread by eating with an infected person; and (5) Someone who looks healthy can still have HIV infection. About half were able to answer all five questions. Older MSM were generally more knowledgeable about HIV.

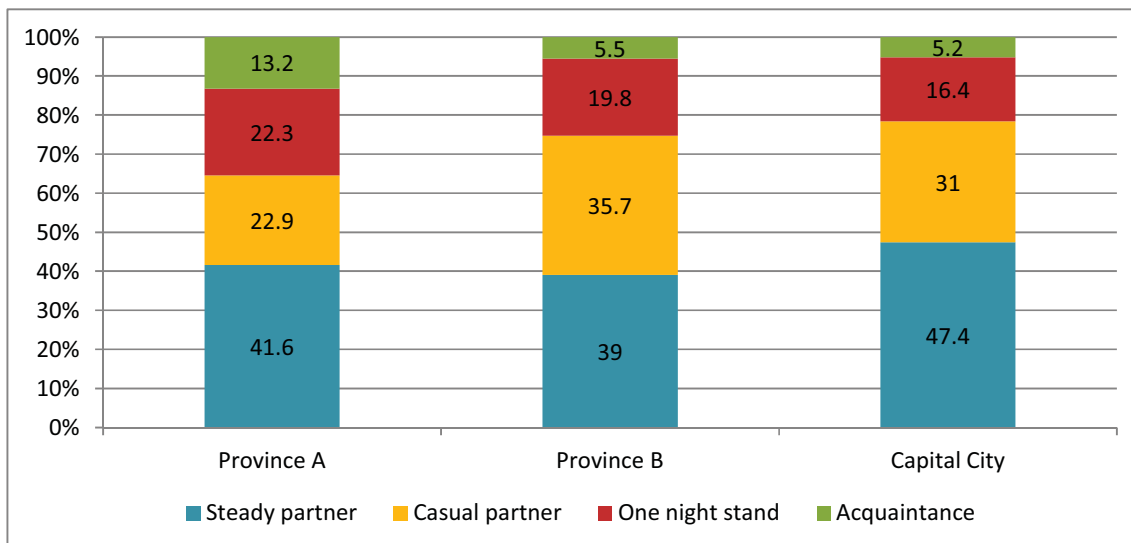
Tables A4.11 and A4.12, as well as the figures below, present results on MSM sexual behavior. The first set of findings presented is for non-paying male partners, both for MSWs and for non-MSWs. About one-third of MSM had only one male partner in the past six months, across sites (Figure 4.9). About 25% had two or three partners. Consistently across sites, about 40% had four or more non-paying partners in the past six months. Male sex workers had more non-client partners on average than other MSM across sites.

**Figure 4.9: Number of non-paying partners in the past 6 months for all MSM**



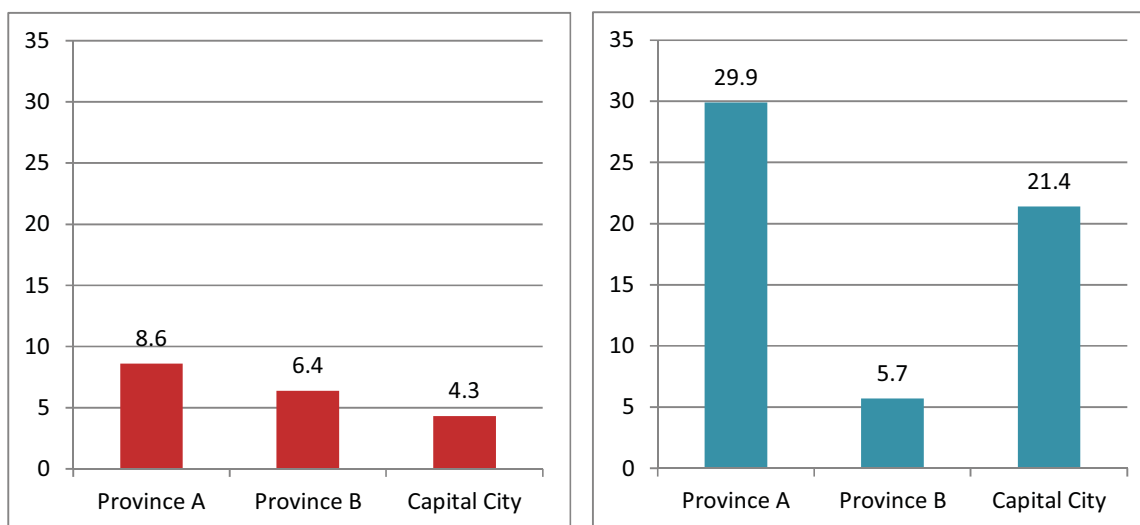
About 40% of the respondents said that their last male partner was a steady partner, with 23-36% saying it was a casual partner (Figure 4.10). Bangkok MSMs tended to report more steady partners than those in the provincial sites, with Province A having the highest percentage saying the last partner was a one-night stand or acquaintance.

**Figure 4.10: Relationship to last non-paying partner for all MSM**



The survey also asked about whether the respondent himself paid for sex in the past six months. Only a small percentage (less than 10%) said that they did so (Figure 4.11). When asked about female partners, the results varied greatly by site. About 30% of MSM in Province A said they had a female partner, compared to only 7% in province B.

**Figure 4.11: Percentage of MSM having paid partners and female partners in the past six months**

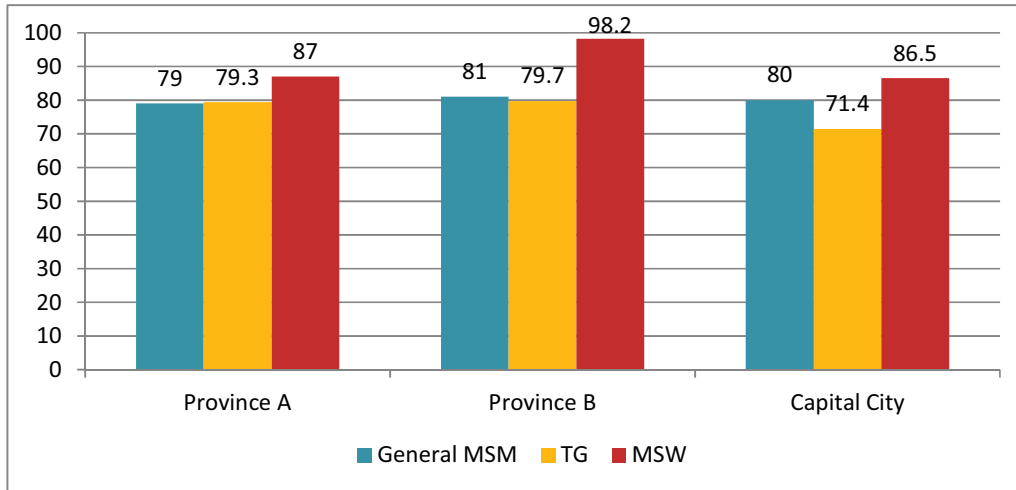


Further detail about the sexual behavior of the sample, including the number of partners for insertive anal sex, receptive anal sex, and oral sex, is found in Tables A4.11 and A4.12.

Findings on HIV prevention behavior for MSM is found in Tables A4.13 and A4.14 as well as the figures below. Condom use with the last male (non-paying) partner is found in Figure 4.12. Male sex workers were more likely to use a condom with their non-paying partners than non-sex-workers,

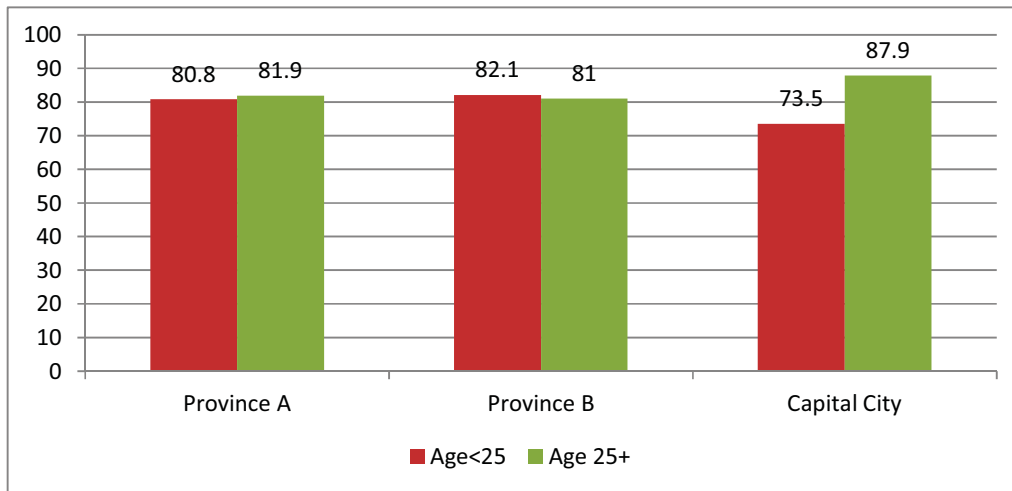
though the difference was only significant in Bangkok. Transgender MSM used condoms less frequently in Bangkok (71%). In general condom use with the last partner was 90% or higher for MSWs and around 80% for non-MSWs.

**Figure 4.12: Condom use with last non-paying partner by MSM group**



By age, there is no difference between younger and older MSM in the provincial sites (Figure 4.13). In Bangkok, MSM aged 25 or older were significantly more likely to say that they used a condom with their last partner (88%) than younger MSM (74%).

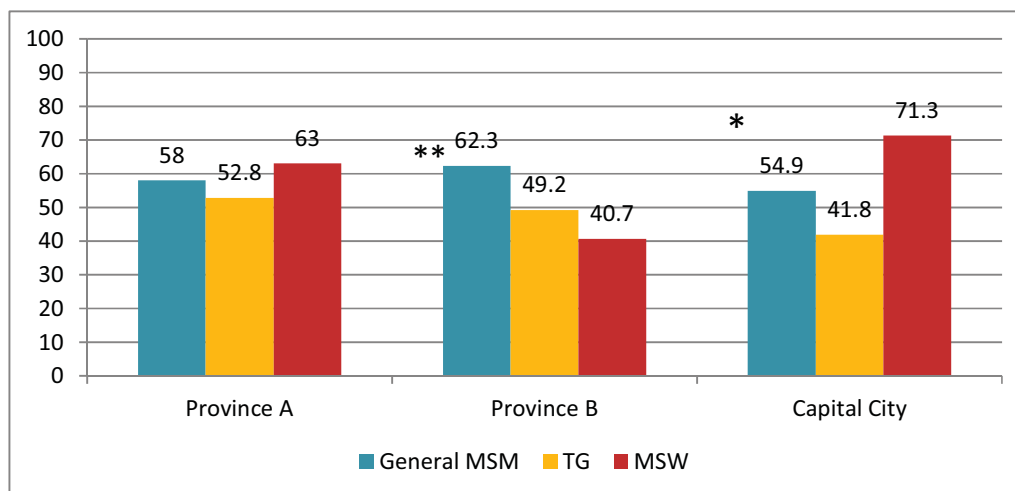
**Figure 4.13: Condom use with last non-paying partners by age**



Respondents were also asked about their frequency of condom use with non-paying partners in general. Those who said that they used a condom “every time” were asked a follow-up question, “Was there any time in the past six months that you didn’t use a condom with clients?” This follow-up question was used to revise the results on frequency of condom use to a more accurate figure. As seen in Figure 4.14, the percentage who said that they use a condom every time is much lower than those using a condom last time. There is a significant difference by MSM group in all sites, however

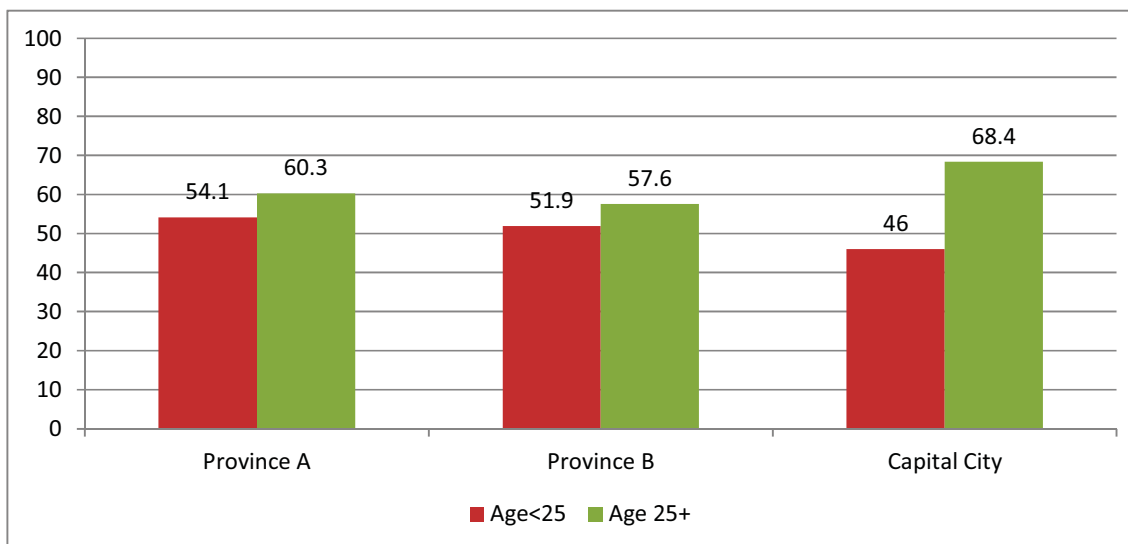
the pattern is different in Province B than in Province A and Bangkok. In the latter two sites, MSW are most likely to be consistent in their condom use, with general MSM next and transgender least likely. In Province B, MSWs are least likely to say they use condoms every time (41%).

**Figure 4.14: Frequency of condom every time with non-paying partners by MSM group**



By age, again in Bangkok younger MSM are less likely to have consistent condom use (46%) than older MSM (68%) (Figure 4.15).

**Figure 4.15: Frequency of condom every time with non-paying partners by age**



Respondents were also asked about their lubricant use with their last non-paying partner. In contrast to FSWs, few MSM said that they used non-water-based lubricant. MSWs were least likely to say that they used a lubricant across sites. Over half of general MSM and transgender MSM said that they used lubricant last time (Figure 4.16).

**Figure 4.16 Lubricant use with last non-paying partner by MSM group**

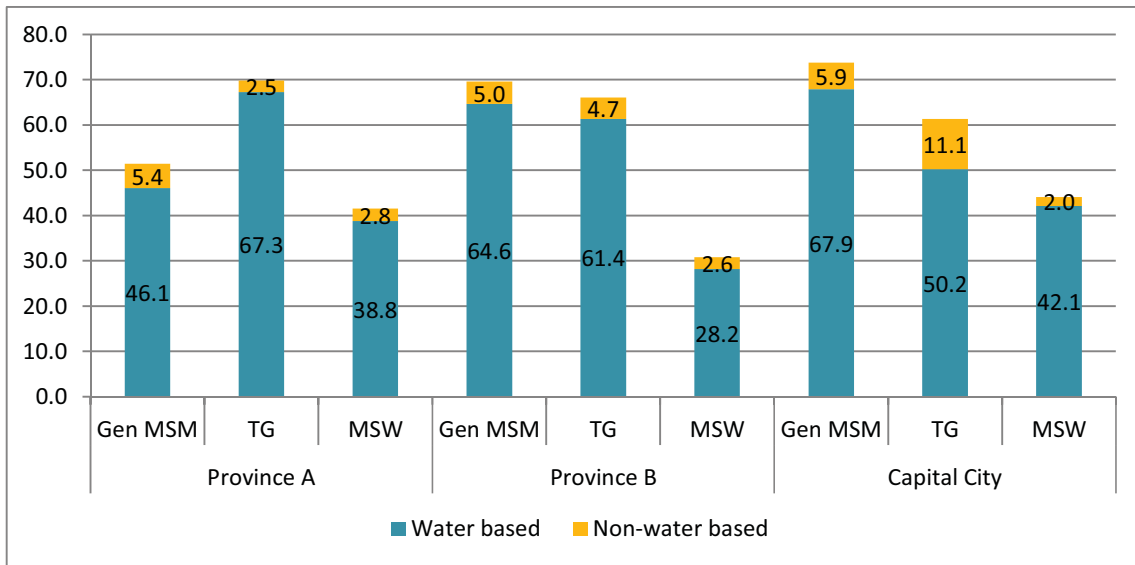
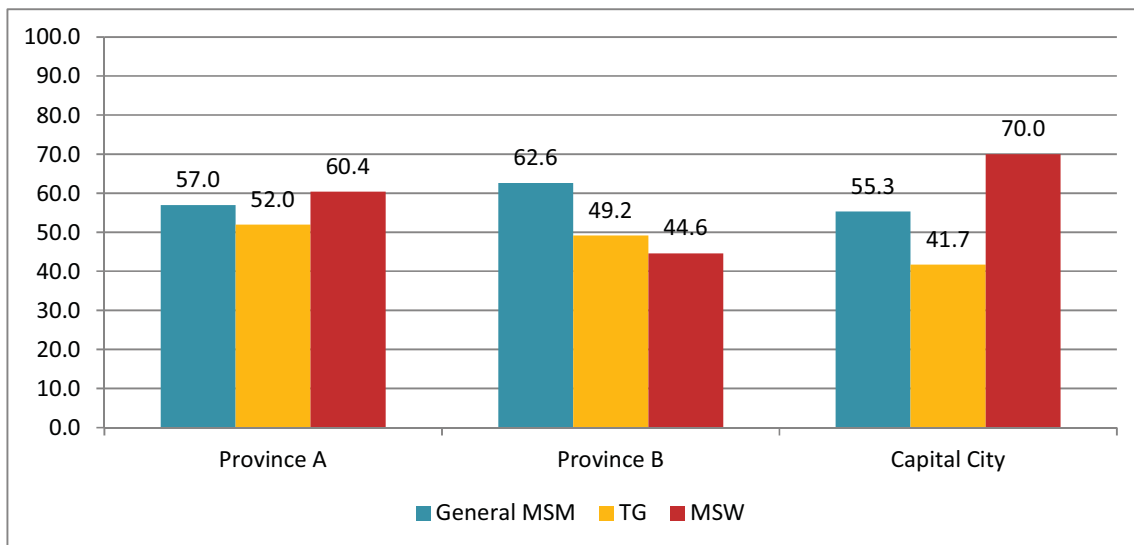


Figure 4.17 looks at consistent condom use across all partners (including females and for MSWs, paying partners). In Province A, there was no difference by MSM group, with about 52-60% using condoms with all partners. In Province B there were significant differences by group, with general MSM most likely to be consistent (63%), transgender next (about half) and MSWs least likely to use condoms consistently (45%). Finally, in Bangkok only 41% of transgender MSM used condoms consistently while 70% of MSWs did.

**Figure 4.17: Consistent condom use with all partners by MSM group**





By age, older MSM were significantly more likely to use condoms consistently in Province A and Bangkok (Figure 4.18).

**Figure 4.18: Consistent condom use with all partners by age**

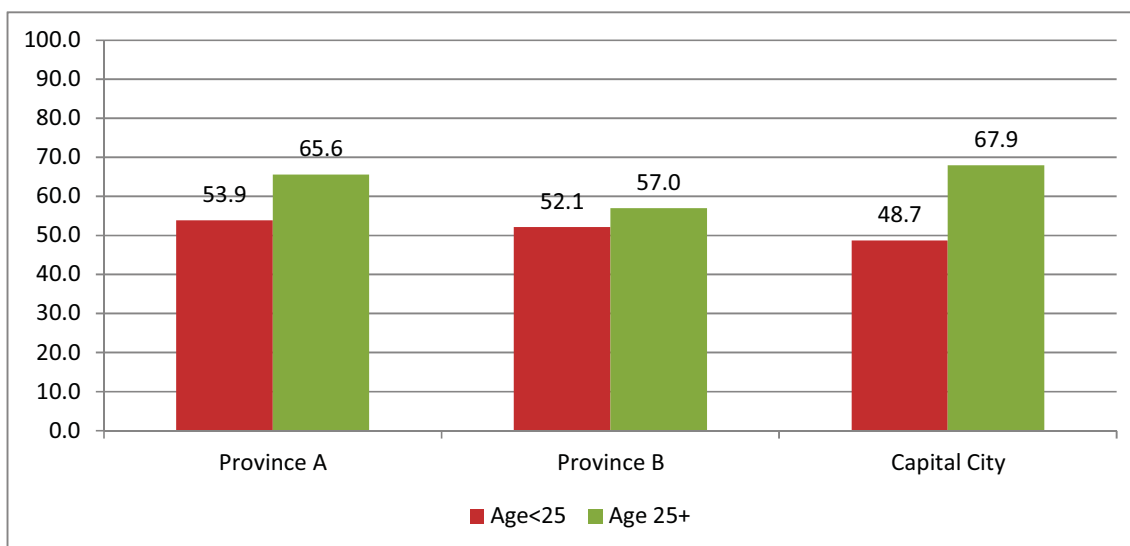
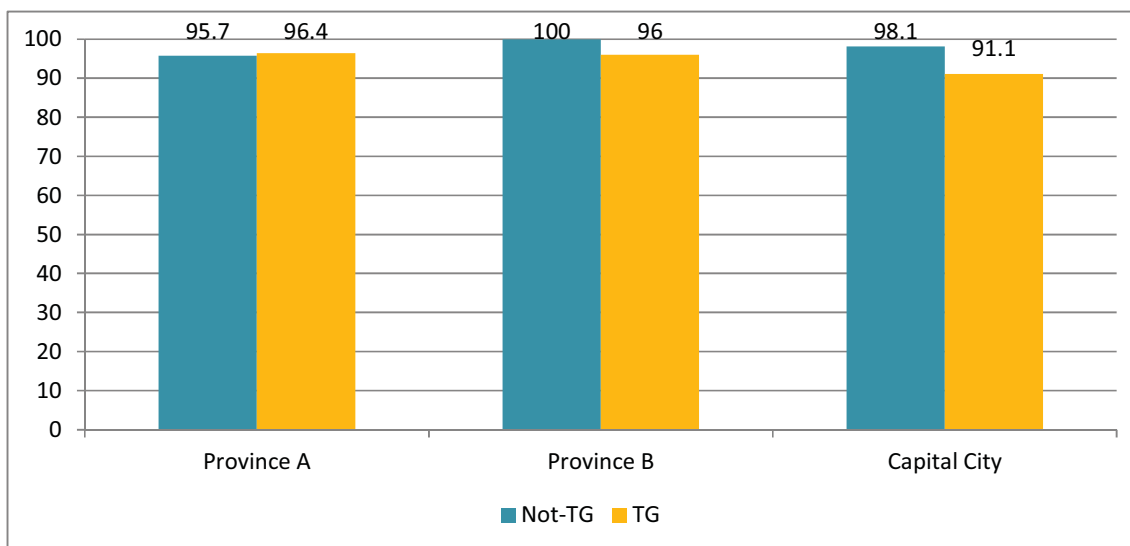


Table A4.13 and A4.14, as well as Figure 4.19 and 4.20, examine MSWs' use of condoms with their clients. The percentage who said they used a condom with their last client is high (from 91-100%) and there is no significant difference between transgender and non-transgender MSWs.

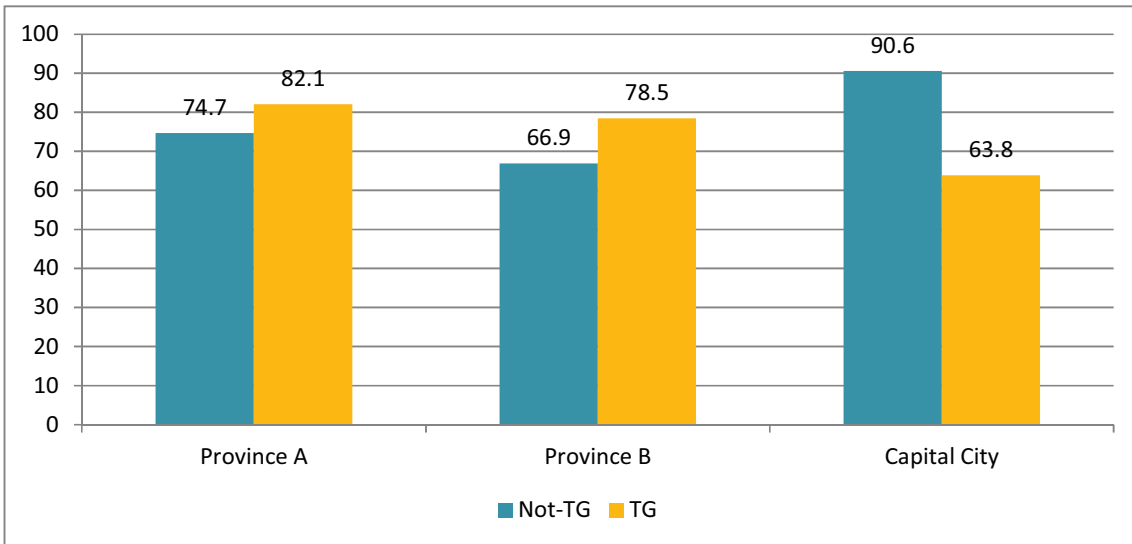
**Figure 4.19: Percent who used a condom last time with client, non-TG MSW and TG MSW**



Responses on whether MSW used a condom every time with clients, which should be more accurate since it includes a follow-up probe, are lower and show a different pattern by site and transgender status. In the provincial sites, from 67-82% said that they used a condom every time and there was

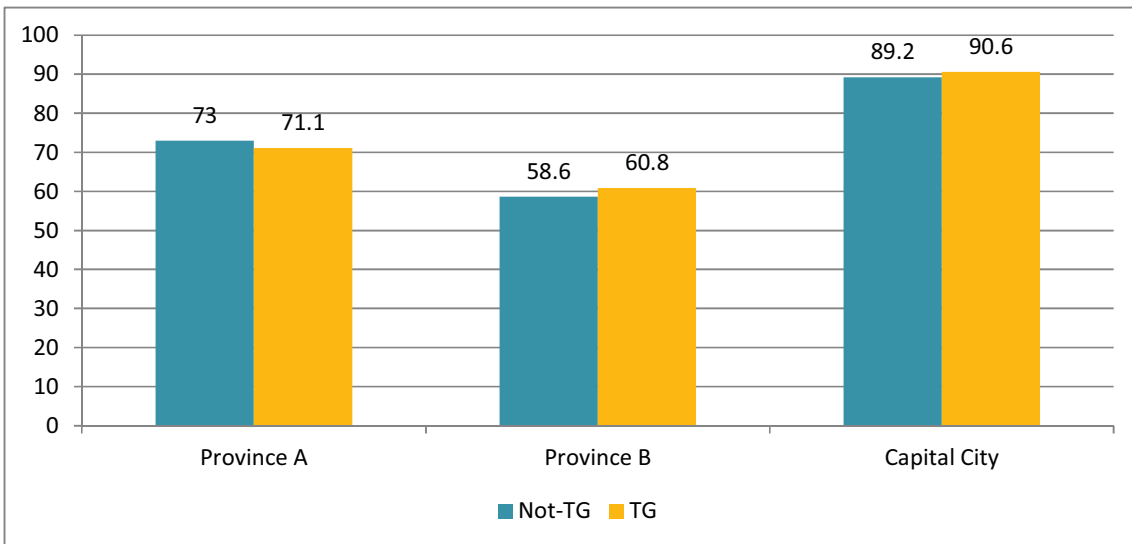
no significant difference between transgender and other MSWs. In Bangkok however, non-TG MSWs were significantly more likely to use a condom (91%) than transgender MSWs (64%).

**Figure 4.20: Percent who always use condoms with clients, non-TG and TG MSW**



Finally, MSWs were also asked whether they used lubricant with their last client. Lubricant use showed no difference by transgender status but varied by site; Bangkok had the most frequent use of lubricants among MSWs (about 90%) and Province B the lowest (about 60%) (Figure 4.21).

**Figure 4.21: Percent who used lubricant with last client, non-TG MSW and TG**



In summary, in line with findings from surveillance on HIV prevalence among MSM, the survey found considerable risk behavior among all MSM groups. Condom use was not consistent and about 40%

of the MSM surveyed had multiple partners. Because lubricant use is very different by site, it is likely that this is related to promotional activities by the program. The Bangkok site seems to be most successful in promoting lubricant use.

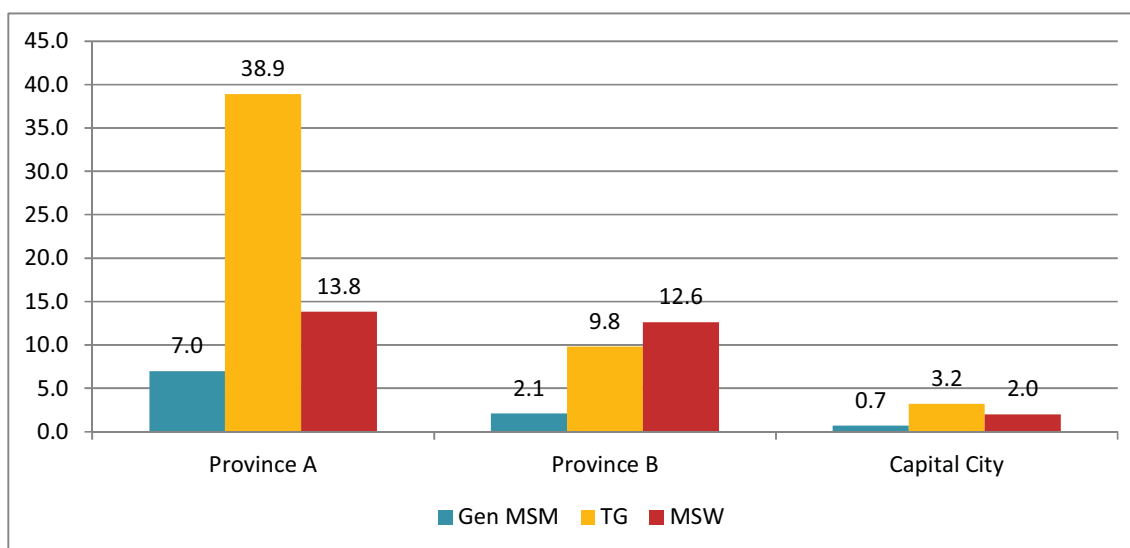
#### 4.6 Stigma and discrimination towards MSM in daily life

As discussed in the previous chapter, Thailand’s National HIV/AIDS Strategy includes the vision of “getting to zero” stigma and discrimination (S&D) towards key affected groups. Two goals that will contribute to this vision are 1) that human rights and gender-specific needs are addressed in all HIV responses; and 2) that stigma and discrimination towards people living with HIV (PLHIV) and key affected populations (KAPs) is reduced by half. These two types of stigma and discrimination are examined separately in this chapter: findings on S&D experienced at HIV prevention services from the service study and the quantitative survey is discussed within the sections on individual services, whereas findings on S&D experienced by MSM in daily life as reported in the MSM survey is discussed here.

##### *Difficulties in daily life*

When asked if they ever face difficulties in their daily life because they are MSM, the results varied by MSM group and site (Figure 4.22). MSM in Province A had the highest percentage saying they faced difficulties in each MSM group, while Bangkok had the lowest percentage. Being called names or ridiculed, not being treated with respect, and being treated differently from others were the top difficulties mentioned.

**Figure 4.22 Percentage of MSM who say they face difficulties in daily life by MSM group**

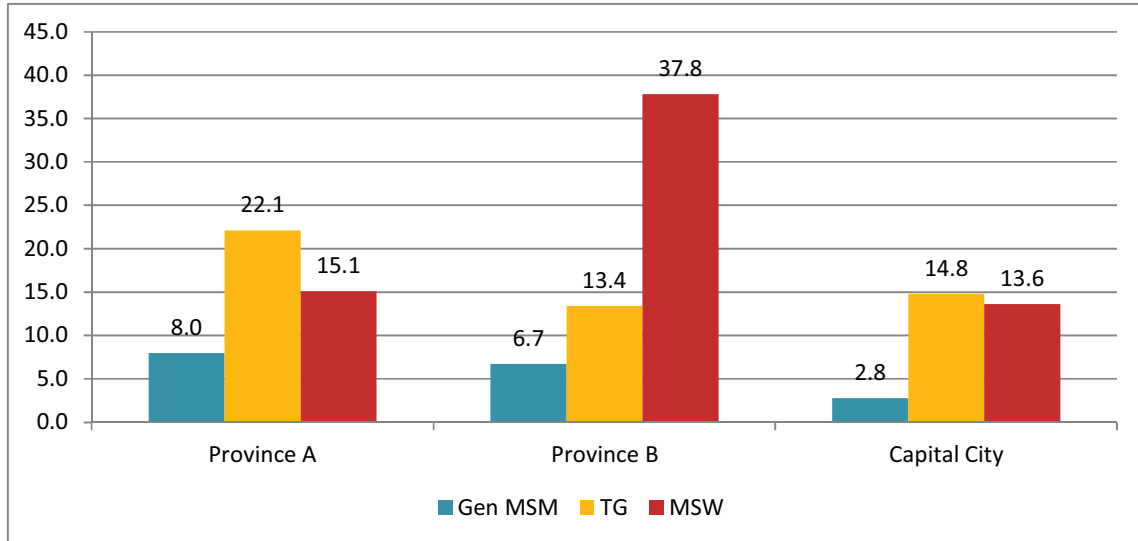


##### *Violence and forced sex*

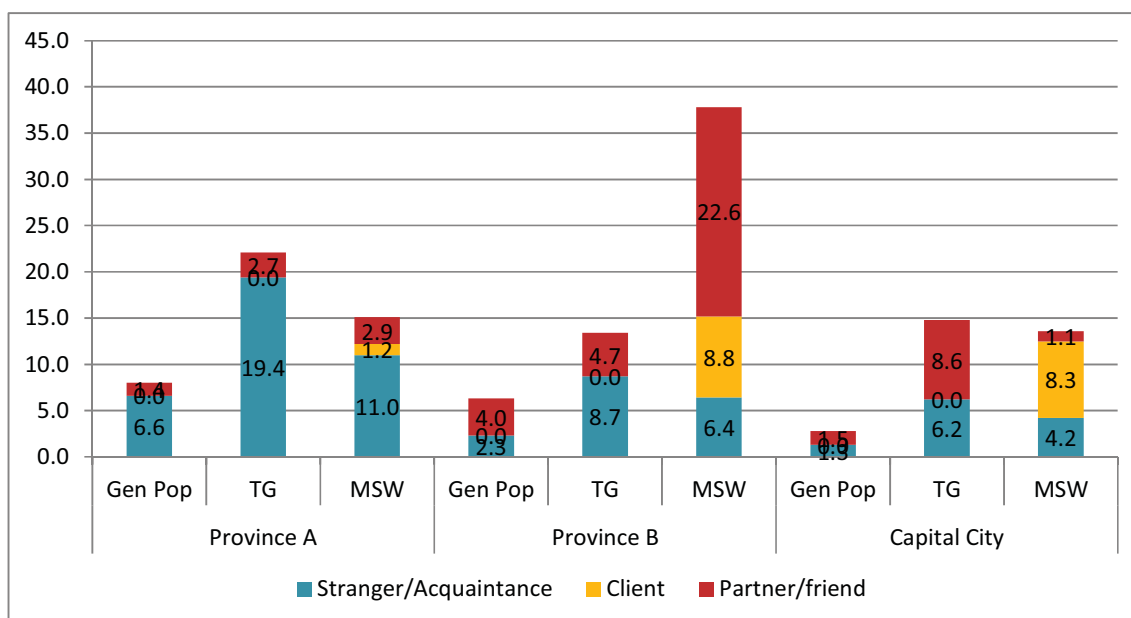
When asked whether they had ever been beaten because of their MSM status, only a few MSM (<2%) said yes. However, a fairly high proportion said that they had been forced to have sex against their will in the past 12 months (Figure 4.23). The percentage was particularly high among

transgender MSM and male sex workers, and was generally higher in provincial areas than in Bangkok.

**Figure 4.23 Percentage of MSM saying that they had been forced to have sex against their will in the past 12 months by MSM group**



When asked who had forced him to have sex against his will, respondents from Province A, general population MSM in all sites and TG MSM in provincial areas were more likely to say it was a stranger or acquaintance rather than someone that he knew well (Figure 4.24). However, MSW in Province B and Bangkok had a substantial proportion saying that clients forced them to have sex, and MSW in Province B also named a friend or sexual partner in large proportion. As is the case with FSW, violence has a negative effect on the supportive environment for HIV prevention; it is necessary for the program to further investigate the issue of forced sex among MSM, especially TG and MSW MSM.

**Figure 4.24 Relationship with person who forced him to have sex against his will in the past 12 months**


#### 4.7 Services available to MSM

Table 4.2 summarizes the services available to FSW that were included in the service listing for each study site. Province A has only three sites with specialized STI screening and HCT for MSM. Province B has a much larger variety of sites, including a mobile clinic. Bangkok has a large number of specialized sites, though proportionate to the MSM population it has fewer than Province B. Province B also has two DiCs for MSM while Bangkok has four.

**Table 4.2 Number and type of services available to MSM by study site**

	Province A	Province B	Capital City
Drop-in centers	1 DiC	2 DiCs	4 DiCs
Office of Disease Prevention & Control	1 STI/HCT		
Government hospitals	2 STI/HCT	6 STI/HCT	
Bangkok Health Centers			9 STI/HCT
Private hospitals		2 STI/HCT	1 STI/HCT
Private clinics			1 STI/HCT
International NGO			1 STI/HCT
Mobile clinics		1 STI/HCT	1 STI/HCT
<b>Total</b>	<b>1 DiC, 3 STI, 3 HCT</b>	<b>2 DiC, 9 STI, 9 HCT</b>	<b>4 DiC, 13 STI, 13 HCT</b>

## 4.8 Outreach program evaluation and coverage

### 4.8.1 Management and staffing of the outreach program

Outreach and peer education is the responsibility of NGOs in all three study provinces. The implementing agencies (IA) are all experienced in working with MSM and/or with HIV/AIDS programming. The manpower structure for the IAs is similar. The DiCs have two full-time staff, one manager and one field manager, as well as a cadre of peer outreach workers. Field volunteers do not receive a salary, just a stipend on days of project activities. The number of volunteers varies in accordance with the size of the MSM population in the site, in a ratio of about one volunteer per 50 MSM. The IAs in this study usually have about 33-40 volunteers, but some had as few as 20 active volunteers. The volunteers are recruited from the MSM population, both adolescents and working age. Some sites had more student volunteers if their project entailed school-based interventions. Many facilities in Province A and Province B have HIV+ MSM helping as volunteers. Some of the volunteers had been trained as peer leaders in previous projects, and received additional training for this project.

The service study found some key differences among the three sites that affected the effectiveness of the outreach program. Province B was seen to have an effective management structure and good coordination of volunteers and peer educators. Province B staff had been trained in mapping by the SR and used a team leader approach to divide up the province geographically. As mentioned in the FSW chapter, the Province B IAs have very good linkages with the government health care services and particularly the mobile clinic. Peer educators facilitate MSMs' use of the mobile clinic and the clinic may even go to the MSM. Also, the Province B IA was previously part of a TUC project and received technical support from them. Finally, as mentioned above the PCM in Province B takes a strong role in the HIV prevention project.

In contrast Province A has experienced high turnover of staff and volunteers. This hindered project continuity, and training of new staff was not timely. The reasons for staff/volunteer drop-out include the fact that some volunteers were students and had to move when advancing to a new grade level. Also, motivation was not always optimal since the job is not full time, and compensation is minimal. The sole field coordinator has many functions to fulfill including field activities, data collection, and report preparation. This limited the time available to visit the volunteers and motivate them. Allocation of project budget was not always efficient because it was not allocated to reflect the local context, the size of the MSM community, and HIV prevalence. The budget for certain items was the same for each province (e.g., the DiC) even though the context differed. Also, there were interruptions in the flow of funds between quarters and fiscal years. Small IAs had trouble during funding gaps and had to suspend operations.

In Bangkok, some of the IAs also experienced difficulties in management. The IAs divide up responsibility for outreach by geographic area, but there is some overlap. From the outset of the Global Fund project, some IAs did not have experience in doing outreach and were somewhat forced into this role. The outreach IAs tend to each promote different specialized HCT and STI screening facilities for MSM; some work jointly with the mobile clinic.

The IAs were able to achieve performance targets, often without stress or pressure, especially in the more rural areas with a larger population to canvass. However, in the urban areas such as Bangkok

which are expected to have a large concentration of MSM, some SSR/IA can barely reach the target number of contacts due to budget limits, since budgets are calculated per capita MSM.

It is worth noting that some IAs conduct more outreach to rural areas where they think it is easier to contact MSM, and avoid the harder-to-reach establishments and locations in urban areas. In Bangkok, it is hard to reach MSM in the residential community (schools are an exception). Thus, the Bangkok IAs have to work more in the MSM entertainment establishments (saunas, spas, pubs, etc). Usually, they only contact the staff, not the customers. Also, it is more difficult to achieve three repeat contacts with the same MSM in urban areas compared to rural areas. Thus, there will be under-coverage of middle and higher status MSM, adults, night scene clients, etc. Some IAs do not have transgender volunteers.

In Year 3 of the project, the activity report forms of the volunteers will be maintained with adjustments on how to count contacts. Only genuinely new contacts will be recorded to avoid duplicate counts among IAs by using a Unique Identification Code (UIC) across the entire SR implementation area. IA staff and volunteers say they will continue to distribute condoms and supplies to continuing contacts, but not record them in the activity log.

#### ***4.8.2 Capacity building and quality control***

The SSR workplan includes training of field staff annually (training of trainers). The field staff also received the CHAMPION project handbook and attended life skills camps as refresher sessions. The outreach volunteers are selected from the experienced MSM groups and given booster training. There are two scheduled trainings of volunteers in HIV/AIDS/STI prevention, risk behavior assessment, creating an enabling environment for lower risk, removing barriers to safe behavior, techniques of community work, communication and counseling skills, and behavior change communication (BCC). They also become familiar with the service network for referral. But this evaluation found that the training events did not always take place as planned or according to the project curriculum. Only certain topics were covered or curricula from other projects were substituted. Thus, the volunteers may have different levels of knowledge and skills across IA. Plus, there is little on-site monitoring of the volunteers to see how well they mastered the training content or apply it.

As mentioned above, the IA in Province B received capacity building from TUC and Family Health International (FHI), the PCMO, RDCO, among others. The training in Year 3 focuses on data systems because of the frequent modifications to the service statistics forms and recording procedures. All of the respondents in this study complained about the lack of refresher training and technical assistance in previous project years by the SR and SSR. The individual support and refresher training for the outreach volunteers is incomplete because the field coordinator is over-worked. Thus, this is addressed in group sessions with the volunteers. So far, the project has not conducted a training needs assessment of the field staff. When reviewing the outreach worker handbook and training curricula, there is no separate content on gender issues, stigma and discrimination, though these may be integrated into other broad training events.

#### ***4.8.3 Peer education***

The peer volunteers have the primary role of contacting the target MSM and providing project services and referral for HCT/STI. Each volunteer has a target number of MSM to reach. They have forms to record risk behavior, distribution of condoms and lubricant, and educational media

emphasizing nine core knowledge areas. The volunteers are supposed to contact a given MSM at least three times within two months, and record risk behavior and the educational items covered. The project criterion is that each contact should cover a period of 3 to 4 hours and volunteer compensation is conditional on this time investment. In fact, the staff admit that the volunteer usually has only 20 minutes to one hour to spend on an outreach session.

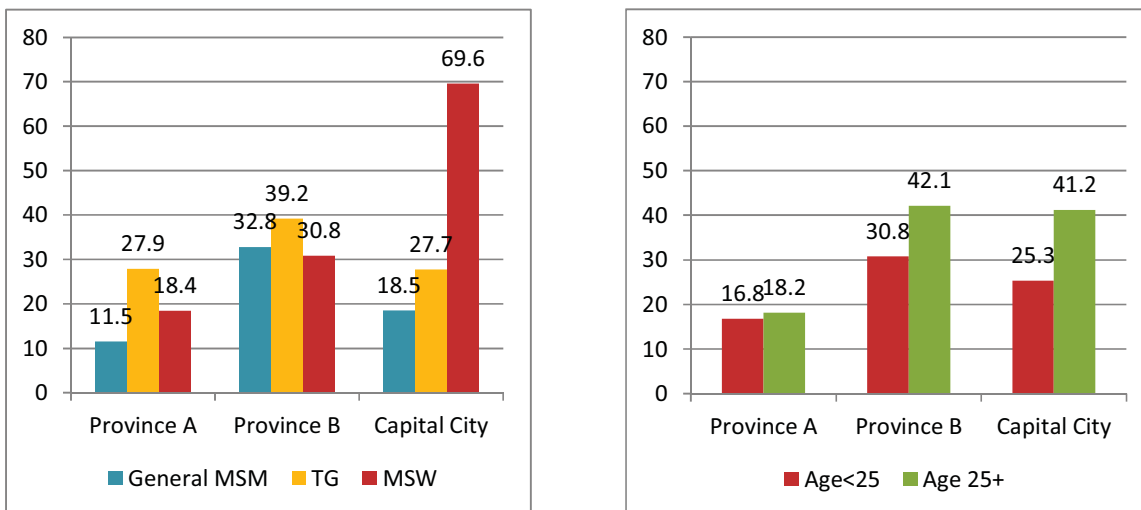
This evaluation observed that the average volunteer outreach interaction – for new and continuing contacts – was never more than 10 to 20 minutes. The information given included condom use and HCT. The majority of the communication time was used to refer to services rather than discuss risk behavior reduction.

Also, the understanding of staff and volunteers is not always consistent. For some IA, the volunteer is expected to cover all nine core knowledge areas per contact; others divide the task equally over the three prescribed outreach contacts. Other IAs instruct the volunteers to talk about those topics that are of interest to the MSM, but should ensure that all nine areas are touched on. This deviation is the result of vague communication from the SR/SSR to the IA. For example, staff could not explain where the three-hour outreach contact time quota came from, or cite any reference document. The project partners may agree on new criteria and guidelines, but these don't seem to be reaching the field IA and staff.

As was the case for the FSW survey, the MSM survey was not able to distinguish between the different types of outreach workers, such as peer support and volunteers, since the respondents were not likely to know the difference between them. Instead they were asked whether someone approached them to talk about HIV/AIDS in the past 12 months. The survey found that about one out of three MSM had been reached by an outreach worker in the past year in Province B, with no significant difference by MSM group (Figure 4.25). In Province A coverage was lower, and transgender MSM were more likely to be reached by outreach (28%). Only 12% of general population MSM talked with an outreach worker in the past year. The findings were similar in Bangkok, except that fully 70% of MSWs had been reached in the past year. In Province B and Bangkok, older MSM were significantly more likely to be reached by outreach.



**Figure 4.25 Coverage of MSM outreach program by MSM group and age group**

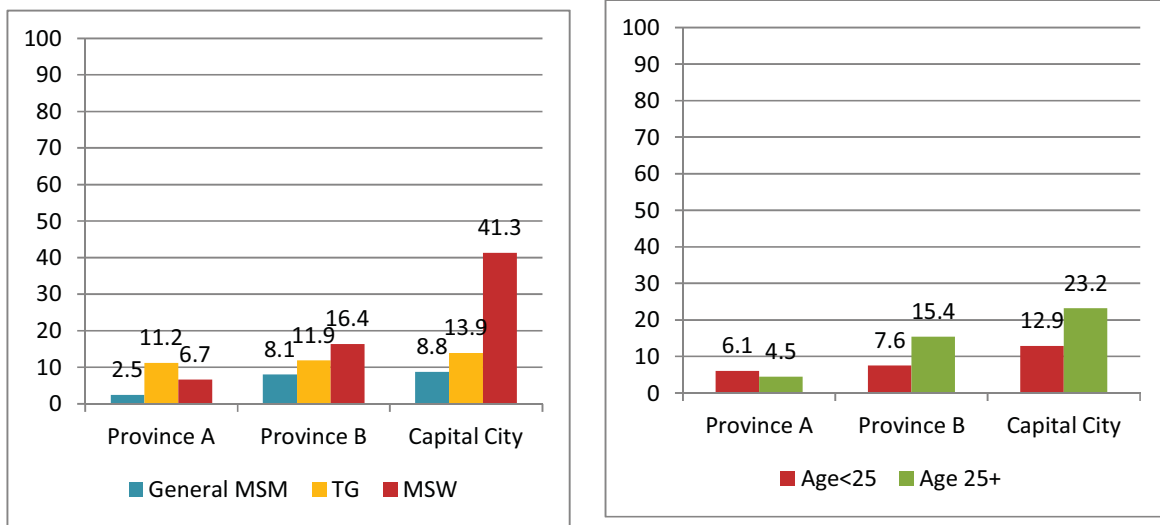


#### 4.8.4 Drop-in Centers (DiCs)

IAs in the three study provinces have set up the DiC as a friendly center for knowledge and learning activities for the MSM. Two of the provinces had community-based DiC while the other province moved the DiC from the community to the government hospital. The implementation of the DiC is not entirely as planned. The DiC is being used by some of the newer IAs as the project office as well using the limited budget of 6,000 – 8,000 baht for operations. Also, the budget for the DiC is roughly the same across provinces without regard to the different costs of living (rent, utilities, etc.). With that limited budget, it was not always possible to locate the DiC in the most convenient spot for MSM access, especially in Bangkok. In the case of Province A, the DiC is located in a remote residential area that is not near places where MSM hang out. Thus, it is difficult for some MSM without personal transportation to visit the DiC. Also, the operating hours of the DiC are not always consistent with the free time of the MSM. Most of the counseling for MSM is phone-based; there are few walk-in clients at the DiC. Most of the visits are for condom resupply.

The DiC according to the project concept was as a coordination center rather than as a peer hang-out. Few MSM visit the DiC for services, unless there is a special campaign. Most of the people at the DiC are peer leaders and volunteers who are there for meetings, preparing reports, and training. These findings are reflected in the results for coverage of the drop-in centers for MSM. While 41% of MSWs in Bangkok said they had been to an MSM drop-in center, for other groups and in the provincial sites less than 20% had done so. Older MSM were also more likely to visit a drop-in center in Bangkok than their younger counterparts.

**Figure 4.26 Coverage of MSM drop-in center program by MSM group and age group**



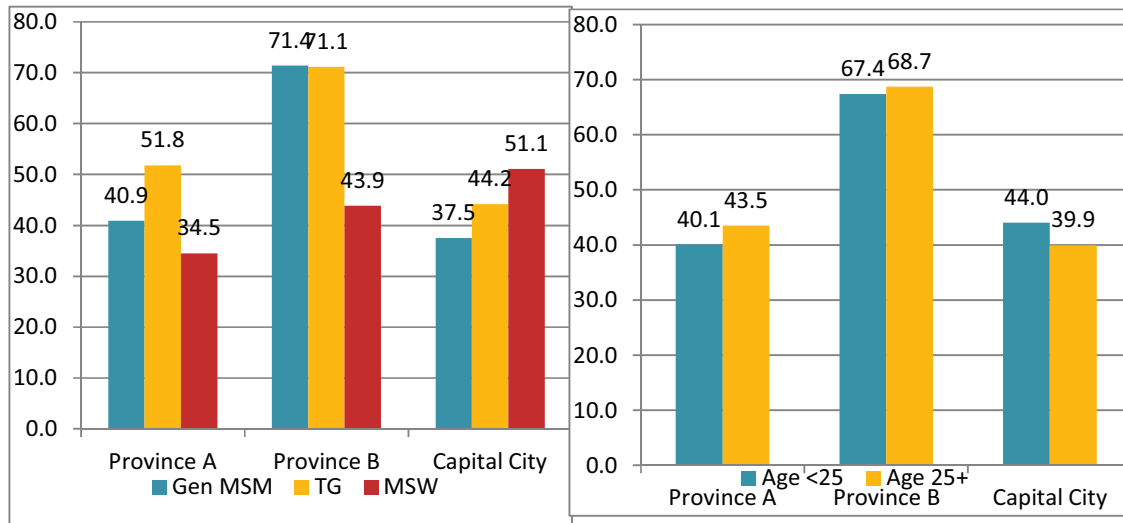
**4.8.5 Behavior change communication materials**

Media for outreach education is limited and in few formats. Production of new media is irregular due to limited budget. Media from centrally-based agencies came from SR (RSAT) in the first two years. Other media come from the Ministry of Public Health (MOPH) and TUC. Most of the media are booklets on STI and health service outlets. The respondents said the centrally-developed media are not eye-catching and are incomplete in certain content areas or the content is not relevant to the local interests and needs. Most are discarded after distribution to the MSM.

The budget for broad campaign media production from the province is limited and sporadic. Most of the campaigning for MSM is through outreach to entertainment establishments, World AIDS Day fairs, and various festivals. The Year 3 budget for public campaigns has been reduced, and the intensity of these activities has declined, even though community awareness about MSM is still deficient, and stigma remains. Thus, some volunteers do not want to work in their home communities and prefer to travel to outside areas instead, and this increases the travel cost. MSM participation in media production – whether among outreach volunteers or MSM beneficiaries – was low to non-existent. Volunteers said they were involved in planning outreach events and campaigns as part of a division of labor.

The MSM survey found that Province B MSM had the highest level of exposure to BCC materials, especially for general population MSM and TG MSM (Figure 4.27). In Bangkok, MSW had the highest degree of exposure to BCC materials.

**Figure 4.27 Coverage of BCC materials by MSM group and age group**



**4.8.6 Summary of outreach program quality and coverage**

Key aspects of the outreach program affecting the quality and effectiveness of the services are as follows:

- Outreach for behavior change by the project emphasizes finding brand new contacts over meeting with repeat contacts. This reduces the focus on providing reinforcing education to continuing contacts. The strict adherence to quantitative targets calls into question the validity of counts of contacts, and the number of knowledge areas covered. Some IA report volunteers covering all nine knowledge areas per contact even though staff and volunteers admit that the duration is only 20 to 30 minutes per contact.
- Outreach is still missing some groups of MSM and there is a lack of situation assessment and strategic planning for reaching those groups.
- The implementation of the volunteers is not yet standardized; there are different understandings of the process of the work and what data should be recorded. There is an excessive focus on achieving the numeric target, and this works counter to improving the quality of services. The volunteers do not have a set of handbooks with SOP for their duties which can serve as a resource to take with them on outreach visits.
- There is a lack of monitoring and support for the volunteers when conducting outreach. This is because there is only one field supervisor per area who has multiple responsibilities and inadequate budget for field monitoring. Thus, most of the IAs hold progress report meetings with the volunteers as a means of group monitoring and addressing field problems and skills building.
- The risk behavior assessment questionnaire is not applied well, and there is inadequate follow-up of clients whether at the level of the IA, SSR, and SR.

Coverage of the outreach program was lower than desired, with the exception of MSW in Bangkok. Still, about one out of three MSM were reached by an outreach worker in Province B and Bangkok (Table 4.2).

**Table 4.2: Summary table for coverage by the outreach program**

	Province A	Province B	Capital City
Talked to a peer educator/outreach worker	17.3	35.5	32.6
Visited a drop-in center	5.6	10.8	23.2
Saw a brochure or poster for MSMs	a	a	a

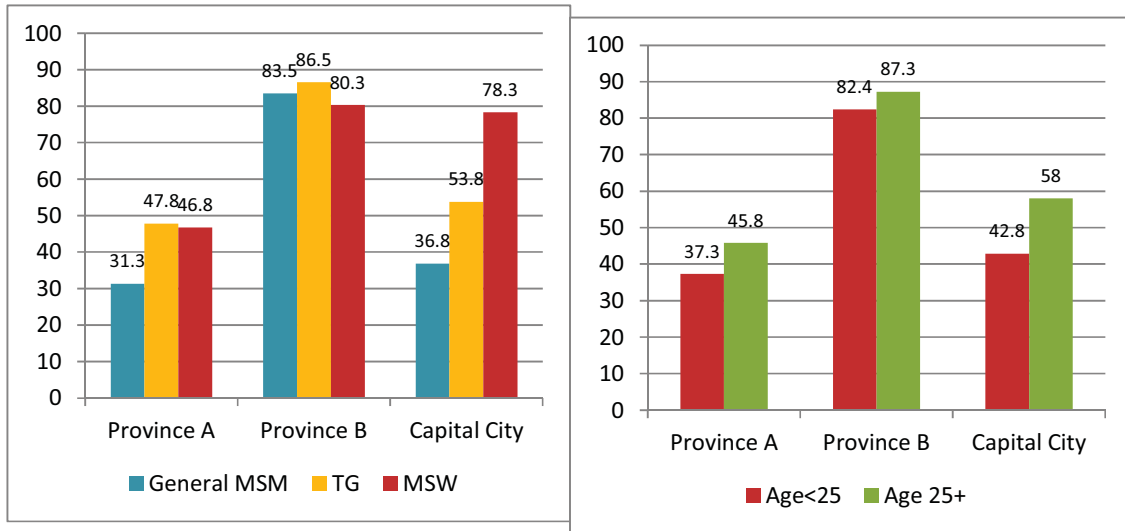
#### 4.9 Distribution of condoms and lubricant

Estimations of the condom supply for the provinces are derived from counts of the targeted number of MSM for outreach. The project assigns a quota of 100 pieces per MSM per year. Condom and lubricant distribution in the three project years has faced challenges related to management of procurement and timely transfer of supplies to IA. Thus, shortages are common and IAs have to borrow condoms from other sources (mostly the PCMO). The PR instructed the condom supplier to send supplies directly to the IA. But these are sent in bulk at one time and exceed the ability of the IA to store them properly. The storage practices are not standard either, and there is no budget for condom storage. Stocks are mixed with paper and materials storage. There are no temperature controls or skids to place the boxes on.

It is not possible to accurately quantify how much condom supply the MSM target received. Most are distributed through the network of volunteers, the DiC, entertainment establishments, gathering areas of MSM (e.g., salons, dress rental shops) or through public campaigns. Some IAs re-package the condoms into packets or 10 or 3 pieces and distribute one per MSM. For Bangkok, the IA agreed not to distribute more than 30% of its condom stock to entertainment establishments, since part of the supply might be diverted to non-MSM. All respondents complained about condom shortages. But there is no system for monitoring or surveying the target population as to whether they received supply or not, and whether the supply is used.

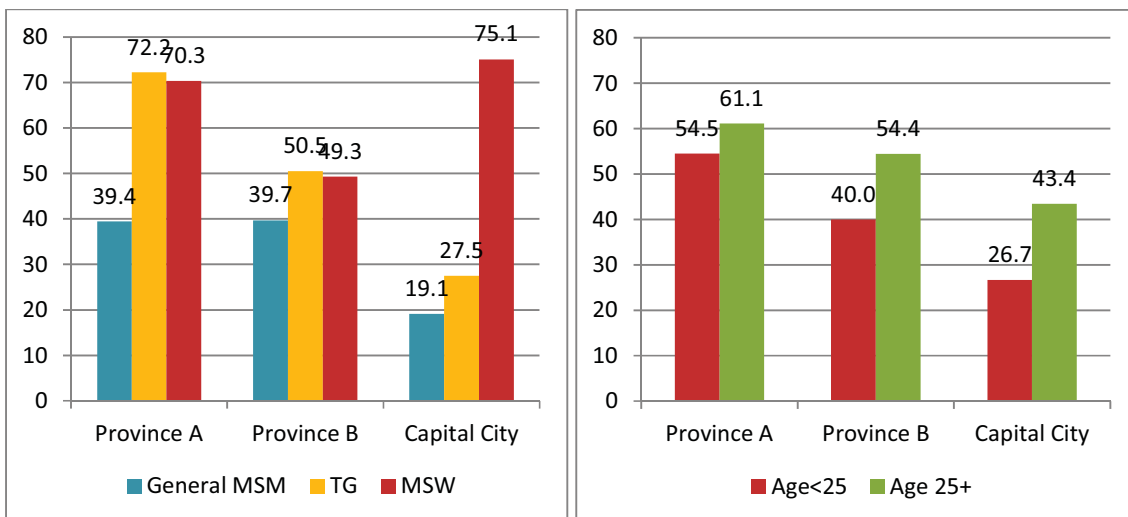
Coverage by the condom distribution program varied by site and among groups, as seen in Figure 4.28. Over 80% of MSM surveyed in Province B had received a condom in the past year, across MSM groups and age groups. Condom distribution coverage is lower in Province A and Bangkok, and differs by group. General population MSM were less likely to receive a condom in Province A and Bangkok. While transgender and MSWs received condoms about equally in Province A (46-48%), MSWs in Bangkok had the highest coverage (78% vs. 54% for transgender). Older men were significantly more likely to receive a condom in Bangkok.

**Figure 4.28: Coverage of condom distribution for MSMs by MSM group and age group**



Lubricant distribution coverage shows a different pattern (Figure 4.29). Coverage of lubricant in Province A is at about 70% for TGs and MSWs, but much lower for general MSM. In Bangkok 75% of MSW had received lubricant. The same age pattern is seen in Bangkok with significantly more older men covered by the lubricant program.

**Figure 4.29: Coverage of lubricant distribution for MSMs by MSM group and age group**



Summary findings for condom and lubricant distribution are seen in Table 4.3.

**Table 4.3: Summary table for coverage by the condom and lubricant distribution program**

	Province A	Province B	Capital City
Received a free condom in the past 12 mos.	39.9	84.4	49.8
Received free lubricant in the past 12 mos.	56.5	46.0	34.3

## 4.10 STI screening and HCT program evaluation and coverage

### 4.10.1 Management and accessibility

The service units in this evaluation include primary clinical facilities, community hospitals, regional hospitals, STI clinics under the MOPH, and public service agencies which operate special clinics for MSM. None of the government hospitals have a specific STI clinic (except for the RDCO); men must go to the general medicine or surgery department. If there are signs of HIV, then they are referred for HCT at the community medicine section or ART clinic. This evaluation found that most facilities did not have a service package with condoms and literature. Nor did it find SOP for serving MSM.

STI screening and HCT services require an extra level of collaboration among partners in the public sector. At the beginning most participating agencies at all levels had limited awareness and participation in the system design for the MSM. In Province B, good collaboration has been achieved between the IA and the government services. When the PCM came into prominence in the past three years, the outreach and service agencies were more involved through meetings and referral system development, especially for HCT and STI. This helped to create more client-friendly services, especially in the case of the mobile clinic where the agencies work together.

Usually there is one central service partner agency in each province for each MSM. In Province B, this principal partner had four client-friendly outlets for both MSM and FSW. But this was reduced for Year 3 due to policy to convert the outlets serve the general population too. Bangkok is the only province with more than one dedicated MSM-only clinic. Some have multiple sources of funds such as the Red Cross and Silom and Bang Rak clinics.

In Year 2, a mobile HCT service was launched with rapid testing in Bangkok. This increased client uptake. Outreach staff assembled interested MSM in the morning and conducted group activities at the DiC or community until the mobile unit arrived. However too few government outlets are using rapid testing. It is noteworthy that the IA with mobile units and rapid testing are affiliated with non-government entities such as the Red Cross, or Silom and Bang Rak clinics. The mobile service requires extra collaboration since the project does not have direct budget to fund this activity and must rely on partners. The TUC helps operate a mobile HIV and syphilis HCT clinic in Province B. Thus, the increases in HCT cases through mobile outreach are subsidized by other sources. But there is limited capacity to conduct the pre and post-test counseling with a mobile service and this limits caseloads and may degrade quality of post-test counseling.

The MOPH provides refresher training for clinical staff in MSM counseling, STI and HIV laboratory functions. Others, with special projects (e.g. TUC) get additional training in aspects of sexuality and gender. Staff at primary care outlets feel they need more training; they have small caseloads and

feel they lack experience and more complete knowledge. Some of the provincial physicians feel they lack skills in STI case management. Staff directly involved in AIDS care have received training in gender and sexuality.

This evaluation found that implementation at the facilities varies, even though the government hospitals are committed to following the MOPH standards for STI care. The MSM service package differs by facility and level, depending on local policy and budget (and this relates to the NHSO as well). The project lacks indicators for service quality improvement, and this reduces motivation to raise services to the standard. A constraint in treating syphilis is the lack of penicillin at some outlets, thus requiring referral. Also, if the client wants to claim free service through national insurance, he needs to show his Thai ID card, and this reduces confidence in ability to protect confidentiality.

#### ***4.10.2 Referral to STI screening and HCT services***

Program data shows that there are only a few MSM clients referred to STI service outlets by IAs in Province A and Province B. The numbers do not meet the target. The project has a referral form, but this is rarely used. Outreach groups have different referral forms. Some IAs ask the service provider to keep the referral book and fill in referral slips for MSM they see. Then the IA staff collect these periodically for follow up. But there is little case follow-up. There is also the problem of the MSM not complying with IA referral advice. There is no follow-up to determine the reason for non-compliance. Another obstacle is lack of consent from the MSM client for follow up. Thus, the referral coupon is only useful for producing counts of service. As seen in Table A4.17 and A4.19, only very few respondents said that they got a referral for these services.

#### ***4.10.3 Links between prevention, care and treatment of HIV+ MSM***

MSM who are diagnosed with HIV are referred to the ARV clinic for comprehensive care. The system is set up and the staff are conscientious about referral as needed. However, there may be some shortcomings in the holistic care for MSM, in the area of MSM gender and lifestyle issues. In Province B, they have started a project to develop a model of care and prevention specifically for HIV+ MSM, with a support group. There is a space for counseling and care for the MSM separate from the other PLHIV. This activity is supported by TUC and has coordination links with ACHIEVED.

#### ***4.10.4 MSM satisfaction with services and reports of stigma and discrimination***

The qualitative study found the staff who work in the STI and HCT facilities to be open-minded and not discriminatory towards MSM, and the clients interviewed agree with this assessment. The problem of stigma is more with the admitting and screening staff; these staff usually do not receive training as the clinicians do. However some MSM interviewed said that they do not use the services due to a lack of trust, the negative attitudes of service providers in the screening facilities and OPD, concern about receiving test results, fear of being seen by acquaintances and the lack of confidentiality perceived at government services. Others pointed out that most of the service providers in the clinical setting are women; even though they are friendly to the MSM clients, MSM are uncomfortable when it comes to anal exams. Other comments by MSM interviewed included that the services don't suit the lifestyle of the MSM (e.g., who sleep late and rise late); afternoon and evening hours would be more convenient. One clinic converted its MSM-only clinic to one serving the general populations; the MSM caseload dropped off dramatically.

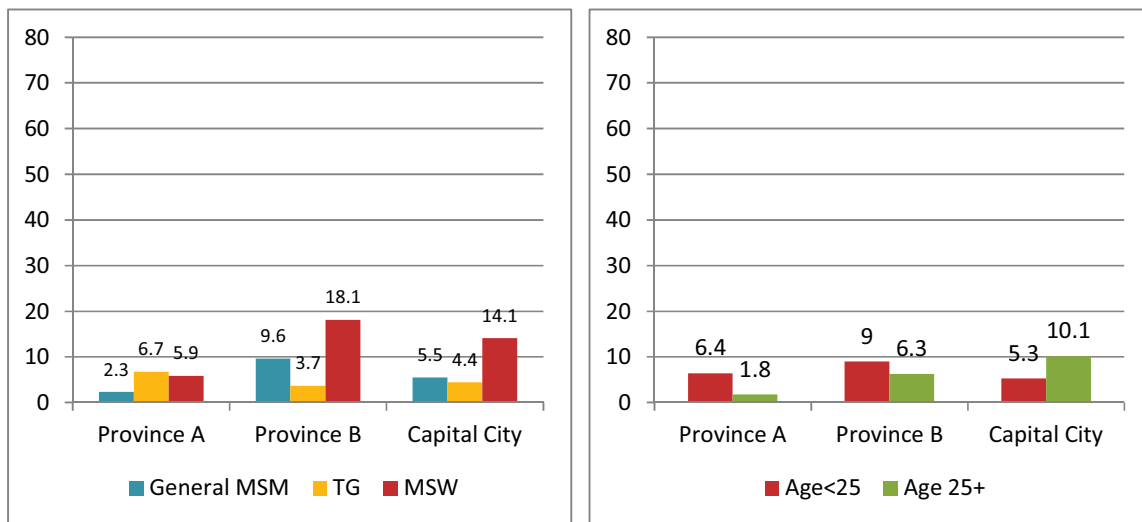
The quantitative survey however found that the clients were generally satisfied with the STI screening and HCT services (Tables A4.19-22). Responses to whether the service gave sufficient

information, answered questions and maintained confidentiality were generally answered positively by more than 80% of respondents. In many cases, the small N for those who received services means that the responses should be treated with caution. One exception to the generally positive findings is the response to the question on patient confidentiality of HCT services in Province A; about 50% said that they were less than “very confident” that their confidentiality was maintained.

**4.10.4 STI screening and HCT coverage**

As seen in Figure 4.30, coverage figures for STI screening among MSM are quite low, across MSM groups and for both age groups. Only about 10% were screened overall, with higher levels for MSW in Province B and Bangkok (14-18%).

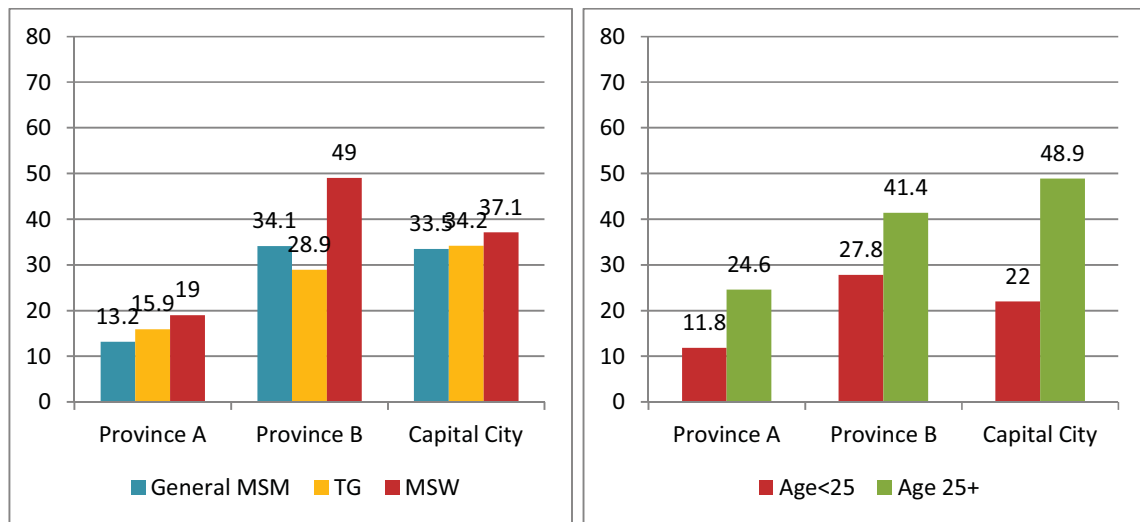
**Figure 4.30: Coverage STI screening by MSM group and age group**



Coverage figures for HCT were higher than for STI screening. In Province B and Bangkok, about one-third of MSM had used HCT services in the past year, but in Province A only 16% were tested (Figure 4.31). About half of MSWs went to HCT in Province B, and about half of older men went to HCT in Bangkok. As shown in Table A4.15, nearly all of those who went to HCT services also received their test results.



**Figure 4.31: Coverage of HCT by MSM group and age group**



**Table 4.4: Summary table for coverage by the STI screening and HCT programs**

	Province A	Province B	Capital City
STI screening	5.0	7.9	7.6
HCT	15.6	33.5	34.5

The reason for HCT coverage being higher than that for STI screening may be due to the nature of the process. HCT does not require disrobing or a physical examination, therefore mobile clinics can perform the test without needing a private room. MSM are likely to see the process as easier and quicker and thus may be more likely to use HCT services for that reason.

#### 4.11 Package of services

A summary graph of coverage across each type of service is shown in Figure 4.32. Province B and Bangkok have generally higher coverage levels than Province A. Condom distribution has the highest levels of any program, reaching more than half of MSM at all study sites.

**Figure 4.32 Coverage for Single Services**

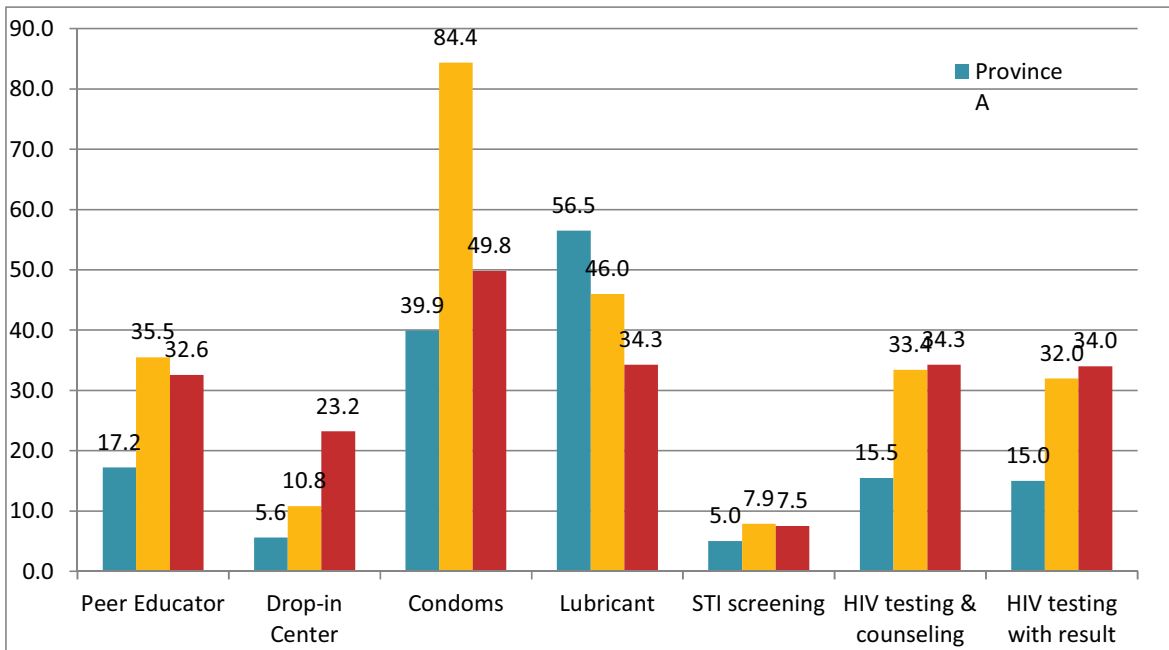
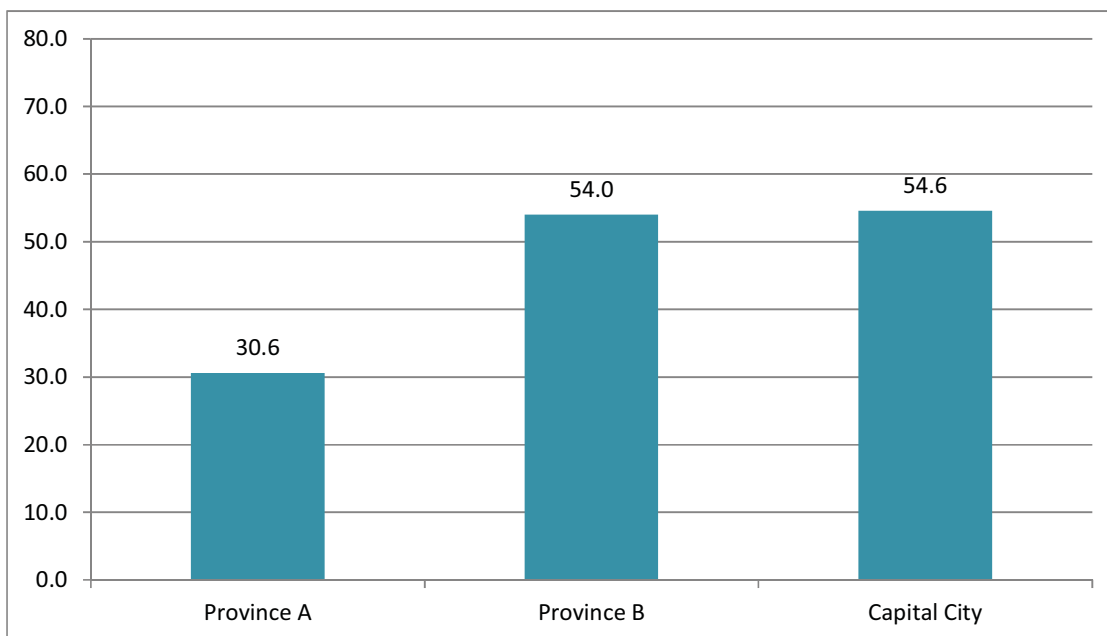


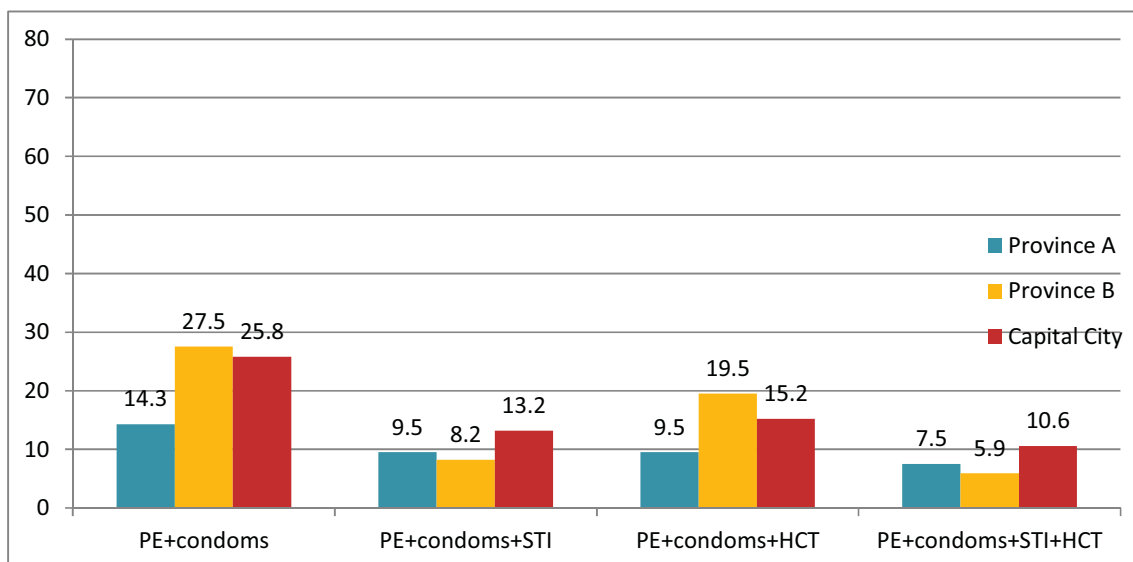
Figure 4.33 looks at the percentage of MSM who received at least one service, apart from condom and lubricant distribution. Province B and Bangkok reached about 55% of MSM, while Province A reached 31%.

**Figure 4.33: Percentage of MSM who received any service (outreach, drop-in center, STI screening and/or HCT)**



Finally, Figure 4.34 examines coverage for various combinations of services that make up the comprehensive package. Peer education plus condom distribution reached about ¼ of MSM in Province B and Bangkok; other combinations did not reach beyond 15%.

**Figure 4.34: Coverage for Package of Services**



## 4.12 Data System and Data Quality

After the switch of SRs, PPAT has not modified the data system developed by RSAT. The system is well-designed and easy to enter data (using the Pivot software). There are automatic edit checks during data entry. The data are entered on-line by the IA and the software generates reports. But there are regular modifications to certain aspects of the monitoring system. Plus, the IAs have continuous staff turnover, and the new staff may have incomplete orientation to the data system. This could lead to inconsistencies and applications of the data system. The SR does not have a data system user’s handbook, but just hold periodic trainings. They address ad hoc problems by phone. When there are changes to indicators, the responsible field staff are informed, individually by phone, instead of a group meeting, and without supporting documentation sent out to the IA. Thus far, training in data management has been about entry and compilation of data for the indicators. Staff of the organizations have not been trained in data analysis and data application for planning and improving implementation. There are forms to collect data on the key indicators such as to record training participants, volunteer activity summary, client behavior report, summary form for walk-in activity participants at the DiC, a form on distribution of condoms and lubricant and referrals for HCT and STI.

### 4.12.1 Data Quality

The volunteer activity report has information on each target MSM receiving a service. There are three sets of forms to report on activities. Each form uses the UIC to prevent duplicate counts. The forms indicate new/continuing contact, which of the 9 knowledge areas were discussed, condoms

and lubricant distributed, educational media distributed, and appointment for next meeting. The field staff and volunteers understand the importance of the UIC; no names are recorded. But conversations with clients found that they are asked their name and surname, suggesting that perhaps some volunteers did not adhere to the UIC system. The 11-item risk behavior assessment form is to be filled out by the volunteer at each contact. The method of recording differs across IAs. Some volunteers ask the MSM contact to fill out the form themselves. Others ask the contact and record the response. Others have a casual conversation and record the findings later on the form. The volunteers have to compile these forms and send them to the field coordinator every month. These forms are the basis for compensation, rather than for use in planning or modifying interventions. The data from the three forms are entered into the system. But the field staff is still weak in data analysis. Thus, they tend to produce total counts rather than individual analysis of the data. This could lead to inaccuracy and misinterpretation of the situation (e.g., condom use levels).

The three forms are filled out for each contact and the originals are stored as back-up documentation. Thus, there is an accumulation of paper and this is becoming a burden without any real purpose. Thus, the project could consider reducing the paper work or reduce the number of questions asked for each contact in order to promote greater use of the data.

The Team has observations on the condoms and lubricant stock system of some IAs and which may be sub-standard. Also, the distribution data may not be accurate. Some volunteers give out only 3 condoms per contact, 3 times per time period. However, the quota is 100 pieces per target population per year. So it is hard to know what the coverage of the target is for this item, and whether there is diversion of stock to non-MSM populations.

The referral form for MSM needing exams or treatment has three copies: 1 for the IA, 1 kept in the referral form book and 1 for the client. This system has not worked well due to low caseloads, and lack of provider motivation to store the referral slips; since they have their own recording system already. Also, sometimes the MSM goes to a different provider than he was referred to, or forgets to take the referral form. Thus, it is not possible to get a clear picture of actual referral success. Also, the system doesn't allow a count of clients going for STI who also receive HCT.

Looking at the data on new/continuing contacts, the project focus is on new client counts; but still allows for services to continue for returning contacts. Returning contacts can be counted as new again if they receive the same service in a new project Year. Also, there is probably some overstatement of contacts by some IA; it is not possible to verify the contact counts. Other IA do not adhere to the requirement to cover the nine knowledge areas per contact but instead focus on the areas of interest and need of the client. Others will re-count a returning contact as new after the nine knowledge areas are covered. Some HCT clinics count clients while others count visits (if they are more than 3 months apart).

The system identifies duplicate counts of individuals to some extent; and is more precise on counts of new contacts. But the system cannot spot duplication if the UICs are unique. The rule is to count unique UICs as new when they appear. The system does not allow for in-depth analysis of client by service received. There is also no analysis of the needs of the returning clients and how those are addressed.

#### 4.12.2 Monitoring

The summary data reports of the IA are sent up to the SSR and the SR respectively. The reporting interaction with the PCM, in view of its role as the M&E coordinator, is minimal. All the PCMO said the PCM does not have much opportunity to visit and monitor the work of the IA. Instead, it uses the PCM meetings for progress review. If the PCM needs certain project data, it will make a request on an ad hoc basis. One PCMO staff said they had no knowledge of the IA data system. The normal data system cannot segregate clients by project. They feel that the Routine Integrated HIV Information System (RIHIS), which is the pilot phase, should help the PCMO see the larger situation. The RIHIS system was designed by NAMc to track services across outreach activities and static services units. But in the pilot site areas, the input data are still minimal; so its success cannot yet be judged. Some staff of the PCMO reflected that, while it is good to improve the M&E system, that should not increase the workload of the staff; instead the goal should be more toward streamlining the data system.

The target population participates in the project activities in terms of being represented by MSM groups at the PCM level, and by the MSM outreach volunteers. But that is where the participation ends, and does not extend to planning and needs assessment of the target beneficiaries. The provinces do not have a system of assessing client satisfaction with services rendered.

#### 4.13 Summary of service quality

The evaluation Team has summarized the quality of services in comparison with the six service standards as follows: rights, quality control, service access, participation of the target group, service package, and monitoring, as shown in Table 4.x.

Standard	Quality issues from the evaluation	Rating
<b>1. All HIV Prevention Services</b>		
<b>1.1. Rights to Service</b>		
1.1.1. Clients are fully informed about the service, the risks and expected benefits.	Volunteers in many sites simply informed contacts about service sites; they did not try to motivate to seek service.	++
1.1.2. Confidentiality is protected, and client privacy is respected throughout.	- Outreach and service facility providers understand the need for confidentiality; the UIC system helps protect anonymity	++
	- Privacy of service area is problematic in some places; such as lack of separate counseling rooms. But protection of privacy is handled well.	
1.1.3. Equal service for all (absent of stigma or discrimination)	Service is equal and unbiased; client-friendly.  (Exception: Admission and screening section staff of clinical facilities are not always client-friendly.)	+++

Standard	Quality issues from the evaluation	Rating
<b>1.2. Quality Control</b>		
1.2.1. All core services have written SOP that is accessible as a reference at any time.	No equivalent written SOP found. Some have written procedures for their own unit.	+
1.2.2. Staff receive regular monitoring and inspection from supervisors for quality control.	There is little monitoring and mentoring for volunteers on a regular basis. Some volunteers and staff have not received any monitoring visits.	-
1.2.3. Service providers have been trained to be sensitive to issues of stigma and discrimination, to prevent this from happening to MSM	All staff and volunteers have been trained by the project/IA in this area.	+++
<b>1.3 Access to Services</b>		
1.3.1. Access to services is universal without discrimination according to age, sex, ethnicity, gender, nationality, religion, occupation, health insurance coverage, or drug use.	No discrimination. MSM can exercise their full rights to service as Thai citizens.	+++
1.3.2. Access is convenient by location, travel, travel time, and cost of travel.	- DiCs are not conveniently located without a variety of needed services to draw in clients.	+
	- There are more client-friendly clinics being launched, increasing options for MSM.  - Yet there may be obstacles of obtaining reimbursement and service hours, and clinic lay-out.	++
1.3.3. Safe atmosphere (Internet chat option, hot line, peer support group) for the MSM to obtain information and referral.	- Lack of safe service outlets, with the exception of Bangkok (with special services outside GF-support).  - Many sites are trying to set up phone counseling or Internet chat forums but this is not systematic.	-
1.3.4. No stock-outs of essential equipment for services, including HIV tests, condoms, lubricant, and clean needles/syringes, in the prior 12 months.	External re-supply is irregular, resulting in shortages of condoms and lubricant.	-

Standard	Quality issues from the evaluation	Rating
<b>2. Services for Key Affected Populations (MSM)</b>		
<b>2.1. Participation in Services by the MSM</b>		
2.1.1. The MSM participate in needs assessment of their peers, planning, services and evaluation.	- The MSM are active as volunteer service providers for MSM.	+++
	- Lack of MSM participation in planning and evaluation of field activities. No client satisfaction assessment.	-
<b>2.2. Service Package</b>		
2.2.1. There is outreach to motivate and increase access to services; covering a range of areas; to ease access of MSM to services, information, referral and prevention supplies.	The IAs conduct outreach; there are outlets for information, referral and prevention supplies. BCC is inadequate however.	++
2.2.2. Field staff have correct knowledge about HIV prevention and provided services.	- Staff and volunteers understand the services well; some new staff are weak.  - The observational findings show that some volunteers still lack knowledge on AIDS and STI, when providing information to MSM.	++
2.2.3. Field staff understanding the need to protect the client during service encounters. They must have ethics and professionalism	Field staff and volunteers understand well about this. They use the UIC system to protect the confidentiality of the clients.	+++
2.2.4. Outreach, HCT, and STI services are available for the MSM in particular and at convenient times for them.	- There are efforts to provide mobile HCT to improve MSM access and at convenient times. But the service is irregular.  - The STI service is still not convenient for MSM.	++  -
2.2.5. Condoms and lubricant, clean needles, etc. are provided in sites near where the MSM congregate at a convenient time.	Prevention supplies are distributed through the DiC, volunteers, and service facilities.	+++
2.2.6. The clients have risk assessments as part of the HIV prevention communication.	There is a risk behavior assessment form as part of the outreach BCC. But use of the results for planning BCC is minimal.	++
2.2.7. There is monitoring of the outreach to see if the MSM received STI screening or HIV HCT.	There is no system for monitoring the MSM as to whether they go for HCT or STI after being referred.	-

Standard	Quality issues from the evaluation	Rating
2.2.8. Educational media are developed for behavior change, with participation by the MSM. The media are distributed/communicated to the MSM through appropriate channels.	Education media are minimal. There is limited budget for media development. Thus, only the cheapest materials are reproduced. These are not popular with the MSM; the MSM did not participate in media development.	+
<b>2.3. Monitoring</b>		
2.3.1. Clients have a UIC, and the monitoring system can track these individuals by UIC. Or, there is an alternate system for monitoring client receipt of services.	The UIC is only used in the GF-supported outreach activities. It is still not possible to track all service clients or link client movement between the outreach and clinical facilities.	-
2.3.2. Field staff receive refresher training, mentoring and supervision on service quality (including HCT and STI).	- Volunteers receive refresher training occasionally. But there is little monitoring and supervision from supervisors.	+
	- Most service providers for HCT and STI have opportunities for in-service training on counseling and STI. But they only receive minimal monitoring and supervision for quality control. There are no indicators for improving quality of services.	++

**Remarks:** +++ denotes good, ++ denotes fair, + denotes poor, - denotes no implementation  
*NA denotes Not Applicable*

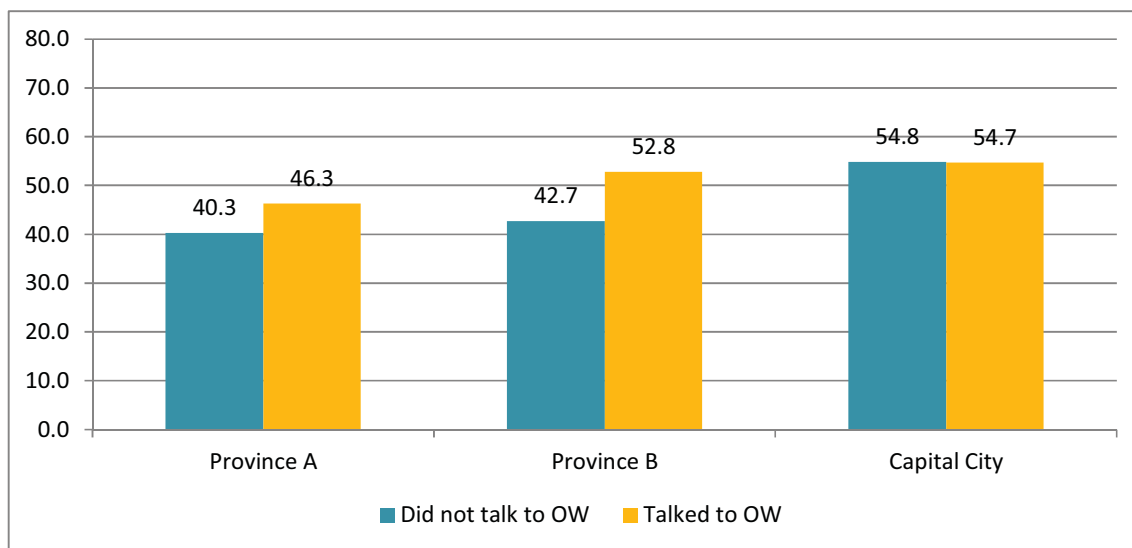
#### 4.14 Effect of the program on HIV knowledge and prevention behavior

Finally we look at whether exposure to the HIV prevention program is associated with higher rates of knowledge, HIV prevention or health-seeking behavior. As discussed in the methodology chapter, no causality between program exposure and differences in knowledge or prevention behavior can be concluded, as the data is cross-sectional.

The percentage of MSM who answered five GARPR questions correctly was significantly higher for those who had spoken to an outreach worker in Province A and B; for Bangkok there was no difference (Figure 4.35).

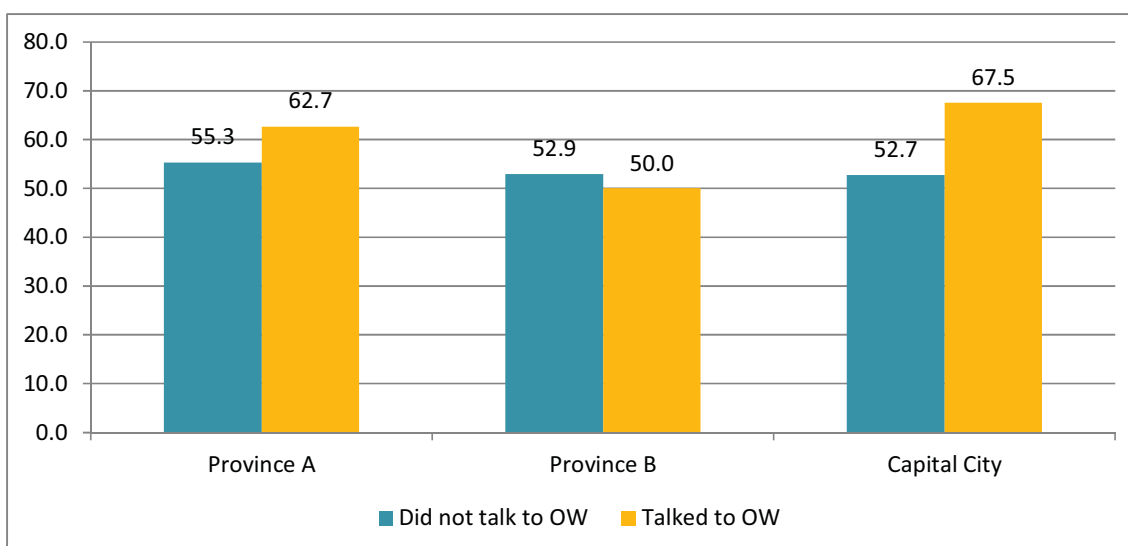


**Figure 4.35 Percentage able to answer five GARPR questions correctly by whether talked to an outreach worker in the past 12 months**



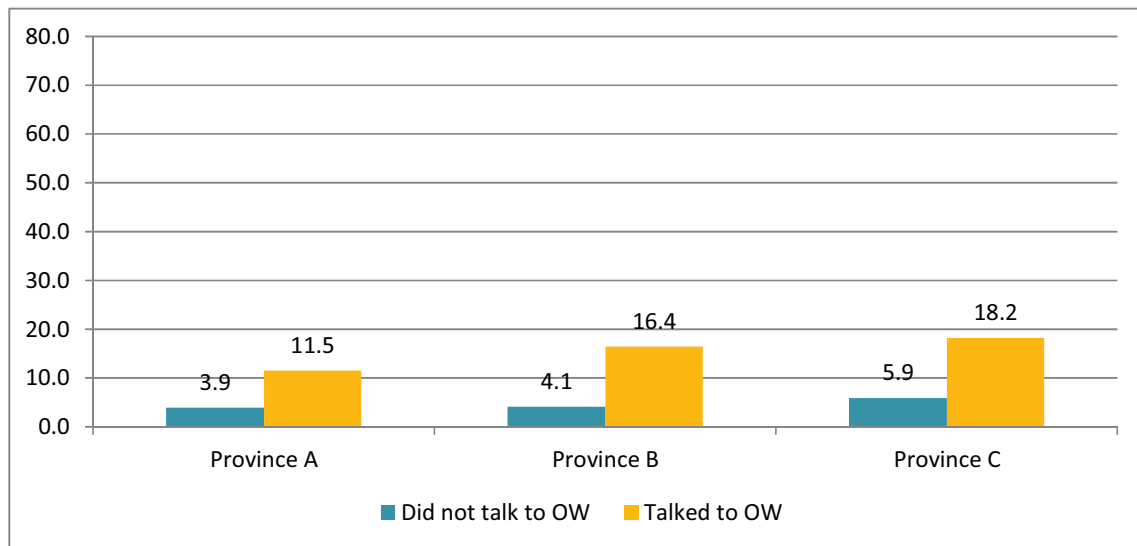
As seen in Figure 4.36, MSM from the Bangkok sample were significantly more likely to use condoms every time with their partners if they had talked to a peer educator in the past 12 months. Those in Province A were also more likely to do so, but not significantly so; and for those in Province B there was no difference in condom use by exposure to a peer educator.

**Figure 4.36: Percentage using condoms every time with non-paying partner by whether talked to an outreach worker in the past 12 months**

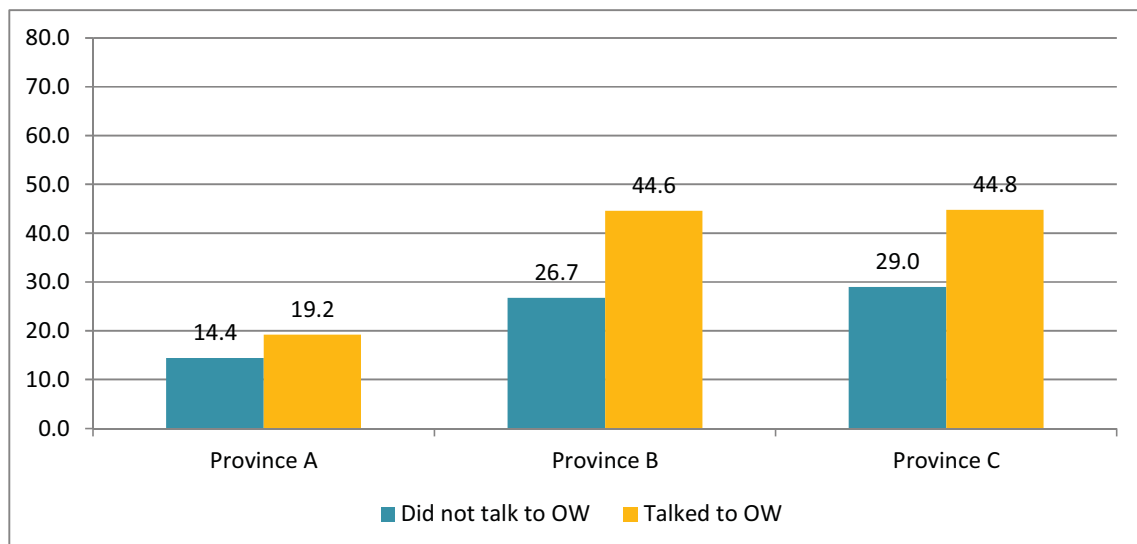


The findings for seeking HIV prevention services show significant differences by exposure to the outreach program. Across all sites, MSM who talked to an outreach worker were significantly more likely to say they had been screened for STIs in the past year (Figure 4.37). The same was true for using HCT services in Province B and Bangkok, although the difference was not significant in Province A (Figure 4.33).

**Figure 4.37: Percentage who got STI screening by whether talked to an outreach worker in the past 12 months**



**Figure 4.38 Percentage who used HCT services in past 12 months and got results by whether talked to an outreach worker in the past 12 months**



These quantitative findings reinforce the service study findings that, while some services are not user friendly for MSM, the outreach program has been effective at increasing knowledge and promoting services. However, it should be remembered that coverage levels are low. The findings indicate that a more intensified and focused effort, with a rationalization of the allocation of resources by location, could increase the success of the outreach program. Province B's experience of cooperation between the IA for outreach and the government-based services, especially with the specialized mobile services, provides a model for an effective multi-sector program.

## 5. PEOPLE WHO INJECT DRUGS

The design for the PWID program evaluation study had to be revised subsequent to the Technical Review Panel's approval. As mentioned in the Methodology chapter, the quantitative survey was cancelled after we learned that the BoE would be conducting their IBBS in a similar time period in the same sites. Preliminary IBBS data for the two selected sites, Province C and Bangkok, is presented in this chapter, subject to its availability at the time of this writing. The data is disaggregated by sex for the Bangkok sample but only the total figures were available for Province C. Statistical testing to examine the difference in key outcomes by program exposure was not available.

The service study also had to cancel their data collection in Bangkok for two reasons. Field staff turnover during the time of data collection in two IA made it impossible to conduct interviews for these key informants. Second, the Bangkok Metropolitan Authority (BMA) did not authorize data collection because the study proposal had not been cleared by their own ethical review committee. Thus, the service study evaluation applies only to the Province C implementation.

### 5.1 Sociodemographic and drug use profile of the IBBS samples

Table 5.1 presents preliminary findings on the IBBS sample in Province C and Bangkok. Very few of the PWID respondents in the Capital City are less than 25 years old. Age data was not available for Province C. While a large majority of PWID in Province C were working at the time of the survey (88%), only about 60% of men and about half of women in the Bangkok survey were working.

**Table 5.1 Sociodemographic characteristics of PWID**

	Province C		Capital City	
	Total	Male	Female	Total
<b>Age group</b>				
<25	NA	2.8	4.6	3.1
25+	NA	97.2	95.4	96.9
Total	100.0	100.0	100.0	100.0
(N)	(xxx)	(264)	(58)	(322)
<b>Education</b>				
Primary of Less	10.8	14.0	15.4	13.8
Secondary or higher	89.2	86.0	84.6	86.2
Total	100.0	100.0	100.0	100.0
(N)	(173)	(264)	(58)	(322)
<b>Work status</b>				
Working	87.8	60.6	52.6	59.6
Not working	12.2	39.4	47.4	40.4
Total	100.0	100.0	100.0	100.0
(N)	(173)	(264)	(58)	(322)

The findings on the types of drugs injected in the past 12 months show that the PWID in Bangkok tended to use multiple types of drugs (Table 5.2). About three-quarters said that they injected heroin and about the same proportion *ya ba*, implying that a good proportion of these injected both. About half of men and one-third of women injected domicum. About 40% of men and one-third of

women said they had injected methadone, with about 40% of both men and women injecting ice. Only 10% or less listed opium, valium or amytrypt. No figures on type of drug used were available for Province C. Nearly all of the drug users surveyed had injected for at least two years, and in Province C nearly all (99%) had injected in the past month. In Bangkok however, about 11% had injected more than one month ago, though only 1% injected between two and three months ago.

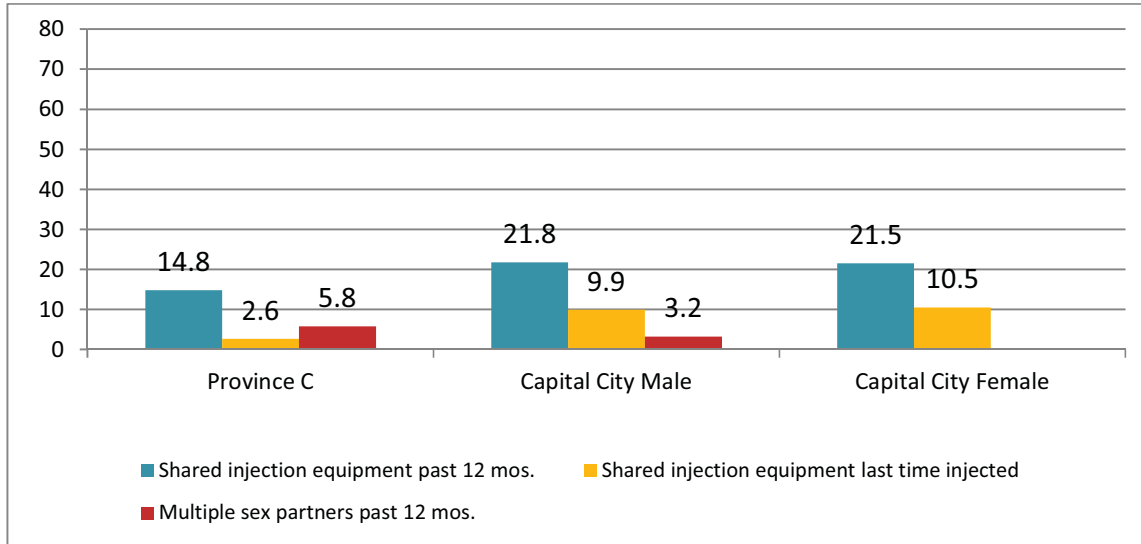
**Table 5.2 Type of drug injected and duration of injecting drug use**

	Province C		Capital City	
	Total	Male	Female	Total
<b>Type of drugs injected in the past 12 months (multiple response)</b>				
Heroin	NA	79.2	75.0	78.3
<i>Ya ba</i> (methamphetamine)	NA	6.2	7.0	6.9
Domicum	NA	48.4	34.3	46.9
Methadone	NA	39.5	33.3	39.0
Ice (crystal methamphetamine)	NA	67.4	72.3	68.3
Valium	NA	38.4	42.4	39.0
Opium	NA	10.3	6.4	9.8
Amytrypt	NA	5.4	9.0	5.9
Total		100.0	100.0	100.0
(N)		(264)	(58)	(322)
<b>Duration of injecting drug use</b>				
Less than 2 years	8.1	1.7	1.4	1.6
2 years +	91.9	98.3	98.6	98.4
Total	100.0	100.0	100.0	100.0
(N)	(173)	(264)	(58)	(322)
<b>How long since last injection</b>				
Within one month	99	NA	NA	88.1
1-3 months	1	NA	NA	11.2
3-6 months	0	NA	NA	0.7
Total	100			100.0
(N)	(140)			(279)

## 5.2 HIV risk and prevention behavior

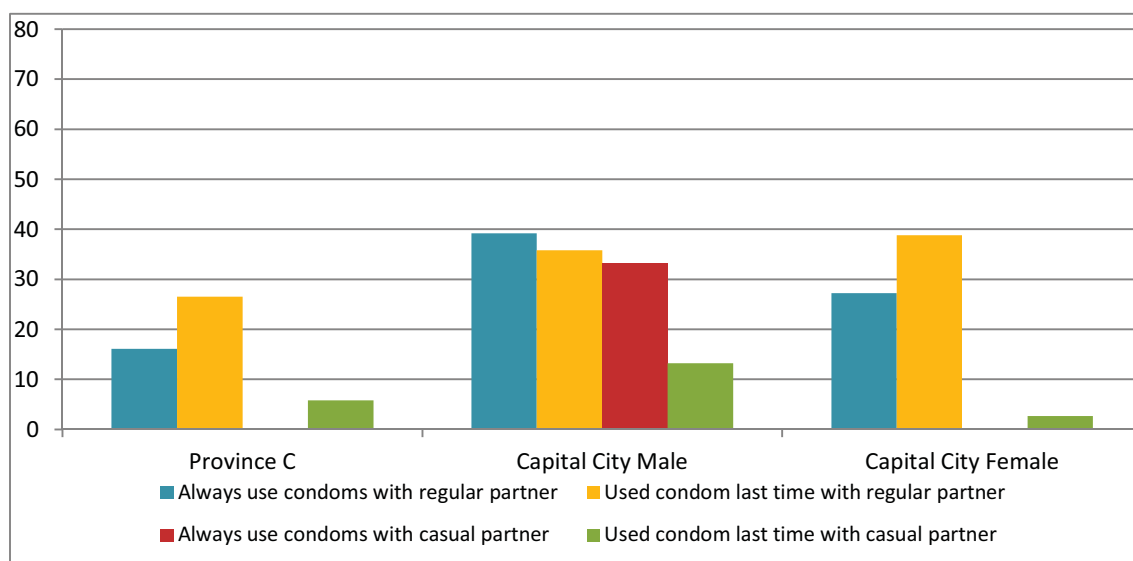
As seen in Figure 5.1 and Table A5.1 in Appendix 9.2, Section A5, about 22% of both men and women in Bangkok said that they had shared injection equipment in the past 12 months, but the percentage in Province C was somewhat lower (15%). A much smaller proportion said that they shared equipment the last time that they injected (about 10% in Bangkok and 3% in Province C). The proportion who said they had multiple sexual partners in the past 12 months was very low in both sites (6% in Province C, 4% for Bangkok men and 0% for Bangkok women).

**Figure 5.1 HIV risk behaviors by site**



With regard to HIV prevention behavior, condom use among the PWID respondents is found to be very low (Figure 5.2 and Table A5.2). Among those who said that they had a regular partner, only 16% of those in Province C said that they always use condoms with regular partners, with 27% using a condom last time. Condom use with regular partners was somewhat higher among Capital City respondents, with 36% of men and 39% of women using a condom the last time they had sex with their regular partner. Surprisingly, condom use with casual partners was less frequent than that for regular partners, which is the opposite of the pattern that is found in most populations. Only 6% of those in the Capital City, 13% of Bangkok men and 3% of Bangkok women said they used a condom the last time they had sex with a regular partner.

**Figure 5.2 Condom use by type of partner (from among those having that type of partner)**



### 5.3 Services available to PWID

Table 5.3 summarizes the services available to PWID that were included in the service listing for each study site. These include HCT services, facilities that provide methadone maintenance treatment (MMT), and DiCs.

**Table 5.3 Number and type of services available to PWID by study site**

	Province C	Capital City
Drop-in centers	1	4
Government hospitals	6 HCT/MMT	2 MMT
Bangkok Health Center		17 HCT/MMT
Private clinics		1 MMT
<b>Total</b>	<b>1 DiC, 6 HCT, 6 MMT</b>	<b>4 DiC, 17 HCT, 20 MMT</b>

### 5.3 Outreach program evaluation and coverage

The PR for Thailand’s PWID program is Population Services International (PSI) with SRs including the Raks Thai Foundation (RTF) and the Thai Treatment Action Group (TTAG). RTF has three SSRs including the Thai Drug Users Network (TDN), Alden House, and the Thai Red Cross (TRC). The evaluation was conducted only in Province C.

#### 5.3.1 Management and staffing of the outreach program

The service management structure includes a DiC manager, finance officer, field officer, and volunteers. The number of outreach staff varies slightly by size of target area. There is an average of one field staff per 300 PWID and 1 volunteer per 30 PWID. The three IAs have both male and female

workers, former PWID and those who were never PWID. Some of the volunteers are current or former PWID. Almost all the field staff had worked with PWID projects before.

Data were collected from 5-7 volunteers per IA. One IA divides volunteers into part-time and full-time workers. All volunteers receive financial compensation and a travel stipend. The IAs recruit staff and volunteers differently: some recruit broadly from the community, while others recruit internally through the network. PWID are a hard-to-reach KAP. The three IAs use a team approach including a volunteer who is a former/current PWID and a never-user. The ever-user will know the gathering spots and can speak the “language” of the PWID. But sometimes, these volunteers are somewhat drowsy if on methadone maintenance therapy (MMT) so the other volunteer can help with outreach education. Also, the acceptance of the PWID by the government and the community is still problematic. All three IAs had problems with high volunteer turnover. Reasons for this include economic, health, family problems, or recidivism into heavy drug use.

### ***5.3.2 Capacity building and quality control***

Capacity building of staff and volunteers is the responsibility of PSI. Building capacity of the service facility staff is the responsibility of another SR (a local hospital) under the DDC of the MOPH. But there was not much collaboration found between these two functions. PSI did extensive training across 16 topics in the first year. Staff and volunteers were trained together over multiple rounds. Due to staff turnover, PSI had to condense the training for new staff and volunteers in later years to first build a basic foundation and then add other topics over time. The IA managers and staff agree that this training format is more suitable. New volunteers learn from the continuing volunteers and staff. Field staff give close mentoring in the field for new volunteers at first, and teach by case studies during meetings.

Staff and volunteers also receive PSI media on routes of HIV transmission, prevention, STI, as well as handbooks on conducting campaigns, SOP for the DiC, working with volunteers, needle exchange, and flip charts on AIDS and other infectious disease. The staff and volunteers said that they have not used the SOP for the DiC, the handbook on working with volunteers, or the needle exchange guide, but that they implement based on past experience. Some felt the BATS handbooks were easier to apply than the PSI versions.

Staff in Province C service outlets received in-service training from the MOPH on a regular basis on mental health, drug addiction, AIDS, ART, etc. Staff of the hospital SR are resource persons for training events in harm reduction. Program training on stigma and discrimination involve the service providers as well. However, some PWID complained that some staff in MMT and ART clinics still display discrimination and prejudice against PWID. They may not serve PWID in order, speak harshly, and show displeasure in providing service. This has caused some PWID to visit other, less convenient sites for ART. It wasn't possible, in this evaluation to see whether the central office curricula of the hospital SR had protocols for establishing client-friendly services.

### ***5.3.3 Peer education***

To find new PWID contacts, a peer-based method is used. The PWID who are current or former drug users invites peers to visit the DiC, meets them at the MMT clinic, or meets them at injecting sites. The volunteers explain who they are and what the project is about. Then there is a discussion of health problems and the places they can go to for help. The education on prevention of HIV by safe



sex and harm reduction is delivered by the field supervisor and the volunteers who are never-PWID. Counts of new PWID cases include those receiving at least two of three services: education, distribution of harm reduction supplies (clean needles and condoms) and referral. There are four knowledge areas covered by the education component: the spread of the HIV epidemic, prevention, typical symptoms of opportunistic infections (OIs), and ART. Harm reduction consists of education on safe injecting, helping cases of drug overdose, advice on different types of drugs, hepatitis B, and life skills.

One of the IAs specifies target areas and target quotas for reaching PWID. The other two only specify target areas since they do not want to pressure the volunteers with quotas of contacts; their strategy is that if former PWID get stressed, they are more likely to return to drug use. Some IAs deliver education 3 days/week, while the other two days are for group activities. Other IAs have all staff/volunteers meetings every morning to plan the day's events. After doing outreach work they reconvene to report outputs.

In the past year the three IAs have not met their new case or HCT referral targets. Some had no new contacts in the last quarter. Causes include government crack downs, changing drug use patterns, out migration, and others. Some PWID don't go for HCT because they don't have an ID card to claim insurance, while others don't care about their health much anymore. Also, internal problems and staff/volunteer turnover may also contribute to not meeting targets.

Each IA has project-assigned targets for outreach contacts, which increase each year. This creates pressure on staff and volunteers, and they have to expand their aerial coverage accordingly. The emphasis on new contacts is thought to be reducing quality and coverage of outreach -- i.e., the limited staff and volunteers are spread too thin. Communication by the volunteers with the PWID is smooth and covers the essential topic areas. They refer for HCT and STI, and resupply injection equipment. There are some gaps on information about AIDS/STI due to limited time and circumstances, as PWID have to be on alert for arrest. Staff and volunteers of all three IAs said the outreach plan has to be continually up-dated. It is hard to set up advance meetings.

#### ***5.3.4 Drop-in Centers (DiCs)***

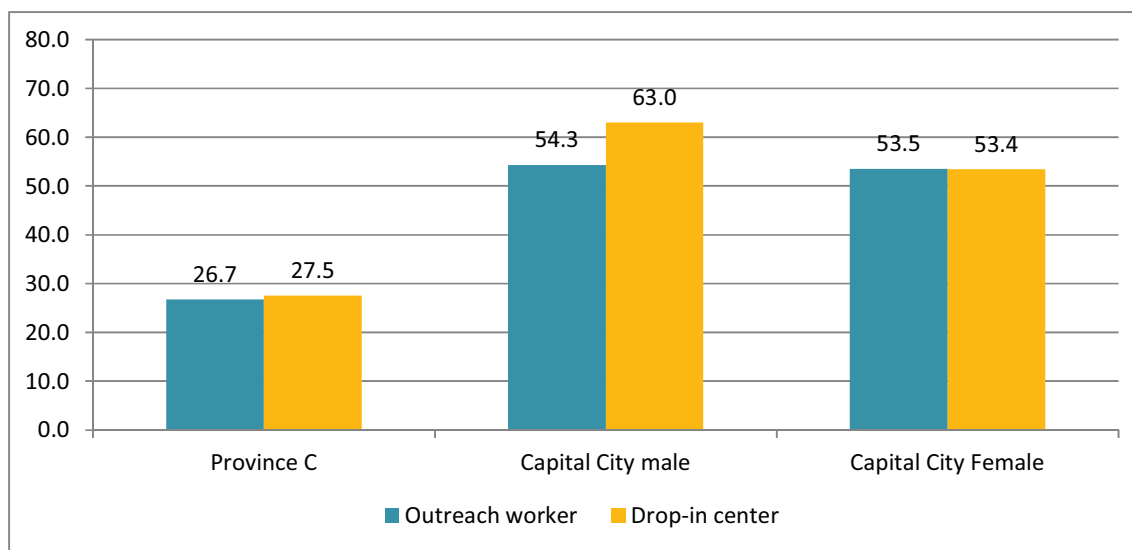
Each IA operates a DiC with the following objectives:

- To be a rest and recuperation area for PWID to watch TV, talk and exchange information after MMT, read the newspaper, eat snacks or soft drinks.
- To be a place for group activities on harm reduction, health care, and prevention.
- To be a re-supply point for harm reduction supplies.
- To serve as a meeting point for groups of PWID who want to go to a health service outlet.
- To be a place for health exams for PWID and community residents, when clinical staff visit (weekly or monthly).

The DiC are located in convenient areas for PWID to access. They have fixed operating days and hours and are closed on weekends. The DiC have about 7-8 visitors on an average day. But on

special activity days, the DiC is crowded. The three IAs differ in approach to public relations, how public they are about the DiC, and involvement of the community and community leaders. Two DiC are quite open and public. The 3<sup>rd</sup> DiC is also a safe house for PWID PLHIV and is less public and keeps the door closed. In the other sites, the community leaders are involved in progress review meetings and merit making activities.

**Figure 5.3 Coverage of the PWID outreach worker program and the drop-in centers in the past 12 months by study site**



Despite some shortcomings, the DiC is an important sanctuary for the PWID. Despite government policy which views drug addiction as a health problem, the practice is still crime suppression, and crack downs. Communities are encouraged to report drug users to the police. Thus PWID are reluctant to be exposed and this hinders outreach.

The IBBS found that coverage for the outreach program and drop-in centers was much higher in Bangkok than in Province C (Figure 3.3 and Table A5.3). In Bangkok, more than half of respondents surveyed had talked to an outreach worker and visited a drop-in center, while in Province C the percentage was about 27%. For Province C and for women in Bangkok, the percentage speaking to an outreach worker and visiting the drop-in center was about equal, implying that the respondents met the outreach workers at the drop-in centers (although this cannot be established without further data analysis). For Bangkok men, a higher percentage said they visited the drop-in center than had talked to an outreach worker, meaning that some visited the drop-in center to hang out and/or pick up supplies without receiving peer education.

### **5.3.5 Behavior change communication materials**

Most all the media are developed by PSI with staff, volunteers and PWID input. The PSI media include leaflets and booklets, with the following objectives:

- Introduce the project
- Describe services such as MMT

- Harm reduction education
- Education of illnesses related to injecting such as Hepatitis B

The materials with too much text are difficult for some of the PWID to read, but they may be useful for PWID family members. The staff and volunteers said that they would like more media on sex education, AIDS, STI, cervical cancer, and HPV, that are easy to understand. They would also like video media and film. However PWID also said that they like inter-personal communication best.

#### **5.4 Distribution of safe injecting equipment and condoms**

PWID can get resupply of clean needles and syringes from several sources. At the DiC, harm reduction resupply packs are available that include a clean needle, syringe, distilled water, alcohol swab, cotton, condoms, a spoon and a rubber hose. The PWID register using a UIC in some settings, while others use a name. Some DiCs allow only personal resupply, while others allow pick-up for peers. Volunteers also distribute them in the community where PWID gather, such as in front of the MMT clinic, or shooting areas. One Tambon Health Promotion Hospital at the Tambon level gives resupply in collaboration with the project DiC to improve convenience. Finally participating drug stores give them in exchange for a voucher in Bangkok only. The supply has been adequate for the demand.

The number of participating drugstores in Bangkok has declined because of concern for the lack of government policy in favor of harm reduction, and the tendency of clients to inject in the area near the pharmacy, thus causing it to be a location of interest by the police. MOPH outlets do not provide needle exchange, citing lack of a harm reduction policy. But they do provide information on harm reduction.

PSI has arranged for deposit boxes for used needles and placed in the community. Boxes are weighed and PWID receive credit for soap and other sundry items in exchange for bringing the box in.

The PWID in the project are very satisfied with the harm reduction supplies. They understand how it protects them from HIV and Hepatitis B by not needing to share needles and helps them save money. Because AIDS and drug abuse are the responsibility of separate organizations there is less than optimal coordination in the area of harm reduction.

The harm reduction resupply packets each contain five condoms. PWID can request more condoms at the DiC or from volunteers. Some PWID did not use the condoms received due to a low sex drive. It is also a bit sensitive to promote condoms in Muslim communities in the South, due to its contraceptive properties. Thus, some staff and volunteers promote condoms as harm reduction. Condom supplies are adequate to meet demand, but storage could be improved. There is little demand for lubricant and only a few PWID who are MSM, if any. The staff and volunteers do not ask PWID about their sexual orientation.

**Figure 5.4: Coverage of injection equipment and condom distribution for PWID by study site**

The IBBS found that just over half of Bangkok males and females and 29% of Province C respondents said that they had received free injecting equipment in the past 12 months (Figure 5.4 and Table A5.3). The coverage of condom distribution was lower in all groups, but this could be due to the lack of demand for condoms mentioned earlier; if condoms are not being used due to a lack of sexual activity, respondents might not remember that they were included in the harm reduction packet.

## 5.6 Methadone Maintenance Therapy (MMT)

PWID can receive MMT in the provincial and district hospitals. Some facilities have introduced one-stop clinics which take a history, conduct a physical exam, assess mental health, and do HCT with rapid testing, and Hepatitis B and C testing, without charge. If the PWID reports coughing for 15 days or more, s/he will be given a chest X-ray before providing MMT. The local hospitals deviate somewhat from central guidelines for MMT and attempt detoxification if the PWID consents. Methadone doses are normally consumed in the presence of an MMT clinic staff. Some hospitals do not have both MMT and ARV clinics, requiring HIV+ PWID to go to separate facilities. Coordination between these needs improvement.

## 5.7 STI screening and HCT program evaluation and coverage

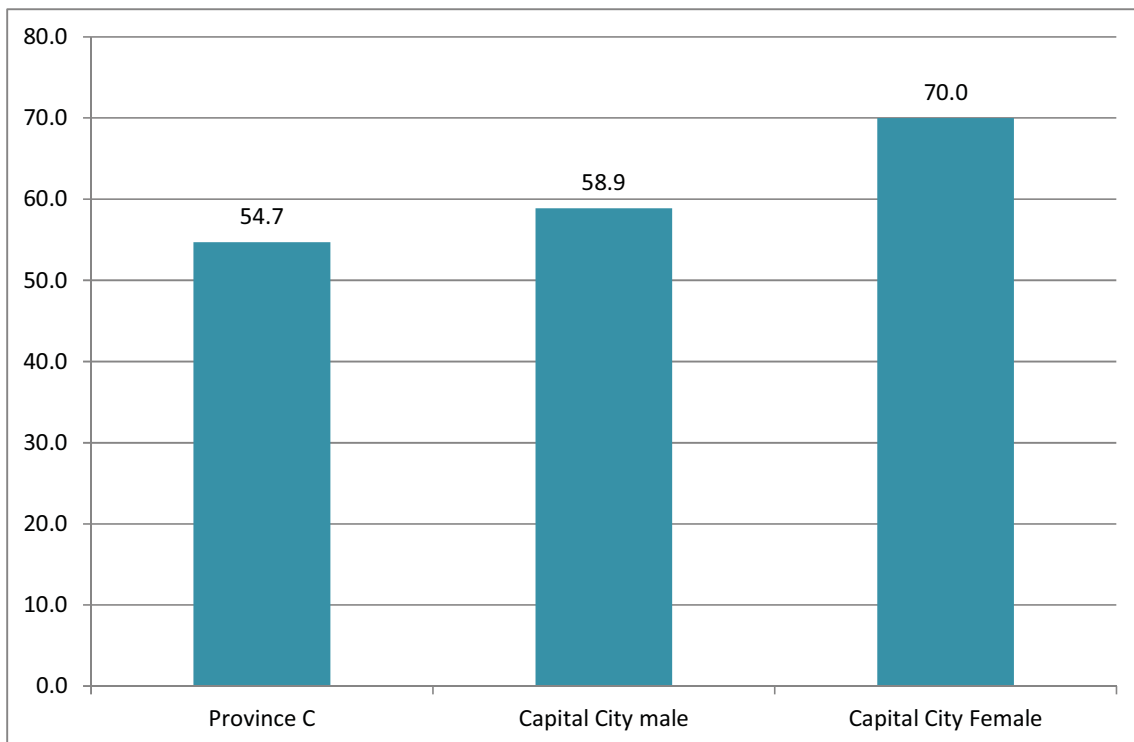
Referral is mostly for drug treatment, MMT, and HCT; less so for STI. The drug and MMT referral is not part of the evaluation system. Staff or volunteers accompany PWID for HCT or STI clinic visits. In the past, monitoring after clinic visits was not intensive. But, lately there is more concern from ART clinics that HIV+ PWID be closely followed up to ensure compliance with the regimen.

Staff and volunteers do not give much priority to STI case management and prevention with the PWID population. The belief is that the PWID have low levels of sexual activity, there is little request for consultation, and few reported STI cases.

The number of HCT clients is one of the ACHIEVED indicators for PWID. The data for all three IA in the last quarter show low numbers of PWID HCT clients. Many of the PWID had received HCT at the MMT clinic in the past. Field staff report few HCT referrals as well. Current HCT clinics in the locality use rapid testing with same-day results, and this is appropriate for the PWID lifestyle.

The IBBS however reported fairly high levels of HCT among the PWID (Figure 5.5 and Table A5.3). Over half of Province C respondents and Bangkok males reported going to HCT and fully 70% of Bangkok females. It is not known why the program data are so different from the IBBS results for HCT, and this should be further investigated as the results of the IBBS are further analyzed.

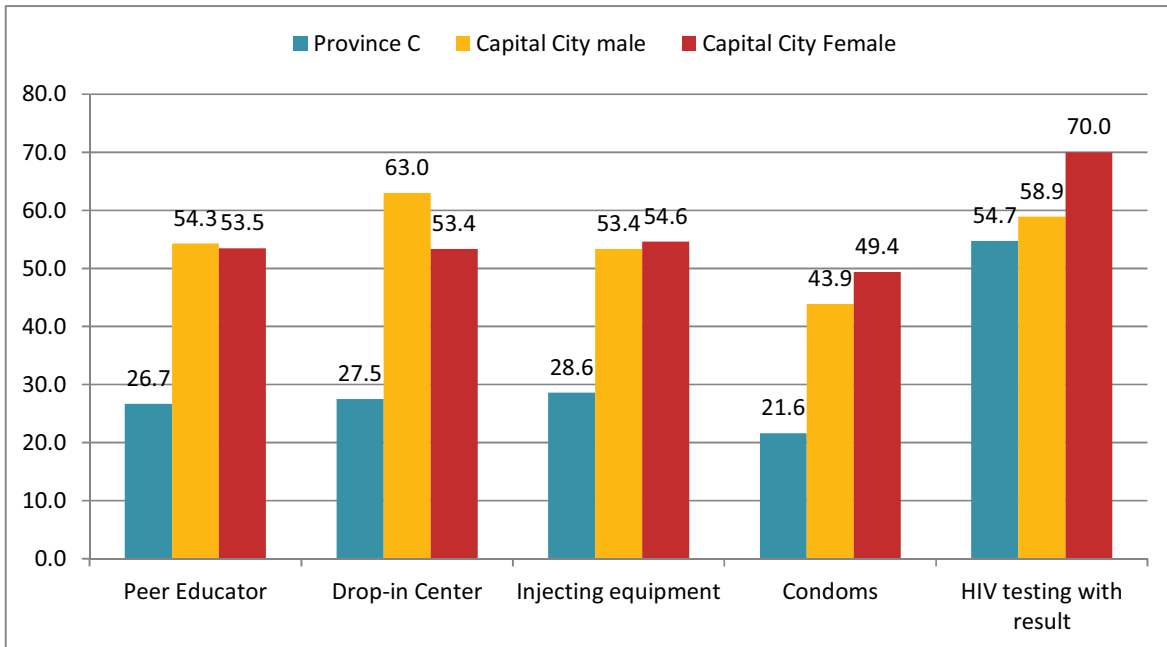
**Figure 5.5: Coverage of HCT for PWID by study site**



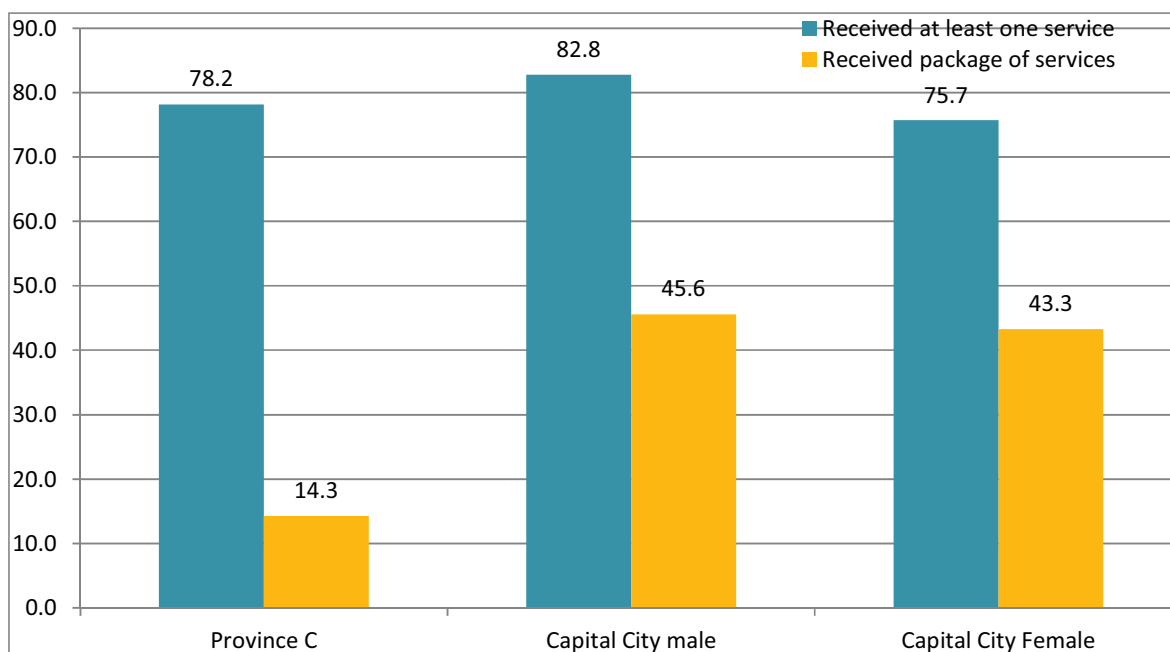
### 5.8 Package of services

Summary results for coverage of single services and for the package of services provided by the PWID program are shown in Figures 5.6 and 5.7. Coverage of services is lower in Province C for all services except HCT (check). For Bangkok males, the drop-in center had the highest level of coverage (63%). For Bangkok females, HCT is highest at 70% (check). Figure 5.7 gives summary results for the percentage who received at least one service in each site, as well as the percentage who received the package of services (outreach, injecting equipment and condoms).

**Figure 5.6: Summary of coverage of single services for PWID**



**Figure 5.7: Summary of coverage of at least one service and for the package of services for PWID**



## 5.9 Data System and Data Quality

PSI has prepared forms, log books and a management information system (MIS) to record service statistics. The forms record supplies received and distributed. The log book records PWID data by responsible volunteer, including UIC, sex, age, date of birth, area of contact, information exchanged, referral, type and quantity of supplies distributed. There is a record form for participation in group activities, training, knowledge gained, problems and recommendations. Some IAs train the volunteers to enter data. Other IAs have the field staff or DiC manager enter data.

Periodic changes to the forms have caused considerable confusion. Staff and volunteers feel they spend too much time on data collection and processing. Data are not used enough for improving implementation or analysis. They seem only to be used for reporting purposes. The UIC system is used to protect PWID confidentiality. However, in practice it was found that often the name of the PWID is recorded on some forms or log books, which are exposed to others in the DiC. There is no attempt to verify that a contact is real. None of the three IA had data on the total number of PWID in their province. Mapping of the PWID is difficult because of high mobility and periodic police round-ups. The findings for PCM involvement in data monitoring are the same as for the MSM population described earlier.

## 5.10 Summary of service quality

The evaluation team has summarized the quality of services in comparison with the following six service standards: rights, quality control, service access, participation of the target group, service

package, and monitoring (Table 5.3). As noted above, the standards come from UNAIDS and other international agencies (Weir, 2011).

**Table 5.3: Summary of Quality of Services for PWID**

Standard	PWID program	
<b>1. HIV prevention services</b>		
<b>1.1. Rights to Service</b>		
1.1.1. Clients are fully informed about the service, the risks and expected benefits.	Capacity of volunteers varies; especially between those who are/were PWID and never-PWID). Volunteers provide outreach education and supplies, and serve as a link with the field officer. But due to limited personnel and effort, PWID still are not motivated to seek HCT and STI services.	+
1.1.2. Confidentiality is protected, and client privacy is respected throughout.	<ul style="list-style-type: none"> <li>- - Outreach and service facility providers understand the need for confidentiality; the UIC system helps protect anonymity. But in practice, some IA record names of PWID in logs.</li> <li>- Privacy is protected in the service sites and DiC through separate counseling rooms.</li> </ul>	++
1.1.3. Equal service for all (absent of stigma or discrimination)	Outreach personnel have been trained in stigma and discrimination and attitude issues. They have past experience working with PWID. Services are client-friendly.	+++
<b>1.2. Quality Control</b>		
1.2.1. All core services have written SOP accessible as a reference at any time.	No SOP found. There are handbooks about managing a DiC, working with volunteers, and needle exchange. But they are not used by IA. IAs use the guide books from BATS which they say are easier to understand.	++
1.2.2. Staff receive regular monitoring and inspection from supervisors for quality control.	Monitoring of volunteers by field staff varies among IA. In general, it is inadequate. Some staff and volunteers have not received any mentoring.	+
1.2.3. Service providers have been trained to be sensitive to issues of stigma and discrimination, to prevent this from happening to KAP.	<ul style="list-style-type: none"> <li>- Outreach personnel have been trained and are experienced in working with PWID. Some volunteers are former PWID and understand the KAP well.</li> <li>- There are some reports of stigma and discrimination by government facility providers.</li> </ul>	+++ -
<b>1.3 Access to Services</b>		
1.3.1. Access to services is universal without discrimination according to age, sex, ethnicity, gender, nationality, religion, occupation, health insurance coverage, or drug use.	<ul style="list-style-type: none"> <li>-There is no stigma or discrimination against PWID and all have rights to services. But some PWID do not have Thai ID cards.</li> <li>- One service outlet has set up a one-stop service to improve convenience for PWID. But service varies by site, especially for MMT.</li> </ul>	++





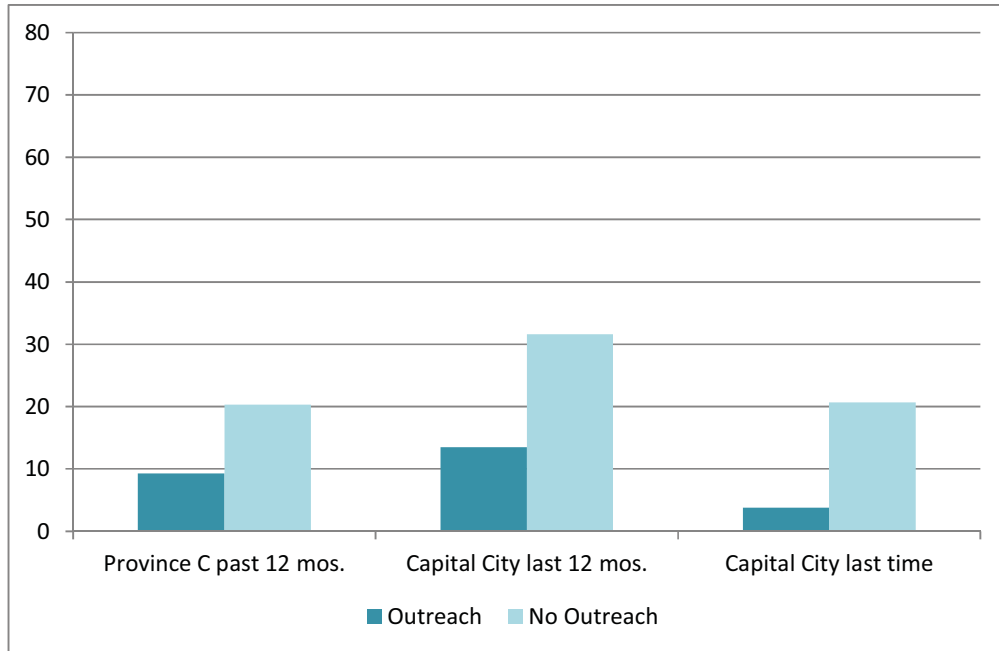
Standard	PWID program	
2.2.6. The clients have risk assessments as part of the HIV prevention communication.	PWID are asked about drug use and sex to assess need for harm reduction kits.	+
2.2.7. There is monitoring of the outreach to see if the KAP received STI screening or HIV HCT.	None. Some staff or volunteers accompany the PWID to the service site.	-
2.2.8. Educational media are developed for behavior change, with participation by the KAP. The media are distributed/communicated to the KAP through appropriate channels.	PSI has produced printer material in leaflet, booklet, flip chart formats. Some IAs have invented learning games for the PWID. Information-heavy media are not popular with the PWID since reading skill and attention span are limited.	+
<b>2.3. Monitoring</b>		
2.3.1. Clients have a UIC, and the monitoring system can track these individuals by UIC. Or, there is an alternate system for monitoring client receipt of services.	The UIC is only used in the outreach facilities (under GF). The hospitals use the 13-digit Thai ID card number and the OPD number for following up PWID. This makes monitoring referred PWID difficult.	-
2.3.2. Field staff receive refresher training, mentoring and supervision on service quality (including HCT and STI).	<ul style="list-style-type: none"> <li>- Volunteers receive refresher training occasionally. But monitoring and supervision from supervisors is limited and mostly conducted during meetings.</li> <li>- Most service providers for HCT and STI have had training on counseling.</li> <li>- There are no data on the extent of supervision that these staff receive.</li> </ul>	+

**Remarks:** +++ denotes good, ++ denotes fair, + denotes poor, - denotes no implementation  
NA denotes Not Applicable

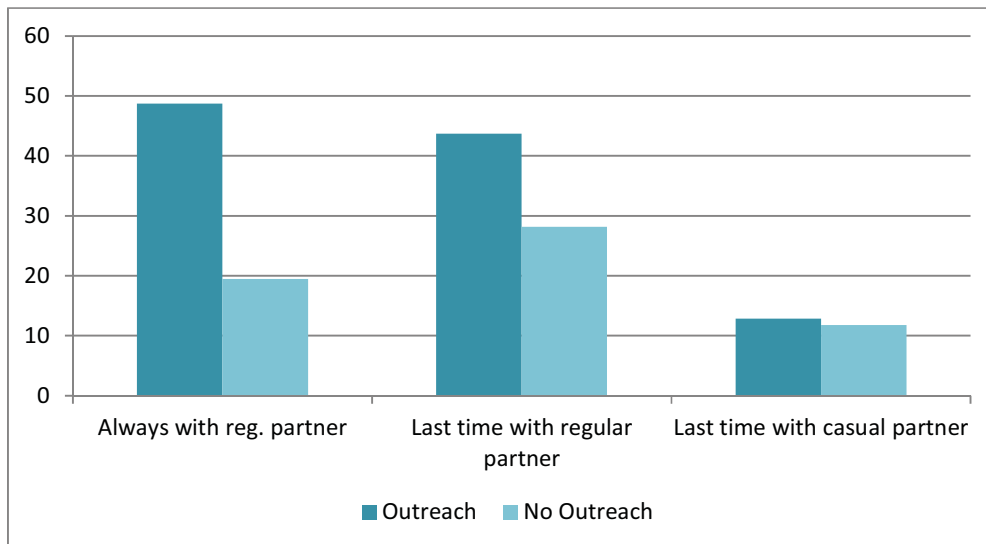
### 5.11 Effect of the program on HIV knowledge and prevention behavior

Preliminary analysis of the IBBS is used to explore whether there is an association between exposure to the PWID program and HIV prevention behavior. While no statistical testing has been done to test whether the differences are significant, the percentage of those who shared injection equipment in the past 12 months is much lower for those who also talked to an outreach worker (Figure 5.8 and Table A5.4). Finally with figures only available for Bangkok, the percentage who report condom use with regular partners is much higher for those who talked to an outreach worker. Casual partner condom use is low and there is no difference between those who talked to an outreach worker and those who did not (Figure 5.9 and Table A5.4).

**Figure 5.8 Percentage sharing injection equipment in the past 12 months and last time injected based on whether talked to an outreach worker**



**Figure 5.9: Percentage who report condom use by type of partner and whether talked to an outreach worker in the past 12 months, Capital City**



## 6. RESULTS: PRISONERS

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This study of prisoners was conducted in three places of incarceration in the Capital City, Province D and Province E (as described in the Methodology chapter). These are referred to below as Prison C, Prison D and Prison E. One institution was selected in each province based on the recommendation of the Medical Services Division of the Department of Corrections (DoC), which is one of the SRs under the ACHIEVED program (originally called “CHAMPION”). The institutions in this study include a central prison, a special prison and a rehabilitation corrections facility. Only the central prison has female inmates.

### 6.1 Characteristics of the sample population

This study collected data from 1,543 male prisoners: 778 from Prison C; 421 from Prison D and 344 from Prison E. Almost all of the respondents reported that they were male; 1.4% reported that they were not male, and these may be presumed to be transgender. Approximately half the sample were age 25 to 34 years while one in three were 35 years or older. Approximately 13% were under 25 years (Table 6.1). Over 80% had high school or vocational education and 58% were single. Before imprisonment, approximately one-third of the sample worked as day-wage laborers and 16.5% worked for a company.

**Prison C:** This is a large institution with a capacity of 4,000 to 6,000 inmates per year. As of February 1, 2012, Prison C had 3,668 inmates, including those pending appeal and sentenced to a period of incarceration not exceeding 15 years. There are eight zones in this prison: (1) Reception; (2) Male Teen, and (3) – (8) for general prison cells. The prison provides adult education opportunities, medical care, recreation, and welfare, including vocational training for released prisoners.

The 788 respondents refer to prisoners who have been in jail for three months or more were randomly selected. Of these, 98% are male and 25% are between 25 and 29 years of age, followed in frequency by those age 30-34, 20-24, 35-39, 45 or older, and 18-19 years, respectively. Over 30% had either lower or higher secondary school and 5% had more than a bachelor’s degree. Approximately 62% are single, 22.5% married, 2.7% widowed, and 12.5% divorced or separated from their spouse. Before imprisonment, 29% worked as day laborers, 21% worked for a company, 17% were business owners, 5% were full-time students, and 15% were unemployed. Over half the inmates were charged with property-related offenses, 19% for personal injury, and only 1% for drug-related offenses. The average duration of imprisonment of Prison C inmates is 24.7 months, with an average sentence of 80.6 months.

**Prison D:** This institution is a rehabilitative corrections facility which, as of February 1, 2012, had 1,997 inmates. Most of the crimes are drug offenses. There are eight zones in the facility and one infirmary. A total of 1,526 had been inmates for three months or more, and 421 were sampled for inclusion in this study.

Nearly all (99.3%) are male and 38% are age 30-34 years, followed in frequency by 25-29, 35-39, 45 or older, 40-44, and 20-24 years of age respectively. There were no inmates under age 20. Over 30%

had either lower or higher secondary education, 13% had vocational education, and 8% had a bachelor's degree. Approximately 57% are single, 28.0% married, 2.1% widowed, and 12.6% divorced or separated. Before imprisonment, about one-third (32%) worked as day laborers, one-fifth (19%) worked for a company, 17% owned a business, and 17% were unemployed. The inmates had been incarcerated for an average of 31.2 months and had average sentence durations of 88.1 months.

**Prison E:** This institution is a central prison with an area of 18 rai. There were a total of 1,282 inmates as of February 1, 2012, including both males and females. The prison has the following zones: (1) Holding center for prisoners awaiting sentencing; and (2) Permanent facility, with a separate women's zone, infirmary, and education area. The prison includes three sections for AIDS. There are 608 male inmates in the permanent facility for three months or more. Of these 346 inmates were randomly selected for this study.

Almost all (98.6%) are male, and the remaining 1.4% may be presumed to consider themselves to be transgender. The largest percentage (27%) are age 30-34 years, followed in frequency by 25-29, 35-39, 45 or older, 20-24, and 40-44 years respectively. None of the inmates was under age 20 years. Over a third (36%) had lower secondary education, 29% had upper secondary education, 23% had vocational education, 7% had a bachelor's degree, and 4% had more than a bachelor's degree. Under half (47%) are single, 42.4% are married, 5.5% are widowed, 5.5% are divorced or separated. Before incarceration, one-third worked as farmers, 26% worked as day laborers, 21% owned their own business, 5% were full-time students and 6% were unemployed. Fully 64% of inmates had committed drug-related offenses, followed by property-related crimes, and personal injury. The average duration of incarceration is 33.8 months while the average duration of sentence is 358.2 months (Tables 6.1 and 6.2).

**Table 6.1 Socio-demographic characteristics of the sample**

	Prison C	Prison D	Prison E	Total
<b>Sex</b>				
Male	97.8	99.3	99.4	98.6
Not male (Transgender)	2.2	0.7	0.6	1.4
<b>Age (years)</b>				
18-19	1.7	0.0	0.0	0.8
20-24	18.0	1.7	11.3	12.1
25-29	25.4	23.5	27.3	25.3
30-34	22.9	37.8	26.5	27.7
35-39	13.1	17.1	14.5	14.5
40-44	9.5	8.8	8.4	9.1
45 or over	9.4	11.2	11.9	10.4
<b>Education</b>				
None/primary	2.2	1.0	0.9	1.6
Lower secondary	37.7	38.5	36.3	37.6
Upper secondary	31.1	37.8	29.1	32.5
Vocational	15.2	13.1	22.7	16.3
Bachelor's	8.7	7.6	7.0	8.0
Higher than bachelor's	5.1	2.1	4.1	4.1
<b>Marital status</b>				
Single	62.3	57.2	46.5	57.4
Married	22.5	28.0	42.4	28.5

	Prison C	Prison D	Prison E	Total
Divorced	2.7	2.1	5.5	3.2
Divorced/separated	12.5	12.6	5.5	11.0
<b>Occupation prior to incarceration</b>				
Full-time student	5.1	2.1	4.9	4.3
Farmer	4.1	6.2	33.4	11.2
Daily wage laborer	29.3	32.1	25.9	29.3
Company employee	21.0	18.5	4.1	16.5
Civil servant	3.7	2.1	2.3	3.0
Business owner	17.1	15.7	20.6	17.5
Unemployed	14.9	16.9	6.4	13.5
Other	4.8	6.4	2.3	4.7
<b>Total (%)</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
<b>N</b>	<b>778</b>	<b>421</b>	<b>344</b>	<b>1,543</b>

Overall, most prisoners were incarcerated for drug-related crime (42%) followed by property-related offenses, and personal injury. Fully 91% of the inmates had been sentenced and the average length of sentence was 12.4 years (148.6 months). The average duration of current imprisonment was 2.4 years (28.5 months). Over half had been in prison two years or less. Inmates in Prison E had the longest duration of current incarceration with 11% in prison more than five years (Table 6.2).

**Table 6.2: Type of offense and duration of incarceration**

	Prison C	Prison D	Prison E	Total
<b>Type of offense</b>				
Property-related	53.9	0.2	10.8	29.6
Drug-related	1.4	99.0	63.7	41.9
Personal injury	19.3	-	14.5	13.0
Physical injury	6.4	0.5	2.3	3.9
Sex crime	9.5	-	6.1	6.2
Danger to society	0.9	-	0.3	0.5
Other	8.0	0.2	2.0	4.5
unknown	0.6	-	0.3	0.4
<b>Status of sentencing</b>				
Awaiting appeal verdict	15.9	1.0	2.0	8.7
Already sentenced	84.1	99.0	98.0	91.3
<b>Duration of current incarceration (month)</b>				
6-12	30.5	14.0	19.8	23.6
13-24	37.0	29.9	35.8	34.8
25-59	28.1	48.2	33.7	34.9
60months or more	4.4	7.8	10.8	6.7
<i>Average duration of incarceration (month)</i>	<i>24.7</i>	<i>31.2</i>	<i>33.8</i>	<i>28.5</i>
<i>Average duration of sentence (month)</i>	<i>80.6</i>	<i>88.1</i>	<i>358.2</i>	<i>148.6</i>
<b>N</b>	<b>778</b>	<b>421</b>	<b>344</b>	<b>1,543</b>

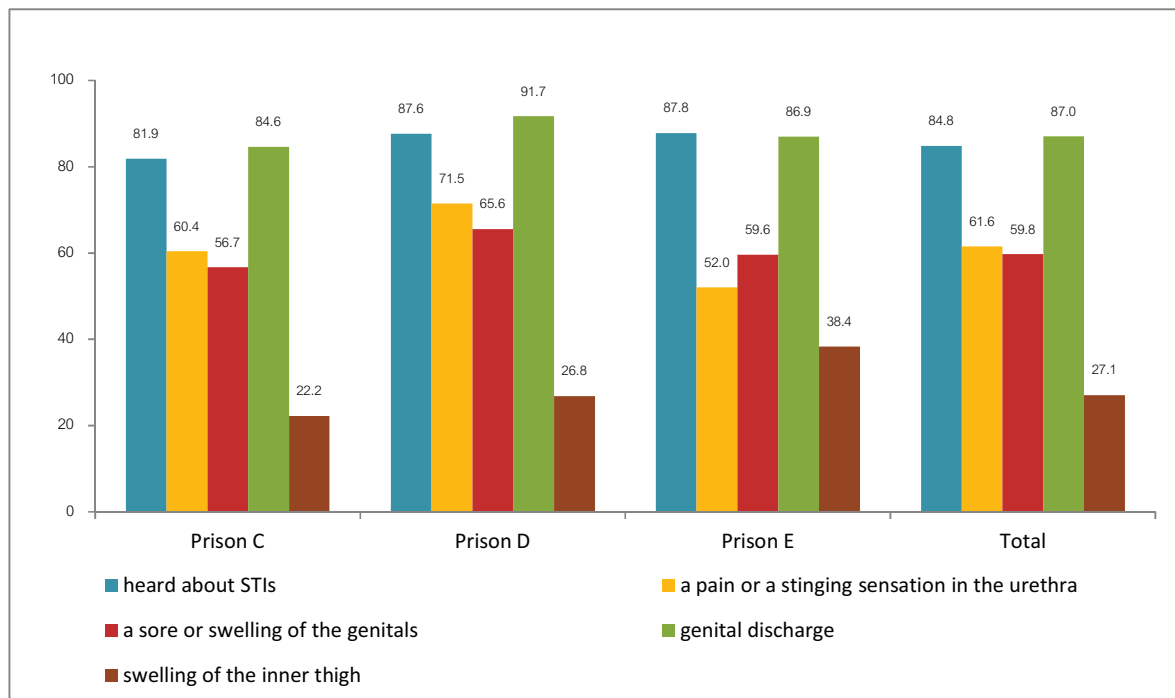
## 6.2 Sexually transmitted infections (STI) and HIV/AIDS

### 6.2.1 Knowledge about STIs

For the combined sample of 1,543 persons, over 85% had heard of STI and know that a common symptom is genital discharge. About two-thirds know that an STI may cause pain or a stinging sensation in the urethra or a sore or swelling of the genitals. Only 27% knew that swelling of the inner thigh is a symptom of an STI.

When comparing across prison populations, this study found that there is a similar pattern of knowledge of STI symptoms. Prison D inmates had more correct knowledge of STI than Prison C and E. It is noteworthy that proportionately more inmates in Prison E knew that inner thigh swelling was an STI symptom than C or D inmates. But fewer Prison E inmates were aware that urethral pain/stinging and genital sores were STI symptoms than Prison C and B inmates (Figure 6.1).

**Figure 6.1 Knowledge about STI symptoms**



When examining the association between whether the prisoner could correctly choose 4 STI symptoms (a sore or swelling of the genitals, swelling of the inner thigh, a pain or stinging sensation in the urethra and genital discharge) and meeting with peer educator while they are in the prison. It is found that there is a significant relationship between meeting/not meeting with peer and the knowledge on STIs. About 63% of those who correctly assess 4 items of STI knowledge met with PE, compared with 37% of those who did not meet with a PE (Figure A6.1, Appendix 9.2).

### 6.2.2 Knowledge about HIV/AIDS

The five AIDS knowledge questions prescribed by the GARPR include the following true/false statements: (1) Using a condom during sex can prevent HIV; (2) Sex between two mutually faithful monogamous partners can prevent HIV; (3) HIV cannot be spread by mosquito bites; (4) HIV cannot

be spread by eating with an infected person; and (5) Someone who looks healthy can still have HIV infection. Just under half (49.4%) of the total sample of prisoners could correctly assess all five items as true or false, while only 6.6% could correctly assess only one to two items. (Figure A6.2, Appendix 9.2).

Because this is a cross-sectional survey, it is not possible to assume that there is a causal effect between exposure to the HIV prevention program and differentials in the prisoners' knowledge and behavior. But the data in Figure A6.3 (Appendix 9.2) suggests that the efforts of the prison peer educators had a statistically significant effect on inmate AIDS knowledge. About 56% of those who met with a PE correctly assessed all 5 items of GARPR AIDS knowledge, compared to 43% of those who did not (Figure A6.3).

## 6.3 Implementation of AIDS prevention peer educators in the prisons

### 6.3.1 Prison staff and peer educators

The prisons which are participating in the Global Funded prevention program have staff and volunteers who are trained to educate the inmates on HIV prevention, and to promote more positive attitudes of the prison staff toward the inmates, PLHIV, and persons with diverse sexual behaviors. The staff are also trained so that they understand HCT. The trainers are resource persons from outside the prison including hospital staff in the network, NGO staff, or teams of trainers including staff of the prison infirmary who have passed the DoC- AIDS training course. The training uses the "Handbook for Training Staff of the Corrections Institutions on Prevention and Response to AIDS in the Prison Setting," developed by the Medical Services Division (MSD) of the DoC.

The MSD of the DoC conducted a training of trainers (TOT) on AIDS with resource persons from the TUC and FHI. The content includes AIDS knowledge, ART counseling, essential skills of the trainer, and constructive attitudes about sex, stigma and discrimination. The TOT takes three days. The prison staffs are trained in batches of about 25 to 30 persons per year. Typical trainees include the zone chiefs or monitors. The results of evaluation show that the cooperation of staff in the training program is still limited due to competing demands on their time. Other staffs were not interested in the training, and refused to participate. Thus, the training teams are less motivated to conduct the training and may discontinue this activity.

The peer educators were recruited from the population of inmates themselves. Majority of peer educators are selected from inmates who score highly on the training post-test, are literate, with good human relations skills, and who have at least two years remaining on their sentence. Some prisons specifically try to recruit volunteers who can relate to the highest risk inmates such as MSM, transgender, those with tattoos, ever injected drugs or former HIV/AIDS infection. The peer educators were trained in HIV/AIDS in annual courses over a two-day period in groups of 15 to 20 individuals. The trainers were staff of the prison infirmary and corrections officers.

The DoC, Department for Disease Control (DDC) and the TUC developed a handbook for the peer educators in 2011. The handbook consists of information about AIDS, STI, HCT, ART, condom distribution, and essential recording forms. Only the first cohorts of trained peer educators received



the handbook. Subsequent cohorts did not receive the handbook because there was a shortage of supply.

Some prisons worked with partners in the prevention network to conduct the activities. For example, Prison E collaborated with the provincial hospital to conduct supplemental workshops with the peer educators on condom distribution in the prison to maximize coverage, and to ensure that the volunteers had correct knowledge about condoms.

Staff of the prison infirmary and corrections officers receive annual supervisory visits from the DoC, and have opportunities to participate in evaluation meetings or refresher training on topics such as HCT and ART. And also, the peer educators are given supplemental training. The program provides budget for annual refresher training for one to two groups of 25-35 persons per year. The number of peer educators in two of the sample prisons totaled 25 persons each. In the third prison the number of peer educators was 60, including 20 female volunteers. There is turnover of the peer educators, and this is a problem in each of the prisons, especially in the special corrections facility which has a number of inmates whose case is under appeal. Other peer educators are released during the annual amnesty. One prison lost seven recently-trained volunteers in an amnesty.

In any event, this prevention program still lacks an M&E system for the activities of the peer educators and satisfaction levels of the inmates toward the prevention activities. That information would be useful in order to refine and improve the intervention.

Results from this cross-sectional survey show that about half of the prison inmates received AIDS knowledge from the Peer Educators-PE (Table 6.3). The proportion was highest for Prison E inmates and lowest for Prison C inmates. Inmates who had received AIDS education from the volunteers had an average duration of incarceration of under 3 years (31.4 months) or 26.7, 30.9, and 36.8 months for Prisons C, D, and E respectively (data not shown).

Of those who did receive AIDS knowledge from the peer educators, 82% said the information was about HIV, followed by STI, advice to seek HIV/HCT in the prison, tuberculosis (TB), condom resupply and lubricant. When ranking the information by usefulness, the inmates said the most helpful was the information on HIV, followed by STI, TB, risk reduction counseling, and risk assessment. These patterns were similar across prisons.

The results from the cross-sectional survey are consistent with the qualitative study finding that the information provided was mostly factual content about HIV/AIDS, STI, HIV/HCT, OIs, TB and HIV risk assessment rather than content on improving attitudes toward PLHIV, sex behavior, and reduction of discrimination. That said, 40% of the inmates who had contact with the peer educators said there was content on acceptance of and sympathy for PLHIV. However only 15% of the total sample felt that this information was useful.

In terms of the role of the peer educators in improving access to health services, increasing knowledge and understanding about AIDS, TB and STI, this study found that nearly all respondents (95%) said that the peer educators were very or somewhat useful (Table 6.3).

**Table 6.3 Percent of prison inmates by receipt of services from the AIDS prevention peer educators by prison**

	Prison C	Prison D	Prison E	Total
<b>Received AIDS information from the peer educator (PE) in the prison</b>				
yes	31.7	66.4	71.0	50.2
no	68.3	33.6	29.0	49.8
<b>N</b>	<b>744</b>	<b>417</b>	<b>334</b>	<b>1495</b>
<b>Type of information/service received (multiple response allowed)</b>				
HIV/AIDS	77.1	82.3	85.2	81.6
STI	77.1	76.5	81.9	78.4
TB	49.6	54.2	66.2	56.5
HIV risk assessment	38.6	34.7	50.2	40.8
HIV risk counseling	31.4	32.1	48.5	37.1
Condoms/lubricant resupply	37.3	44.0	43.9	41.9
Care counseling	25.4	23.8	44.7	30.9
Acceptance and empathy for PLHIV	37.7	34.7	49.8	40.4
Motivation to seek HIV/HCT in prison	52.5	74.7	80.6	69.6
Motivation to have a health check-up	33.5	47.7	62.9	48.0
Other health counseling	40.3	43.0	57.8	46.8
Life problem counseling	31.4	21.3	41.8	30.9
Other	15.3	14.4	27.8	18.9
<b>N</b>	<b>236</b>	<b>277</b>	<b>237</b>	<b>750</b>
<b>Services/information from the volunteers which are felt to be useful for the inmates (Multiple response allowed)</b>				
HIV/AIDS	64.4	69.0	73.8	69.1
STI	51.7	54.9	46.8	51.3
TB	41.1	40.8	31.2	37.9
HIV risk assessment	22.9	18.8	17.7	19.7
HIV risk counseling	25.8	23.8	23.6	24.4
Condoms/lubricant resupply	14.0	19.1	12.7	15.5
Care counseling	19.9	13.0	14.3	15.6
Acceptance and empathy for PLHIV	20.8	10.8	13.1	14.7
Motivation to seek HIV/HCT in prison	14.0	16.2	20.7	16.9
Motivation to have a health check-up	7.2	13.0	19.4	13.2
Other health counseling	8.9	11.6	16.9	12.4
Life problem counseling	9.3	9.0	9.7	9.3
<b>N</b>	<b>236</b>	<b>277</b>	<b>237</b>	<b>750</b>
<b>How much was health service access improved by peer educator effort?</b>				
Very much	50.8	56.7	73.4	60.1
Somewhat	43.6	41.5	25.7	37.2
So-so	4.2	1.8	0.0	2.0
Not at all	1.3	0.0	0.8	0.7
<b>N</b>	<b>236</b>	<b>277</b>	<b>237</b>	<b>750</b>

	Prison C	Prison D	Prison E	Total
<b>How much did the peer educators help improve understanding of HIV/AIDS, TB and STI?</b>				
Very much	58.5	57.4	72.6	62.5
Somewhat	37.7	40.8	26.6	35.3
So-so	3.0	1.4	0.4	1.6
Not at all	0.8	0.4	0.4	0.5
<b>N</b>	<b>236</b>	<b>277</b>	<b>237</b>	<b>750</b>

### 6.3.2 Peer corner

The peer corner is another component of the Global Funded intervention in prisons. There is no opportunity for a drop-in center in the prison setting as in other program locations. There is a plan to set up peer or information corners but it is not easy to find an appropriate space in the various prisons' zones. This evaluation found that, in two prisons, there are no information centers as yet. One prison merely put up an information sign and peg board, which is moved from zone to zone. The other prison has not initiated any learning corner activities but plans to have bookshelves for educational media. The third prison has set up information corners in the various zones, and the AIDS peer educators sit in these corners during lunch breaks three days a week for males and every day for females. The educational media in the corner come from the provincial chief medical office, the partner hospitals, the DoC, among other sources. Preliminary counseling is also provided in the corners.

The survey found that 78% of inmates who had received AIDS education from a peer educator reported that they received this information in the "peer corner," followed by inter-personal HIV risk-reduction counseling, going for condom resupply, and health counseling. Only 7% said they had interacted with the Peer educators but had never gone to the peer leader corner. The pattern is similar across prisons (Table 6.4).

**Table 6.4 Percent of prison inmates by type of service/information received in the peer corner by prison**

	Prison C	Prison D	Prison E	Total
<b>Information/service received (multiple response allowed)</b>				
<b>HIV/STI knowledge</b>	71.2	75.8	87.3	78.0
HIV risk-reduction counseling	52.5	50.2	69.2	56.9
Registering for HIV testing	7.6	17.3	38.0	20.8
Condom resupply	30.9	41.5	46.0	39.6
Lubricant resupply	18.2	27.8	34.6	26.9
Health counseling	26.7	30.3	52.7	36.3
Recreational games/activities	19.5	12.3	35.0	21.7
Never went to the peer leader corner	11.0	6.9	3.8	7.2
<b>N</b>	<b>236</b>	<b>277</b>	<b>237</b>	<b>750</b>

The qualitative approach found that support for AIDS media for prisoners differs among the prisons in this study, depending on how active the local partner agencies are. If the prison has a TB control program they will have more media on TB. Overall, the amount of educational media at the prisons was insufficient, despite the expressed demand of the prisoners for more media on any topic

because they feel cut off from the outside world of information. The prison staff says that they have to ration the number of copies of media they place in the information corner because they disappear fast.

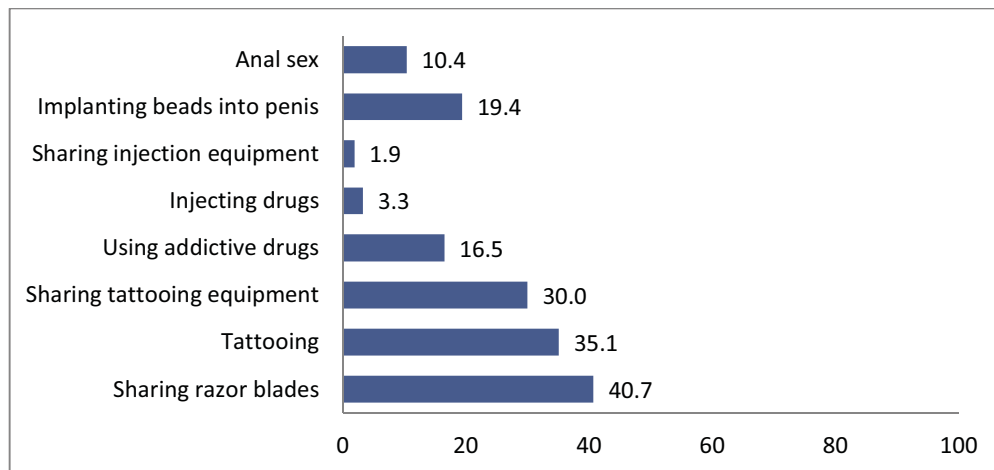
In the prison which has an information corner in each of the prison zones, the average number of users per corner is ten per day. The prison which put up an information peg board was not well-used since it was too close to the work area. They recommended distributing educational media through the peer educators, and various media such as CD.

## 6.4 Risk Behavior for HIV/AIDS

### 6.4.1 Risk behavior

Even though the inmates in this study had rather high knowledge levels of HIV/AIDS risk, this did not necessarily translate into safer behavior while in prison. Based on the total sample, 1543 cases, it's found that 41% reported that they had shared razor blades, 35 % got a tattoo, 30 % had shared tattooing equipment, 17% had used addictive drugs, 3 % had injected drugs, 2% shared injection equipment, 19% implanted beads into their penis, 10% had anal sex. Of those who said that they had injected drugs, it is found that more than half (57%) said that they shared injection equipment. Among those who said they had anal sex, 58% said that they used a condom every or almost every time.

**Figure 6.2 Risk behavior while in the prisons (N=1543)**



When comparing risk behavior of the prisoners before and after incarceration, the proportion with no risk behavior increased from 14.2% before incarceration to 36.8% while in prison (Table A6.1, Appendix 9.2). The average number of risk behaviors decreased from 2.4 to 1.5 before and during imprisonment respectively. Table A6.2 (Appendix 9.2) looks at risk behaviors before and after imprisonment in more detail. Highlights include that approximately 17% of the sample had the same level of risk for use of illegal drugs before and during incarceration, while half discontinued use. Only 2% continue to inject drugs while in prison, but 16 out of the 20 who do (80%) share injection equipment. One out of ten had increased risk for sharing injection after being incarcerated. Another ten percent had increased risk of HIV due to anal sex while in prison than before incarceration, while

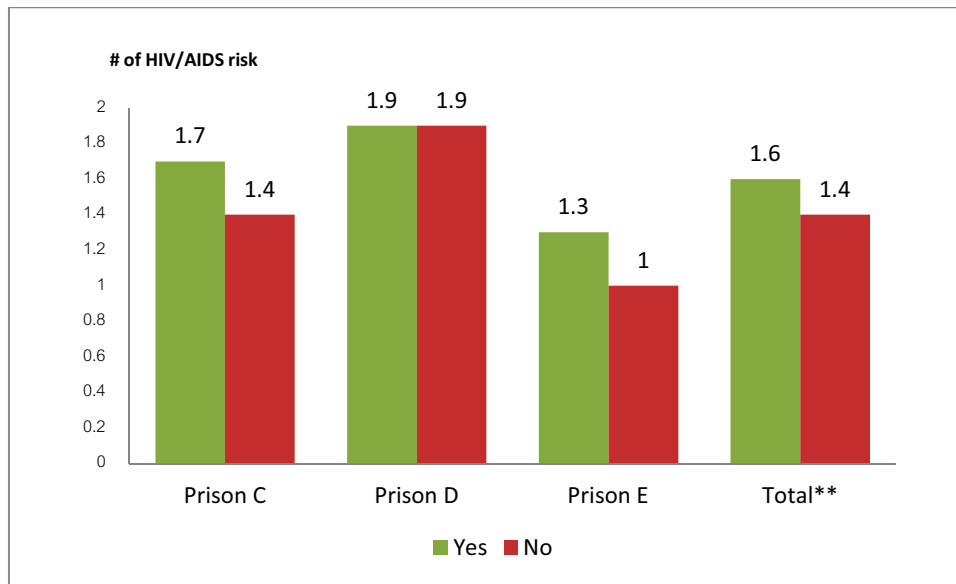
13% had a reduced risk because of abstinence. Of the 118 male inmates who had anal sex with another male, about two-fifths used condoms for every episode, while one-third continued to have the same or increased level of risk from this behavior because of inconsistent or no condom use.

The higher risk level of drug-related behavior in Prison D is probably attributable to the fact that a greater proportion of inmates in Prison D are in prison for drug-related crimes, some of whom are still addicted to those drugs. These findings are contradicted by the official position of the prisons that addictive drug use is not allowed, and that addicts are given the “cold turkey” treatment to cure them of addiction at admission. The prisons have no policy to introduce methadone maintenance therapy for heroin addicts. Thus, ironically, the abstinence position of the prison authorities may be contributing to increased risk through inmate findings ways to obtain and inject drugs by crude, unsterile means.

#### ***6.4.2 Risk behavior and peer educator***

The AIDS peer educators are supposed to identify those with high risk and provide information about AIDS and the HCT/STI service, along with condom resupply. The peer educators use a simple tool for assessing risk of their fellow inmates and determining interest in HCT (Form HIV/STI-3). The peer educators forward the screening form to the prison nurse. The nurse then invites those who are interested in HCT for a counseling session. If there is signed, voluntary consent, blood is taken for an HIV test. The priority for new case recruitment is men who have sex with men, those with chronic illnesses, those with a history of selling sex, and women with a history of sexual risk.

This cross-sectional survey reveals a statistically significant association between the average number of risk behaviors and whether the inmate met with peer educators. However, it should be noted that it is more likely that the peer educators approach prisoners who have high HIV/AIDS risks than those who have lower risks, or on the contrary, that the prison inmates with high risk of HIV/AIDS are more likely to meet the peer educators (Figure 6.3).

**Figure 6.3 Average number of risk behaviors by meeting with PE**

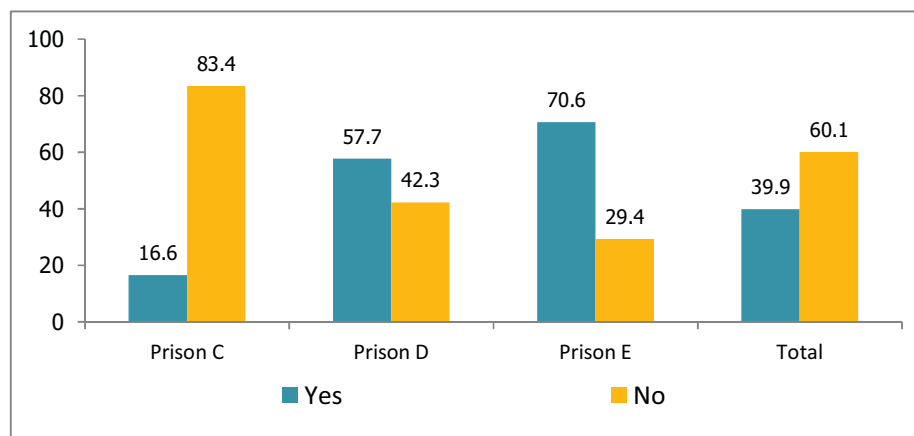
A challenge of AIDS education in the prison setting is the fact that the inmates work every day (weaving, carpentry, umbrella construction, etc.). Also, the zone warden is responsible for selecting those inmates to receive training, and usually screens out those who are more violent or might cause trouble. In some prisons, the zones are defined by type of prisoner, and some do not allow HIV preventions peer educators in some zones. There are also limitations of the training venue, and finding the best time, since most of the rooms are in use every day.

## 6.5 HCT and STI Services

### 6.5.1 HCT service

The participating prisons in the Global Funded program normally provide HCT. The designated and trained clinical personnel are competent in counseling and taking blood samples. The blood is forward to a collaborating hospital in the program network for diagnosis. The different prisons have different partner hospitals both within and outside the DoC.

However, only two out of five of the sample inmates were aware of the HIV testing service in the prison (Figure 6.4). Inmates in Prison E were least aware, followed by Prisons D and C.

**Figure 6.4 Percent of prisoners who were aware of the HIV testing in the prison**


Among those who were aware, the source of knowledge was varied. About three-fourths knew of the service from the infirmary staff, followed by the peer educators, and AIDS training. More inmates in Prison E were informed by infirmary staff than the other prisons, whereas the AIDS peer educators were more likely the source of the service in Prison D (Table 6.5).

**Table 6.5 Percent of prisoners who knew about the HCT service in the prison by source of knowledge (multiple response allowed) and by prison**

Source of knowledge	Prison C	Prison D	Prison E	Total
AIDS peer educator	36.2	70.2	62.1	59.7
HIV prevention activities in zone	29.8	22.0	41.8	31.8
Monitoring officers	25.5	10.7	58.2	33.3
Staff of the prison infirmary	48.9	69.0	88.5	72.7
AIDS training	53.2	52.4	59.9	55.6
Print media such as news boards	36.2	29.2	57.1	42.1
Word of mouth	27.7	31.0	42.3	34.9
<i>N</i>	94	168	182	444

Table 6.6 shows that of the 1,543 prisoners in this study, 444 or just under 30% had received HCT while in prison. The inmates in Prison C had the lowest percent of inmates being tested. Of those who were tested, approximately 60% knew the test results: 74% of inmates in Prison E but only 34% in Prison C.

The average time lapse until the results were known was 24 days or about three weeks, though one-third was informed within one week. Notably, in Prison E (72%), prisoners who were tested were informed of the results within three days.

Although it is clinically possible to know the test results within one day, in fact the time lapse depends on the work schedule of the staff of the hospital since there is a shortage of staff. Thus, the schedule for sending and receiving results can range from two days to weeks. In some facilities, the

designated prison staff will conduct the pre- and post-test counseling. In other facilities, staff from the DoC hospital will make site visits to conduct the post-test counseling for inmates who are HIV-positive. Of those who knew the test results, 80% were informed by prison nurses. Most of the HCT clients (71%) received counseling on HIV prevention, follow by risk assessment, risk reduction and condom resupply as part of the service.

**Table 6.6 Percent of prisoner HCT clients who knew the test results and time lapse until they were informed of the results by prison**

	Prison C	Prison D	Prison E	Total
<b>HCT in the prison***</b>				
Tested	12.1	39.9	52.9	28.8
Not tested	87.9	60.1	47.1	71.2
<b>N</b>	<b>778</b>	<b>421</b>	<b>344</b>	<b>1,543</b>
<b>Informed of the test results***</b>				
Yes	34.0	58.3	73.6	59.5
No	66.0	41.7	26.4	40.5
<b>N</b>	<b>94</b>	<b>168</b>	<b>182</b>	<b>444</b>
<b>Number of days until informed of results***</b>				
1-3	12.5	5.1	71.6	12.5
4-7	18.8	10.2	9.0	18.8
8-14	15.6	13.3	4.5	15.6
15-30	21.9	41.8	9.0	21.9
31 - 60	9.4	8.2	0.0	9.4
61 -180	15.6	16.3	6.0	15.6
181-365	6.3	5.1	0.0	6.3
<b>Average number of days</b>	<b>29.9</b>	<b>41.0</b>	<b>10.3</b>	<b>23.8</b>
<b>N</b>	<b>32</b>	<b>98</b>	<b>134</b>	<b>264</b>
<b>Informed of results by:***</b>				
Prison nurse	64.1	69.0	93.0	79.8
MD or nurse from the hospital	30.8	19.8	2.8	13.1
Prisoner nurse assistant	5.1	11.2	4.2	7.1
<b>N</b>	<b>39</b>	<b>116</b>	<b>142</b>	<b>297</b>
<b>Information received before test results (multiple responses allowed)</b>				
Review of HIV risk*	66.7	53.9	68.3	62.5
Rational for taking the test**	28.2	27.8	41.5	34.5
Results of the test**	23.1	42.6	53.5	45.3
HIV prevention**	66.7	66.1	76.8	71.3
Window period	7.7	6.1	13.4	9.8
Risk reduction and condoms**	35.9	37.4	56.3	46.3
CD4 and health exams**	15.4	15.7	34.5	24.7
Health maintenance plan**	28.2	27.0	46.5	36.5
Confidentiality of test results	28.2	37.4	44.4	39.5
<b>N</b>	<b>39</b>	<b>115</b>	<b>142</b>	<b>296</b>

\*\*\* p< 0.001, \*\* p< 0.050,\* p< 0.100

Findings from the qualitative study support that the prison-based AIDS prevention work is mostly delegated to the nursing staff in the prison. The number of these staff varies by size of prison. In this



study, the number ranged from three to eight in the three facilities. There were no resident doctors in two of the prisons. A visiting doctor came to these prisons on some days. This number of staff is inadequate for a prison population that can range from 1,000 to 5,000 inmates.

### 6.5.2 Content of HCT service

About three-fourths of those tested for HIV received pre-test counseling. Prison E inmates had the highest proportion (86%) and Prison C the lowest (57%). And Table 6.7 presents results for content of the pre-test counseling among the inmates who received it. Most received information on HIV prevention, HIV transmission, rationale for being tested, and HIV risk assessment.

**Table 6.7 Pre-test HIV counseling in the prison**

	Prison C	Prison D	Prison E	Total
<b>Received pre-test counseling***</b>				
Yes	57.4	76.2	86.3	76.4
No	42.6	23.8	13.7	23.6
<i>N</i>	<b>94</b>	<b>168</b>	<b>182</b>	<b>444</b>
<b>Content of pre-test counseling (multiple responses allowed)</b>				
Rationale for being tested	48.1	53.1	50.3	51.0
HIV transmission**	38.9	52.3	59.9	53.7
HIV risk assessment***	40.7	41.4	55.4	47.8
HIV prevention	61.1	64.8	73.9	68.4
Condom use demonstration	25.9	36.7	42.0	37.5
Protection of privacy of results**	27.8	28.9	47.1	37.2
Meaning of the test result**	31.5	26.6	42.7	34.8
Plan for accepting a positive result***	24.1	29.7	51.0	38.6
Right to be/not be tested**	22.2	35.9	47.8	39.2
<i>N</i>	<b>54</b>	<b>128</b>	<b>157</b>	<b>339</b>

\*\*\*  $p < 0.001$ , \*\*  $p < 0.050$

From an in-depth interview, this study found that some prisons do not have proper counseling rooms. Some simply provide the service in a corner of the infirmary to offer some privacy. There is reluctance to set up a closed private room out of concern for the safety of the staff. Other facilities have set up a private room, however, it has a window so that the interaction can be watched while preserving the privacy of the conversation.

The pre- post-test counseling record forms were only just developed in the 3<sup>rd</sup> year of the program. The counselor fills out the form. Some facilities require the name, ID card number and test results of the prisoner in order to process benefits from the national health insurance program as appropriate. Others keep the forms anonymous.

The activity log in the infirmary may indicate the name of the HCT client, but that log may be accessible only to the counseling staff. But it is unsure how confidential the information is, for example, each prison recruits prisoners to be assistants to the infirmary nurses. One of their jobs may be to enter activity log data into a computer. If the assistant hasn't been trained in the importance of confidentiality of testing data, then rights might be violated.

### 6.5.3 HIV testing prior to imprisonment

Of the entire sample, about one-third (35%) said they had received HIV testing before being imprisoned and 98% said the testing was conducted with their voluntary informed consent (Table 6.8).

**Table 6.8 Percent of prisoners who had ever been tested for HIV prior to incarceration, and whether it was voluntary and by prison**

HIV test	Prison C	Prison D	Prison E	Total
<b>Had ever been tested for HIV before incarceration</b>				
Yes	33.5	33.9	41.6	35.4
No	66.5	66.1	58.4	64.6
<b>Total</b>	100.0	100.0	100.0	100.0
<b>N</b>	<b>761</b>	<b>419</b>	<b>341</b>	<b>1521</b>
<b>Whether the test was voluntary</b>				
Voluntary	98.8	97.9	96.5	98.0
Required	1.2	2.1	3.5	2.0
<b>Total</b>	100.0	100.0	100.0	100.0
<b>N</b>	<b>257</b>	<b>141</b>	<b>142</b>	<b>540</b>

### 6.5.4 STI Services

Data from the qualitative research show that there was of STI-like symptoms. Common genital conditions include scabies and herpes at a level of about one to three cases per quarter. The service providers at the prison said that the cases of gonorrhea they saw were probably contracted before incarceration. In simple cases, the visiting doctor could administer the treatment. If referral was required, inmates would be sent to a partner hospital for treatment.

However, the quantitative data (Table 6.9) provide a different picture, since approximately 12% of the sampled inmates reported having at least one STI-like symptom. Of these inmates, less than half (47.8%) received health information from the AIDS peer educator volunteer. Of those that did, three-fourths received information on STI, with the highest in Prison E at 86.4%. About half (52.3%) of those contacted by the AIDS peer educators felt that the information provided was very useful, especially those in Prison E (72.7%).

Slightly over one-fourth (28%) of inmates reporting STI-like symptoms were tested for HIV while in prison. It is noteworthy that only 16% of inmates reporting symptoms in Prison C had an HIV test in prison.

**Table 6.9 Percent of prisoners reporting STI-like symptoms and receipt of information/services from the program by prison**

	Prison C	Prison D	Prison E	Total
<b>STIs symptoms at time of interview**</b>				
Yes	14.4	11.4	8.7	12.3
No	85.6	88.6	91.3	87.7
<i>N</i>	<b>778</b>	<b>421</b>	<b>344</b>	<b>1543</b>
<b>Received information from the AIDS peer educator in prison***</b>				
Yes	35.5	58.3	75.9	47.8
No	64.5	41.7	24.1	52.2
<i>N</i>	<b>107</b>	<b>48</b>	<b>29</b>	<b>184</b>
<b>Received information about STI from the AIDS peer educator in prison</b>				
Yes	71.1	75.0	86.4	76.1
No	28.9	25.0	13.6	23.9
<i>N</i>	<b>38</b>	<b>28</b>	<b>22</b>	<b>88</b>
<b>The AIDS peer educator helped me understand about HIV/AIDS and STI</b>				
Helped a lot	47.4	42.9	72.7	52.3
Helped somewhat	47.3	53.5	27.3	44.3
So-so	5.3	3.6	0.0	3.4
<i>N</i>	<b>38</b>	<b>28</b>	<b>22</b>	<b>88</b>
<b>Received HIV testing in prison***</b>				
Yes	16.1	33.3	63.3	27.9
No	83.9	66.7	36.7	72.1
<i>N</i>	<b>112</b>	<b>48</b>	<b>30</b>	<b>190</b>

\*\*\*  $p < 0.001$ , \*\*  $p < 0.050$

### **6.5.5 Protecting the confidentiality of HCT clients**

Data from the qualitative research show that when an inmate goes for HCT in the prison setting, the infirmary staff will record results of a risk behavior assessment, and a pre-post-test counseling record, neither of which had the name of the client; a code number is used for identification. Actual names are kept in a separate file, there is no reporting of new/returning cases, and confidentiality is not necessarily enforced in all sites.

It is also found that nursing staff in the prisons professed an understanding of and compassionate attitudes toward PLHIV, sexual diversity, and eliminating discrimination. However, in practice, the limited number of staff might result in an environment that is not always reassuring to the inmates, such as the signs in the peer leader corner about "AIDS counseling" and public address announcements encouraging inmates to have HIV tests.

Data in Table 6.10 shows that the vast majority of the sample feels that HIV test results should be confidential in the prison (95%). However, only 40% know that there is a policy of confidentiality of tests in the prison. While there was just over one-fourth (27%) were "very interested" in having an HIV test within the coming quarter, while 41% were "interested", 25% were "not interested", and 8% said "unsure".

When comparing across prisons, the results were most favorable for Prison E. More inmates in Prison E knew about the confidentiality policy. However, more inmates in Prison C and more were “very interested” in being HIV tested in the coming three months than in Prison E and D.

**Table 6.10 Percent of prisoners by opinion of the HCT service in prison by prison**

	Prison C	Prison D	Prison E	Total
<b>Confidentiality of HCT service in prison</b>				
Appropriate	96.1	94.9	93.5	95.2
Inappropriate	3.9	5.1	6.5	4.8
<b>N</b>	<b>696</b>	<b>394</b>	<b>321</b>	<b>1,411</b>
<b>Knows of the requirement to keep test results confidential in prison***</b>				
Yes	16.6	57.7	70.6	39.9
No	83.4	42.3	29.4	60.1
<b>N</b>	<b>778</b>	<b>421</b>	<b>344</b>	<b>1,543</b>
<b>Interest in having an HIV test in the coming three months***</b>				
Very interested	32.4	17.6	24.4	26.6
Interested	35.9	42.8	49.1	40.7
Not interested	23.1	32.1	18.6	24.6
Unsure	8.6	7.6	7.8	8.2
<b>N</b>	<b>778</b>	<b>421</b>	<b>344</b>	<b>1,543</b>

\*\*\*  $p < 0.001$

## 6.6 Other aspects of service quality

### 6.6.1 Coordination between prevention and care for inmates living with HIV

The system for dispensing ART medicines and monitoring of CD4 and viral load for the infected inmates is rather orderly. If a blood test comes back HIV-positive, the inmate receives post-test counseling and is then seen by a doctor for CD4 screening and preparation for initiating ART. The clinician will resupply the ARV drugs every two to three months. Blood is taken periodically at the infirmary for CD4 monitoring.

The data in Table 6.11 show that only one in five prisoners had CD4 counts after knowing the results of the HIV test. The level for this variable was lowest in Prison D (16%) followed by Prison C (18%). The principle reason for the lack of a CD4 test was that the inmate was HIV negative, or the results were pending. One-fifth of those receiving screening had CD4 levels below 200, with the highest (33.3%) in among Prison C inmates. Some of the “don’t know” responses may be the result of concern for privacy, or could not distinguish between CD4 and blood test, than ignorance. About half received sputum tests for TB and one-fourth received OI prophylaxis.

**Table 6.11 Percent of HIV-tested prisoners by HIV/AIDS service received by prison**

	Prison C	Prison D	Prison E	Total
<b>Received a CD4 check**</b>				
yes	18.1	16.1	32.4	23.2
no	34.0	39.3	36.3	36.9
unsure	47.9	44.6	31.3	39.9
<b>N</b>	<b>94</b>	<b>168</b>	<b>182</b>	<b>444</b>
<b>Reason for not receiving a CD4 check***</b>				
HIV test was negative	18.2	45.4	61.8	45.2
Don't know the test results	58.4	41.8	24.4	39.3
Test results are pending	13.0	9.9	9.8	10.6
Not covered by health insurance	10.4	2.8	4.1	5.0
<b>N</b>	<b>77</b>	<b>141</b>	<b>123</b>	<b>341</b>
<b>CD4 level</b>				
≤ 200	33.3	16.7	16.3	19.3
> 200	20.0	29.2	44.9	36.4
Don't know	46.7	54.2	38.8	44.3
<b>N</b>	<b>15</b>	<b>24</b>	<b>49</b>	<b>88</b>
<b>Additional service received after CD4 count is known (multiple response allowed)</b>				
Physical exam at the hospital**	53.3	12.5	59.2	45.5
TB sputum exam	26.7	50.0	55.1	48.9
Information and counseling about ART*	13.3	37.5	46.9	38.6
ARV drugs	20.0	20.8	36.7	29.5
OI prophylaxis**	0.0	20.8	34.7	25.0
Treatment of OI	6.7	16.7	28.6	21.6
No service	20.0	16.7	8.2	12.5
<b>N</b>	<b>15</b>	<b>24</b>	<b>49</b>	<b>88</b>

\*\*\* p < 0.001, \*\* p < 0.050, \* p < 0.10

Among PLHIV prisoners, there are reports that some did not take their ARV drugs on schedule. Some prisons give periodic resupply of the drugs to prisoners and expect them to manage the prescribed schedule. Other prisons keep the drugs in the infirmary and have the prisoner volunteer assigned to the infirmary to give the ARV drugs to the PLHIV on a daily basis. Others distribute the drugs to the various zones for local dispensing and record keeping, thus possibly compromising prisoner confidentiality.

Also, it was observed that there is no organized system for follow-up of ARV treatment by the prison or partner hospital after the inmate is released. Staff of the ART clinic at the partner hospitals report that they are not informed of where the released prisoners register for continuing treatment, and they do not have enough staff to conduct extensive follow-up. The prison nurse will inform the hospital when a PLHIV prisoner is to be released, and the attending physician will give the PLHIV referral instructions. But it is not known if the PLHIV follows the instructions.

### **6.6.2 Referral and follow-up**

The referral procedure from the prison infirmary to an external hospital does not use the ACHIEVED program forms. Some prisons use an informal system of phone contact to make the referral. Other prisons use a two-part form, one of which is kept at the prison and the other taken by the prisoner

to the OPD facility, where the referral form is attached to the OPD card. The hospital issues an appointment card for receiving treatment and monitoring. The limitations of the prison referral system for PLHIV has to do with the time constraints on the prison staff and hospital staff since there needs to be at least two correction officers to accompany the prisoner every time they travel outside the facility.

### ***6.6.3 Treatment for drug addiction in the prison***

As documented earlier, many of the prisoners are in prison for drug-related offenses. Among these are persons who were already addicted to narcotics before incarceration. Some these addicts find ways to obtain and inject drugs even while in prison.

There is general mental and physical health treatment for drug addicts, including therapeutic communities in some prisons. These treatments are mostly focused on methamphetamine addicts. However, there is still no policy to offer methadone maintenance therapy (MMT) to prisoners who are addicted to opiates and continue to inject. The policy of the prison for these addicts is to treat them with the “cold turkey” total abstinence method, despite the fact that MMT is covered under the national health insurance scheme. The standpoint of the prisons is that there is no injection drug use allowed in the corrections facility. This policy and official denial may in fact increase risk since heroin addicts may turn to crude methods of injection and sharing equipment, and proceed to inject other drugs which can be more easily obtained in prison than heroin. Another problem is that prisoners who were on MMT prior to the current incarceration, but do not receive treatment continuously while in the prison. These inmates might be increased HIV/AIDS risks, if return to injecting drugs to ease withdrawal symptoms from the “cold turkey” approach.

### ***6.6.4 Monitoring system and quality of data***

The Medical Services Division of the DoC has produced an operations manual for recording activities conducted under the Global Fund program for prison interventions. The records include services provided and costs. The forms are simple and easy to fill out due to having only a few indicators and less complications than that of other KAP groups. The completed forms are forwarded to the DoC every three months, where the data are compiled with other reporting facilities. The data on HCT and STI cases and condom resupply are recorded and reported to the central office, but do not address the core indicators and are not compared against the target.

Reports that are submitted to headquarters include name and surname of clients, training reports, training checklist, number of trainees, photo montage of activities, and data summary of condom distribution, number of STI and HCT clients, number of HCT clients informed of test results, and number of PLHIV with CD4 counts.

The form for AIDS peer educator prevention activity has two parts. The first part has knowledge items and condom/lubricant distribution. However, condom/lubricant are not allowed to be distributed in the prisons. The second part is a behavior change screening form. It contains short questions about behavior and services received. It is not clear how much use of the data is made by the staff for producing behavior change plans for inmates.

### 6.6.5 Satisfaction with services

Table 6.12 shows results for the survey of inmate satisfaction of services related to health examination and care and treatment while in prison, including for HIV/AIDS. Just under 60% of prisoners said they had received treatment from the infirmary when they were ill, with the most in Prison D. The treatment seemed to be effective as 93% reported improved outcomes. Thus, three-fourths of the inmates said they were satisfied with the prison infirmary, over 90% in Prisons B and C, while only 55% in Prison C.

When expressing client satisfaction related to HIV testing and/or care and treatment in terms of a 10-point score, 40% give full ten marks to the prison health service (average score 8.3). By contrast, the average score for satisfaction with the prison infirmary was only 6.6 (out of a maximum possible of 10).

**Table 6.12 Percent of prisoners by attitude toward health examinations and/or care and treatment by the prison infirmary**

	Prison C	Prison D	Prison E	Total
<b>Received treatment when ill</b>				
Yes	54.8	68.9	56.3	59.0
No	45.2	31.1	43.7	41.0
<b>N</b>	<b>768</b>	<b>421</b>	<b>341</b>	<b>1,530</b>
<b>Treatment outcome</b>				
Better	86.6	97.2	99.0	92.7
Not better	13.4	2.8	1.0	7.3
<b>N</b>	<b>418</b>	<b>289</b>	<b>192</b>	<b>899</b>
<b>Satisfied with the infirmary</b>				
Yes	54.8	90.9	94.3	75.3
No	45.2	9.1	5.7	24.7
<b>N</b>	<b>396</b>	<b>286</b>	<b>193</b>	<b>875</b>
<b>HIV/AIDS examination and/or care and treatment for HIV/AIDS</b>				
1-3 points	22.3	3.0	0.5	6.1
4-6 points	23.4	16.7	4.4	13.1
7-9 points	23.4	42.2	30.8	33.6
10 points	30.9	38.1	64.3	47.3
<b>Average (maximum of 10)</b>	<b>6.6</b>	<b>8.2</b>	<b>9.2</b>	<b>8.3</b>
<b>N</b>	<b>94</b>	<b>168</b>	<b>182</b>	<b>444</b>
<b>Service of the prison infirmary</b>				
1-3 points	28.1	2.8	3.6	14.8
4-6 points	40.1	25.9	13.3	29.9
7-9 points	20.9	46.5	39.0	32.9
10 points	10.9	24.8	44.1	22.4
<b>Average (maximum of 10)</b>	<b>5.2</b>	<b>7.5</b>	<b>8.4</b>	<b>6.6</b>
<b>N</b>	<b>778</b>	<b>421</b>	<b>344</b>	<b>1,543</b>

## 6.7 Summary of quality of services

The research team has summarized the findings of service quality as compared against standards across six dimensions: (1) Client rights; (2) Quality control; (3) Access; (4) Participation of the target beneficiary; (5) Service package; (6) Follow up. These findings are summarized in Table 6.13.

**Table 6.13 Quality of Service Summary Table for the prison program**

Standard	Prison HIV Prevention Program	Rating
<b>1.1. Client rights</b>		
Client is fully informed about the service, including the risks and benefits to be expected	Prisoners reported being informed by the AIDS peer educators and from the HCT training	+++
Confidentiality and privacy throughout	Not entirely strict confidentiality Not all prison infirmaries are able to set up a private room for the client service	++
Equal treatment of all clients (absent stigma or discrimination)	Some services are unequal, such as condom distribution and some discriminatory policies	++
<b>1.2. Quality control</b>		
All services have documented standard operating procedures (SOP) which can be referenced at all times	Did not observe written SOP	–
Staff receive supervision and inspection of their performance from their superiors on a regular basis to maintain quality	There is no system for M&E of the volunteers' performance	–
Providers have been trained to be sensitive to issues of stigma and discrimination in order not to alienate the target population of at-risk persons	Staff have been trained but some aspects of implementation lack sensitivity which contribute to unintentional stigmatization	++
<b>1.3 Access to services</b>		
All persons in need have access without bias by age, gender, ethnicity, sexuality, nationality, religion, occupation, coverage by national health insurance or drug addiction	The services do not segregate PLHIV, but there is some bias in condom/lubricant distribution since it focuses on certain risk populations	++
There is convenient access by location, transportation, duration and cost of travel	Access to news and information is still only through limited channels	+
The service site is safe (e.g., through the Internet, hot line, drop-in center) for the target population to access information and referral for prevention and treatment	Not applicable to the Prison context	NA
Essential equipment, and that for HIV diagnosis, condoms, lubricant, clean needles have not been out of stock in prior 12 months	Insufficient attention to procurement of equipment for prevention; unclear policy at all levels, and staff deny there is sex in prison.	+
<b>2.1 Participation of high-risk populations in service delivery and management</b>		



Standard	Prison HIV Prevention Program	Rating
The key target population participates in conducting a needs assessment of their peers, assist in planning, service provision and evaluation	The prisoners do not participate and there is no evaluation of client satisfaction	–
<b>2.2. Service provision</b>		
There is outreach to improve motivation and access to an array of services, information, referral, and prevention supplies	The outreach has improved access to services for prisoners but coverage is not complete	++
Staff are knowledgeable about HIV prevention and peripheral services	The volunteers understand the services well and have frequent refresher training	++
Field staff understand safety issues for the client, and have ethics and professionalism	Protection of client confidentiality is still not strong enough, particularly data record keeping	+
Outreach HCT, STI care are provided near the places where the target population engages in risk, and at a convenient time	HCT/STI treatment are available in the prison and are accessible	+++
Condoms, lubricant, clean needles are available near where the target population congregates, and at a convenient time	Provision of prevention supplies is conducted by the volunteers and zone chiefs, but this is limited by the context	+
There is a client risk assessment as part of a discussion of HIV prevention	There is risk assessment using a form during outreach visits by the volunteer, but is not as useful as it could be	+
There is evaluation of the outreach to see if the target population received screening for STI or HCT	There is no monitoring of released prisoners who are PLHIV to ensure continued treatment	–
Media are developed for behavior change with involvement of the target population, and the media are distributed to the target groups in appropriate ways	There is too little education media in the prisons. The distribution to the target population is inadequate	–
<b>2.3. Monitoring of implementation</b>		
Clients are given UIC codes when going For service. The monitoring system can use the UIC for client follow-up	There is no UIC system even though the record form suggests using an alias	NA

Standard	Prison HIV Prevention Program	Rating
Field staff receive refresher training, including monitoring and supervision for service quality (including HCT and STI service providers)	<p>- The peer educators join in the training of the prison inmates often and there is little monitoring and supervision during implementation</p> <p>- Staff receive regular training at a certain level but lack monitoring and supervision in the area of quality of service; and there is no indicator for improving quality of service</p>	<p>–</p> <p>+</p>

**Remarks:** +++ denotes good performance; ++ denotes fair performance; + denotes poor performance; and – denotes no performance.  
NA = not applicable

## 7. EVALUATION CONCLUSIONS

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In this concluding chapter we summarize the findings of the evaluation according to the study research questions.

### 7.1. Are all interventions being implemented as planned?

The evaluation of the service system found that HIV prevention for the three KAP and prisoners for the most part were being implemented according to plan, with budget for core activities which addressed the key indicators. Services covered five components including behavior change, outreach education, distribution of condoms and lubricant, HIV counseling and testing (HCT), screening and treatment of sexually transmitted infections (STIs), and harm reduction for PWID.

Two major exceptions to the implementation of the program as designed were found. First, the drop-in centers for FSW and MSM for the most part are not functioning as designed, with the exception of MSWs in Bangkok. Second, the linkage between the outreach programs and the clinical services (STI screening and HCT) is not functioning as designed, with the referral system not being used. There remain challenges also with the quality and efficiency of services, occasionally resulting in less-than-targeted caseloads. The following are areas for consideration:

#### *Outreach and peer-based education*

**Management.** The project quotas for field staff to manage outreach to MSM and FSW was too low for efficient implementation. Field staff numbered only 1 to 3 individuals per implementation agency (IA) with multiple tasks in addition to managing outreach. In addition, in the PWID program, a number of the volunteers were current or former PWID, some of whom relapsed to serious drug use during the course of implementation and could not perform their tasks effectively. All IAs reported high levels of field staff and volunteer turnover, and this disrupted continuity of implementation. Program budget allocation did not always reflect the context or scale of the challenge in the different locations. Thus, implementation was less cost-effective than it could have been.

**Accessing the target populations.** The outreach components for MSM and FSW emphasized new contacts. This led to some neglect of continuing contacts. Interactions with contacts were of limited duration, and the volunteers focused more on information about HIV prevention and clinic-based services more than behavior change communication (BCC). Finding new PWID contacts was limited by the poor health of some of the volunteers, and by the evolution of drug use from heroin to other drugs. Police crack downs on PWID also had the effect of driving PWID underground and harder-to-reach than normal. Condom distribution and STI referral for PWID was low because of staff belief that PWID sexual activity was low. In prisons, the volunteers were not able to cover all the targeted areas, and project orientation for prisoners achieved limited coverage.

**Monitoring and mentoring for volunteers.** The ratio of 1-3 field staff to 25-30 MSM and FSW outreach volunteers was too low to permit adequate supervision and mentoring of the volunteers. On the other hand, some PWID IAs lost their entire cadre of outreach volunteers for some periods. In addition, the program did not provide adequate budget for field supervision of the

volunteers. Risk assessment check-lists were developed for MSM and prisoners, but the data were not used to improve BCC interventions.

**Drop-in Centers (DiC).** Overall, the implementation of DiC for MSM and FSW did not satisfy the program specifications. Budget allocated for DiC was inadequate and did not allow strategy placement of the DiC at convenient locations for the MSM and FSW. The hours and activities of the DiC did not address the lifestyle or needs of these two KAP. For PWID, by contrast, the DiC were well-located and met the needs of the PWID well. DiC were used by PWID after receiving their daily methadone maintenance therapy (MMT) and obtain resupply of harm reduction kits. For prisons, information corners were planned but only implemented in two of the three sites in the evaluation.

**Behavior change communications.** There were only a limited amount and variety of media for awareness campaigns, and the information did not address the specific needs of the KAPs. Budget for media reproduction was small and coverage of campaigns was narrow. Thus, community attitudes toward KAP did not improve. Prisoners showed strong demand for educational media on any topic, but supplies were limited.

### *Distribution of condoms, lubricant, safe injecting equipment and MMT*

**Condoms and lubricant.** There were shortages of condoms and lubricant for MSM and FSW in each program year. By contrast, PWID had a surplus of condoms. Condom distribution in prisons was impeded by unclear policy by the prison and official denial of sex among inmates. All IAs had limited storage capacity for condoms, since supply was sent in bulk, a few times a year. Storage conditions were sub-standard. Qualitative interviews of the KAP members showed that attitudes toward condoms have not changed much since earlier years. For example, FSWs are still reluctant to use condoms with boyfriends or regular customers. This also reflects the limited impact of the BCC of the field staff and volunteers to some extent. None of the IAs have monitoring systems to see how many clients receive condoms, or distribution numbers by channel.

**Harm reduction kits** Despite the large demand by PWID for harm reduction kits, the government still does not have an official policy to support provision of the kits. Population Services International (PSI, the PR for the PWID component) and its participating pharmacies in Bangkok prepared these kits for distribution to PWID in Bangkok and the provinces. Over the course of the program, the number of participating pharmacies has declined because of concern for the lack of government supportive policy and potential for harassment by police. Some PWID inject near the pharmacy after obtaining kits. Changing drug use patterns is resulting in a new array of injected drugs, different locations on the body where drugs are injected, and demand for longer needles.

**MMT.** Satisfaction with the methadone maintenance therapy clinics differs by location/nature of the clinic, service coverage, and PWID-friendly atmosphere. Some sites seem to have negative attitudes towards PWID. Also, there are different standards for MMT across different clinics. The Department of Corrections (DoC) does not have a policy to provide MMT in prisons. Thus, prisoners who had been on MMT prior to incarceration experience higher vulnerability for relapse to injection while in prison and corresponding risk for HIV from shared needles.

### *Clinical services: STI screening and HCT*

**Services.** The Ministry of Public Health has increased the number of client-friendly HCT/STI clinics for KAP. However, all the sites in this evaluation said caseloads were low and below target.

This reflects that lack of outreach effectiveness in increasing demand for these services. For their part, the service outlets need to tailor their services a bit more to accommodate the lifestyle of the clients (such as having later hours and having KAP peer assistants in the clinic). There are no separate rooms for client counseling or clinical services. Mobile clinic services were launched in Year 2 with rapid testing and same-day results, and this helped boost caseloads for HCT. Not all standing clinics use rapid testing however, and there is limited budget to deploy the mobile units on a regular basis. There are no MSM or FSW-specific STI clinics, with the exception of those managed by the DDC of the MOPH. Also, clients need to show their Thai ID card in order to be eligible for free/subsidized service, and this reduces confidence in confidentiality. Prisoners can access STI in participating hospitals linked with the prison, but caseloads are very low. Venue-based FSW are still being coerced to have HIV testing or lose their job, and HIV+ FSW are fired. This reduces FSW demand for testing if they can avoid it.

**Referral and follow-up.** This component is not yet efficient for all populations. Even though a referral form exists, it is not often used. Post-service follow-up is minimal since it is not clear whose responsibility it is.

**Links between prevention, care and treatment for KAP who are HIV+.** This is an area that needs strengthening. Even though the system is well-established for HCT and ART in government outlets, comprehensive care of KAP in holistic centers is not optimal or sensitive to the lifestyle context of the KAP. In prisons, there is no system for following up released inmates who are on ART.

## 9.2 Are interventions reaching the intended and right clients?

Both the qualitative and quantitative components of the evaluation found that outreach for FSW and MSM still centers around contacting the more easily-located individuals, with limited coverage of the province as a whole. This means that other FSW and MSM are being overlooked. There is a lack of situation assessments and strategic planning on how to better access populations (e.g., MSM who do not frequent venues, young FSW and MSM, and non-venue based FSW and MSW). Distribution of condoms in prisons is not yet universal. The finding that young FSWs and MSM are not being reached by the prevention program is worrisome and requires serious assessment.

## 9.3 Are interventions being implemented according to a) an integrated, defined package of HIV prevention services; and b) defined standards/good quality (quality and intensity)? If not, what is missing and why?

The outreach programs for the KAP have defined service packages but these are not standard across IA. Volunteers do not have written handbooks as a reference to take with them. Communication between SR/SSR and IA is inefficient resulting in misunderstanding about outreach procedures. Vague government policies are hampering the outreach to PWID and prisoner populations.

Services by the government outlets have uneven standards for HCT and STI for KAP across sites. For example, some have rapid testing, others do not. Some service packages for FSW only screen for STI, while others also screen for hepatitis B and cervical cancer. There are no program indicators for quality of service for the static sites and this reduces motivation to excel.

Services were assessed across six standards of quality (see full report for details). Following are key findings from that assessment.

1. *Rights of the client* This covers providing information to the client, protecting confidentiality, and providing equitable service to all. All target groups could access services to varying degrees, with equitable service being the most well-realized aspect of service quality. However, motivation for FSW and PWID to seek clinical services is inadequate. The program has designed forms for use by the outreach teams which reflect concern for confidentiality, such as the UIC. Still, some of the outreach staff and volunteers record actual names of clients or did not explain the purpose of the UIC.

2. *Quality control* This covers SOP, supervisory monitoring, and training of service providers to be sensitive to issues of stigma and discrimination. The third area is the most well-realized in the program. For the first two, IAs have plans or drafts of these but are not fully implementing them.

3. *Access to services:* This covers access to services without discrimination; convenience of location, travel, time and cost of travel; creating a safe environment for services; and no stock-outs of essential supplies over the prior 12 months. The first area is covered more or less well for all the target populations, followed by the second item. Area three is not addressed well for any of the groups except for FSWs in one area of Bangkok. The PR/SR are still not managing stocks adequately causing oversupply and shortages during parts of the year.

4. *Participation of KAP in service provision:* The MSM and prisoners have not participated in services, and there have not yet been any client satisfaction assessments. There is some, but inadequate, participation of FSW and PWID in services.

5. *Standard service package:* This covers eight areas including (1) Outreach to motivate and assist access to services; (2) Field staff are knowledgeable on prevention and services; (3) Field staff are mindful of a safe environment, ethical and profession behavior; (4) Outreach service and HCT/STI service is offered at convenient times; (5) Prevention material resupply for KAP is convenient; (6) Clients receive risk assessments; (7) There is monitoring of outreach; and (8) There is development of BCC media. Items 1 – 5 are well-covered to different degrees. However, implementation of items 6 – 8 is unsatisfactory or non-existent.

6. *Monitoring:* This covers the provision of UIC (unique identification codes) for clients which allows follow-up and refresher training for field staff on monitoring and supervision of service quality. All three KAP have UIC but there is no linkage with the service provider system. The second item is covered for all KAP but not the prisoners. But implementation is sporadic. There are no needs assessments, and there is a lack of monitoring during actual implementation. By contrast, the HCT/STI providers have received in-service training on client monitoring.

### **7.3 To what extent do the key interventions appropriately address stigma and discrimination toward MARP?**

While the program gives importance to training of staff on stigma and gender issues, this is not done in practice (except for PWID). Instead, these topics are integrated into the modules of general training sessions. Most staff in government service outlets (HCT/STI/ART) have worked in HIV/AIDS for many years, have been trained often and have good attitudes toward the KAP clients. However

the OPD admissions and screening staff may not have had this training and this is reflected in unfriendly communication with the KAP clients. The quantitative data showed very few respondents who said they had faced stigma and discrimination at a health service. However, the percentage of respondents who did not use the services due to fear of stigma and discrimination is not known.

When asked about the difficulties that they face in their daily lives, both FSW and MSM reported a troubling level of violence and particularly of forced sex. For MSM, most of the reported forced sex was by a stranger or acquaintance. Whether this takes place in the context of a random attack, or through risky interpersonal situations is not known. For both groups, the HIV prevention programs have not had the resources to address the need for a more supportive enabling environment for HIV prevention. It is hoped that both this larger issue as well as the specific issue of violence against FSW and MSM can be addressed as the programs re-focus.

#### **7.4 To what extent is gender integrated into program planning, implementation, and capacity building of key interventions?**

This evaluation did not find that the issue of gender is reflected in planning and implementation. The program has plans for training in this area and PSI has conducted training for its field staff and volunteers in this areas. For other populations, this issue is integrated into the modules of routine training curricula. The static service providers do not have strategies for dealing with overlapping gender orientations in some clients (bisexuality), perhaps because they are confined by target requirements and time limitation.

#### **7.5 Are members of the target population satisfied with the intervention and services provided? How is the program design and actual service delivery informed by clients' needs and satisfaction?**

Overall, both the qualitative and quantitative evaluation found that the KAP and prisoners were satisfied with the outreach services, the volunteers and the government service facilities, including staff attitudes that are client-friendly. There is a need for more needs assessment and client satisfaction surveys.

#### **7.6 What are appropriate tools and mechanisms, particularly provincial coordinating mechanism (PCM) for implementers to monitor regularly both the coverage and the behavior change reached through prevention services?**

The quarterly reports of the IA are sent up through the system, but there are problems of data collection, particularly concerning the volunteers. The data from the systems designed by the SR are not really used for in-depth evaluation on areas of coverage or risk behavior of the KAP and prisoners. This is especially the case for the behavior risk assessment form. Client counts are not tabulated by number of repeat contacts by type of service. The PCM is the focal point for program M&E in the province but this mechanism is not being used efficiently. The provincial chief medical office does not conduct much monitoring of the IA. Most interaction is through the ad hoc PCM meetings. The program data reporting system does not have a direct channel to the PCM. Thus it has been difficult for the PCM to see the whole picture of services for KAP in the province. As a result,

the RIHIS (Routine Integrated HIV Information System) is being pilot tested, and includes HCT and STI cases who are referred by program outreach. But RIHIS is only in the early stage of development.

## 7.6 What is the extent of participatory involvement of MARP in planning and evaluating services?

This evaluation found that there is no active involvement of KAP or prisoners in planning and evaluation. There is of course involvement in the outreach service through the use of peer volunteers. But the volunteers mostly only perform their assigned duties and do not get involved in activity design, planning and evaluation.

## 7.8 What is the coverage of people reached by defined HIV prevention packages?

The quantitative surveys found that coverage of key program components is lower than desired.

**Outreach.** From 20-37% of venue-based FSWs were reached by outreach in the past year, but only 11-20% of non-venue-based FSWs. Among MSM, transgender (TG) (28-39%) and male sex workers (MSW) (18-70%) were reached by outreach at a higher rate than general population MSM (12-33%). By site, the MSM program in Province B and for MSW in Bangkok were reached at a higher rate than others. For PWID, the results varied greatly by site, with 54% in Bangkok reached but only 27% in Province C. The prison outreach program showed good coverage although the results varied by prison; 1 of 3 inmates in the Bangkok prison were reached, but 2 of 3 in Province D and 3 of 4 in Province E.

**Drop-in centers.** DiCs for FSWs and MSM had very low coverage (2-16%), and most respondents surveyed were not aware of the drop-in center in their community. The exception is MSW in Bangkok, where 41% reported visiting the drop-in center. Drop-in centers for PWID had higher coverage (28-53%), especially in Bangkok where more than half said they had been to the drop-in center in the past year. The information corner in the prison was visited by the majority of prisoners in Province D & E (61-66%) but only 27% of those in the Bangkok prison.

**Condom, lubricant and safe injection equipment.** Coverage for these programs was found to vary by site in the quantitative survey. From 70-87% of FSWs and MSM in Province B reported receiving a free condom in the past year, but only 31-60% in Province A and Bangkok. The exception is MSWs in Bangkok where 78% received a condom. The qualitative studies found that there was a mismatch of condom size supply and demand for both FSWs and MSMs. Both groups reported that the quality of the lubricant did not meet the standard. From 22-45% of PWID reported receiving a condom, but it should be noted that the low sex drive among some PWID affects demand for condoms. In the prisons, 24-38% of the inmates reported receiving condoms in the past year; some prisons do not officially allow condom distribution, and most condoms are targeted to TG and other MSM. Regarding safe injection equipment, 29% of PWID in Province A and 54% of those in Bangkok received it in the past year. The qualitative study found that safe injection equipment distribution and outreach are affected by law enforcement.

**STI screening.** Coverage for FSWs and MSWs were found to be lower than the guideline for screening twice a year. Venue- and non-venue based FSWs were screened at about the same rate



(39-52% screened in the past year). Coverage of STI screening for MSWs was low (6-18%). This follows from the qualitative studies found that outreach focuses on information communication rather than service promotion, and that the linkage between CSOs and government clinics is not operating effectively. The referral system from outreach to STI services is not being used. Some FSWs prefer the private sector for convenience and confidentiality. For both MSWs and FSWs, specialized and anonymous clinics are frequently used where available.

**HCT.** Coverage for the KAPs was found to be somewhat higher than that found by other studies. From 41-65% of FSWs reported being tested in the past year, and the rates for venue-based and non-venue based FSWs were the same. Coverage was lower for MSM (12-46%) with MSWs more likely to be tested than other MSM in Province B. More than half of PWID, both in Province C and Bangkok, reported using HCT services in the past year. The percentage of inmates requesting HCT was 23-39% in Province D & E; in Bangkok, the small percentage (4%) reflects shorter duration in the prison.

## 7.9 What is the effect of the package of services that may be attributed to the interventions?

Quantitative results found a **positive relationship between contact with an outreach worker and health-seeking and HIV prevention behavior**. This finding comes despite the qualitative components' conclusions that the outreach and clinical services are not well integrated. While not all populations at all sites are included in this finding, significant associations were found between exposure to the outreach program and consistent condom use among MSM, higher STI screening rates among FSWs and MSM, higher HCT service use among FSWs, MSM and prisoners, and lower injection equipment sharing among PWID.

The finding that contact with an outreach worker is associated with higher use of services, while admittedly in a context of generally low coverage, provides additional evidence that the HIV prevention model providing a package of services has merit. The report also highlights some key differences between study sites, particularly in program management and in technical support. This evidence should guide the program in re-allocation of resources and refocusing the prevention effort.

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## 9. APPENDIX

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### Appendix 9.1 Population Survey Questionnaires

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**9.1.1 Female Sex Worker Screening Questionnaire**

**Form 1: Screening form for Female Sex Workers**

Date \_\_\_\_\_

Coupon ID \_ \_ \_ \_ \_

Welcome, thanks for coming in and helping us with our research study. Your friend who gave you the coupon may have told you something about our study. I’m going to now go over everything with you, to make sure you are eligible for the study and tell you how it works.

**Coupon checking:** Could you please show me the coupon that you got from your friend?

- ⇒ Check that the coupon is from our study, that the color is correct and that it is not a photocopy
- ⇒ Check the ID number on the coupon and enter it in the coupon tracking form. Make sure there is no duplicate ID number

**F1. Checking eligibility :** Now I need to make sure that you are eligible for our study. I need to ask you a few question.

Province			
No	Question	Eligible	Not eligible
F1.1	How old are you	≥ 18 Years Age_____Years	≥ 18 Years Age_____Years
		Date of birth Day___Month___Year___	
<p><b><u>Born after today’s date in 1994:</u></b> I’m sorry, we can only include people in our study who are age 18 and older. Thanks for coming to the site and we are sorry for the inconvenience.</p>			
F1.2	We are only interviewing female sex workers for this study. Have you had sex with a man for money in the past 12 months?	Yes	No
⇒ No: I’m sorry, we are only interviewing women who are currently working as sex workers. Thanks for coming to the site and we are sorry for the inconvenience. ⇒ Yes: If you are not sure that the person is really an FSW, please ask these additional questions. If you are sure, go to F2.1. OK, I have a few more questions to ask you:			

*These questions are designed to check if the woman is really a sex worker or is just trying to do the interview for the incentive. If the screener has strong doubts that the woman is telling the truth, she should exclude the woman from the study. If not sure, include them, but ask the interviewer if she has any doubts after the interview and make a note on the questionnaire.*

No	Questions	Answers	
F1.3	Last time you have sex with the client how much money do you charge?	_____ Baht	
F1.4	Where do your clients usually contact you?		
F1.5	How much do you charge your clients?	_____ Baht	
F1.6	How do you negotiate your price with your clients?		
F1.7	Have you been living in this province continuously for more than 3 months?	More than 3 months	Less than 3 month
F1.8	Are you now being outreach worker of the program?	Yes	No

**F2. Questions about recruiters:** Now I have a few questions for you about the woman who recruited you for this study.

Question	Number
F2.1. How would you describe your relationship with the person who gave you the coupon for this study? Is she:  <i>Give only one answer</i>	<ul style="list-style-type: none"> <li>• A stranger, someone you met for the first time</li> <li>• Someone you know, but not closely</li> <li>• A friend, but not a close friend</li> <li>• A close friend, someone you knew very well</li> <li>• A sexual partner/girlfriend</li> <li>• A family member or relation</li> </ul>
F2.2 How often do you see this person?	<ul style="list-style-type: none"> <li>• Every day</li> <li>• Once a week</li> <li>• Once a month</li> <li>• Less than once a month</li> </ul>
F2.3 About how long have you known her?	<ul style="list-style-type: none"> <li>• Less than a month</li> <li>• More than a month but less than 6 months</li> <li>• More than 6 months but less than a year</li> <li>• 1-2 years</li> <li>• 3-5 years</li> <li>• More than 5 years</li> </ul>
F2.4 Why did you accept the coupon and agree to be part of the study?	<ul style="list-style-type: none"> <li>• For incentive</li> <li>• My friend asked me to do it</li> </ul>

*Check all that apply—multiple response*

- The study seems to be interesting/useful
- Curious about the study
- Had time to spend
- Others (Specify): \_\_\_\_\_

*Introduce her to the interviewer for the full interview.*

**9.1.2 Female Sex Worker Interview Questionnaire**

**Section 1 – Background characteristics**

No.	Question	Answer coding	Skip to
101	How old are you?	_____ Years <i>COMPLETED YEAR OF AGE</i>	
102	What is the highest level of school you completed?	Never attend school 1 Primary 2 Up to Mattayom 3 or equivalent 3 Up to Mattayom 6 or equivalent 4 Higher than Mattayom 6 or equivalent e.g. vocational college 5 Bachelor's degree or higher 6 No response 9	
103	Do you have a job, besides doing sex work?	Yes 1 No 2 No response 9	2=>Q105
104	What is your job?	Work in restaurant Work in karaoke Work in bar/disco/Agogo Work in massage parlor Other entertainment work Government officer 1 Professional 2 Technical work 3 Clerical work 4 Service employee 5 Sale in shops or market 6 Agriculture and fishing 7 Skilled and other enterprise 8 Construction 9 Day laborer 10 Military/ Police 11 Other (Specify) 12 Not response 99	
105	Do you live in this province?	Yes 1 No 2 No response 9	2=>Q107



No.	Question	Answer coding	Skip to
106	What district do you live in?	Specify:	Go to Q108
107	What province do you live in?	Specify:	
108	How long have you been living in this province?	If less than one year: /_/_/ months or /_/_/ years 77 All my life 99 No response	
109	In the last 12 months, have you been away from your home (here in this province) for more than one month at one time?	Yes 1 No 2 No response 9	
110	Have you ever been married?	Yes 1 No 2 No response 9	
111	Are you currently married or living with a male sexual partner?	Currently married, living with spouse 1 Currently married, living with other sexual partner 2 Currently married, not living with spouse or other sexual partner 3 Not married, living with sexual partner 4 Not married, not living with sexual partner 5 No response 9	
112	During the last 4 weeks how often have you had drinks containing alcohol?  <i>READ THE ANSWERS</i>	Every day 1 At least once a week 2 Less often 3 Did not drink alcohol in last 4 weeks 4 No response 9	

No.	Question	Answer coding								Skip to
113	Some people have tried a range of different types of drugs. Which of the following, if any, have you used in the past 12 months?	Past 12 months				Past 3 months				
	(If yes) Have you used it in the past 3 months?									
		Yes	No	Do not know	No respnse	Yes	No	Do not know	No respnse	
	Amphetamine (ยาบ้า)									
	Marijuana (กัญชา)									
	Cocaine									
	Ecstasy/MDMA (ยาอี แฟนตาซี ยาเลิฟ)									
	Heroin									
	Methamphetamine (ยาไอซ์)									
	Other (Specify _____)									
Never try any drug									h=>Q201	
114	Some people have tried injecting drugs using needle and syringe. Have you injected drugs in the last 12 months?	Yes	1	No	2	No response	9			2=>Q201
115	Have you injected drugs in the last 3 months?	Yes	1	No	2	No response	9			

**Section 2 – Sexual behavior & condom use**

No.	Question	Answer coding	Skip to
201	At what age did you first have sexual intercourse? (I mean any type of anal and or vaginal sex even if you were forced to have it)	_____ Years <i>COMPLETED YEAR OF AGE</i> Do not know/Can't recall 88 No response 99	
202	How long have you been working as a sex worker?	_____ years If <1 year: _____ months	
203	Where do you usually contact your clients?	Brothel 1 Massage parlor (no rooms on site) 2 Massage parlor (with rooms on site) 3 Traditional massage 4 Karaoke bar 5 Agogo bar 6 Restaurant 7 Beer bar 8 Beauty parlor 9 Street/intersection 10 Park/riverside/canal 11 Shopping mall 12 Phone 13 Internet 14 Agent/Pimp 15 Other _____	
204	In what subdistrict do you usually contact your clients? <i>If there is more than two, can list up to three most frequent</i>	1. _____ 2. _____ 3. _____	
205	When was the last time you had sex with a client? <i>If respondent cannot remember, probe for the approximate number of months</i>	Today 1 Yesterday 2 _____ days ago or 3 _____ weeks ago or 4 _____ months ago 5 No answer 9	> 1 month: =>Q208
206	About how many clients did you have in the past month? This includes oral, anal and vaginal sex. <i>If client cannot remember, ask how many clients in the past week and multiply by 4.</i>	Specify number [ ____ ] Cannot remember 888 No response 999	

No.	Question	Answer coding	Skip to
207	With what frequency did you and all of your paying clients use condoms in the past month? <i>Can be male or female condom</i>	Every time 1 Almost every time 2 Sometimes 3 Never 4 Don't know 7 No response 9	1=> Q210 } }=>Q211 } } } } }
208	In a typical month when you are working as a sex worker, about how many clients did you have? This includes oral, anal and vaginal sex.  <i>If respondent cannot remember, ask how many clients in a typical week and multiply by 4.</i>	Specify number [ ____ ] Cannot remember 888 No response 999	
209	With what frequency did you and all of your paying clients use condoms in a typical month?	Every time 1 Almost every time 2 Sometimes 3 Never 4 Don't know 7 No response 9	1: 210 } }=>Q211 } } }
210	<i>(If they say "every time" in Q207 or Q209)</i> Did you not use a condom any time at all in the past 6 months with clients?	Yes 1 No 2 No response 9	
211	The last time you had sexual intercourse with a client did you or your partner use a condom?	Yes 1 No 2 No response 9	2=>Q215
212	Was it a regular (male) condom or female condom?	Male (regular) 1 Female condom 2 Used both 3	
213	Did you use a lubricant with the condom?	Yes 1 No 2 No response 9	2=>Q215

No.	Question	Answer coding	Skip to
214	What kind of lubricant did you use?	Aqualube a Vaseline b KY Jelly c Hand lotion d Vaginal gel e Baby oilf Butter g Cooking oil h Other _____ Do not remember 9 No response 99	
215	The last time you had sex with a client, how much did he pay you?	_____ baht Don't remember Don't know Regular client who doesn't pay every time Other.....	
216	How many partners have you had sex with in the past month who are not clients? This includes oral, anal and vaginal sex with partners who are your lovers, casual partners, boyfriend or husband.  <i>If client cannot remember, ask how many partners in the past week and multiply by 4.</i>	Specify number [ ____ ] Cannot remember 888 No response 999	0=>Q217
217	With what frequency did you and your non-client partners use condoms in the past month? <i>Can be female or male (regular) condom</i>	Every time 1 Almost every time 2 Sometimes 3 Never 4 Don't know 7 Do not have sex with others except clients 8 No response 9	} }=>Q223 } } } }
218	Did you not use a condom any time at all in the past 6 months with your non-paying partners?	Yes 1 No 2 No response 9	

No.	Question	Answer coding	Skip to
219	The <u>last time</u> you had sex with a non-client partner, what was your relationship with that man?	Steady partner(boyfriend or husband) 1 Casual partner 2 Friend 3 "One night stand" 4 Acquaintance 5 Other (specify) 7 No response 9	
220	The last time you had oral, anal or vaginal sexual intercourse with a non-client did your partner use a condom?	Yes 1 No 2 No response 9	2=>Q223
221	If yes, did you use a water-based lubricant with the condom?	Yes 1 No 2 No response 9	2=>Q223
222	What kind of lubricant did you use?	Aqualube a Vaseline b KY Jelly c Hand lotion d Vaginal gel e Baby oilf Butter g Cooking oil h Other _____ Do not remember 9 No response 99	
223	Have you ever used a male (regular) condom?	Yes 1 No 2 No response 9	2=>Q226
224	Have you ever used a lubricant along with a male condom?	Yes 1 No 2 No response 9	2=>Q226

No.	Question	Answer coding	Skip to
225	<p>What type of lubricant have you ever used?</p> <p><i>Multiple response possible, do not read the responses</i></p>	<p>Aqualube a</p> <p>Vaseline b</p> <p>KY Jelly c</p> <p>Hand lotion d</p> <p>Vaginal gel e</p> <p>Baby oilf</p> <p>Butter g</p> <p>Cooking oil h</p> <p>Other _____</p> <p>Do not remember 9</p> <p>No response 99</p>	
226	<p>Have you ever used a female condom?</p>	<p>Yes 1</p> <p>No 2</p> <p>No response 9</p>	

NO SECTION 3

**Section 4 – Stigma, discrimination and violence**

Now I'm going to ask some questions about your life as an FSW:

No.	Question	Answer coding	Skip to
401	<p>Do your family, friends and co-workers know that you are an FSW or receive money or other support for having sex? Would you say that all or nearly all know, some know, or most don't know?</p>	<p>All know/nearly all know 1</p> <p>Some know 2</p> <p>Most don't know 3</p> <p>Nobody knows 4</p> <p>Not sure 5</p> <p>No answer 9</p>	<p>1: go to Q404</p> <p>Q403</p>
402	<p>Who knows that you are an FSW? <i>(Multiple answers possible don't read possible answer)</i></p>	<p>Non client Sex partners 1</p> <p>Close friends 2</p> <p>Family 3</p> <p>Relatives 4</p> <p>Co-workers 5</p>	
403	<p>Why don't you want everyone to know that you are an FSW? <i>(Multiple answers possible don't read possible answer)</i></p>	<p>Personal/private issue 1</p> <p>They won't respect be any more 2</p> <p>Family would be upset 3</p> <p>People would look down on me 4</p> <p>Friends won't treat me the same 5</p> <p>Makes people uncomfortable 6</p> <p>Others (to be pretested)</p>	

No.	Question	Answer coding	Skip to
404	In your daily life, do you ever face difficulties because you are an FSW?	Yes 1 No 2 Don't know 3 No response 4	2, 3, 4 to to Q406
405	What are these difficulties? <i>(Multiple answers possible don't read possible answer)</i>	Violence 1 Threats 2 Making fun/teasing/ call bad word 3 People treat me differently 4 People don't treat me with respect 5 People are uncomfortable around me 6 People accuse me of having HIV/AIDS 7 People accuse me of spreading HIV/AIDS 8 Other (pre-test)	
406	In the past 12 months, were you the victim of violence by a client?	Yes 1 No 2 Do not know 3 No response 9	2=>Q408 3, 4
407	What kind of violence did you face?	Beaten/physically assaulted...1 Forced to have sex against my will.....2 Forced to have a type of sex I did not want to have.....3 Other.....	
408	In the past 12 months, were you forced to have sex with someone against your wishes?	Yes 1 No 2 Do not know 3 No response 9	2=>Q410 3, 4
409	Who were these people who forced you to have sex against your will? <i>Can be multiple response</i>	Police 1 Military 2 Client 3 Regular partner 4 Sexual partner 5 Friends 6 Relatives 7 Employers 8 Acquaintance 9 Unknown people 10 Pimp/agent.....11 Mamasan.....12 Other (Specify) _____ Do not remember 98 No response 99	



No.	Question	Answer coding	Skip to
410	In the past 12 months, have you ever face discrimination at the health center because of your sex work?	Yes 1 No 2 Do not know 3 No response 9	2, 3, 4 =>Q414
411	What kind of health service did this discrimination take place?	Government hospital Private doctor	
412	What kind of service were you getting when this discrimination took place?	HIV testing a STI screening b ART c Gynecological services d General health services e Other f	
413	What kind of kind of discrimination took place?	Health service would not serve me 1 Health service treated me badly 2 People speaking rudely to me 3 Calling bad word 4 Other.....	
414	Besides what we already talked about, have you ever faced any problems in your daily life because of your sex work?	Yes 1 No 2 Do not know 3 No response 9	2=>Q501
415	What kind of problems?	(Code after pretesting).	

### Section 5 – HIV knowledge and information

No.	Question	Answer coding	Skip to
501	Have you ever heard of HIV or AIDS?	Yes 1 No 2 No response 9	
502	Do you know anyone who is infected with HIV or has died of AIDS?	Yes 1 No 2 No response 9	

No.	Question	Answer coding	Skip to
503	Do you have a close relative or close friend who is infected with HIV or has died of AIDS?	Yes 1 No 2 No response 9	
504	Can people reduce their risk of HIV by using a condom correctly every time they have sex?	Yes 1 No 2 Do not know 3 No response 9	
505	Can people reduce their risk of HIV by using a condom correctly every time they have anal sex?	Yes 1 No 2 Do not know 3 No response 9	
506	Can a person get the HIV virus from mosquito bites?	Yes 1 No 2 Do not know 3 No response 9	
507	Can people protect themselves from HIV by having one uninfected faithful sex partner?	Yes 1 No 2 Do not know 3 No response 9	
508	Can people protect themselves from HIV by abstaining from sexual intercourse? (This means abstaining from anal as well as oral sex)	Yes 1 No 2 Do not know 3 No response 9	
509	Can a person get the HIV virus by sharing meal with someone who is infected?	Yes 1 No 2 Do not know 3 No response 9	
510	Can a person get the HIV virus by using a needle that is used by someone else?	Yes 1 No 2 Do not know 3 No response 9	
511	Do you think that a healthy-looking person can be infected with HIV, the virus that causes AIDS?	Yes 1 No 2 Do not know 3 No response 9	

No.	Question	Answer coding	Skip to
512	What have you done for yourself to avoid getting HIV? (Multiple response possible)	Take medicine 1 (Specify _____) Nothing 2 Always use condom 3 Other (specify) _____ Do not know 98 No response 99	
513	To what extent do you think that you are at risk of HIV infection?	High risk 1 Some risk 2 Little or no risk 3 Do not know 98 No response 99	3 => Q515
514	Why do you think you are at risk of getting HIV? Multiple answers possible (DO NOT READ OUT)	High risk job a Multiple partners b Frequency and regular anal sex c Do not use condom at all d Irregular condom use e Needles sharing f Other (specify) _____ Do not know 98 No response 99	GO TO Q601
515	Why do you think you are at little or no risk of HIV? Multiple answers possible (DO NOT READ OUT)	Always a Only one sex partner b Partners are clean c Partners are healthy d Never share injections e Share needles sometime only f Do not know 98 No response 99	

### Section 6 – Condom and lubricants

No.	Question	Answer coding	Skip to
601	In the last 12 months have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)	Yes 1 No 2 Do not remember 3 No response 9	

No.	Question	Answer coding	Skip to
602	Last time you got a condom, from where did you get it?	Drug store 1 Convenient store (7-eleven, etc.) 2 Health facility 3 Bar/Guest House/Hotel 4 Friends 5 Clients 6 Drop-in center 7 PE or OE 8 Do not remember 9 No response 99	
603	How much did you pay for one piece of condom the last time you got one?	_____ THB Free 1 Do not remember 2 No response 9	
604	Can you obtain a condom every time you need it?	Yes 1 No 2 Do not need one 3 Do not remember 4 No response 9	1=>Q606 3=>Q606
605	Why can't you get a condom every time you need it?  (Multiple answers. DO NOT READ the possible answers)	Too costly a Shop/pharmacy too far away b Shops/pharmacies closed c Too shy to buy or get one d Do not know where to get e Do not want to carry condom f Other (Specify) _____ Do not know 98 No response 99	
606	Do you know a place where you can get a condom for free?	Yes 1 No 2 No response 9	2, 9=>Q609
607	Where is that place?  (Multiple answers. DO NOT READ the possible answers)	Health facility a Bar/Guest House/Hotel b Friends c Clients d Drop-in center e PE or OE f Do not remember g No response h	
608	In what subdistrict is that place (in Q607) (If multiple) that is the most convenient place for you?	_____ 98 No response .....99	

No.	Question	Answer coding	Skip to
609	In the past 30 days, how often have you used a special lubricant for condoms together with a condom during sex? This includes anal and vaginal sex.	Every time 1 Most of the time 2 Sometimes 3 Never 4 Do not remember 98 No response 99	4=>Q617
610	Which lubricants do you commonly use?	Aqualube a Vaseline b KY Jelly c Hand lotion d Vaginal gel e Baby oil f Butter g Cooking oil h Other _____ Do not remember 9 No response 99	
611	Do you know a place where you can get lubricant for free?	Yes 1 No 2 No response 9	2, 9=>Q614
612	Where is that place?  (Multiple answers. DO NOT READ the possible answers)	Health facility a Bar/Guest House/Hotel b Friends c Clients d Drop-in center e PE or OE f Do not remember g No response h	
613	In what subdistrict is that place? (in Q612) (If multiple) that is the most convenient place for you?	_____ Do not know 98 No response 99	
614	Can you obtain a lubricant every time you need it?	Yes 1 No 2 Do not need one 3 Do not remember 8 No response 9	1=>Q616

No.	Question	Answer coding	Skip to
615	Why can't you get a lubricant every time you need it?  (Multiple answers. DO NOT READ the possible answers)	Too costly a Shop/pharmacy too far away b Shops/pharmacies closed c Too shy to buy or get one d Do not know where to get e Do not want to carry condom f Other (Specify) _____ Do not know 98 No response 99	
616	Last time you got a lubricant, from where did you get it?	Drug store 1 Convenient store (7-eleven, etc.) 2 Health facility 3 Bar/Guest House/Hotel 4 Friends 5 Clients 6 Drop-in center 7 PE or OE 8 Do not remember 9 No response 99	<i>GO TO Q701</i>
617	Why have you never used a lubricant?  (Multiple answers. DO NOT READ the possible answers)	Partner objects a Afraid to use it b Cannot get it c Do not like lubricants d Other (Specify) _____ Do not remember 9 No response 99	

**Section 7 – Sexually Transmitted Infections (STI)**

No.	Question	Answer coding	Skip to
701	Can you tell me about the symptoms of STIs in women?  (Multiple answers. DO NOT READ the possible answers)	Painful sex Abdominal Pain Vaginal itching Vaginal odor Vaginal discharge Painful urination Frequent urination Genital ulcers Unusual vaginal bleeding (discharge) Genital warts Other (Specify) _____ Do not know 98 No response 99	

No.	Question	Answer coding	Skip to
702	Have you had any unusual vaginal discharge during the past 12 months?	Yes 1 No 2 Do not know 8 No response 9	
703	Have you had painful urination during the last 12 months?	Yes 1 No 2 Do not know 8 No response 9	
704	Have you had a genital ulcer/sore during the past 12 months?	Yes 1 No 2 Do not know 8 No response 9	
705	Have you had an anal ulcer/sore during the past 12 months?	Yes 1 No 2 Do not know 8 No response 9	<i>Check Q702-706: all '2' =&gt; Q801</i>
706	What was the first thing you did when you had those symptoms?  <i>Do not read the answer</i>	Went to hospital/clinic 1 Went to mobile clinic 2 Went to private doctor 3 Went to pharmacy 4 Did nothing 5 Don't remember 8 No response 9	
707	Last time you had one of those symptoms how many days did you wait between discovering symptoms and going for treatment? (If getting the treatment in the same day, code 01)	Number of days □□ No treatment at all 00 Do not know/remember 98 No response 99	00 go to Q801
708	Last time you sought treatment for those symptoms, how much did the treatment cost you, including the medicine and the fees for the service?	Baht □□□□ No treatment at all 0000 Do not know/remember 9998 No response 9999	
709	Last time you sought treatment for those symptoms, did you finish all of the medicine that the doctor or pharmacist gave you?	Yes 1 No 2 Do not know 3 No response 9	

**Section 8-13 - Service Utilization**

No.	Question	Answer coding	Skip to
801	In the past 12 months have you received any information or knowledge or services about HIV/AIDS?	Yes 1 No 2 No response 9	
802	If yes, from where or from whom?  Please name the programs that HIV prevention service that you know or have heard about  (Multiple answers. DO NOT READ the possible answers)	Rainbow Sky a SWING b Rainbow Ratchaburi c SDA d M Reach e PPAT f Condom outreach g Other (please specify) _____ _____	
803	Have you heard of any of these programs  (Multiple answers. READ the possible answers)	Rainbow Sky a SWING b Rainbow Ratchaburi c SDA d M Reach e PPAT f Condom outreach g Other (please specify) _____ _____	
804	How do you know about the programs?	Through peer educators a Recommended by friends b Advertisement/Campaign c Other d	
805	Have you ever participated in any activity of the program or ever receive any services of the program?	Yes 1 No 2 No response 9	2=>Q901
806	Please name the activity or service you received from the program during the <u>past 12 months</u> ?	Activity a Activity b Activity c Other d	
<b>Peer Outreach Education</b>			
901	Have you met someone who came to talk to you about HIV/AIDS or did in the <u>past 12 months</u> ?	Yes 1 No 2 No response 9	2=>914



No.	Question	Answer coding	Skip to
902	How often have you met or interacted with Peer Educators (PE) or Outreach Educators (OE) in the <u>past 12 months</u> ?	At least twice a week 1 About once a week 2 2-3 times a month 3 About once a month 4 Every 2-3 months 5 Less than 4 times in the past year 6 Do not remember 98 No response 99	
903	In the past 3 months, how often have you met or interacted with Peer Educators (PE) or Outreach Educators (OE)	Never 1 1-3 times (once a month or less) 2 About 3-6 times 3 More than 6 times but less than once a week 4 About once a week 5 From 2-4 times a week 6 At least 5 times a week or every day 7 Do not remember 98 No response 99	1, 2, 3 =>Q905  4, 5, 6, 7 =>skip to Q904
904	When was the last time that you met or interacted with Peer Educators (PE) or Outreach Educators (OE)	Today 1 Yesterday 2 In the past week (2-7 days ago) 3 More than a week but less than a month ago 4 More than a month ago 5 Do not remember 98 No response 99	
905	Why did you stop interacting with any PE or OE for FSW, or go only a few times in the past 3 months?  multiple	Not know where to meet them a Do not like b Service lack of privacy c Service lack of confidentiality d Friend not support e Service too far away f Service too costly g Have no travel expense h Time inconvenience i No friends k Other (please specify) _____	

No.	Question	Answer coding	Skip to
906	Do you know from what program those PE or OE are? Please name	Rainbow Sky a SWING b Rainbow Ratchaburi c SDA d M Reach e PPAT f Other (please specify) _____ Do not know 97 Do not remember 98 No response 99	
	<i>For 907a, do not read the responses. For 907b, read the responses and circle yes or no</i>	Q907a	Q907b Yes No
907	What kind of activities did you participate in with such PE /OE?  (Multiple answers. DO NOT READ the possible answers)	Get condom and lubricant a Discuss about HIV and AIDS b Discuss about VCCT c Discuss about STI d Discuss about condom use e Discuss about lubricant f Get written materials like brochures, etc. g Get referral for VCCT h Get referral for STI screening i No response c	1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0
No.	Question	Answer coding	Skip to
908	Do you feel that the peer educators have provided you with sufficient information about HIV/AIDS?	Yes 1 No 2 No response 9	1=>910
909	If no, what information do you think you still require?  (Multiple answer)DO NOT READ RESPONSES	Safer sex a Anal sex b Condom use c STI d HIV testing e ARTs f Other (specify) g No response h	
910	Are you provided with opportunities to ask questions about HIV/AIDS during your contacts with the peer educators?	Yes 1 No 2 No response 9	
911	Were the explanations that the peer educators provided easy to understand?	Yes 1 No 2 No response 9	

No.	Question	Answer coding	Skip to
912	How satisfied are you that the peer educator protects your confidentiality?	Very much 1 Moderately 2 No much 3 Not at all 4 No response 9	
913	Overall, how satisfied are you with your interrelations with the peer educators?	Very much 1 Moderately 2 Not much 3 Not at all 4 No response 9	<i>Go to 1001</i>
914	Why have you never interacted with any PE or OE for FSW?  Multiple response, do not prompt	Not know where to meet them a Do not like b Service lack of privacy c Service lack of confidentiality d Friend not support e Service too far away f Service too costly g Have no travel expense h Time inconvenience i No friends k Other (please specify)_____	

No.	Question	Answer coding	Skip to
	1000 Drop in Center		
1001	Have you visited or been to any drop in center for FSW in the <u>past 12 months</u> ?	Yes 1 No 2 No response 9	2=>Q1016
1002	How often have you visited or been to any drop in center for FSW in the <u>past 12 months</u> ?	At least twice a week 1 About once a week 2 2-3 times a month 3 About once a month 4 Every 2-3 months 5 Less than 4 times in the past year 6 Do not remember 98 No response 99	

No.	Question	Answer coding	Skip to
1003	In the past 3 months, how often have you been to a drop-in center?	Never 1 1-3 times (once a month or less) 2 About 3-6 times 3 More than 6 times but less than once a week 4 About once a week 5 From 2-4 times a week 6 At least 5 times a week or every day 7 Do not remember 98 No response 99	1, 2,3 =>Q1005
1004	When was the last time that you went to a drop-in center?	Today 1 Yesterday 2 In the past week (2-7 days ago) 3 More than a week but less than a month ago 4 More than a month ago 5 Do not remember 98 No response 99	Go to 1006
1005	Why did you stop going to the drop-in center?  Multiple response	Do not like a Service lack of privacy b Service lack of confidentiality c Friend not support d Service too far away e Service too costly f Have no travel expense g Time inconvenience h No friends i Other (please specify)_____	
1006	Do you know which organizations run those FSW drop in center? Please name  Multiple	Rainbow Sky a SWING b Rainbow Ratchaburi c SDA d M Reach e PPAT f Other (please specify)_____	
		Do not know 97 Do not remember 98 No response 99	

No.	Question	Answer coding	Skip to
1007	When you visited the FSW drop in center, which activity you took part in?  Multiple response	Get condom a Learn how to use condom b Get HIV information c Participate in HIV discussion d Participate in HIV activities e Get personal counseling on HIV f Get personal counseling on STI g Hang with FSW friends h Other (please specify) _____ Do not know 97 Do not remember 98 No response 99	
1008	Do you feel that the drop-in center is a comfortable place for you to meet and hang out?	Yes 1 No 2 No response 9	
1009	Are you provided with opportunities to ask questions about HIV/AIDS during your time at the drop-in center?	Yes 1 No 2 No response 9	
1010	Were the explanations provided easy to understand?	Yes 1 No 2 No response 9	
1011	How satisfied are you that the drop-in center protects your confidentiality?	Very much 1 Moderately 2 No much 3 Not at all 4 No response 9	
1012	Overall, how satisfied are you with the drop-in center?	Very much 1 Moderately 2 Not much 3 Not at all 4 No response 9	
1013	How could the drop-in center be improved?  Multiple response	Better location a More space b More comfortable atmosphere c More privacy for FSW d More activities e More interesting activities f Other.....	
1014	How difficult is it for you to access the drop-in center?	Very difficult 1 Moderately 2 Not much 3 Not at all 4 No response 9	3, 4=> Q1101

No.	Question	Answer coding	Skip to
1015	Why is it difficult for you to access the drop-in center?	Specify: _____ _____	Go to Q1101
1016	Why have you never go to any drop in center for FSW?  Multiple response	Not know where to go a Do not like b Service lack of privacy c Service lack of confidentiality d Friend not support e Service too far away f Service too costly g Have no travel expense h Time inconvenience i No friends k Other (please specify)_____	

No.	Question	Answer coding	Skip to
	11 IEC Materials		
1101	Have you ever seen any published materials, such as brochures or posters, that are for FSW? You may get them from an out-reach worker or see them at the drop-in center; or you may see them at a clinic or a bar.	Yes 1 No 2 No response 9	2=>Q1201
1102	What did you see?	Brochure a Document b Poster c Book c etc.: to be filled in	
1103	Did you read the brochure or poster?	Yes 1 No 2 No response 9	2=>Q1201
1104	What message was the poster or brochure saying?	Condom use Lubricant use Partner reduction STI screening/treatment VCCT Other.....	
	STI screening and treatment		
1201	Do you know any place in this province where you could have STI screening and treatment especially for FSW?	Yes 1 No 2 No response 9	

No.	Question	Answer coding	Skip to
1202	I don't want to know the result, but have <i>you</i> ever had an STI screening?	Yes 1 No 2 No response 9	2=>Q1222
1203	In the <u>past 12 months</u> , how many STI screenings have you had?	No. of STI screening or treatment: _____ Never 0 Do not remember 8 No response 9	0=>Q1222
1204	When is the last time you had an STI screening?	This week 1 This month 2 Last month 3 More than 2 but less than 6 months ago 4 From 6-12 months ago 5 Do not remember 8 No response 9	
1205	The last time you went for STI screening, where did you go?	Specific per province	
1206	For the latest STI screening, did you decide to do it yourself or did someone else ask you to do?	Voluntarily 1 Asked by someone 2 By rules of workplace 3 Do not remember 4 No response 9	
1207	For the latest STI screening, did you get a referral from an outreach worker, drop-in center, or someone else?	Yes 1 No 2 Don't know.....8 No response 9	2=>Q1209
1208	Who was the referral from?	Outreach worker Drop-in center Employer Other medical personnel	Go to Q1210
1209	For the latest STI screening you have, how did you know or get to the clinic?	Go by myself 1 Referred by the program 2 Go with friends or others 3 Do not remember 4 No response 9	

No.	Question	Answer coding	Skip to
1210	For the latest STI screening you received, was it an FSW clinic or a clinic with special hours for FSW?	Yes 1 No 2 Don't know.....8 No response 9	
1211	Do you feel that the STI screening facility provided you with sufficient information about STIs, their prevention and treatment?	Yes 1 No 2 No response 9	1=>Q1213
1212	If no, what information do you think you still require? <i>(Multiple answer)</i>	Safer sex a Anal sex b Condom use c STI treatment d Other (specify) g No response h	
1213	Were you provided with opportunities to ask questions about STIs and their treatment at your last STI screening?	Yes 1 No 2 No response 9	2=>Q1215
1214	Were the explanations provided easy to understand?	Yes 1 No 2 No response 9	
1215	How satisfied are you that the STI facility protects your confidentiality?	Very much 1 Moderately 2 No much 3 Not at all 4 No response 9	
1216	Did you feel that the staff at STI clinic treated you with respect?	Yes 1 No 2 No response 9	
1217	Did you feel that the staff at the STI clinic treated you differently than they would treat other women who are not FSW?	Yes 1 No 2 No response 9	2=>Q1219
1218	(If yes) How did they treat you differently?	Not polite.....1 Seemed uncomfortable with me.....2 Did not want to touch me.....3 Blamed me for my FSWatus as cause of STI.....4 Made me wait longer than other people.....5 Other (pre-test).....	
1219	Overall, how satisfied were you with your STI screening visit?	Very much 1 Moderately 2 Not much 3 Not at all 4 No response 9	



No.	Question	Answer coding	Skip to
1220	How difficult is it for you to access the STI screening facility	Very difficult 1 Moderately 2 Not much .3 Not at all 4 No response 9	3,4 => Q1301
1221	Why is it difficult for you to access the STI screening facility?	Specify: _____ _____	Go to Q1301
1222	Why have you never had any STI screening ? OR Why have you not had any STI screening or treatment in the last 12 months?	Not know where to go a Afraid of results b Service lack of privacy c Service lack of confidentiality d Friend not support e Service too far away f Service too costly g Have no travel expense h Time inconvenience i Cannot go by myself k Have no risk l Other (please specify) _____	
	<b>Voluntary and Confidential Counseling and Testing (VCCT)</b>		
1301	Do you know any place in this province where you could have a confidential HIV test? By confidential, I mean that no one will know the result if you don't want them to know it.	Yes 1 No 2 No response 9	
1302	I don't want to know the result, but have <i>you</i> ever had an HIV test?	Yes 1 No 2 No response 9	2=>Q1324
1303	In the <u>past 12 months</u> , how many HV tests have you had?	No. of HIV Test: _____ Never 0 Do not remember 8 No response 9	0=>Q1324
1304	When is the last time you had an HIV test?	This week 1 This month 2 Last month 3 From 2-6 months ago 4 From 7-12 months ago 5 Do not remember 8 No response 9	

No.	Question	Answer coding	Skip to
1305	The last time you went for an HIV test, where did you go?	Provincial hospital District hospital Mobile clinic MSM clinic Other.....	
1306	For the latest HIV test you have, did you yourself decide to take the test or did someone else ask you to have the test?	Voluntarily 1 Asked by someone 2 By rules of workplace 3 Do not remember 4 No response 9	
1307	For the latest HIV test, did you get a referral from an outreach worker, drop-in center, or someone else?	Yes 1 No 2 Don't know.....8 No response 9	2=>Q130 9
1308	Where was the referral from?	Outreach worker Drop-in center Employer Other medical personnel	Go to Q1310
1309	For the latest HIV test you have, how did you know or get to the clinic?	Go by myself 1 Referred by the program 2 Go with friends or others 3 Do not remember 4 No response 9	
1310	When you were tested for HIV, did you receive counseling at the clinic? (I mean proper information about HIV infection and prevention, the reason for taking HIV test and post test counseling)	Yes 1 No 2 No response 9	
1311	Please do not tell me the result, but did you yourself find out the result of your test?	Yes 1 No 2 No response 9	
1312	For the latest time that you received HIV testing services, was it an FSW clinic or a clinic with special hours for FSW?	Yes 1 No 2 Don't know.....8 No response 9	
1313	Do you feel that the testing facility provided you with sufficient information about HIV, its prevention and treatment?	Yes 1 No 2 No response 9	1=>Q131 5

No.	Question	Answer coding	Skip to
1314	If no, what information do you think you still require? (Multiple answer)	Safer sex a Anal sex b Condom use c STI treatment d Other (specify) g No response h	
1315	Were you provided with opportunities to ask questions about HIV, the testing procedure and other issues?	Yes 1 No 2 No response 9	2=>Q131 7
1316	Were the explanations provided easy to understand?	Yes 1 No 2 No response 9	
1317	How satisfied are you that the testing and counseling facility protects your confidentiality?	Very much 1 Moderately 2 No much 3 Not at all 4 No response 9	
1318	Did you feel that the staff at the testing and counseling clinic treated you with respect?	Yes 1 No 2 No response 9	
1319	Did you feel that the staff at the HCT clinic treated you differently than they would treat other women who are not FSW?	Yes 1 No 2 No response 9	2=>Q132 1
1320	(If yes) How did they treat you differently?	Not polite.....1 Seemed uncomfortable with me.....2 Did not want to touch me.....3 Blamed me for my MSM status as cause of HIV.....4 Made me wait longer than other people.....5 Other (pre-test).....	
1321	Overall, how satisfied were you with your testing and counseling visit?	Very much 1 Moderately 2 Not much 3 Not at all 4 No response 9	
1322	How difficult is it for you to access the HCT facility	Very difficult 1 Moderately 2 Not much .3 Not at all 4 No response 9	

No.	Question	Answer coding	Skip to
1323	Why is it difficult for you to access the HCT facility?	Specify: _____ _____	
1324	Why have you never had any HIV test? OR Why have you not had a test in the past 12 months?	Not know where to get HIV test a Afraid of results b Service lack of privacy c Service lack of confidentiality d Friend not support e Service too far away f Service too costly g Have no travel expense h Time inconvenience i Cannot go by myself k Have no risk l Other (please specify) _____	

*IF RESPONDENT HAS NOT RECEIVED ANY HIV PREVENTION SERVICES, END INTERVIEW*

Section 14 Self-reported Change				
Question	Answer	Skip		
1401	We have just talked about several types of services that you have received from the HIV program here. Since you first received services from this program, do you feel that you have changed your sexual behavior?	Yes 1 No 2 No response 9	2=>END	
1402	How did you change your sexual risk behavior?  (multiple responses)	Use condom more a Reduce number of paying sexual partners b Reduce number of total sexual partners c Get screened for STIs regularly d Get screened for HIV/go to VCT service regularly.....e		
1403	Is this change related to any of the services that you have received from this program?	Yes 1 No 2 Don't know 3		

*THANK YOU VERY MUCH FOR YOUR PARTICIPATION IN THE STUDY!*

### 9.1.3 Female Sex Worker Post-Interview Questionnaire

**F1.4 Network questions.** Now I have a few questions for you about the other women you know who are sex workers.

Question	Number
<p>1.4.1. How many women do you know who are sex workers who live in (this province)? These should be women who you know face-to-face, who know you also; you know their name (at least nickname) and they know yours. If you don't know the number exactly, just estimate.</p> <p><i>Prompt if she cannot name: Would you say it's about 20? Is it higher than that, like 25? Is it lower than that, like 15? Keep probing until she gives a number.</i></p>	
<p>1.4.2. Out of the number you just named, how many of them are age 18 or older? <i>(If "all", write down the same number here)</i></p>	
<p>1.4.3. Out of that number, how many of them had sex for money in the past 12 months—that is, they are currently working as sex workers? <i>(If "all", write down the same number here)</i></p>	
<p>1.4.4. And out of that number, how many of them have you seen face-to-face in the past month?</p>	
<p>1.4.5. You said that you know ____ (1.4.3) women in this province who are age 18 or over and have had sex for money in the past 12 months. And out of that number, you saw ____ (1.4.4) face-to-face in the past month. It means you know ____ (1.4.3-1.4.4) women like this who you didn't see in the past month.</p>	
<p>1.4.6. Out of that number (1.4.5), how many were you in contact in another way, such as talking on the phone, texting, Facebook, email, etc.?</p>	

### **F1.6 Instructions for recruiting new respondents:**

*Please follow these guidelines when providing coupons and explaining the recruitment process to a study participant.*

“Here are three (two or one) coupons for you to use to recruit other people like you. Please make sure that the persons you give the coupons to are female sex workers who live in this province, who have received money for sex in the past year, who are at least 18 years old and have not received this coupon from someone else (i.e., has not participated in this study before).”

“Let’s go back to the question about how many female sex workers you know, who you have seen in the past month. The number you gave was \_\_\_\_ (1.4.4). Please give your coupons to the people you included in this number.”

“Do not give any coupons to strangers when deciding who you should give the coupons to. Can you think of three (two or one) people you listed in the question above to whom you can give your coupons to?”

“Please inform your recruits that this study is anonymous and confidential and to explain to them that the information they provide is used for developing HIV/AIDS prevention programs. If that person accepts the coupon, show him/her the address and map where he/she can go to be interviewed and inform him/her that he/she can call the number on the coupon to make an appointment. Also, explain to him/her that the interview will take at least one hour.”

“Please look at the coupon. Each coupon has two parts with a unique number filled in. This is the special number of the person you will give the coupon to. Please give the top portion to the person you are recruiting. The bottom part is for you to keep in order for you to claim your reimbursement for recruiting one of your peers.”

“For each person you recruit who is eligible and completes an interview, you will be given an incentive worth 100 baht.”

“Once you give a coupon to one of your peers, and that peer enrolls into the study and completes the interview, you can come back to the interview site to claim your compensation. You can also call the number provided on the bottom portion of the coupon to check your incentive status (whether the person you recruited has enrolled and completed his interview).”

“Only you can recruit peers with your coupons. If you have another person recruit peers for you, you will become ineligible to receive your incentive. Remember to keep the bottom portion of the coupon because you will not be able to claim your incentive without it.”

“Thank you for your participation. Do you have any questions?”

9.1.4 MSM Screening Questionnaire

**Form 1**  
**Screening form for MSM MSW TG**

Date \_\_\_\_\_

Coupon ID \_ \_ \_ \_ \_

Welcome, thanks for coming in and helping us with our research study. Your friend who gave you the coupon may have told you something about our study. I'm going to now go over everything with you, to make sure you are eligible for the study and tell you how it works.

**Coupon checking:** Could you please show me the coupon that you got from your friend?

- ⇒ Check that the coupon is from our study, that the color is correct and that it is not a photocopy
- ⇒ Check the ID number on the coupon and enter it in the coupon tracking form. Make sure there is no duplicate ID number

**M1. Checking eligibility :** Now I need to make sure that you are eligible for our study. I need to ask you a few question.

Province			
No	Question	Eligible	Not eligible
M1.1	How old are you	≥ 18 Years Age _____ Years	≥ 18 Years Age _____ Years
		Date of birth Day ___ Month ___ Year ___	
<b><i>Born after today's date in 2537:</i></b> I'm sorry, we can only include people in our study who are age 18 and older. Thanks for coming to the site and we are sorry for the inconvenience.			
M1.2	We are only interviewing men who have sex with men, who may be gay men, bisexual or transgender for this study. Have you had sex with a man (either oral or anal sex) in the past 12 months?	Yes	No
⇒ No: I'm sorry, we are only interviewing men who have sex with men for this study. Thanks for coming to the site and we are sorry for the inconvenience. ⇒ Yes: If you are not sure that the person is really an MSM, please ask these additional questions .If you are sure, introduce him to the interviewer. OK, I have a few more questions to ask you:			

*These questions are designed to check if the person is really an MSM or is just trying to do the interview for the incentive. If the screener has strong doubts that the person is telling the truth, he/she should exclude the person from the study. If not sure, include them, but ask the interviewer if he has any doubts after the interview and make a note on the questionnaire.*

No	Questions	Answers	
<b>M1.3</b>	How often do you sleep with men?		
<b>M1.4</b>	Do you enjoy receptive sex with a man?	Yes	No
<b>M1.5</b>	Do you enjoy penetrative sex with a man?	Yes	No
<b>M1.6</b>	Have you been living in this province continuously for more than 3 months?	More than 3 months	Less than 3 month
<b>M1.7</b>	Are you now being Outreach worker of the program?	Yes	No

*If you are still not sure that the person is really an MSM, thank him and tell him he is not eligible for the study. If you are sure, continue to M2.1.*



**M2. Questions about recruiters:** Now I have a few questions for you about the person who recruited you for this study.

Questions	Number
<p><b>M2.1</b> How would you describe your relationship with the person who gave you the coupon for this study? Is he: <i>Give only one answer (multiple response)</i></p>	<ul style="list-style-type: none"> <li>• A stranger, someone you met for the first time</li> <li>• Someone you know, but not closely</li> <li>• A friend, but not a close friend</li> <li>• A close friend, someone you knew very well</li> <li>• A sexual partner/boyfriend</li> <li>• A family member or relation</li> </ul>
<p><b>M2.2</b> How often do you see this person?</p>	<ul style="list-style-type: none"> <li>• Every day</li> <li>• Once a week</li> <li>• Once a month</li> <li>• Less than once a month</li> </ul>
<p><b>M2.3</b> About how long have you known him?</p>	<ul style="list-style-type: none"> <li>• Less than a month</li> <li>• More than a month but less than 6 months</li> <li>• More than 6 months but less than a year</li> <li>• 1-2 years</li> <li>• 3-5 years</li> <li>• More than 5 years</li> </ul>
<p><b>M2.4</b> Why did you accept the coupon and agree to be part of the study? <i>Check all that apply—multiple response</i></p>	<ul style="list-style-type: none"> <li>• For incentive</li> <li>• My friend asked me to do it</li> <li>• The study seems to be interesting/useful</li> <li>• Curious about the study</li> <li>• Had time to spend</li> <li>• Others (Specify)_____</li> </ul>

*Introduce the person to the interviewer for the main interview.*

**9.1.5 MSM Interview Questionnaire**  
**Section 1 – Background characteristics**

No.	Question	Answer coding	Skip to
101	How old are you?	_____ Years <i>COMPLETED YEAR OF AGE</i>	
102	What is the highest level of school you completed?	Never attend school..... 1 Primary..... 2 Secondary..... 3 Higher..... 4 No response ..... 9	
103	What is your work status?	Working..... 1 No job, looking for job ..... 2 } Studying..... 3 } Doing housework only ..... 4 }=>Q105 Retired..... 5 } Health problem, can't work ..... 6 } Pause during agricultural season . 7 } Other (specify) _____ ..... 8	
104	What is your main occupation?	<b>Currently not working</b> <b>Government officer</b> <b>Professional</b> <b>Technical work</b> <b>Clerical work</b> <b>Service employee</b> <b>Sale in shops or market</b> <b>Agriculture and fishing</b> <b>Skilled and other enterprise</b> Construction -Related to metal, machine and others -Related to manufacturing and printing -Related to other skills <b>Day laborer</b> -Sale & service -Labor in agriculture & fishing -Labor in mining, construction, production, & transportation <b>Military/ Police</b>	
105	Do you live in this province?	Yes..... 1 No..... 2 No response ..... 9	1=>Q107
106	What province do you live in?		

No.	Question	Answer coding	Skip to
107	What district do you live in?		
108	How long have you been living in this province?	Yes..... 1 No..... 2 No response ..... 9	
109	In the last 12 months, have you been away from your home (here in this province) for more than one month at one time?	Yes..... 1 No..... 2 No response ..... 9	
110	Have you ever been married to a woman?	Yes..... 1 No..... 2 No response ..... 9	
111	Are you currently married or living with a female sexual partner?	Currently married, living with spouse 1 Currently married, living with other sexual partner ..... 2 Currently married, not living with spouse or other sexual partner ..... 3 Not married, living with sexual partner 4 Not married, not living with sexual partner ..... 5 No response ..... 9	
112	During the last 4 weeks how often have you had drinks containing alcohol?  <i>READ THE ANSWERS</i>	Every day..... 1 At least once a week ..... 2 Less often ..... 3 Did not drink alcohol in last 4 weeks ..... 4 No response ..... 9	

No.	Question	Answer coding								Skip to
113	Some people have tried a range of different types of drugs. Which of the following, if any, have you used in the past 12 months?  (If yes) Have you used it in the past 3 months?	Past 12 months				Past 3 months				
		Yes	No	Do not know	No response	Yes	No	Do not know	No response	
	a. Amphetamine (ยาบ้า)									
	b. Marijuana (กัญชา)									
	c. Cocaine									
	d. Ecstasy/MDMA (ยาอี แพนตาซี ยาเลิฟ)									
	e. Heroin									
	f. Methamphetamine (ยาไอซ์)									
	g. Other (Specify _____)									
h. Never try any drug										
									h=>Q201	
114	Some people have tried injecting drugs using needle and syringe. Have you injected drug in the last 12 months?	Yes..... 1 No..... 2 No response ..... 9								2=>Q201
115	Have you injected drugs in the last 3 months?	Yes..... 1 No..... 2 No response ..... 9								

**Section 2 – Sexual experiences**

No.	Question	Answer coding	Skip to
202	Was your first sexual partner male or female or others?	Male ..... 1 Female..... 2 Transgendered ..... 3 MSM ..... 4 Do not know ..... 5 No response ..... 9	

No.	Question	Answer coding	Skip to
203	In the past six months, have you had any sexual contact with another man, that is have you had oral sex or anal sex with another man?	Yes ..... 1 No ..... 2 No response ..... 9	2=>Q215
204	How many different <b>men</b> have you had anal sex with, that is, both the number where you have been the insertive partner and the number where you have been the receptive partner in the past six months?	[ ][ ][ ]	0=>Q207
205	How many men have you had anal sex with the past six months <b>where you were the insertive partner</b> ?	Insertive ..... [ ][ ][ ] Do not know/Can't recall ..... 98 No response ..... 99	
206	How many men have you had anal sex with the past six months <b>where you were the receptive partner</b> ?	Receptive..... [ ][ ][ ] Do not know/Can't recall ..... 98 No response ..... 99	
207	How many different men have you had oral sex with the past six months, that is, where another man has put his penis in your mouth or you have put your penis in his mouth?	Number ..... [ ][ ][ ] Do not know/Can't recall ..... 98 No response ..... 99	0=>Q209
208	In the past six month, did you ejaculate in another man's mouth or did a man ejaculate in your mouth?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	
209	In the past six months, have you had sex with men for money?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	2=>Q211
210	How many men have you had sex with for money during the past six months?	Number ..... [ ][ ][ ] Do not know/Can't recall ..... 98 No response ..... 99	
211	In the past six months have you ever paid another man for sex?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	2=>Q213

No.	Question	Answer coding	Skip to
212	How many men have you paid for sex in the past six months?	Number ..... [ ] [ ] [ ] Do not know/Can't recall ..... 98 No response ..... 99	
213	In the past six months, have you had sex with any females?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	2=>Q215
214	How many females have you had sex with during the past six months?	Number ..... [ ] [ ] [ ] Do not know/Can't recall ..... 98 No response ..... 99	
215	Would you say that you are sexually attracted to women only, to men only, or both?	Women only ..... 1 Men only ..... 2 Both men and women ..... 3 Don't know/difficult to say ..... 8 No response ..... 9	
216	Would you say that you are a heterosexual (straight) man, a gay man, a bisexual man, or transgender?	Heterosexual man ..... 1 Gay man ..... 2 Bisexual man ..... 3 Transgender ..... 4 Don't know/difficult to say ..... 8 No response ..... 9	

**Section 3 – Condom use**

No.	Question	Answer coding	Skip to
301	With what frequency did you and your male partners (who are not paying clients) use condoms over the last 30 days? Would you say it was every time, almost every time, sometimes or never?	Every time ..... 1 Almost every time ..... 2 Sometimes ..... 3 Never ..... 4 Do not know ..... 5 Have no sex with non-paying male partners in the past 30 days .... 8 No response ..... 9	} } } } }Skip to >> } Q303
302	(If Q301 "Every time") Was there any time at all in the past six months that you did <u>not use a condom</u> with male partners (who are not paying clients)?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	

No.	Question	Answer coding	Skip to
303	The last time you had anal sex with a man (who is not a paying client), did you or your partner use a male condom?	Yes .....1 No .....2 Do not know .....3 No response.....9	
304	The last time you had anal sex with man who is not a paying client, did you use a lubricant?	Yes .....1 No .....2 No response.....9	2=>Q306
305	What kind of lubricant did you use?	Aqualube .....a Vasaline .....b KY Jelly .....c Hand lotion.....d Vaginal gel .....e Baby oil .....f Butter.....g Cooking oil .....h Other _____ Do not remember .....9 No response.....99	
306	The last time you had anal sex with a man (who is not a paying client), what was your relationship with that man?	Steady partner .....1 Casual partner .....2 One night stand .....3 Acquaintance .....4 Unknown .....5 Other (Specify) _____ Do not remember .....8 No response.....9	
307	In the past six months, did anyone pay you to have sex?	Yes .....1 No .....2 Do not know .....3 No response.....9	2=>Q315

No.	Question	Answer coding	Skip to
308	Where do you usually meet your clients? You can either name the exact place or tell me what type of place.	Name of place _____ -- or Bar/restaurant.....1 Sauna .....2 Massage parlor .....3 Hotel/guest house .....4 At my home .....5 At their home .....6 Through the internet .....7 By mobile phone.....8 Other _____	
309	In what subdistrict do you usually meet your clients?	_____	
310	With what frequency did you and your paying clients use condom over the last 30 days? Would you say it was every time, almost every time, sometimes or never?	Every time.....1 Almost every time .....2 Sometimes.....3 Never .....4 Do not know .....5 Have no sex with paying clients in the past 30 days.....8 No response.....9	} } } } <i>Skip to &gt;&gt;&gt; Q312</i>
311	(Q308 "Every time") Did you not use a condom any time at all in the past six months with paying clients?	Yes .....1 No .....2 Do not know .....3 No response.....9	
312	The last time you had anal sex with a paying client, did you or your partner use a male condom?	Yes .....1 No .....2 Do not know .....3 No response.....9	
313	The last time you had anal sex with a paying client, did you use a lubricant with the condom?	Yes .....1 No .....2 No response.....9	2=>Q315



No.	Question	Answer coding	Skip to
314	The last time you had anal sex with a paying client, What kind of lubricant did you use?	Aqualube ..... a Vasaline ..... b KY Jelly ..... c Hand lotion ..... d Vaginal gel ..... e Baby oil ..... f Butter ..... g Cooking oil ..... h Other _____ Do not remember ..... 9 No response ..... 99	
315	Have you had sexual intercourse with a woman during the past 6 months?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	2=>Q401
316	The last time you had sex with a woman; did you use a male condom?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	
317	The last time you had sex with a woman, what was your relationship with that woman?	Steady partner ..... 1 Casual partner ..... 2 One night stand ..... 3 Acquaintance ..... 4 Unknown ..... 5 Other (Specify) _____ Do not remember ..... 8 No response ..... 9	

#### Section 4 – Stigma, discrimination and violence

Now I'm going to ask some questions about your life as an MSM:

No.	Question	Answer coding	Skip to
401	Do your family, friends and co-workers know that you are an MSM or have sex with other men? Would you say that all or nearly all know, some know, or most don't know?	All/nearly all know 1 Some know 2 Most don't know 3	1: go to Q404
402	Who knows that you are MSM/ have sex with other men? <i>(Multiple answers possible don't read possible answer)</i>	Sex partners Close friends Family Relatives Co-workers	
403	Why don't you want everyone to know that you are MSM / have sex with other men?	Personal/private issue 1 They would think of me differently 2 Family would be upset 3 People would look down on me 4 Co-workers wouldn't treat me the same 5 Makes people uncomfortable 6 Others (to be pretested)	
404	In your daily life, do you ever face difficulties because you are MSM / have sex with other men?	Yes 1 No 2 Don't know 3 No response 4	2, 3, 4 to Q406
405	What are these difficulties? <i>(Multiple answers possible don't read possible answer)</i>	Violence Threats Making fun/teasing/name calling People treat me differently People don't treat me with respect People are uncomfortable around me People accuse me of having HIV/AIDS People accuse me of spreading HIV/AIDS Other (pre-test)	

No.	Question	Answer coding	Skip to
406	In the past 12 months, were you ever beaten because of your sexual behavior or because you are an MSM/TG?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	2=>Q408
407	Who was/were the people who beat you?  <i>(Multiple answers possible don't read possible answer)</i>	Police ..... 1 Military ..... 2 Client ..... 3 Regular partner ..... 4 Sexual partner ..... 5 Paying partner Paid partner Friends ..... 6 Relatives ..... 7 Employers ..... 8 Acquaintance ..... 9 Unknown people ..... 10 Other (Specify) _____ Do not remember ..... 98 No response ..... 99	
408	In the past 12 months, were you forced to have sex with someone against your wishes?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	2=>Q410
409	Who were these people who forced you to have sex against your will?	Police ..... 1 Military ..... 2 Client ..... 3 Regular partner ..... 4 Sexual partner ..... 5 Paying partner Paid partner Friends ..... 6 Relatives ..... 7 Employers ..... 8 Acquaintance ..... 9 Unknown people ..... 10 Other (Specify) _____ Do not remember ..... 98 No response ..... 99	

No.	Question	Answer coding	Skip to
410	In the past 12 months, have you been cheated /threatened because of your sexual behavior/orientation/identity?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	
411	In the past 12 months, have you been insulted, called names or made fun of because of your sexual behavior/orientation/identity?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	2=>Q412
412	Who were these people who insulted/made fun of you?	Friends Family Acquaintances Strangers/people on the street Work colleagues/fellow workers Boss/supervisor Health care provider Other	
413	In the past 12 months, have you faced any kind of discrimination in your job because of your sexual behavior/orientation/identity?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	
417	Besides what we already talked about, have you ever faced any problems because of your sexual identity?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	2=>Q501
418	What kind of problems?	(Code after pretesting).	

**Section 5 – HIV knowledge and information**

No.	Question	Answer coding	Skip to
501	Have you ever heard of HIV or AIDS?	Yes ..... 1 No ..... 2 No response ..... 9	
502	Do you know anyone who is infected with HIV or has died of AIDS?	Yes ..... 1 No ..... 2 No response ..... 9	

No.	Question	Answer coding	Skip to
503	Do you have a close relative or close friend who is infected with HIV or has died of AIDS?	Yes..... 1 No..... 2 No response ..... 9	
504	Can people reduce their risk of HIV by using a condom correctly every time they have sex?	Yes..... 1 No..... 2 Do not know..... 3 No response ..... 9	
505	Can people reduce their risk of HIV by using a condom correctly every time they have anal sex?	Yes..... 1 No..... 2 Do not know..... 3 No response ..... 9	
506	Can a person get the HIV virus from mosquito bites?	Yes..... 1 No..... 2 Do not know..... 3 No response ..... 9	
507	Can people protect themselves from HIV by having one uninfected faithful sex partner?	Yes..... 1 No..... 2 Do not know..... 3 No response ..... 9	
508	Can people protect themselves from HIV by abstaining from sexual intercourse? <b>(This means abstaining from anal as well as oral sex)</b>	Yes..... 1 No..... 2 Do not know..... 3 No response ..... 9	
509	Can a person get the HIV virus by sharing meal with someone who is infected?	Yes..... 1 No..... 2 Do not know..... 3 No response ..... 9	
510	Can a person get the HIV virus by using a needle that is used by someone else?	Yes..... 1 No..... 2 Do not know..... 3 No response ..... 9	
511	Do you think that a healthy-looking person can be infected with HIV, the virus that causes AIDS?	Yes..... 1 No..... 2 Do not know..... 3 No response ..... 9	

No.	Question	Answer coding	Skip to
512	What have you done for yourself to avoid getting HIV? <b>(Multiple response possible)</b>	Take medicine ..... 1 (Specify _____) Nothing ..... 2 Always use condom ..... 3 Other (specify) _____ Do not know ..... 98 No response ..... 99	
513	To what extent do you think that you are at risk of HIV infection?	High risk ..... 1 Some risk..... 2 Little or no risk ..... 3 Do not know..... 98 No response ..... 99	3 => Q515
514	Why do you think you are at risk of getting HIV? <b>Multiple answers possible (DO NOT READ OUT)</b>	High risk job ..... a Multiple partners ..... b Frequency and regular anal sex ....c Do not use condom at all ..... d Irregular condom use..... e Needles sharing..... f Other (specify) _____ Do not know ..... 98 No response ..... 99	GO TO Q601
515	Why do you think you are at little or no risk of HIV? <b>Multiple answers possible (DO NOT READ OUT)</b>	Always ..... a Only one sex partner..... b Partners are clean .....c Partners are healthy ..... d Never share injections ..... e Share needles sometime only..... f Do not know ..... 98 No response ..... 99	

**Section 6 – Condom and lubricants**

No.	Question	Answer coding	Skip to
601	In the last 12 months have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)	Yes ..... 1 No ..... 2 Do not remember ..... 3 No response ..... 9	
602	Last time, from where did you get condom?  <b>(Multiple answers. DO NOT READ the possible answers)</b>	Drug store..... 1 Convenient store (7-eleven, etc.) 2 Health facility..... 3 Bar/Guest House/Hotel ..... 4 Friends..... 5 Clients..... 6 Drop-in center ..... 7 PE or OE..... 8 Do not remember..... 9 No response ..... 99	
603	How much did you pay for one piece of condom the last time you got one?	_____ THB Free..... 1 Do not remember ..... 2 No response ..... 9	
604	Can you obtain a condom every time you need it?	Yes ..... 1 No ..... 2 Do not need one..... 3 Do not remember..... 4 No response ..... 9	1=>Q606
605	Why can't you get a condom every time you need it?  <b>(Multiple answers. DO NOT READ the possible answers)</b>	Too costly ..... a Shop/pharmacy too far away ..... b Shops/pharmacies closed..... c Too shy to buy or get one..... d Do not know where to get ..... e Do not want to carry condom ..... f Other (Specify) _____ Do not know ..... 98 No response ..... 99	
606	Do you know a place where you can get a condom for free?	Yes ..... 1 No ..... 2 No response ..... 9	2, 9=>Q609

No.	Question	Answer coding	Skip to
607	Where is that place?	Health facility..... 3 Bar/Guest House/Hotel ..... 4 Friends ..... 5 Clients ..... 6 Drop-in center ..... 7 PE or OE ..... 8 Do not remember ..... 9 No response ..... 99	
608	In what subdistrict is that place?	<i>if they do not know we should fill in later</i>	
609	In the past 30 days, how often have you used a special lubricant for condoms together with a condom during anal sex?	Every time..... 1 Most of the time..... 2 Sometimes..... 3 Never ..... 4 Do not remember..... 98 No response ..... 99	4=>Q617
610	Which lubricants do you commonly use?  MULTIPLE RESPONSE, DO NOT READ THE ANSWERS	Aqualube ..... a Vaseline ..... b KY Jelly ..... c Hand lotion..... d Vaginal gel ..... e Baby oil..... f Butter..... g Cooking oil..... h Other _____ Do not remember..... 9 No response ..... 99	
611	Do you know a place where you can get lubricant for free?	Yes ..... 1 No ..... 2 No response ..... 9	2, 9=>Q614
612	Where is that place?	Health facility ..... 3 Bar/Guest House/Hotel ..... 4 Friends ..... 5 Clients ..... 6 Drop-in center ..... 7 PE or OE ..... 8 Do not remember ..... 9 No response ..... 99	
613	In what subdistrict is that place?	<i>if they do not know we should fill in later</i>	



No.	Question	Answer coding	Skip to
614	Can you obtain a lubricant every time you need it?	Yes ..... 1 No ..... 2 Do not need one..... 3 Do not remember..... 4 No response ..... 9	2=>Q616
615	Why can't you get a lubricant every time you need it?  <b>(Multiple answers. DO NOT READ the possible answers)</b>	Too costly ..... a Shop/pharmacy too far away ..... b Shops/pharmacies closed..... c Too shy to buy or get one..... d Do not know where to get ..... e Do not want to carry condom ..... f Other (Specify) _____ Do not know ..... 98 No response ..... 99	
616	Last time, from where did you get a lubricant?  <b>(Multiple answers. DO NOT READ the possible answers)</b>	Drug store..... 1 Convenient store (7-eleven, etc.) 2 Health facility..... 3 Bar/Guest House/Hotel ..... 4 Friends..... 5 Clients..... 6 Drop-in center ..... 7 PE or OE..... 8 Do not remember..... 9 No response ..... 99	GO TO 701
617	Why have you not used a lubricant in the past 3 months?  <i>PROBE AND RECORD ALL ANSWERS</i>	Partner objects ..... a Afraid to use it..... b Cannot get it..... c Do not like lubricants ..... d Other (Specify) _____ Do not remember..... 9 No response ..... 99	

**Section 7 – Sexually Transmitted Infections (STI)**

No.	Question	Answer coding	Skip to
701	Can you tell me about the symptoms of STIs in men?	Penis discharge ..... a Burning pain during urination ..... b Genital ulcers/sores ..... c Swellings in groin area ..... d Anal charge ..... e Anal ulcers/sores ..... f Other (Specify) _____ Do not know ..... 98 No response ..... 99	
702	Have you had a urethral discharge during the past 12 months?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	
703	Have you had painful urination during the last 12 months?	Yes ..... 1 No ..... 2 Do not know ..... 8 No response ..... 9	
704	Have you had anal discharge during the last 12 months?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	
705	Have you had a genital ulcer/sore during the past 12 months?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	
706	Have you had an anal ulcer/sore during the past 12 months?	Yes ..... 1 No ..... 2 Do not know ..... 3 No response ..... 9	
	<i>INTERVIEWER: Check Q702-706: all '2' =&gt; Q801</i>		
707	What was the <b>first</b> thing you did when you had those symptoms?  <i>Do not read the answer</i>	Went to hospital/clinic Went to mobile clinic Went to private doctor Went to pharmacy Did nothing	

No.	Question	Answer coding	Skip to
708	Last time you had one of those symptoms that you just told me about, how many days did you wait between discovering symptoms and going for treatment? <b>(If getting the treatment in the same day, code 1)</b>	Number of days .....□□ No treatment at all .....0 Do not know/remember.....98 No response.....99	Skip to >>
709	Last time you sought treatment for those symptoms, how much did the treatment cost you, including the medicine and the fees for the service?	Baht.....□□ Do not know/remember.....98 No response.....99	
710	Last time you sought treatment for those symptoms, did you finish all of the medicine that the doctor or pharmacist gave you?	Yes.....1 No .....2 Do not know .....3 No response.....9	

**Section 8 - 13 –Service Utilization**

No.	Question	Answer coding	Skip to
801	In the past 12 months have you received any information or knowledge or services about HIV/AIDS	Yes.....1 No .....2 No response.....9	2=>Q901
802	If yes, from where or from whom?  Please name the programs you know or have heard about  <b>(Multiple answers. DO NOT READ the possible answers)</b>	Rainbow Sky.....a SWING.....b Rainbow Ratchaburi.....c SDA.....d M Reach .....e PPAT.....f Condom outreach .....g  Other (please specify)_____	
803	Have you heard of any of these programs?  <b>(Multiple answers. READ each answer)</b>	Rainbow Sky.....a SWING.....b Rainbow Ratchaburi.....c SDA.....d M Reach .....e PPAT.....f Condom outreach .....g  Other (please specify)_____	

No.	Question	Answer coding	Skip to
804	How do you know about the programs?	Through peer educators .....a Recommended by friends.....b Advertisement/Campaign..... c Other.....d	
805	Have you ever participated in any activity of the program or ever receive any services of the program?	Yes.....1 No .....2 No response.....9	2=>Q901
806	Please name the activity or service you received from the program during the <b>past 12 months</b> ?	Activity .....a Activity .....b Activity ..... c Other.....d	
<b>Peer Outreach Education</b>			
901	Have you met someone who came to talk to you about HIV/AIDS or interacted with Peer Educators (PE) or Outreach Educators (OE) in the <b>past 12 months</b> ?	Yes.....1 No .....2 No response.....9	2=>914
902	How often have you met or interacted with Peer Educators (PE) or Outreach Educators (OE) in the <b>past 12 months</b> ?	Once.....1 2-3 times .....2 4-6 times .....3 7-12 times .....4 More than 12 times .....5 Do not remember .....98 No response.....99	
903	In the past 3 months, how often have you met or interacted with Peer Educators (PE) or Outreach Educators (OE)	Never .....1 1-3 times (once a month or less) .2 About 3-6 times .....3 More than 6 times but less than once a week .....4 About once a week .....5 From 2-4 times a week .....6 At least 5 times a week or every day .....7 Do not remember .....98 No response.....99	1, 2 ,3 =>Q905  4, 5, 6, 7 =>skip to Q904

No.	Question	Answer coding	Skip to
904	When was the last time that you met or interacted with Peer Educators (PE) or Outreach Educators (OE)	Today ..... 1 Yesterday ..... 2 In the past week (2-7 days ago)... 3 More than a week but less than a month ago..... 4 More than a month ago..... 5 Do not remember ..... 98 No response ..... 99	
905	Why did you stop interacting with any PE or OE for FSW, or go only a few times in the past 3 months?  multiple	Not know where to meet them ....a Do not like..... b Service lack of privacy..... c Service lack of confidentiality ..... d Friend not support..... e Service too far away ..... f Service too costly.....g Have no travel expense ..... h Time inconvenience .....i No friends .....k Other (please specify)_____	
906	Do you know from what program those PE or OE are? Please name	Rainbow Sky.....a SWING.....b Rainbow Ratchaburi..... c SDA.....d M Reach .....e PPAT ..... f Other (please specify)_____ Do not know .....97 Do not remember .....98 No response .....99	

No.	Question	Answer coding			Skip to
	<i>For 907a, do not read the responses. For 907b, read the responses and circle yes or no</i>		Q907b		
			Yes	No	
907	What kind of activities did you participate in with such PE /OE?  <b>(Multiple answers. DO NOT READ the possible answers)</b>	Q907a Get condom and lubricant..... a Discuss about HIV and AIDS ..... b Discuss about VCCT ..... c Discuss about STI..... d Discuss about condom use..... e Discuss about lubricant ..... f Get written materials like brochures, etc..... g Get referral for VCCT ..... h Get referral for STI screening ..... i No response..... c	1 1 1 1 1 1 1 1 1 1	0 0 0 0 0 0 0 0 0 0	
908	Do you feel that the peer educators have provided you with sufficient information about HIV/AIDS?	Yes..... 1 No ..... 2 No response..... 9			2=>907
909	If no, what information do you think you still require? <i>(Multiple answer)</i>	Safer sex..... a Anal sex..... b Condom use ..... c STI ..... d HIV testing ..... e ARTs ..... f Other (specify) ..... g No response..... h			
910	Are you provided with opportunities to ask questions about HIV/AIDS during your contacts with the peer educators?	Yes..... 1 No ..... 2 No response..... 9			2=>909
911	Were the explanations that the peer educators provided easy to understand?	Yes..... 1 No ..... 2 No response..... 9			
912	How satisfied are you that the peer educator protects your confidentiality?	Very much..... 1 Moderately ..... 2 No much..... 3 Not at all ..... 4 No response..... 9			
913	Overall, how satisfied are you with your interactions with the peer educator?	Very much..... 1 Moderately ..... 2 Not much ..... 3 Not at all ..... 4 No response..... 9			Go to 1001

No.	Question	Answer coding	Skip to
914	Why have you never interacted with any PE or OE for MSM?	Not know where to meet them ....a Do not like.....b Service lack of privacy.....c Service lack of confidentiality .....d Friend not support.....e Service too far away ..... f Service too costly.....g Have no travel expense .....h Time inconvenience.....i No friends .....k Other (please specify)_____	
<b>Drop in Center</b>			
1001	Have you visited or been to any drop in center for MSM in the <b>past 12 months</b> ?	Yes.....1 No .....2 No response.....9	2=>Q1013
1002	How often have you visited or been to any drop in center for MSM in the <b>past 12 months</b> ?	Once.....1 2-3 times .....2 4-6 times .....3 7-12 times .....4 More than 12 times .....5 Do not remember .....98 No response.....99	
1003	In the past 3 months, how often have you been to a drop-in center?	Never ..... 1 1-3 times (once a month or less) 2 About 3-6 times ..... 3 More than 6 times but less than once a week ..... 4 About once a week ..... 5 From 2-4 times a week ..... 6 At least 5 times a week or every day ..... 7 Do not remember ..... 98 No response..... 99	1, 2 ,3 =>Q1005

No.	Question	Answer coding	Skip to
1004	When was the last time that you went to a drop-in center?	Today .....1 Yesterday .....2 In the past week (2-7 days ago)....3 More than a week but less than a month ago.....4 More than a month ago.....5 Do not remember ..... 98 No response.....99	Go to 1006
1005	Why did you stop going to the drop-in center?  Multiple response	Do not like..... a Service lack of privacy.....b Service lack of confidentiality ..... c Friend not support.....d Service too far away .....e Service too costly..... f Have no travel expense .....g Time inconvenience.....h No friends .....i Other (please specify)_____	
1006	Do you know which organizations run those MSM drop in center? Please name	Rainbow Sky.....a SWING.....b Rainbow Ratchaburi..... c SDA.....d M Reach .....e PPAT..... f Other (please specify)_____ Do not know .....97 Do not remember .....98 No response.....99	
1007	When you visited the MSM drop in center, which activity you took part in?	Get condom ..... a Learn how to use condom .....b Get HIV information..... c Participate in HIV discussion.....d Participate in HIV activities.....e Get personal counseling on HIV ... f Get personal counseling on STI ....g Hang with MSM friends .....h Other (please specify)_____ Do not know .....97 Do not remember .....98 No response.....99	



No.	Question	Answer coding	Skip to
1008	Do you feel that the drop-in center is a comfortable place for MSM to meet and hang out?	Yes..... 1 No ..... 2 No response..... 9	
1009	Are you provided with opportunities to ask questions about HIV/AIDS during your time at the drop-in center?	Yes..... 1 No ..... 2 No response..... 9	
1010	Were the explanations provided easy to understand?	Yes..... 1 No ..... 2 No response..... 9	
1011	How satisfied are you that the drop-in center protects your confidentiality?	Very much..... 1 Moderately ..... 2 No much..... 3 Not at all ..... 4 No response..... 9	
1012	Overall, how satisfied are you with the drop-in center?	Very much..... 1 Moderately ..... 2 Not much ..... 3 Not at all ..... 4 No response..... 9	
1013	How could the drop-in center be improved?	Better location More space More comfortable atmosphere More privacy for MSM More activities More interesting activities Other.....	
1014	How difficult is it for you to access the drop-in center?	Very difficult ..... 1 Moderately ..... 2 Not much ..... 3 Not at all ..... 4 No response..... 9	3, 4=> Q1101
1015	Why is it difficult for you to access the drop-in center?	Specify: _____ _____	Go to Q1101
1016	Why have you never go to any drop in center for MSM?	Not know where to go ..... a Do not like..... b Service lack of privacy..... c Service lack of confidentiality ..... d Friend not support..... e Service too far away ..... f Service too costly..... g Have no travel expense ..... h Time inconvenience..... i No friends ..... k Other (please specify) _____	

No.	Question	Answer coding	Skip to
<b>IEC Materials</b>			
1101	Have you ever seen any written materials, such as brochures or posters, that are for MSM? You may get them from an out-reach worker or see them at the drop-in center; or you may see them at a clinic or bar.	Yes..... 1 No..... 2 No response ..... 9	2=>Q1201
1102	What did you see?	Brochure Poster etc.: to be filled in	
1103	Did you read the brochure or poster?	Yes..... 1 No..... 2 No response ..... 9	2=>Q1201
1104	What message was the poster or brochure saying?	Condom use Lubricant use Partner reduction STI screening/treatment VCCT Other.....	
<b>STI screening and treatment</b>			
1201	Do you know any place in this province where you could have STI screening and treatment especially for MSM?	Yes..... 1 No..... 2 No response ..... 9	
1202	I don't want to know the result, but have <i>you</i> ever had an STI screening or treatment?	Yes..... 1 No..... 2 No response ..... 9	2=>Q1222
1203	In the <b>past 12 months</b> , how many STI screening or treatment have you had?	No. of STI screening or treatment: _____ Never..... 0 Do not remember ..... 8 No response ..... 9	0=>Q1222
1204	When is the last time you have STI screening or treatment?	This week ..... 1 This month ..... 2 Last month ..... 3 Within last 12 months..... 4 Do not remember ..... 5 No response ..... 6	
1205	The last time you went for STI screening or treatment, where did you go?	Specific per province	

No.	Question	Answer coding	Skip to
1206	For the latest STI screening or treatment, did you decide to do it yourself or did someone else ask you to do?	Voluntarily..... 1 Asked by someone ..... 2 By rules of workplace..... 3 Do not remember ..... 4 No response ..... 9	
1207	For the latest STI screening or treatment, did you get a referral from an outreach worker, drop-in center, or someone else?	Yes..... 1 No..... 2 Don't know.....8 No response ..... 9	2=>Q1209
1208	Who was the referral from?	Outreach worker Drop-in center Employer Other medical personnel	Go to Q1210
1209	For the latest STI screening or treatment you have, how did you know or get to the clinic?	Go by myself ..... 1 Referred by the program ..... 2 Go with friends or others..... 3 Do not remember ..... 4 No response ..... 9	
1210	For the latest STI screening or treatment you received, was it an MSM clinic or a clinic with special hours for MSM?	Yes..... 1 No..... 2 Don't know.....8 No response ..... 9	
1211	Do you feel that the STI screening facility provided you with sufficient information about STIs, their prevention and treatment?	Yes .....1 No .....2 No response .....9	1= >Q1213
1212	If no, what information do you think you still require? (Multiple answer)	Safer sex ..... a Anal sex ..... b Condom use.....c STI treatment..... d Other (specify).....g No response ..... h	
1213	Were you provided with opportunities to ask questions about STIs and their treatment at your last STI screening?	Yes .....1 No .....2 No response .....9	2= >Q1215
1214	Were the explanations provided easy to understand?	Yes .....1 No .....2 No response .....9	

No.	Question	Answer coding	Skip to
1215	How satisfied are you that the STI facility protects your confidentiality?	Very much ..... 1 Moderately..... 2 No much ..... 3 Not at all..... 4 No response ..... 9	
1216	Did you feel that the staff at STI clinic treated you with respect?	Yes .....1 No .....2 No response .....9	
1217	Did you feel that the staff at the STI clinic treated you differently than they would treat other men who are not MSM?	Yes .....1 No .....2 No response .....9	2= >Q1219
1218	(If yes) How did they treat you differently?	Not polite.....1 Seemed uncomfortable with me.....2 Did not want to touch me.....3 Blamed me for my MSM status as cause of STI.....4 Made me wait longer than other people.....5 Other (pre-test).....	
1219	Overall, how satisfied were you with your STI screening visit?	Very much ..... 1 Moderately.....2 Not much.....3 Not at all.....4 No response .....9	
1220	How difficult is it for you to access the STI screening facility	Very difficult ..... 1 Moderately ..... 2 Not much ..... 3 Not at all..... 4 No response ..... 9	3,4 = > Q1301
1221	Why is it difficult for you to access the STI screening facility?	Specify: _____ _____	Go to Q1301
1222	Why have you never had any STI screening or treatment? OR Why have you not had any STI screening or treatment in the last 12 months?	Not know where to go..... a Afraid of results ..... b Service lack of privacy ..... c Service lack of confidentiality..... d Friend not support..... e Service too far away ..... f Service too costly ..... g Have no travel expense ..... h Time inconvenience ..... i Cannot go by myself..... k Have no risk..... l Other (please specify) _____	

No.	Question	Answer coding	Skip to
	<b>Voluntary and Confidential Counseling and Testing (VCCT)</b>		
1301	Do you know any place in this province where you could have a confidential HIV test? <b>By confidential, I mean that no one will know the result if you don't want them to know it.</b>	Yes ..... 1 No ..... 2 No response ..... 9	
1302	I don't want to know the result, but have you ever had an HIV test?	Yes ..... 1 No ..... 2 No response ..... 9	2=>Q1324
1303	In the <b>past 12 months</b> , how many HIV tests have you had?	No. of HIV Test: _____ Never ..... 0 Do not remember ..... 8 No response ..... 9	0=>Q1324
1304	When is the last time you have an HIV test?	This week..... 1 This month..... 2 Last month..... 3 Within last 12 months ..... 4 Do not remember ..... 5 No response ..... 6	
1305	The last time you went for an HIV test, where did you go?	Provincial hospital District hospital Mobile clinic MSM clinic Other.....	
1306	For the latest HIV test you have, did you yourself decide to take the test or did someone else ask you to have the test?	Voluntarily ..... 1 Asked by someone ..... 2 By rules of workplace ..... 3 Do not remember ..... 4 No response ..... 9	
1307	For the latest STI screening or treatment, did you get a referral from an outreach worker, drop-in center, or someone else?	Yes ..... 1 No ..... 2 Don't know..... 8 No response ..... 9	2=>Q1309
1308	Where was the referral from?	Outreach worker Drop-in center Employer Other medical personnel	<i>Go to Q1310</i>

No.	Question	Answer coding	Skip to
1309	For the latest HIV test you have, how did you know or get to the clinic?	Go by myself..... 1 Referred by the program..... 2 Go with friends or others ..... 3 Do not remember ..... 4 No response ..... 9	
1310	When you were tested for HIV, did you receive counseling at the clinic? (I mean proper information about HIV infection and prevention, the reason for taking HIV test and post test counseling)	Yes ..... 1 No ..... 2 No response ..... 9	
1311	Please do not tell me the result, but did you yourself find out the result of your test?	Yes ..... 1 No ..... 2 No response ..... 9	
1312	For the latest time that you received VCT services, was it an MSM clinic or a clinic with special hours for MSM?	Yes ..... 1 No ..... 2 Don't know..... 8 No response ..... 9	
1313	Do you feel that the VCT facility provided you with sufficient information about HIV, its prevention and treatment?	Yes ..... 1 No ..... 2 No response ..... 9	1=>Q1315
1314	If no, what information do you think you still require? (Multiple answer)	Safer sex ..... a Anal sex ..... b Condom use..... c STI treatment..... d Other (specify)..... g No response ..... h	
1315	Were you provided with opportunities to ask questions about HIV, the testing procedure and other issues?	Yes ..... 1 No ..... 2 No response ..... 9	2=>Q1317
1316	Were the explanations provided easy to understand?	Yes ..... 1 No ..... 2 No response ..... 9	
1317	How satisfied are you that the VCT facility protects your confidentiality?	Very much ..... 1 Moderately..... 2 No much ..... 3 Not at all ..... 4 No response ..... 9	
1318	Did you feel that the staff at the VCT clinic treated you with respect?	Yes ..... 1 No ..... 2 No response ..... 9	

No.	Question	Answer coding	Skip to
1319	Did you feel that the staff at the VCT clinic treated you differently than they would treat other men who are not MSM?	Yes .....1 No .....2 No response .....9	2=>Q132 1
1320	(If yes) How did they treat you differently?	Not polite.....1 Seemed uncomfortable with me.....2 Did not want to touch me.....3 Blamed me for my MSM status as cause of HIV.....4 Made me wait longer than other people.....5 Other (pre-test).....	
1321	Overall, how satisfied were you with your VCT visit?	Very much .....1 Moderately.....2 Not much.....3 Not at all .....4 No response .....9	
1322	How difficult is it for you to access the VCT facility	Very difficult ..... 1 Moderately ..... 2 Not much ..... 3 Not at all ..... 4 No response ..... 9	3, 4 => Q1401
1323	Why is it difficult for you to access the VCT facility?	Specify: _____ _____	Go to Q1401
1324	Why have you never had any HIV test? OR Why have you not had a test in the past 12 months?	Not know where to get HIV test... a Afraid of results ..... b Service lack of privacy ..... c Service lack of confidentiality..... d Friend not support ..... e Service too far away.....f Service too costly ..... g Have no travel expense ..... h Time inconvenience ..... i Cannot go by myself..... k Have no risk..... l Other (please specify)_____	

*IF RESPONDENT HAS NOT RECEIVED ANY HIV PREVENTION SERVICES, END INTERVIEW*

**Section 14 Self-reported Change**

	<b>Question</b>	<b>Answer</b>	<b>Skip</b>
1401	We have just talked about several types of services that you have received from the HIV program here. Since you first received services from this program, do you feel that you have changed your sexual behavior?	Yes .....1 No .....2 No response.....9	2=>END
1402	How did you change your sexual risk behavior?  (multiple responses)	Use condom more ..... a Reduce number of sexual partners..... b Engage in less receptive sex ..... c Engage in less penetrative anal sex ..... d	
1403	Is this change related to any of the services that you have received from this program?	Yes ..... 1 No ..... 2 Don't know ..... 3	

*THANK YOU VERY MUCH FOR YOUR PARTICIPATION IN THE STUDY!*



### 9.1.6 MSM Post-Interview Questions

**M1.4 Network questions.** Now I have a few questions for you about the other men you know who have sex with men.

Question	Number
<p>1.4.1. How many men do you know who have sex with men who live in (this province)? They may be gay, may have sex with men for money, or may be transgender. These should be people who you know face-to-face, who know you also; you know their name (at least nickname) and they know yours. If you don't know the number exactly, just estimate.  <i>Prompt if he cannot name: Would you say it's about 20? Is it higher than that, like 25? Is it lower than that, like 15?</i>  <i>Keep probing until he gives a number.</i></p>	
<p>1.4.2. Out of the number you just named, how many of them are age 18 or older? <i>(If "all", write down the same number here)</i></p>	
<p>1.4.3. Out of that number, how many of them have had sex with a man in the past 12 months? <i>(If "all", write down the same number here)</i></p>	
<p>1.4.4. And out of that number, how many of them have you seen face-to-face in the past month?</p>	
<p>1.4.5. You said that you know ____ (1.4.3) people in this province who are age 18 or over and have had sex with another man in the past 12 months. And out of that number, you saw ____ (1.4.4) face-to-face in the past month. It means you know ____ (1.4.3-1.4.4) people like this who you didn't see in the past month.</p>	
<p>1.4.6. Out of that number (1.4.5), how many were you in contact in another way, such as talking on the phone, texting, Facebook, email, etc.?</p>	

### **M1.6 Instructions for recruiting new respondents:**

*Please follow these guidelines when providing coupons and explaining the recruitment process to a study participant.*

“Here are three (two or one) coupons for you to use to recruit other people like you. Please make sure that the persons you give the coupons to are men who have sex with other men, who live in this province, who are at least 18 years old and have not received this coupon from someone else (i.e., has not participated in this study before).”

“Let’s go back to the question about how many men who have sex with men that you know, who you have seen in the past month. The number you gave was \_\_\_\_ (1.4.4). Please give your coupons to the people you included in this number.”

“Do not give any coupons to strangers when deciding who you should give the coupons to. Can you think of three (two or one) people you listed in the question above to whom you can give your coupons to?”

“Please inform your recruits that this study is anonymous and confidential and to explain to them that the information they provide is used for developing HIV/AIDS prevention programs. If that person accepts the coupon, show him/her the address and map where he/she can go to be interviewed and inform him/her that he/she can call the number on the coupon to make an appointment. Also, explain to him/her that the interview will take at least one hour.”

“Please look at the coupon. Each coupon has two parts with a unique number filled in. This is the special number of the person you will give the coupon to. Please give the top portion to the person you are recruiting. The bottom part is for you to keep in order for you to claim your reimbursement for recruiting one of your peers.”

“For each person you recruit who is eligible and completes an interview, you will be given an incentive worth 100 baht.”

“Once you give a coupon to one of your peers, and that peer enrolls into the study and completes the interview, you can come back to the interview site to claim your compensation. You can also call the number provided on the bottom portion of the coupon to check your incentive status (whether the person you recruited has enrolled and completed his interview).”

“Only you can recruit peers with your coupons. If you have another person recruit peers for you, you will become ineligible to receive your incentive. Remember to keep the bottom portion of the coupon because you will not be able to claim your incentive without it.”

“Thank you for your participation. Do you have any questions?”

### 9.1.7 Prisoner Questionnaire

#### Section A: Background characteristics

No.	Questions and filters	Coding categories	Skip to
P100	Interview date (dd/mm/yy B.E.)	____/____/____	
P101	Participant I.D.	[ ][ ][ ][ ][ ]	
P102	Sex	Male [1] Female [2] Transgender [3]	
P103	How old are you? Choose the age group that includes your age. For example if you are 28, choose [3].	18-19 [1] 20-24 [2] 25-29 [3] 30-34 [4] 35-39 [5] 40-44 [6] 45 or older [7] Don't know age [8888]	
P104	Where were you born?	Bangkok [1] Southern region [2] Central region [3] Northern region [4] Northeastern region [5] Eastern region [6] Other [7]	
P105	What is the highest level of school you completed?	Never attended school [0] Primary [1] Secondary (Junior high) [2] Senior high school [3] Vocational/technical college [4] Bachelor [5] Higher [6]	
P106	What is your current marital status?	Single [1] Married [2] Widow [3] Separated/divorced [4]	
P107	What was your occupation before incarceration?	Student [1] Farmer [2] Day labor [3] Private employee [4] Government officer [5] Own business/self employed [6] Unemployed [7] Other [8]	
P107.1	If other (8), specify	_____	

**Section B: Prison history (Same as baseline survey)**

No.	Questions and filters	Coding categories	Skip to
P200	Is this your first time in prison (including detention center)?	Yes [1] No [2]	If [1] to 202
P201	How many times have you been in prisons including this time? (Please estimate best answer)	[ ][ ] times	(up to 99)
P202	Please identify your imprisonment status	Pending Appeal [1] Convicted [2]	If [1] skip to P204
P203	Please identify your sentence term (year/month)	[ ][ ]/[ ][ ] Y Y / M M	Data shown in month
P204	How long have you been in this prison (including remand) (year/month)?	[ ][ ]/[ ][ ] Y Y / M M	
P205	Please identify your type of offense	Against Property [1] Against Narcotic Law [2] Against Life [3] Against Person [4] Sex-Related Offences [5] Against Public Safety [6] Other [7] Don't know [88]	

**Section C: STI knowledge and symptoms (Same as baseline survey)**

No.	Questions and filters	Coding categories	Skip to
P300	Have you heard of diseases that can be transmitted through sexual intercourse?	Yes [1] No [2] Don't know [9]	
<b>Please answer True or False on the following statements</b>			
P301	Burning pain on urination may be a symptom of STI	True[1] False [2] Don't know [9]	
P302	Having sores or genital ulcers may be a symptom of STI	True[1] False [2] Don't know [9]	
P303	Having genital discharges may be a symptom of STI	True[1] False [2] Don't know [9]	
P304	Swelling in the groin area may be a symptom of STI	True[1] False [2] Don't know [9]	
<b>Please answer True or False accordingly to your symptoms</b>			
P305	Have you had a genital discharge during incarceration?	Yes [1] No [2] Don't know 9	
P306	Have you had a genital ulcer or sore during incarceration?	Yes [1] No [2] Don't know [9]	
P307	Have you had an anal discharge during the incarceration?	Yes [1] No [2] Don't know [9]	
P308	Have you had an anal ulcer or sore during incarceration?	Yes [1] No [2] Don't know [9]	

**Section D: HIV knowledge & HIV attitudes**

No.	Questions and filters	Coding categories	Skip to
<b>Please answer True or False on the following statements</b>			
P401	You can reduce the risk of getting HIV by using a condom every time you have sex	True[1] False [2] Don't know [9]	
P402	You can protect yourself from HIV by having sex with only one uninfected partner who has no other partners	True[1] False [2] Don't know [9]	
P403	A person can get HIV by sharing food with someone who is infected	True[1] False [2] Don't know [9]	
P404	Sharing injecting equipment with other people can put you at risk to get HIV	True[1] False [2] Don't know [9]	
P405	A person who looks healthy can have HIV	Yes [1] No [2] Don't know [9]	
P406	Having intercourse without using a condom can put you at risk to get HIV despite pre-ejaculation withdrawal	Yes [1] No [2] Don't know [9]	
P407	A person can get HIV from mosquito bites	Yes [1] No [2] Don't know [9]	
P408	Today, anti-retroviral drug is available to for AIDS patients and it helps them to live longer	Yes [1] No [2] Don't know [9]	
P409	To prevent condom break during anal sex, baby oil should be used as a lubricant during intercourse	Yes [1] No [2] Don't know [9]	
P410	Sharing tattoo equipment with other people can put you at risk to get HIV	Yes [1] No [2] Don't know [9]	
<b>Please respond the following statements/questions based on your opinion</b>			
P411	HIV positive prisoners and AIDS patients should be kept separate from other prisoners	Agree [1] Disagree [2] Don't know [3]	
P412	If you are HIV positive, you will tell your partner	Yes [1] No [2] Don't know [9]	
P413	You are willing to share meal with HIV positive person	Yes [1] No [2] Don't know [9]	
P414	You are willing to take care of a family member who is HIV positive	Yes [1] No [2] Don't know [9]	
P415	How severe do you think AIDS situation nowadays is?	Very severe [1] Rather severe [2] Not severe [3] Don't know [4]	
P416	Do you worry that you might have got HIV?	Yes, very [1] Yes, somehow [2] Not really [3] Don't know [4]	

**Section E: HIV risk behaviors before incarceration.** Questions asked in this section are of personal nature. Please take time to think about your answer to these questions so that we can get the most accurate information possible. Please remember that the information is strictly confidential and that your answer cannot be traced back to you in anyway (same as in baseline survey).

No.	Questions and filters	Coding categories	Skip to
P500	<b>Before</b> this incarceration, have you ever shared razor blades with other people?	Yes [1] No [2]	
P501	<b>Before</b> this incarceration, have you had any tattoos done?	Yes [1] No [2]	If [2] skip to P503
P502	If you have, have you ever shared tattooing equipment with other people <b>before</b> this incarceration?	Yes [1] No [2]	
P503	<b>Before</b> this incarceration, have you ever taken narcotics (e.g., heroin, marijuana, methamphetamine, etc)?	Yes [1] No [2]	If [2] skip to P506
P504	<b>Before</b> this incarceration, have you ever injected narcotics?	Yes [1] No [2]	If [2] skip to P506
P505	If you have, have you ever shared injection equipment with others <b>before</b> this incarceration?	Yes [1] No [2]	
P506	<b>Before</b> this incarceration, have you ever had “artificial penile nodule” done?	Yes [1] No [2]	
P507	<b>Before</b> this incarceration, have you ever had anal sex with another man (including gays and transgender)?	Yes [1] No [2]	If [2], skip to P600
P508	<b>Before</b> this incarceration, when you had anal sex with another male, how frequently did you use a condom?	Every or almost every time [1] Sometimes [2] Never [3]	

**Section F: HIV risk behaviors during incarceration.** Questions asked in this section are of personal nature. Please take time to think about your answer to these questions so that we can get the most accurate information possible. Please remember that the information is strictly confidential and that your answer cannot be traced back to you in anyway (same as in baseline survey).

No.	Questions and filters	Coding categories	Skip to
P600	<b>During</b> this incarceration, have you ever shared razor blades with other inmates?	Yes [1] No [2]	If [2] skip to P602
P601	If you have, have you ever shared razor blades with other inmates in the <u>past 3 months</u> ?	Yes [1] No [2]	
P602	Have you had any tattoos done while you are in this prison?	Yes [1] No [2]	If [2] skip to P605
P603	If you have, have you ever shared tattooing equipment with other inmates?	Yes [1] No [2]	If [2] skip to P605
P604	If you have, have you shared tattooing equipment with other inmates in the <u>past 3 months</u> ?	Yes [1] No [2]	

No.	Questions and filters	Coding categories	Skip to
P605	Have you ever taken illegal narcotics while you are in this prison (including drugs prohibited by prison regulations e.g. non-prescribed sleeping pills)?	Yes [1] No [2] No response [99]	If [2] skip to P607
P606	If you have, have you ever taken illegal narcotics as mentioned earlier in the <u>past 3 months</u> ?	Yes [1] No [2] No response [99]	
P607	Have you ever injected narcotics while you are in this prison?	Yes [1] No [2] No response [99]	If [2] skip to P610
P608	If you have, have you ever shared injection equipment (needle and syringe) while you inject narcotics in the prison?	Yes [1] No [2] No response [99]	If [2] skip to P610
P609	If you have, have shared injection equipments while you inject narcotics in the prison in the <u>past 3 months</u> ?	Yes [1] No [2] No response [99]	
P610	Did you have “artificial penile nodule” done in this prison? ( <i>Note to reviewers: This is a well-known phenomenon in Thailand.</i> )	Yes [1] No [2] No response [99]	
P611	Have you ever had anal sex with another male in this prison (including gays and transgender)?	Yes [1] No [2] No response [99]	If [2] skip to P617, then 619
P612	Have you had anal sex with another male in this prison <u>in the past 3 month</u> ?	Yes [1] No [2] No response [99]	
P613	How many total numbers of male have you had anal sex with (receptive or insertive) since you have been in this prison?	Number [ ][ ][ ] Don't know [8888] No response [9999]	(max 999)
P614	When you have anal sex with another male <u>in this prison</u> , are you the receptive or the insertive partner?	Receptive [1] Insertive [2] Both [3] No response [99]	
P615	When you had anal sex with other male inmates in this prison, how frequently did you use a condom?	Every or almost every time [1] Sometimes [2] Never [3] No response [99]	If [5], skip to 617, then 619
P616	The last time you had anal sex with another male inmate, did you use a condom?	Yes [1] No [2] No response [99]	
P617	How easy is it to get condoms while you are in this prison?	Very easy [1] Easy [2] Difficult [3] Very difficult [4] Don't know [9]	<i>Both sexually active &amp; not active should answer</i>
P618	When you used condom during sex with another male, how frequently did you use lubricants?	Every time [1] Almost every time [2] Half of the time [3] Sometime [4]	If [5] to P619

No.	Questions and filters	Coding categories	Skip to
		Never [5] No response [99]	
<b>P618.1</b>	Which lubricants do you commonly use while you are in the prison? ( <i>multiple responses possible</i> )	Body lotion [1] Baby Oil [2] Soapy water [3] Saliva [4] KY or Duo gel [5] Other [6]	
<b>P618.2</b>	If other, specify	_____	
<b>P619</b>	Since you have been in prison, has anyone ever forced you to have anal sex with them even though you did not want to have sex?	Yes [1] No [2] No response [99]	<i>Both sexually active &amp; naïve have to answer</i>
<b>P620</b>	Since you have been in prison, have you ever forced anyone to have anal sex with you even though they did not want to have sex?	Yes [1] No [2] No response [99]	

**Section G: HIV testing and prison health care services**

No.	Questions and filters	Coding categories	Skip to
<b>P700</b>	Have you ever had an HIV test (before you came to this prison)?	Yes [1] No [2] Don't know [9]	If [2], to P703
<b>P701</b>	Did you voluntarily undergo the HIV test, or were you required to have the test?	Voluntary [1] Required [2] Don't know [9]	
<b>P702</b>	Did you find out the result of your test?	Yes [1] No [2]	
<b>P703</b>	Do you think it is appropriate to provide the HIV VCT service in prison clinic?	Yes [1] No [2] Don't know [9]	
<b>P704</b>	Do you know that HIV VCT service is available free of charge at the prison clinic?	Yes [1] No [2]	
<b>P705</b>	How likely is it that you will get tested for HIV at the prison clinic in the next 3 months?	Extremely likely [1] Somewhat likely [2] Not at all likely [3] Don't know [9]	
<b>P706</b>	Have you ever received HIV testing and counseling service (VCT) at the prison clinic during your incarceration in this prison?	Yes [1] No [2]	If [2], to P717



No.	Questions and filters	Coding categories	Skip to
P706.1	How did you know about the HIV VCT at the prison clinic? (you can choose more than one)	from peer educator [1] from HIV prevention event [2] from prison guards [3] from prison clinic/ clinic staff [4] from HIV workshop I attended [5] from poster, media, and brochure [6] from my friend who took it [7]	
P706.2	When was the last time that you received HIV VCT service at the prison clinic?	In the past 3 months [1] More than 3 months but less than 12 months ago [2] More than one year but less than 2 years ago [3] More than 2 years but less than 3 years ago [4] More than 3 years ago [5] Cannot remember/don't know [9]	
P707	At your latest VCT here, did you receive pre HIV test counseling?	Yes [1] No [2]	If [2], to P708
P707.1	What information did you get during such counseling? (you can choose more than one item)	The reason of your VCT [1] HIV transmission knowledge [2] Your HIV risk assessment [3] HIV prevention methods [4] Condom use demonstration [5] Your privacy & confidentiality protection [6] Meaning of positive & negative result [7] Plan for HIV positive result [8] Your freedom to decide to take the test [9]	
P707.2	Who provided you that counseling session at your latest VCT here?	Prison nurse(s) [1] Nurse(s) from community hospital [2] Nurse assistant (prisoner) at prison clinic [3]	
P708	At your latest VCT here, did you receive your HIV result?	Yes [1] No [2]	
P709	How long did it take to get your HIV result since your blood draw?	_____ days (estimation)	
P710	At your latest VCT here, did you receive counseling before the staff gave you your HIV result?	Yes [1] No [2]	If [2], then 711
P710.1	During the post HIV test counseling, did the counselor help you to do the following? (you can choose more than one item)	Revisit your HIV risk [1] Recall the meaning of test result [2] Get your result [3] Know HIV prevention methods [4] Know about window period [5] Know about risk reduction and condom use [6] Know about CD4 testing and medical check up [7] Know about HIV care and future plan [8] Know about confidentiality of your test result [9]	
P710.2	Who provided you that counseling session at your latest VCT here?	Prison nurse(s) [1] Nurse(s) from community hospital [2] Nurse assistant (prisoner) at prison clinic [3]	
P711	After you received your HIV result, did you receive CD4 testing?	Yes [1] No [2] Don't know [9]	If [1], to P713

No.	Questions and filters	Coding categories	Skip to
P712	Why did you not receive CD4 testing?	I got HIV negative result [1] They never called up [2] I am in a process and will get it soon [3] I am not eligible to get it ( non-Thai) [4] Don't know [9]	Then, to P716
P713	How long did it take to receive CD4 result, from the CD4 testing?	____ days (estimation) Still waiting for the result [999]	If 999, to 716
P714	What was your latest CD4 level	Above 200 [1] Below 200 [2] Don't know [3]	
P715	Did you receive the following services after your CD4 test? (you can choose > 1)	Physical check up at hospital [1] TB sputum check [2] ART orientation [3] ART [4] OI prophylaxis [5] OI treatment (including TB) [6] Never received any services stated above [7]	
P716	Please rate how satisfied you are with the VCT and HIV care service provided at the prison clinic	1 /2 /3 /4 /5 /6 /7 /8 /9 /10 (1 = poorly, 10 = very well)	
P717	Have you ever used the health care services provided by the prison?	Yes [1] No [2] Don't know [9]	If [2], to section H
P718	Did you get better after receiving the health care service in the prison?	Yes [1] No [2] Don't know [9]	
P719	Are you satisfied with the quality of the health care service that you received in the prison so far?	Yes [1] No [2] Don't know [9]	
P720	Please rate how well the clinic provides health care to the prison inmates	1 /2 /3 /4 /5 /6 /7 /8 /9 /10 (1 = poorly, 10 = very well)	

**Section H: Exposure to peer education (all new, not in baseline survey)**

No.	Questions and filters	Coding categories	Skip to
<b>P801</b>	Have you been approached by anti-HIV peer educators?	Yes [1] No [2] Don't know [9]	If [2] or [9], to P807
<b>P802</b>	What services have you received from peer educators? (you can answer more than one)	HIV/AIDS information [1] STI information [2] TB information [3] HIV risk assessment [4] Risk reduction counseling [5] Condom/lubricant distribution [6] HIV care counseling [7] Sensitizing PLHA acceptance [8] Promoting HIV/STI service at clinic [9] Promoting other services at clinic [10] General health counseling [11] General prison life counseling [12] Other information [13]	
<b>P803</b>	What services have you received from peer education corner in your compound? (you can select more than 1)	Learn about HIV/ STI [1] Get risk reduction counseling [2] Sign up for HIV VCT [3] Get condoms [4] Get lubricants [5] Get health related counseling [6] Other entertainment purpose [7] Never been to peer education corner [8]	
<b>P804</b>	What peer educator services do you think most useful to prisoners? (pick 3)	HIV/AIDS information [1] STI information [2] TB information [3] HIV risk assessment [4] Risk reduction counseling [5] Condom/lubricant distribution [6] HIV care counseling [7] Sensitizing PLHA acceptance [8] Promoting HIV/STI service at clinic [9] Promoting other services at clinic [10] General health counseling [11] General prison life counseling [12]	If [1], then 806
<b>P805</b>	In your opinion, how well can the peer educators facilitate you & other prisoners to get faster healthcare service?	Very well [1] Moderately [2] Somewhat [3] Not at all [4]	
<b>P806</b>	In your opinion, how well can peer educators help you and other prisoners to better understand HIV, TB and STI?	Very well [1] Moderately [2] Somewhat [3] Not at all [4]	

No.	Questions and filters	Coding categories	Skip to
<b>P807</b>	How much can prisoners benefit from the [HIV prevention] project?	Very much [1] Moderately [2] Somewhat [3] Not at all [4] Never heard of PR2 [5]	If [5], then finish
<b>P808</b>	Does [HIV prevention] project help you to receive better quality healthcare service?	Yes [1] No [2] Don't know [9]	
<b>P809</b>	Does [HIV prevention] project help prisoners to have better quality of life?	Yes [1] No [2] Don't know [9]	
<b>P810</b>	Do you think [HIV prevention] project should be continued?	Yes [1] No [2] Don't know [9]	
<b>P811</b>	Other additional comments	_____ No comment [9999]	optional

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## A2 Methodology Tables and Figures

**Table A2.1: Number of FSWs, MSM and PWID reached by HIV prevention programs supported by the Global Fund**

Province	FSW		MSM		PWID	
	Target	Number reached by program	Target	Number reached by program	Target	Number reached by program
<b>Central</b>						
1. Bangkok	7058	6984	n/a	6706	1964	2301
2. Nakhon Pathom	327	335	n/a	0		
3. Phra Nakhon Si Ayutthaya	341	406	n/a	417		
4. Samut Sakhon	208	234				
5. Phatum Thani	216	220	n/a	1064	85	44
6. Samut Prakan	57	95	n/a	1011	366	174
7. Kanchanaburi	64	85				
8. Ratchaburi	35	72	n/a	1984		
9. Nonthaburi	70	53	n/a	727	208	402
10. Samut Songkhram	14	35				
<b>East</b>						
11. Chonburi	3668	3806	n/a	1723		
12. Rayong	140	271	n/a	269		
13. Trat	155	111	n/a	0		
<b>South</b>						
14. Phuket	1226	1238	n/a	356		
15. Songkhla	767	782	n/a	551	275	225
16. Surat Thani	435	509	n/a	348	156	132
17. Prachuap Khiri Khan	207	349				
18. Nakhon Si Thammarat	206	325	n/a	310	130	5
19. Phang Nga	61	176	n/a	0		
20. Ranong	39	172				
21. Chumphon	67	164				
22. Krabi	175	206				
23. Trang	128	101	n/a	549	90	126
24. Phattalung	131	123	n/a	514	73	47
25. Pattani	79	121				
26. Satun	85	108			145	105
<b>Northeast</b>						
27. Khon Kaen	186	430	n/a	4448		
28. Udon Thani	151	183	n/a	1487		



Province	FSW		MSM		PWID	
	Target	Number reached by program	Target	Number reached by program	Target	Number reached by program
29. Nongkhai	93	224	n/a	683		
30. Nakhon Ratchasima	123	175	n/a	559		
31. Ubon Ratchathani	110	126	n/a	1531		
32. Sisaket	38	149				
33. Roi Et	27	125				
34. Nakhon Phanom	36	99				
35. Sa kaeo	39	71				
36. Mukdahan	25	63	n/a	143		
<b>North</b>						
37. Chiang Mai	437	419	n/a	5605	800	694
38. Tak	168	234	n/a	0		
39. Chiang Rai	46	180	n/a	656	540	661
40. Phitsanulok	159	168	n/a	0		
41. Nakhon Sawan	192	87	n/a	0		
42. Lampang			n/a	605		
43. Lamphoon			n/a	487		
44. Mae Hong Son					105	66
<b>Total</b>	<b>17,789</b>	<b>19,814</b>		<b>32,733</b>	<b>5,024</b>	<b>4,983</b>

**Source of data:** PR-DDC for MSM and FSW, and PSI for PWID

**Note:** The data for MSM and FSW is cumulative from June 2010 – March 2011  
The data for PWID is cumulative from July 2009 – March 2011

Figure A2.1 Network diagram for Province A FSW by venue/non-venue status (red=venue-based; blue=non-venue based)

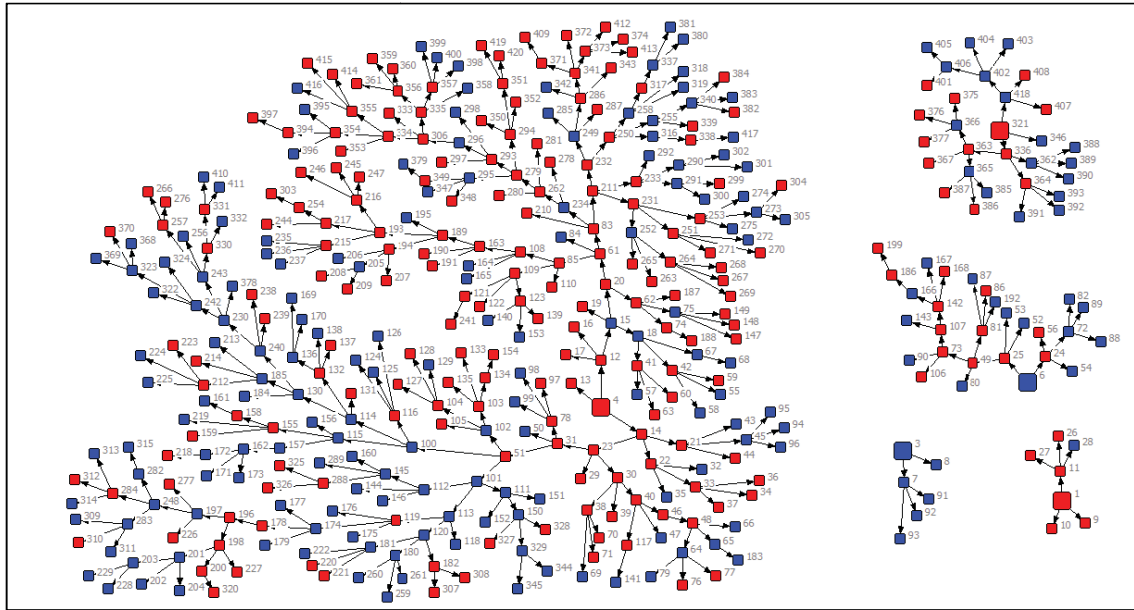
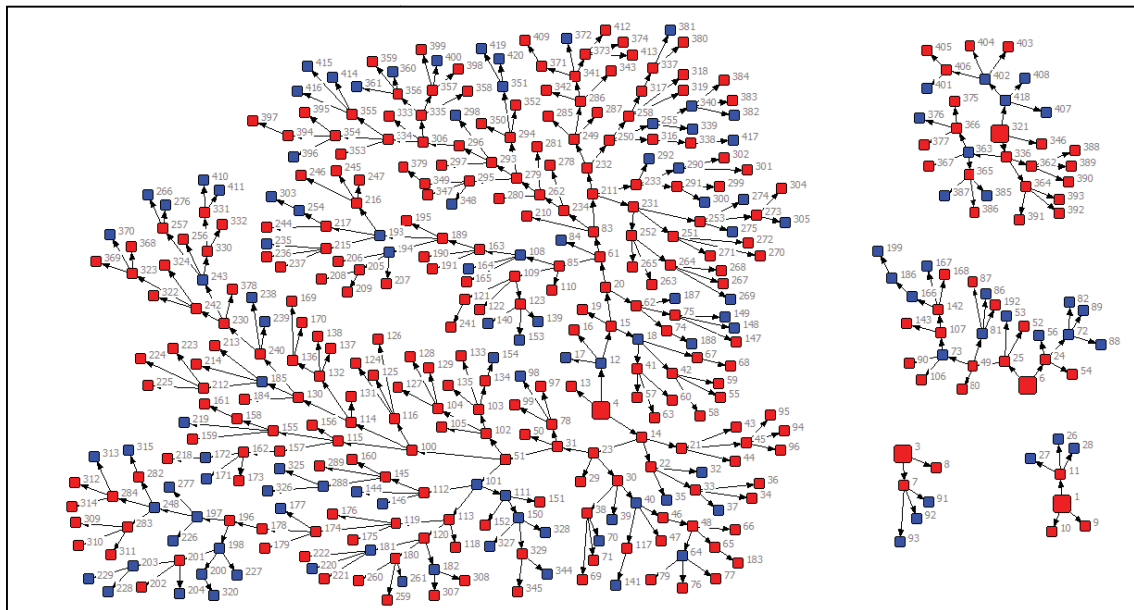
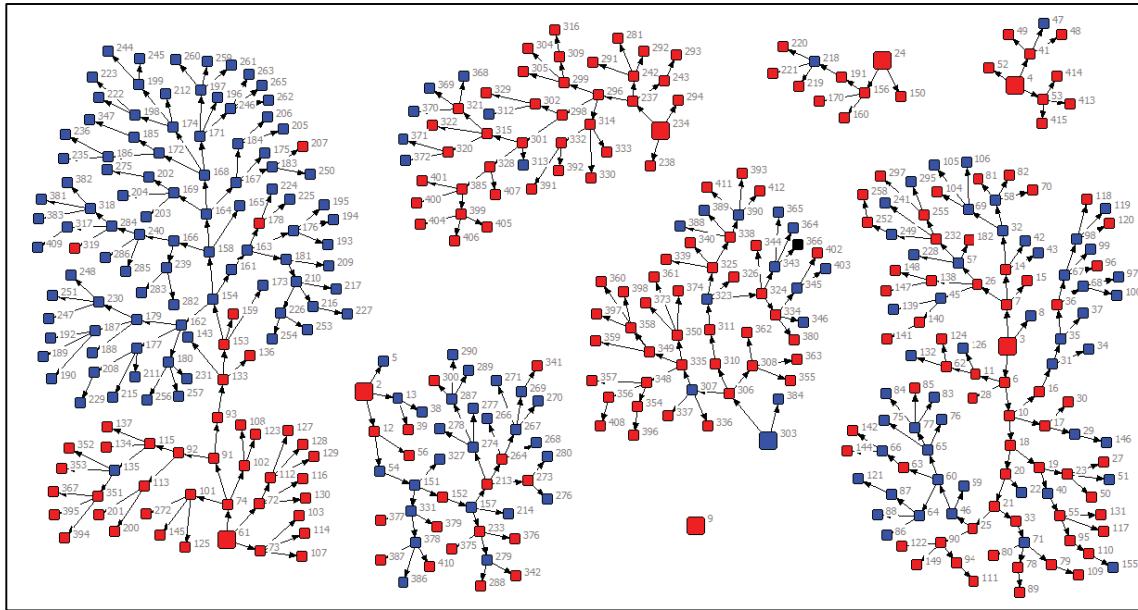


Figure A2.2: Network diagram for Province A FSW by age group (blue=<25, red=25+)



**Figure A2.3 Network diagram for Province B FSW by venue/non-venue status (red=venue-based; blue=non-venue based)**



**Figure A2.4: Network diagram for Province A FSW by age group (blue=<25, red=25+)**

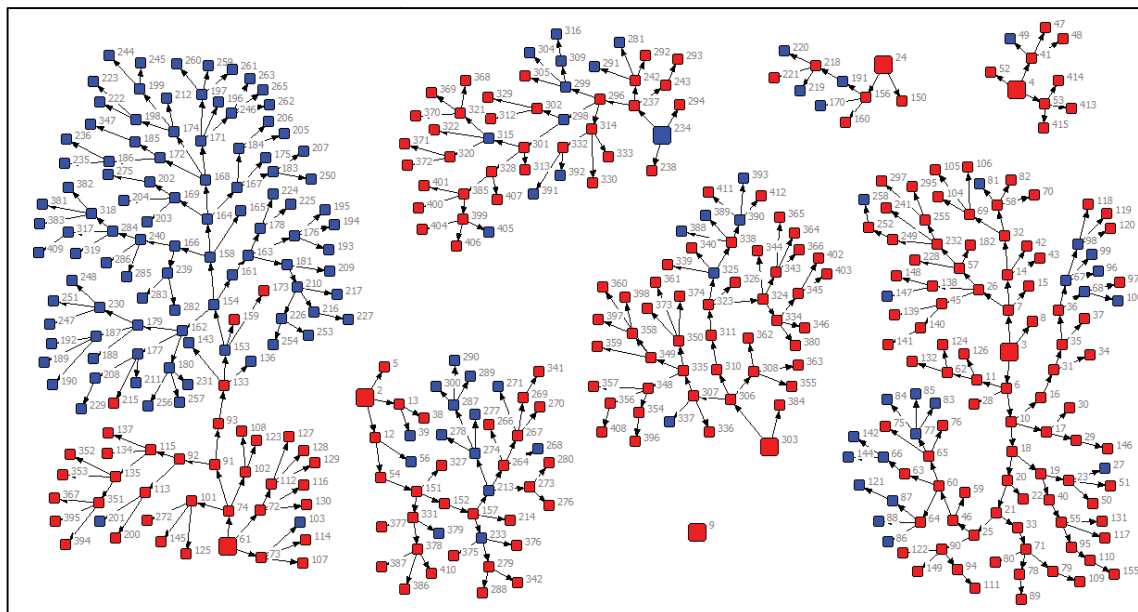


Figure A2.5 Network diagram for Capital City FSW by venue/non-venue status (red=venue-based; blue=non-venue based)

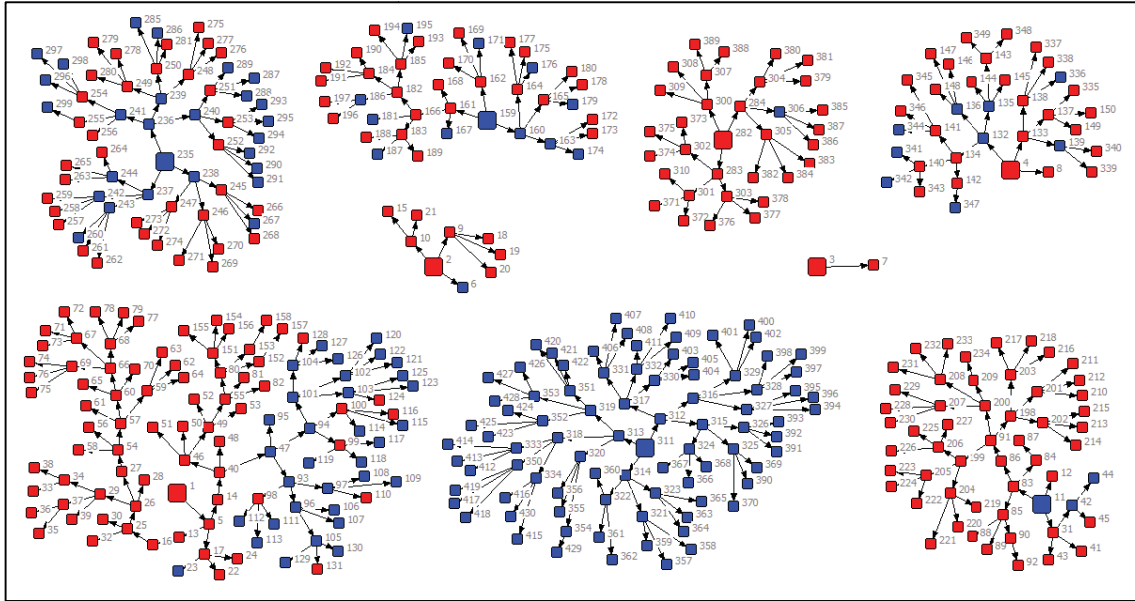
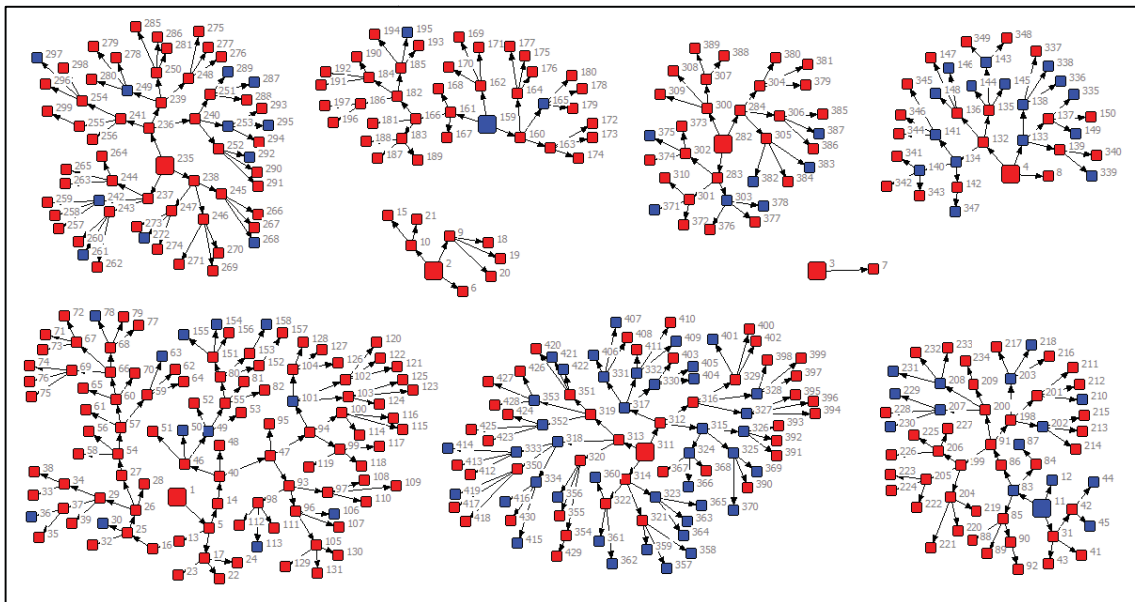
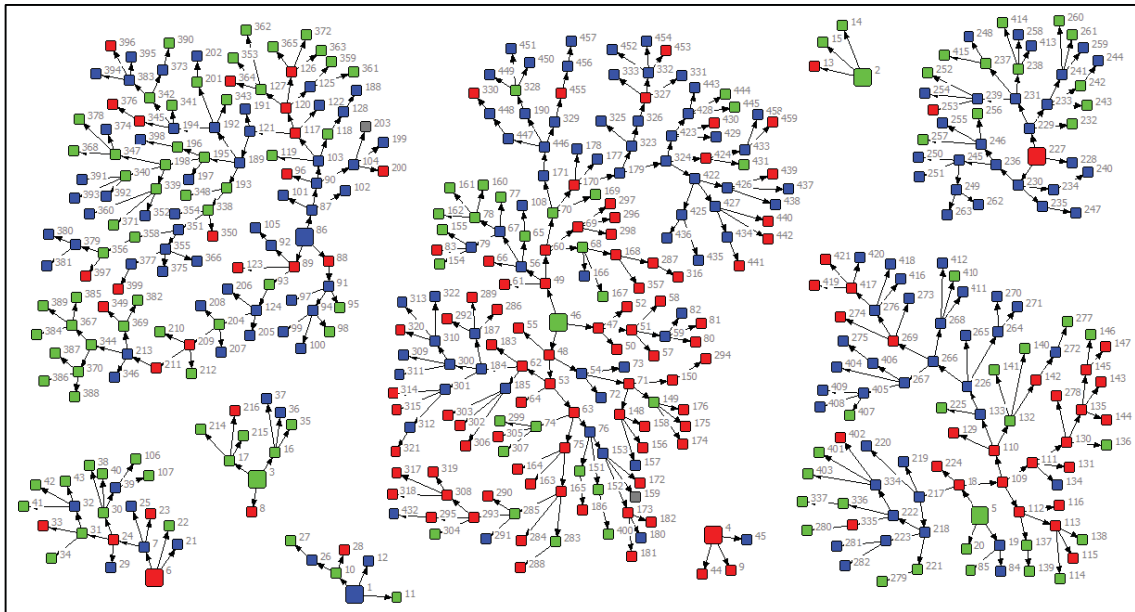


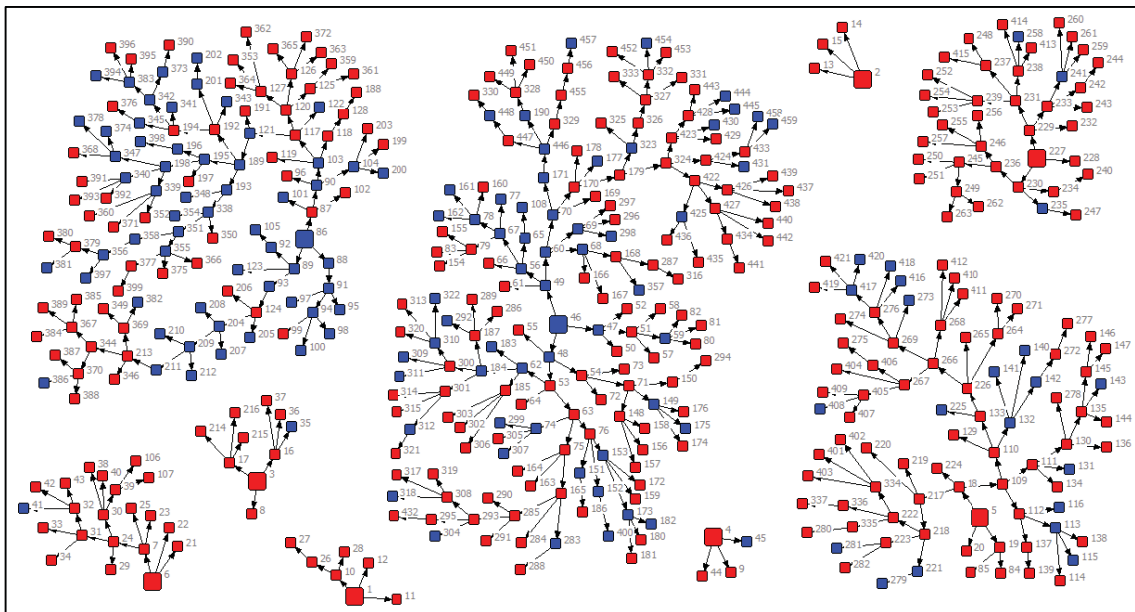
Figure A2.6: Network diagram for Capital City FSW by age group (blue=<25, red=25+)



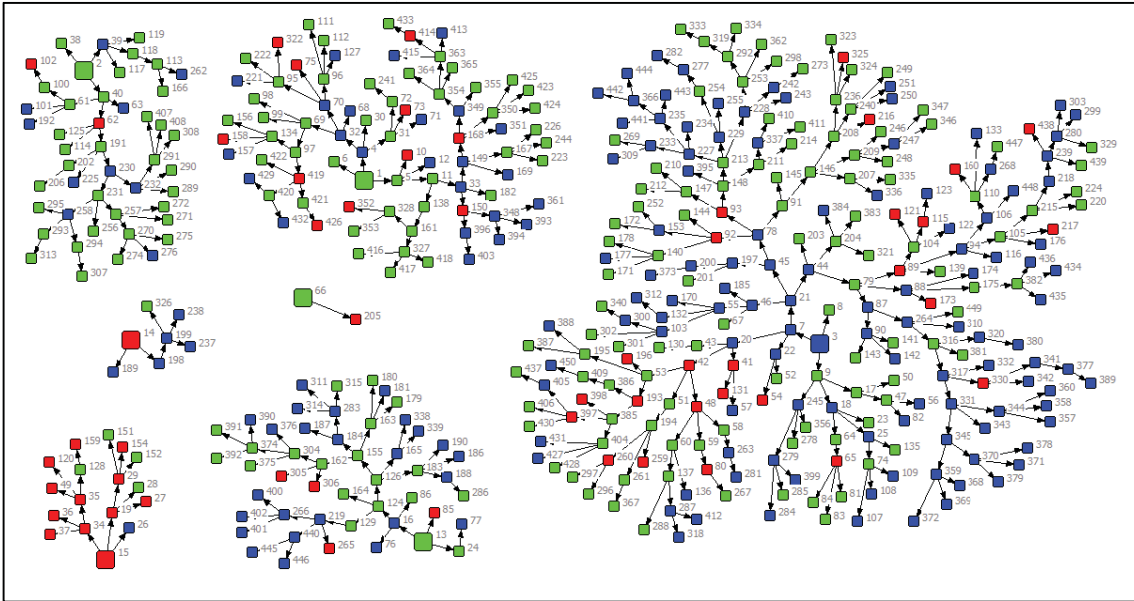
**Figure A2.7 Network diagram for Province A MSM by MSM group (blue=general population MSM; green=transgender; red=male sex workers)**



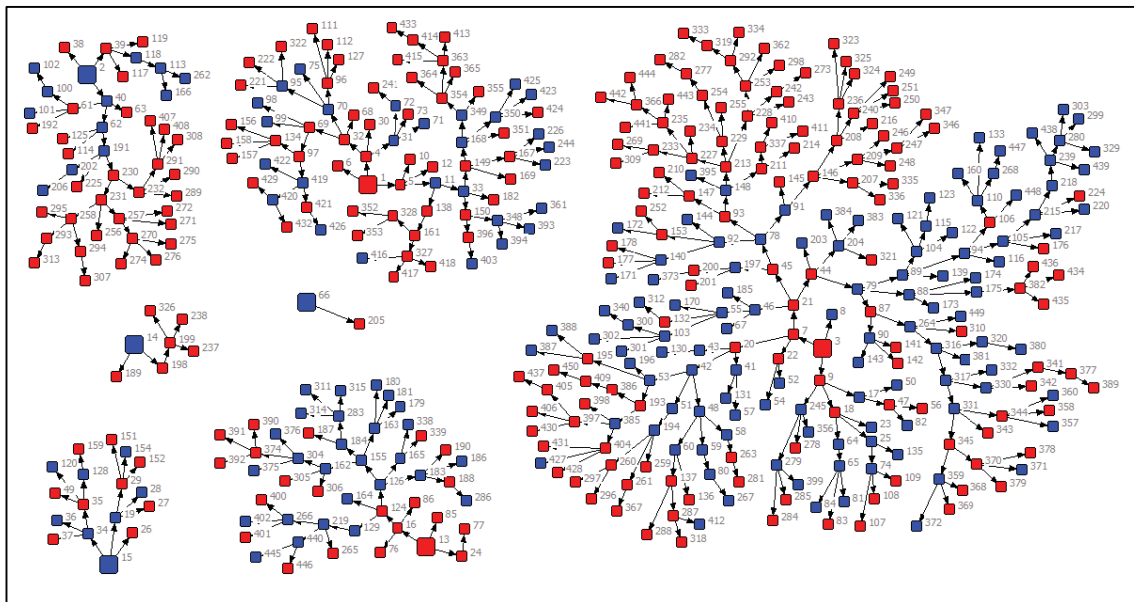
**Figure A2.8: Network diagram for Province A MSM by age group (blue=<25, red=25+)**



**Figure A2.9 Network diagram for Province B MSM by MSM group (blue=general population MSM; green=transgender; red=male sex workers)**

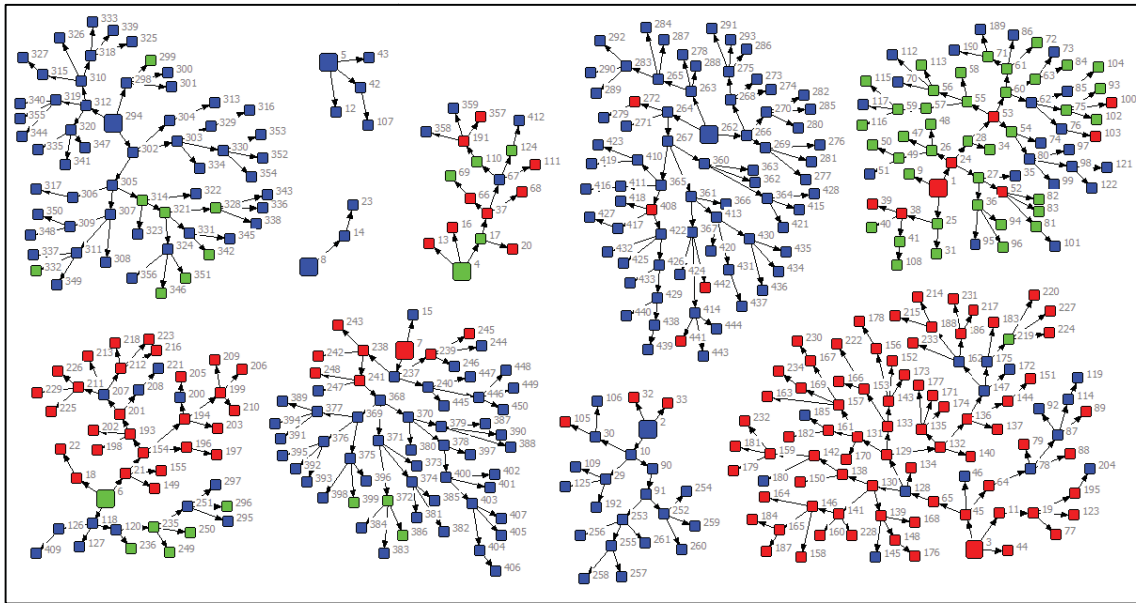


**Figure A2.10 Network diagram for Province B MSM by age group (blue=<25, red=25+)**

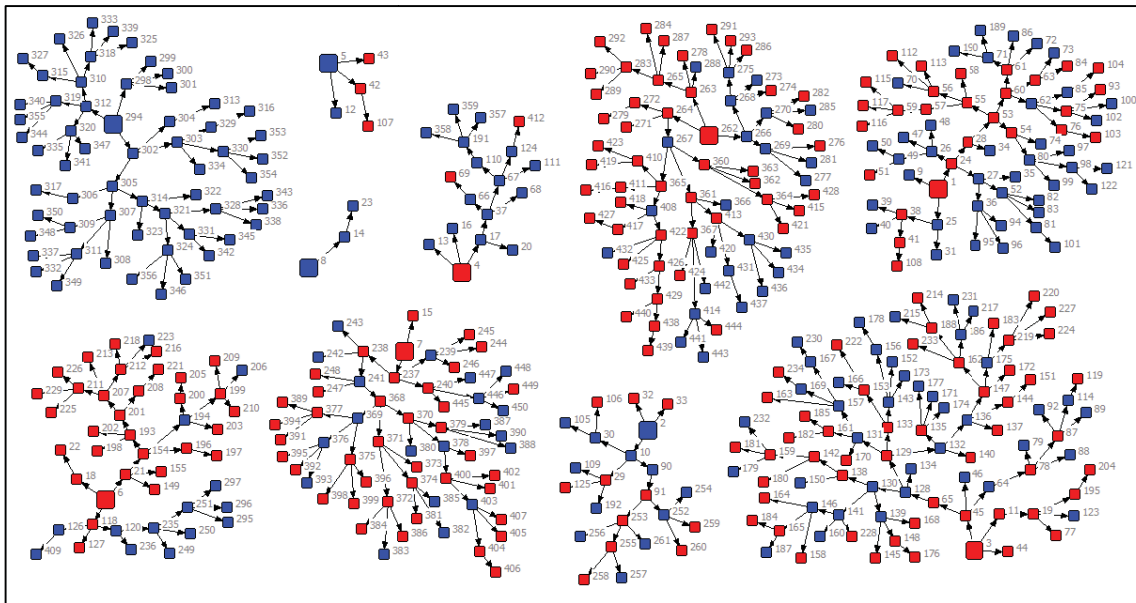




**Figure A2.11 Network diagram for Capital City MSM by MSM group (blue=general population MSM; green=transgender; red=male sex workers)**



**Figure A2.12: Network diagram for Capital City MSM by age group (blue=<25, red=25+)**



## A3 Female Sex Worker Tables

**Table A3.1 Sociodemographic characteristics for venue/non-venue-based FSWs**

	Province A			Province B			Capital City		
	Venue	Non-Venue	Total	Venue	Non-Venue	Total	Venue	Non-Venue	Total
<b>Age group</b>									
18-21	22.0	25.9	23.9	12.0	52.8	34.6	16.0	23.3	19.3
22-24	11.0	13.8	12.4	13.3	9.9	11.4	8.1	9.4	8.7
25-29	18.3	16.2	17.3	17.0	9.7	13.0	16.3	31.9	23.4
30-39	28.5	21.5	25.1	38.2	17.4	26.7	49.4	26.7	39.1
40+	20.2	22.6	21.4	19.5	10.2	14.4	10.2	8.6	9.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(209)	(181)	(390)	(206)	(189)	(395)	(253)	(172)	(425)
<b>Median age</b>	<b>30</b>	<b>29</b>	<b>29.5</b>	<b>33</b>	<b>21</b>	<b>26</b>	<b>31</b>	<b>27</b>	<b>29</b>
<b>Educational attainment</b>									
Never attended school	3.6	5.9	4.7	2.6	0.5	1.5	0.0	2.8	1.3
Primary	54.3	45.7	50.0	34.8	19.6	26.6	35.5	42.3	38.6
Up to Mattayom 3	25.7	31.9	28.8	31.6	34.0	32.9	40.8	26.3	34.2
Up to Mattayom 6	12.9	14.0	13.4	26.1	40.2	33.7	19.2	21.3	20.1
Higher than Mattayom 6 e.g. Vocational college	3.3	2.6	2.9	3.9	4.7	4.3	3.7	5.2	4.4
Bachelor's degree or higher	0.3	0.0	0.1	1.1	1.0	1.0	0.8	2.1	1.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)
<b>Marital status</b>									
Married, living with partner	5.5	1.3	8.3	4.9	4.6	4.7	6.8	4.9	5.9
Not married, living with partner	10.0	4.8	7.4	17.5	12.5	14.8	12.6	17.5	14.8
Ever married, not living with partner	48.6	51.4	32.0	62.3	37.6	48.9	47.0	34.7	41.4
Never married, not living with partner	30.6	33.4	32.0	15.4	45.3	31.6	33.7	42.9	37.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)
<b>Alcohol use in past 4 weeks</b>									
Drink <once a week	67.6	49.1	58.5	67.9	66.2	67.0	78.7	37.4	60.0
Drink at least once a week	32.4	50.9	41.5	32.1	33.8	33.0	21.3	62.6	40.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)
<b>Drug use past 12 mos.</b>									
Yes	11.0	9.8	10.4	3.0	7.9	5.7	8.6	8.8	8.7
No	89.1	90.2	89.6	97.0	92.1	94.4	91.4	91.2	91.3



	Province A			Province B			Capital City		
	Venue	Non-Venue	Total	Venue	Non-Venue	Total	Venue	Non-Venue	Total
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)

**Table A3.2 Sex work characteristics for venue/non-venue-based FSWs**

	Province A			Province B			Capital City		
	Venue	Non-Venue	Total	Venue	Non-Venue	Total	Venue	Non-Venue	Total
<b>Length of time working as a sex worker</b>									
Less than year	5.7	10.4	8.0	10.8	10.2	10.5	16.0	24.8	20.0
1-2 years	34.1	31.1	32.6	33.7	45.8	40.2	32.3	35.8	33.9
3-4 years	26.0	17.2	21.7	20.5	28.4	24.8	16.5	19.1	17.7
5-9 years	19.9	22.9	21.4	21.0	10.1	15.1	26.0	10.0	18.8
10+ years	14.4	18.4	16.3	14.0	5.6	9.4	9.2	10.3	9.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)
<b>Where usually contact clients</b>									
Massage	8.8	-	4.5	57.6	-	26.4	11.4	-	6.3
Entertainment	91.2	-	46.4	42.5	-	19.5	88.6	-	48.5
Public	-	1.2	0.6	-	1.3	0.7	-	55.0	24.9
Pimp	-	48.3	23.8	-	29.8	16.1	-	2.0	0.9
Freelance	-	49.3	24.2	-	69.0	37.4	-	43.0	19.4
Other	-	1.1	0.6	-	0.0	0.0	-	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)
<b>Payment for last sex</b>									
<1000	21.1	23.3	22.2	20.6	5.5	12.4	2.8	42.0	20.5
1000-1499	31.2	26.6	28.9	20.6	24.0	22.4	11.4	13.0	12.1
1500-1999	16.2	25.5	20.8	25.2	17.4	21.0	11.9	14.5	13.1
2000-2499	12.4	14.2	13.3	20.2	21.2	20.8	24.6	13.4	19.5
2500-4999	15.3	9.3	12.3	9.6	25.6	18.3	41.2	13.5	28.6
5000+	3.8	1.1	2.5	3.8	6.3	5.2	8.2	3.6	6.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)
<b>Median price</b>	<b>1300</b>	<b>1500</b>	<b>1300</b>	<b>1500</b>	<b>2000</b>	<b>1500</b>	<b>2000</b>	<b>1000</b>	<b>2000</b>

**Table A3.3 Sex work characteristics of FSWs by age group**

	Province A			Province B			Capital City		
	Age <25	Age 25+	Total	Age <25	Age 25+	Total	Age <25	Age 25+	Total
<b>Length of time working as a sex worker</b>									
Least than year	15.8	4.1	8.1	16.5	5.6	10.4	32.4	15.2	20.0
1-2 years	56.6	20.4	32.6	59.6	24.8	40.1	44.9	29.7	33.9
3-4 years	16.0	24.5	21.6	20.6	28.3	24.9	13.1	19.4	17.7
5-9 years	11.0	26.6	21.3	3.1	24.6	15.1	8.5	22.7	18.8
10+ years	0.6	24.4	16.4	0.3	16.7	9.4	1.2	13.0	9.7
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(124)	(294)	(418)	(157)	(256)	(413)	(105)	(325)	(430)
<b>Where usually contact clients</b>									
Massage/brothel	0.0	6.8	4.5	6.9	41.8	26.4	4.3	7.0	6.3
Entertainment	47.0	46.0	46.3	17.7	20.9	19.5	42.6	50.8	48.5
Public	0.8	0.5	0.6	0.0	1.2	0.7	38.9	19.5	24.9
Pimp	25.3	23.0	23.8	27.4	7.1	16.1	2.8	0.2	0.9
Freelance	26.4	23.1	24.2	48.0	29.0	37.4	11.5	22.5	19.4
Other	0.5	0.6	0.6	0.0	0.0	0.0	0.0	0.0	0.0
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(124)	(294)	(418)	(157)	(255)	(412)	(105)	(325)	(430)
<b>Number of clients in past month</b>									
1-4	41.8	53.3	49.4	59.6	49.9	54.2	38.4	42.9	41.7
5-8	31.1	32.2	31.8	23.0	20.8	21.8	18.9	15.6	16.5
9-14	11.2	8.7	9.5	8.2	10.6	9.5	7.1	15.2	13.1
15-28	10.3	4.5	6.5	5.8	10.2	8.2	14.3	11.6	12.3
30+	5.6	1.4	2.8	3.5	8.5	6.3	21.4	14.7	16.5
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(124)	(293)	(417)	(157)	(254)	(411)	(101)	(323)	(424)
<b>Payment for last sex</b>									
<1000	12.0	27.4	22.2	8.6	15.5	12.4	31.9	16.1	20.5
1000-1499	22.3	32.2	28.9	20.1	24.2	22.4	18.0	9.9	12.1
1500-1999	26.9	17.8	20.9	15.0	25.6	20.9	6.7	15.6	13.1
2000-2499	21.7	9.0	13.3	23.2	18.8	20.8	15.1	21.2	19.5
2500-4999	16.5	10.1	12.3	26.3	12.1	18.4	22.9	30.8	28.6
5000+	0.6	3.5	2.5	6.8	3.9	5.2	5.4	6.4	6.1
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(124)	(294)	(418)	(157)	(256)	(413)	(105)	(325)	(430)
<b>Median price</b>	<b>1500</b>	<b>1000</b>	<b>1300</b>	<b>2000</b>	<b>1500</b>	<b>1500</b>	<b>1425</b>	<b>2000</b>	<b>2000</b>

**Table A3.4: Knowledge and experience with STI symptoms and treatment by venue/non-venue-based FSWs**

	Province A			Province B			Capital City		
	Venue	Non-Venue	Total	Venue	Non-Venue	Total	Venue	Non-Venue	Total
<b>Number of STI symptoms in women able to name spontaneously</b>									
None	60.9	55.6	58.3	19.6	32.4	26.5	22.8	33.3	27.5
1-2	32.2	31.5	31.9	58.2	53.1	55.5	59.8	50.4	55.5
3+	6.9	13.0	9.9	22.2	14.5	18.0	17.5	16.3	16.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)
<b>Experienced symptoms of STIs in the past 12 months</b>									
Yes	43.2	51.8	47.4	38.7	41.2	40.1	39.8	38.8	39.3
No	56.8	48.2	52.6	61.3	58.8	59.9	60.3	61.2	60.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)
<b>How treated symptoms</b>									
Medical visit	32.9	33.7	33.3	44.3	22.8	32.2	37.5	35.8	36.8
Pharmacy	48.1	45.0	46.5	55.7	46.5	50.5	58.2	52.5	55.7
Nothing	19.0	21.3	20.2	0.0	30.8	17.2	4.3	11.7	7.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(92)	(98)	(190)	(74)	(82)	(156)	(98)	(76)	(174)

**Table A3.5: Knowledge and experience with STI symptoms and treatment for FSWs by age group**

	Province A			Province B			Capital City		
	Age <25	Age 25+	Total	Age <25	Age 25+	Total	Age <25	Age 25+	Total
<b>Number of STI symptoms in women able to name spontaneously</b>									
None	66.8	53.9	58.3	29.2	24.3	26.5	37.5	23.7	27.5
1-2	29.7	33.0	31.9	57.8	53.7	55.5	51.8	57.0	55.5
3+	3.5	13.2	9.9	13.0	22.0	18.0	10.7	19.4	16.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(124)	(294)	(418)	(157)	(256)	(413)	(105)	(325)	(430)
<b>Experienced symptoms of STIs in the past 12 months</b>									
Yes	44.0	49.1	47.4	37.3	42.5	40.2	42.3	38.2	39.3
No	56.0	50.9	52.6	62.7	57.5	59.8	57.7	61.8	60.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(124)	(294)	(418)	(157)	(256)	(413)	(105)	(325)	(430)
<b>How treated symptoms</b>									
Medical visit	34.7	32.7	33.3	31.3	33.3	32.5	35.0	37.5	36.8
Pharmacy	28.6	54.9	46.5	39.5	58.1	50.4	57.2	55.1	55.7
Nothing	36.7	12.4	20.2	29.2	8.5	17.2	7.8	7.4	7.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(55)	(135)	(190)	(70)	(87)	(157)	(48)	(126)	(74)

**Table A3.6 Knowledge about HIV as measured by GARPR standard questions by venue/non-venue based FSWs**

	Province A			Province B			Capital City		
	Venue	Non-Venue	Total	Venue	Non-Venue	Total	Venue	Non-Venue	Total
<b>Number of correct answers from GARPR standard questions</b>									
No correct items	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0
1-2 correct items	12.7	14.6	13.7	6.9	7.3	7.1	4.6	8.9	6.5
3-4 correct items	63.3	65.8	64.5	59.6	64.0	62.0	59.1	70.9	64.4
5 correct items	24.0	19.6	21.8	33.6	28.7	30.9	36.4	20.2	29.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)

**Table A3.7 Knowledge about HIV as measured by GARPR standard questions by age group of FSWs**

	Province A			Province B			Capital City		
	Age <25	Age 25+	Total	Age <25	Age 25+	Total	Age <25	Age 25+	Total
<b>Number of correct answers from GARP standard questions</b>									
No correct items	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0
1-2 correct items	16.8	12.1	13.7	9.8	4.9	7.1	10.0	5.2	6.5
3-4 correct items	68.5	62.5	64.5	68.3	56.8	61.9	63.2	64.9	64.4
5 correct items	14.7	25.4	21.8	21.9	38.3	31.0	26.7	29.9	29.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(124)	(294)	(418)	(157)	(256)	(413)	(105)	(325)	(430)

**Table A3.8 HIV risk and prevention behaviors of venue/non-venue-based FSWs**

	Province A			Province B			Capital City		
	Venue	Non-Venue	Total	Venue	Non-Venue	Total	Venue	Non-Venue	Total
<b>Frequency of condom use with clients</b>									
Every time	89.3	87.4	88.4	94.3	84.9	89.2	86.4	90.0	88.0
Almost every time	8.3	10.1	9.2	4.6	7.8	6.4	12.4	6.7	9.8
Sometime	2.4	2.3	2.4	1.0	6.8	4.1	1.2	3.3	2.2
Never	0.0	0.2	0.1	0.0	0.6	0.3	0.0	0.0	0.0
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)
<b>Condom use with last client</b>									
Yes	97.9	98.7	98.3	98.8	97.1	97.9	98.1	99.6	98.8
No	2.1	1.3	1.7	1.2	2.9	2.1	1.9	0.4	1.2
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)
<b>Lubricant use with clients</b>									
Did not use	84.4	86.1	85.2	60.6	79.1	70.6	44.3	47.5	45.8
Non-water based	15.6	11.6	13.6	28.2	17.3	22.3	28.9	14.8	22.5
Water-based	0.0	2.4	1.2	11.2	3.6	7.1	26.8	37.7	31.7
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)
<b>Number of non-client partners in the past month</b>									
None	41.6	45.0	43.3	52.7	39.4	45.5	52.9	41.8	47.9
One	48.1	48.9	48.5	45.5	54.2	50.2	43.3	48.4	45.6
Two or more	10.3	6.2	8.3	1.8	6.5	4.4	3.8	9.8	6.5
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)
<b>Type of last non-client partner</b>									
None	26.6	23.5	25.1	52.7	37.4	44.4	50.4	41.1	46.2
Regular/spouse	44.9	51.3	48.0	38.5	50.4	44.9	36.5	46.3	40.9
Non-regular	28.5	25.2	26.9	8.8	12.2	10.7	13.2	12.6	12.9
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)
<b>Condom use with non-client partners last time</b>									
1 Yes	45.5	36.7	41.1	48.5	63.2	57.5	39.9	44.4	42.1
0 No	54.5	63.3	58.9	51.5	36.8	42.5	60.1	55.7	57.9
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(158)	(149)	(307)	(104)	(122)	(226)	(113)	(96)	(209)
<b>Frequency of condom use with non-clients</b>									
Every time	38.6	30.3	34.7	36.1	29.6	32.1	28.0	38.2	33.1
Almost every time	7.6	9.3	8.4	5.0	13.5	10.1	5.9	6.8	6.3
Sometime	12.0	15.5	13.6	20.0	30.3	26.2	15.6	7.8	11.6
Never	41.9	44.9	43.3	39.0	26.7	31.6	50.6	47.3	48.9
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(124)	(109)	(233)	(104)	(121)	(225)	(106)	(95)	(201)
<b>Ever used female condom</b>									
Yes	4.8	7.2	6.0	6.6	5.7	6.1	2.6	0.8	1.8
No	95.2	92.8	94.0	93.4	94.3	93.9	97.4	99.2	98.3
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)

**Table A3.9 HIV risk and prevention behaviors of older and younger FSWs**

	Province A			Province B			Capital City		
	Age <25	Age 25+	Total	Age <25	Age 25+	Total	Age <25	Age 25+	Total
<b>Frequency of condom use with clients</b>									
Every time	87.5	88.8	88.4	82.1	94.9	89.2	84.8	89.2	88.0
Almost every time	8.9	9.3	9.2	9.3	4.0	6.4	12.4	8.9	9.8
Sometime	3.6	1.7	2.4	8.2	0.9	4.1	2.8	1.9	2.2
Never	0.0	0.2	0.1	0.4	0.2	0.3	0.0	0.0	0.0
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(124)	(294)	(418)	(157)	(256)	(413)	(105)	(325)	(430)
<b>Condom use with last client</b>									
Yes	99.2	97.9	98.3	97.1	98.5	97.9	100.0	98.3	98.8
No	0.8	2.1	.7	2.9	1.5	2.1	0.0	1.7	1.2
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(124)	(294)	(418)	(157)	(256)	(413)	(105)	(325)	(430)
<b>Lubricant use with clients</b>									
Did not use	82.2	86.8	85.2	77.2	65.3	70.5	54.5	42.4	45.8
Non-water based	17.8	11.5	136.6	21.1	23.4	22.4	24.7	21.6	22.5
Water-based	0.0	1.8	1.2	1.7	11.3	7.0	20.8	36.0	31.7
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(124)	(294)	(418)	(157)	(256)	(413)	(105)	(325)	(430)
<b>Number of non-client partners in the past month</b>									
None	35.2	47.4	43.3	30.8	57.3	45.6	39.6	51.1	47.9
One	52.7	46.3	48.5	61.2	41.3	50.1	47.6	44.8	45.6
Two or more	12.1	6.4	8.3	8.0	1.4	4.3	12.9	4.1	6.5
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(124)	(294)	(418)	(157)	(256)	(413)	(105)	(325)	(430)
<b>Type of last non-client partner</b>									
None	24.1	25.5	25.0	30.8	55.3	44.5	38.3	49.2	46.2
Regular/spouse	52.9	45.7	48.1	54.9	36.9	44.9	51.4	36.9	40.9
Non-regular	23.0	28.8	26.9	14.3	7.7	10.6	10.3	13.9	12.9
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(124)	(294)	(418)	(157)	(256)	(413)	(105)	(325)	(430)
<b>Condom use last time with non-client</b>									
1 Yes	42.6	40.3	41.1	69.7	42.4	57.5	48.0	39.3	42.1
0 No	57.4	59.7	58.9	30.3	57.6	42.5	52.0	60.7	57.9
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(92)	(215)	(307)	(110)	(116)	(226)	(67)	(142)	(209)
<b>Frequency condom use non-client</b>									
Every time	37.3	33.0	34.5	39.4	22.7	32.1	30.9	34.2	33.1
Almost every time	4.0	11.2	8.4	8.8	11.9	10.1	8.0	5.5	6.3
Sometime	14.5	13.0	13.6	38.1	10.9	26.2	14.2	10.4	11.6
Never	44.1	42.8	43.3	13.7	54.5	31.6	46.9	49.9	48.9
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<b>Ever used female condom</b>									
Yes	4.3	6.8	9.0	4.9	7.1	6.1	2.2	1.6	1.8
No	95.7	93.2	94.0	95.1	92.9	93.9	97.8	98.4	98.3
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(124)	(294)	(418)	(157)	(256)	(413)	(105)	(325)	(430)

**Table A3.10 Coverage of HIV prevention services for venue and non-venue-based FSWs**

	Province A			Province B			Province C		
	Venue	Non-venue	Total	Venue	Non-venue	Total	Venue	Non-venue	Total
Talked to an outreach worker in the past 12 months	19.8	11.2	15.6	39.1	19.5	28.5	36.8	12.9	26.0
Visited a drop-in center in the past 12 months	1.7	1.5	1.6	5.5	3.4	4.3	8.3	2.6	5.7
Received a free condom in the past 12 months	59.7	49.1	54.5	71.9	69.5	70.6	70.7	44.0	58.6
Received free lubricant in the past 12 months	12.7	6.7	9.7	49.3	27.5	37.5	42.5	16.0	30.5
Went for STI screening in the past 12 months	51.8	47.0	49.4	38.7	41.2	16.2	48.0	43.5	45.9
Went for HIV counseling and testing in the past 12 months	44.9	41.0	43.0	64.7	49.4	56.4	57.1	58.0	57.5
Went for HCT and got results of the test	43.8	40.5	42.2	64.7	41.1	51.9	56.5	55.8	56.1
<b>(N)</b>	<b>(220)</b>	<b>(198)</b>	<b>(418)</b>	<b>(219)</b>	<b>(193)</b>	<b>(412)</b>	<b>(258)</b>	<b>(172)</b>	<b>(430)</b>

**Table A3.11 Coverage of HIV prevention services for older and younger FSWs**

	Province A			Province B			Bangkok		
	Age <25	Age 25+	Total	Age <25	Age 25+	Total	Age <25	Age 25+	Total
Talked to a peer educator in the past 12 months	12.5	17.2	15.6	20.1	35.1	28.5	14.7	30.4	26.0
Visited a drop-in center in the past 12 months	2.3	1.2	1.6	1.6	6.5	4.3	2.4	7.0	5.7
Received a free condom in the past 12 months	48.2	57.7	54.5	69.1	71.6	70.5	52.2	61.1	58.6
Received free lubricant in the past 12 months	9.9	9.6	9.7	34.0	40.2	37.4	21.8	33.9	30.5
Went for STI screening in the past 12 months	43.6	52.4	49.4	37.3	42.5	16.3	36.1	49.7	45.9
Went for HIV counseling and testing in the past 12 months	39.3	44.9	43.0	53.5	58.7	56.4	43.0	63.1	57.5
Went for HCT and got results of the test	39.2	43.7	42.2	43.8	58.6	52.0	58.5	38.2	43.9
<b>(N)</b>	<b>(124)</b>	<b>(294)</b>	<b>(418)</b>	<b>(157)</b>	<b>(256)</b>	<b>(413)</b>	<b>(105)</b>	<b>(325)</b>	<b>(430)</b>

**Table A3.12 Source of STI screening referral, site for STI screening and satisfaction with STI services for venue/non-venue based FSWs**

	Province A			Province B			Province C		
	Venue	Non-venue	Total	Venue	Non-venue	Total	Venue	Non-venue	Total
<b>Got STI referral where</b>									
1 Outreach/DIC	1.8	2.6	2.2	2.2	9.4	3.9	2.4	0.0	1.4
2 Employr/medical	2.1	1.8	2.0	0.0	0.0	0.0	1.9	0.0	1.1
3 No referral	96.1	95.6	95.9	97.8	90.6	96.1	95.7	100.0	97.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(121)	(99)	(220)	(56)	(17)	(73)	(146)	(81)	(227)
<b>Got STI where</b>									
1 None	48.2	53.1	50.6	73.0	92.9	83.8	52.0	56.6	54.1
2 Government	45.4	38.8	42.1	16.1	5.2	10.2	8.4	19.5	13.4
3 FSW-special	1.9	1.7	1.8	6.1	0.9	3.3	6.4	1.7	4.3
4 Private	4.5	6.4	5.4	4.9	0.9	2.8	33.3	22.3	28.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(220)	(198)	(418)	(219)	(193)	(412)	(258)	(172)	(430)
<b>Got enough info STI</b>									
1 Yes	93.9	82.2	88.4	87.0	81.1	85.6	72.5	74.0	73.2
2 No	6.1	17.8	11.6	13.1	18.9	14.4	27.5	26.0	26.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(121)	(99)	(220)	(56)	(17)	(73)	(145)	(81)	(226)
<b>Were you provided with opportunities to ask questions about STIs and their treatment at your last STI</b>									
1 Yes	80.7	75.5	78.3	76.7	94.3	80.8	74.8	74.4	74.7
2 No	19.3	24.5	21.8	23.3	5.7	19.2	25.2	25.6	25.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(121)	(99)	(220)	(56)	(17)	(73)	(146)	(81)	(227)
<b>Were the explanations provided easy to understand?</b>									
1 Yes	98.3	96.3	97.4	100.0	100.0	100.0	99.8	98.8	99.4
2 No	1.7	3.7	2.6	0.0	0.0	0.0	0.2	1.2	0.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(96)	(81)	(177)	(47)	(16)	(63)	(116)	(65)	(181)
<b>Very confident in confidentiality STI</b>									
1 Yes	64.7	56.8	61.0	52.3	60.1	54.1	51.2	77.3	62.4
2 No	35.3	43.2	39.0	47.7	39.9	45.9	48.8	22.7	37.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(121)	(99)	(220)	(56)	(17)	(73)	(146)	(81)	(227)
<b>Not treated differently at STI</b>									
1 Yes	100.0	91.8	96.2	100.0	100.0	100.0	100.0	100.0	100.0
2 No	0.0	8.2	3.8	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(121)	(99)	(220)	(56)	(17)	(73)	(146)	(81)	(227)



**Table A3.13 Source of STI screening referral, site for STI screening and satisfaction with STI services for older and younger FSWs**

	Province A			Province B			Bangkok		
	Age <25	Age 25+	Total	Age <25	Age 25+	Total	Age <25	Age 25+	Total
<b>Got STI referral where</b>									
1 Outreach/DIC	4.1	1.4	2.2	0.0	4.7	3.9	0.0	1.8	1.4
2 Employr/medical	2.3	1.8	2.0	0.0	0.0	0.0	0.0	1.4	1.1
3 No referral	93.7	96.8	95.9	100.0	95.3	96.1	100.0	96.8	97.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(54)	(166)	(220)	(14)	(60)	(74)	(39)	(188)	(227)
<b>Got STI where</b>									
1 None	56.4	47.7	50.6	93.2	76.1	83.7	63.9	50.3	54.1
2 Government	37.9	44.3	42.1	3.6	15.6	10.3	14.7	12.9	13.4
3 FSW-special	0.8	2.3	1.8	0.3	5.7	3.3	3.9	4.4	4.3
4 Private	5.0	5.7	5.4	2.9	2.6	2.8	17.5	32.4	28.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(124)	(294)	(418)	(157)	(256)	(413)	(105)	(325)	(430)
<b>Got enough info STI</b>									
1 Yes	88.8	88.3	88.4	68.7	88.5	84.8	71.5	73.6	73.2
2 No	11.2	11.7	11.6	31.3	11.6	15.2	28.5	26.4	26.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(54)	(166)	(220)	(14)	(60)	(74)	(39)	(187)	(226)
<b>Were you provided with opportunities to ask questions about STIs and their treatment at your last STI</b>									
1 Yes	72.4	80.8	78.6	87.3	78.5	80.1	75.3	74.5	74.7
2 No	27.6	19.3	21.8	12.7	21.5	19.9	24.8	25.5	25.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(54)	(166)	(220)	(14)	(60)	(74)	(39)	(188)	(227)
<b>Were the explanations provided easy to understand</b>									
1 Yes	99.6	96.5	97.4	100.0	100.0	100.0	100.0	99.2	99.4
2 No	0.4	3.5	2.6	0.0	0.0	0.0	0.0	0.8	0.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(41)	(136)	(177)	(12)	(51)	(63)	(30)	(151)	(181)
<b>Very confident in confidentiality STI</b>									
1 Yes	50.5	65.5	61.0	47.4	55.1	53.7	55.7	64.3	62.4
2 No	49.5	34.5	39.0	52.6	44.9	46.3	44.3	35.7	37.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(54)	(166)	(220)	(14)	(60)	(74)	(39)	(188)	(227)
<b>Not treated differently at STI</b>									
1 Yes	90.7	98.5	96.2	100.0	100.0	100.0	100.0	100.0	100.0
2 No	9.3	1.5	3.8	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(54)	(166)	(220)	(14)	(60)	(74)	(39)	(188)	(227)

## A4 Men who have Sex with Men Tables

**Table A4.1 Socio-demographic characteristics by MSM group**

	Province A				Province B				Capital City			
	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total
<b>Age group</b>												
18-21	59.3	41.8	56.3	54.5	50.8	43.5	23.0	44.1	38.2	65.5	25.3	38.0
22-24	14.2	16.8	16.3	15.4	13.2	15.2	17.3	14.6	15.2	6.8	23.8	16.5
25-29	10.2	17.5	13.3	12.7	14.2	17.8	36.5	18.5	21.1	5.6	25.3	20.3
30-39	14.7	15.6	12.8	14.3	14.7	14.8	16.6	15.0	15.3	14.8	23.6	17.4
40+	1.7	8.4	1.3	3.0	7.1	8.8	6.6	7.8	10.2	7.3	2.1	7.8
<b>Total</b>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<b>(N)</b>	(191)	(131)	(135)	(457)	(180)	(220)	(48)	(448)	(253)	(62)	(134)	(449)
<b>Education</b>												
Primary or less	21.3	14.7	19.7	19.4	4.6	7.3	21.5	7.9	6.3	10.7	29.7	12.9
Up to Mattayom 3 or equivalent	28.9	44.9	50.5	39.1	29.2	45.7	22.3	36.0	8.6	13.1	27.6	14.0
Up to Mattayom 6 or equivalent	43.4	30.4	22.8	34.1	45.9	34.4	18.3	37.2	49.3	62.9	32.1	46.4
Higher than Mattayom 6 e.g. vocational collage	3.1	6.3	4.6	4.2	9.7	8.0	34.9	11.9	11.7	9.1	7.1	10.1
Bachelor's degree of higher	3.4	3.8	2.4	3.2	10.6	4.7	3.0	7.0	24.3	4.3	3.4	16.6
<b>Total</b>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<b>(N)</b>	(191)	(130)	(135)	(456)	(180)	(220)	(48)	(448)	(253)	(62)	(134)	(449)

	Province A				Province B				Capital City			
	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total
<b>Marital status</b>												
Never married	90.2	100.0	92.2	93.0	94.2	98.7	82.6	94.9	90.4	100.0	84.6	90.0
Ever married, not living with spouse	7.9	0.0	3.2	4.7	5.5	1.3	13.9	4.6	8.2	0.0	8.3	7.3
Married, living with spouse	1.9	0.0	4.7	2.3	0.3	0.0	3.5	0.6	1.5	0.0	7.2	2.8
<b>Total</b>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<b>(N)</b>	(191)	(131)	(135)	(457)	(180)	(220)	(48)	(448)	(253)	(62)	(134)	(449)
<b>Work status</b>												
Working	52.1	64.8	51.3	54.6	46.1	51.0	64.2	50.6	56.4	34.6	91.4	62.9
Studying	36.4	19.4	18.6	27.1	43.6	34.5	6.5	34.9	29.7	54.2	0.0	24.9
Not working/studying	9.7	15.1	30.2	17.2	8.8	13.0	27.2	13.1	4.7	6.8	0.7	3.9
Other	1.8	0.8	0.0	1.0	1.5	1.2	2.1	1.4	9.3	4.4	7.9	8.3
<b>Total</b>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<b>(N)</b>	(191)	(131)	(135)	(457)	(180)	(220)	(48)	(448)	(253)	(62)	(134)	(449)
<b>Occupation</b>												
Employee/business/professional	44.2	63.9	32.7	46.0	39.2	38.7	14.9	35.3	57.3	24.7	7.0	36.4
Government	3.2	1.5	1.1	2.1	6.2	4.6	3.3	5.0	10.4	4.2	0.4	6.2
Service/Sales	4.4	12.5	15.8	9.8	12.6	18.1	33.9	18.4	17.9	5.9	12.3	15.0
Labor	46.5	20.5	38.7	37.4	18.3	34.3	20.6	26.1	5.8	33.9	6.2	7.7
Entertainment/massage	1.7	1.6	0.0	1.2	23.8	3.7	8.7	12.1	8.0	31.2	44.7	23.2
MSW	0.0	0.0	11.8	3.4	0.0	0.7	18.6	3.2	0.7	0.0	29.5	11.4
<b>Total</b>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<b>(N)</b>	(103)	(85)	(80)	(268)	(98)	(112)	(36)	(246)	(143)	(31)	(126)	(300)

**Table A4.2 Alcohol and drug use among MSM**

	Province A				Province B				Capital City				
	General population on MSM		Male Sex Workers		General population on MSM		Male Sex Workers		General population on MSM		Male Sex Workers		
	Transgender	Male	Transgender	Male	Transgender	Male	Transgender	Male	Transgender	Male	Transgender	Male	
<b>Alcohol use in past 4 weeks</b>													
Drink <once a week	57.7	66.6	44.7	55.6	46.9	36.9	21.5	39.2	58.8	54.1	25.3	49.6	
Drink at least once a week	42.3	33.4	55.3	44.4	53.1	63.1	78.5	60.8	41.2	45.9	74.7	50.4	
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
(N)	(191)	(131)	(135)	(457)	(180)	(220)	(48)	(448)	(253)	(62)	(134)	(449)	
<b>Drug use past 12 mos.</b>													
Percent using any drug	15.5	2.0	22.5	14.7	8.9	11.6	39.6	13.8	10.7	9.0	22.9	13.6	
Percent using amphetamine	7.7	0.5	12.5	7.6	7.8	9.7	21.5	10.3	2.1	0.0	3.5	2.2	
Percent using methamphetamine	6.2	1.5	6.3	5.2	2.0	5.9	23.5	6.4	4.8	8.1	17.2	8.4	
(N)	(191)	(131)	(135)	(457)	(180)	(220)	(48)	(448)	(253)	(62)	(134)	(449)	

**Table A4.3 Sex work profile for MSW and TGSW**

	Province A			Province B			Capital City		
	General population MSW	Transgender MSW	Total	General population MSW	Transgender MSW	Total	General population MSW	Transgender MSW	Total
<b>Where meet clients (multiple response)</b>									
Massage venue	0.0	0.0	0.0	0.0	0.0	0.0	4.12	0.0	35.1
Bar/karaoke venue	1.4	35.0	14.3	0.0	17.1	10.7	48.8	27.8	45.7
Other venue	53.0	22.3	41.2	0.0	17.6	11.0	0.4	14.9	2.5
Public place (street, canal)	21.1	32.0	25.3	25.5	17.9	20.7	1.3	8.9	2.4
By telephone	31.9	45.2	37.0	86.4	31.9	52.2	14.2	66.6	21.9
Through internet	9.7	7.4	8.8	2.0	12.2	8.4	7.1	29.4	10.4
Through pimp	5.8	3.3	4.8	0.0	1.5	1.0	1.9	27.6	5.7
Other	9.0	7.2	8.3	32.8	27.8	30.3	1.3	6.5	4.0
(N)	(78)	(59)	(137)	(12)	(43)	(55)	(115)	(21)	(136)
<b>Venue status</b>									
Venue only	32.5	22.8	28.8	0.0	26.5	16.6	77.3	17.7	68.5
Non-venue only	37.6	37.9	37.7	53.0	47.0	60.7	38.9	61.1	13.8
Both venue and non-venue	21.8	35.0	26.7	0.0	8.11	5.1	13.1	25.0	14.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(59)	(137)	(12)	(43)	(55)	(115)	(21)	(136)
<b>Number of clients in the past 6 months</b>									
1 Only1-2	39.2	41.4	40.1	59.1	36.9	46.0	17.2	30.8	19.2
2 3-5	33.1	24.5	29.7	4.5	25.4	16.8	9.6	16.4	10.6
3 From1/mo to 1/wk	19.0	20.1	19.5	36.4	17.7	25.3	37.6	32.0	36.7
4 1-3 per week	8.2	8.9	8.5	0.0	10.9	6.5	13.3	6.7	12.3
5 4-6 per week	0.4	5.1	2.3	0.0	9.1	5.4	15.8	7.5	14.5

	Province A		Province B		Capital City		Total
	General population MSW	Transgender MSW	General population MSW	Transgender MSW	General population MSW	Transgender MSW	
6 At least 1/day	0.0	0.0	0.0	0.0	6.5	6.7	6.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(75)	(60)	(12)	(36)	(113)	(21)	(134)

**Table A4.4 Sex work profile by age group**

	Province A		Province B		Capital City	
	Age>25	Age 25+	Age>25	Age 25+	Age >25	Age 25+
<b>Where meet clients</b>						
Message venue	0.0	0.0	0.0	0.0	30.2	39.9
Bar/karaoke venue	13.3	16.9	22.1	1.6	41.9	49.4
Other venue	42.2	38.5	0.0	19.6	4.5	0.7
Public place (street, canal)	22.7	32.5	15.3	24.8	2.7	2.2
By telephone	36.4	38.9	50.6	52.9	29.6	17.8
Through internet	7.4	12.9	15.2	3.0	14.8	6.1
Through pimp	5.1	4.0	0.0	1.7	11.6	0.0
Other	8.6	7.5	32.8	27.8	1.3	6.5
(N)	(107)	(30)	(26)	(30)	(58)	(78)
<b>Venue status</b>						
Venue only	31.8	20.2	14.1	18.4	63.1	73.8
Non-venue only	36.7	40.7	63.1	58.1	23.5	4.5
Both venue and non-venue	23.7	35.2	8.0	2.7	13.5	16.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(107)	(30)	(26)	(30)	(58)	(78)
<b>Number of clients in the past 6 months</b>						
Only 1-2	36.2	50.6	40.1	42.6	26.0	12.7
3-5	32.0	23.5	29.7	14.9	9.5	11.7
From 1/mo to 1/wk	19.6	19.1	19.5	30.4	38.3	35.2
1-3 per week	9.1	6.8	8.5	4.7	10.3	14.3
4-6 per week	3.1	0.0	2.3	7.4	11.5	17.5
At least 1/day	0.0	0.0	0.0	0.0	4.4	8.7
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(104)	(31)	(135)	(28)	(57)	(77)

**Table A4.5: Knowledge and experience with STI symptoms and treatment by MSM group**

	Province A					Province B					Capital City				
	General population MSM	Transgender	Male Sex Workers	Total		General population MSM	Transgender	Male Sex Workers	Total		General population MSM	Transgender	Male Sex Workers	Total	
<b>Number of STI symptoms known spontaneously</b>															
0	62.2	55.6	66.8	62.1	37.5	42.1	35.8	39.4	40.7	38.2	47.7	42.2			
1	28.3	25.5	23.5	26.2	26.7	34.7	21.3	29.7	26.6	45.2	24.7	28.3			
2	8.3	17.3	9.5	10.7	32.0	20.4	40.8	27.7	26.6	16.6	27.0	25.5			
3+	1.3	1.6	0.2	1.0	3.9	2.8	2.1	3.2	6.1	0.0	0.7	4.0			
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0			
(N)	(191)	(131)	(135)	(457)	(180)	(220)	(48)	(448)	(253)	(62)	(134)	(449)			
<b>Ever experienced symptoms in the past 12 months</b>															
Yes	4.5	2.7	12.2	6.5	20.1	15.7	26.4	18.8	14.0	15.1	16.6	14.8			
No	95.5	97.4	87.8	93.5	79.9	84.3	73.6	81.2	86.0	84.9	83.4	85.2			
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0			
(N)	(191)	(131)	(135)	(457)	(180)	(220)	(48)	(448)	(253)	(62)	(134)	(449)			
<b>How treated symptoms (of those who had symptoms)</b>															
Medical	61.8	46.4	43.5	49.6	25.7	11.4	8.0	17.1	15.0	3.2	33.3	18.9			
Pharmacy/self-treatment	6.5	15.4	36.3	24.9	41.6	73.9	81.5	61.0	34.8	48.4	50.7	41.0			
Nothing	31.7	38.3	20.2	25.5	32.8	14.7	10.5	22.0	50.3	48.4	16.0	40.2			
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0			
(N)	(9)	(4)	(18)	(31)	(41)	(40)	(12)	(93)	(39)	(8)	(23)	(70)			



**Table A4.6. Knowledge and experience with STI symptoms and treatment by age group**

	Province A			Province B			Province C		
	Age<25	Age 25+	Total	Age<25	Age 25+	Total	Age<25	Age 25+	Total
<b>Number of STI symptoms known spontaneously</b>									
0	66.8	49.7	61.7	43.1	34.2	39.4	47.6	35.4	42.0
1	22.2	35.1	26.1	32.5	25.7	29.7	28.5	27.6	28.1
2	10.1	14.0	11.2	21.6	36.3	27.6	17.6	35.8	26.0
3+	0.9	1.3	1.0	2.8	3.8	3.2	6.3	1.2	4.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(318)	(141)	(459)	(258)	(192)	(450)	(231)	(219)	(450)
<b>Ever experienced symptoms</b>									
Yes	8.8	3.2	7.1	17.7	20.6	18.9	19.3	10.6	15.3
No	91.2	96.8	92.9	82.3	79.4	81.1	80.7	89.4	84.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(318)	(141)	(459)	(258)	(192)	(450)	(231)	(219)	(450)
<b>How treated symptoms (of those who had symptoms)</b>									
Medical	49.6	84.8	54.3	14.7	19.7	17.0	15.9	23.1	18.2
Pharmacy/ self- treatment	23.7	15.2	22.6	55.8	67.5	61.1	43.9	29.8	39.4
Nothing	26.7	0.0	23.1	29.5	12.7	21.9	40.2	47.1	42.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(27)	(5)	(32)	(54)	(40)	(94)	(41)	(30)	(71)

**Table A4.7 Knowledge about HIV as measured by GARPR standard questions by MSM group**

Number of correct answers from GARPR questions	Province A					Province B					Capital City				
	General population MSM	Transgender	Male Sex Workers	Total		General population MSM	Transgender	Male Sex Workers	Total		General population MSM	Transgender	Male Sex Workers	Total	
No correct items	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
1-2 correct items	6.1	3.0	4.0	4.8	3.2	0.3	3.7	1.9	1.4	1.4	0.6	2.8	1.7	1.7	
3-4 correct items	46.9	53.2	66.3	54.3	48.5	54.4	52.9	51.8	40.2	47.3	48.5	43.2	43.2	43.2	
4-5 correct items	46.9	43.8	29.8	40.9	48.3	45.2	43.5	46.3	58.3	52.2	48.7	55.1	55.1	55.1	
<b>Total</b>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
<b>(N)</b>	(191)	(131)	(135)	(457)	(180)	(220)	(48)	(448)	(253)	(62)	(134)	(449)	(449)	(449)	

**Table A4.8 Knowledge about HIV as measured by GARPR standard questions by age group**

Number of correct answers from GARPR questions	Province A				Province B				Province C			
	Age<25	Age 25+	Total		Age<25	Age 25+	Total		Age<25	Age 25+	Total	
No correct items	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1-2 correct items	6.4	0.9	4.8	2.6	1.1	1.9	2.9	0.2	0.7	0.7	0.7	0.7
3-4 correct items	58.7	42.6	53.9	55.6	46.4	51.8	53.2	32.1	43.5	43.5	43.5	43.5
4-5 correct items	34.9	56.5	41.4	41.8	52.5	46.2	43.9	67.7	54.8	54.8	54.8	54.8
<b>Total</b>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<b>(N)</b>	(318)	(141)	(459)	(258)	(192)	(450)	(231)	(219)	(450)	(219)	(450)	(450)

**Table A4.9 Sexual activity of MSM by group (nonpaying partners only)**

	Province A					Province B					Capital City					
	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total
<b>Number of partners for anal sex in the past 6 months</b>																
None	1.9	0.3	0.0	0.6	0.5	0.3	0.0	0.3	0.3	2.9	2.2	0.3	2.2	0.3	0.3	2.2
One	50.9	36.6	10.0	34.1	38.2	35.6	16.0	34.3	39.7	39.7	36.7	4.3	36.7	4.3	4.3	29.9
2-3	22.6	29.9	19.4	23.2	33.5	25.1	8.4	26.5	35.3	25.5	25.5	10.6	25.5	10.6	10.6	27.6
4-10	20.0	16.6	43.9	27.2	25.3	24.9	51.2	28.3	19.6	28.7	28.7	38.4	28.7	38.4	38.4	25.7
11-20	4.0	10.4	9.2	7.2	1.4	7.6	8.9	5.2	1.1	6.4	6.4	9.1	6.4	9.1	9.1	3.8
21+	1.4	6.2	17.5	7.8	1.1	6.6	15.5	5.4	1.4	0.4	0.4	37.2	0.4	37.2	37.2	10.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(174)	(126)	(135)	(435)	(176)	(214)	(48)	(438)	(237)	(58)	(58)	(134)	(429)	(134)	(134)	(429)
<b>Relationship with last non-paying anal sex partner</b>																
Steady partner	46.2	45.9	26.3	41.6	47.0	35.3	15.8	39.0	52.9	45.9	45.9	23.6	45.9	23.6	23.6	47.4
Casual partner	22.7	25.2	20.6	22.9	33.7	36.6	42.4	35.7	27.4	35.7	35.7	43.4	35.7	43.4	43.4	31.0
One night stand	20.8	17.6	31.1	22.3	13.3	22.8	38.4	19.8	13.8	16.2	16.2	28.2	16.2	28.2	28.2	16.4
Acquaintance	10.3	11.3	22.0	13.2	6.1	5.3	3.4	5.5	5.9	2.3	2.3	4.8	2.3	4.8	4.8	5.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(172)	(126)	(82)	(380)	(176)	(214)	(34)	(424)	(238)	(59)	(59)	(63)	(360)	(63)	(63)	(360)
<b>Number of partners for insertive anal sex in the past 6 month</b>																
None	20.5	93.7	38.3	43.0	22.5	93.7	49.3	58.6	36.5	89.0	89.0	14.8	89.0	14.8	14.8	36.8
One	42.3	1.0	9.7	22.1	34.3	3.5	20.7	18.4	25.9	6.1	6.1	9.0	6.1	9.0	9.0	19.1
2-3	23.5	5.3	12.9	15.8	29.5	2.1	5.4	13.9	26.9	0.0	0.0	9.4	0.0	9.4	9.4	19.1
4-10	12.2	0.0	28.6	14.9	11.9	0.7	19.6	7.7	9.4	4.8	4.8	31.2	4.8	31.2	31.2	14.7
11-20	0.9	0.0	3.7	1.6	1.5	0.0	3.9	1.1	0.2	0.0	0.0	7.5	0.0	7.5	7.5	2.1
21+	0.8	0.0	6.8	2.6	0.3	0.0	1.1	0.3	1.2	0.1	0.1	28.2	0.1	28.2	28.2	8.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(174)	(126)	(135)	(435)	(175)	(214)	(48)	(437)	(237)	(58)	(58)	(133)	(428)	(133)	(133)	(428)
<b>Number of partners for receptive anal sex in the past 6 month</b>																

	Province A					Province B					Capital City					
	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total
None	6.7	0.0	56.3	45.9	39.5	1.8	29.6	20.9	42.0	4.3	58.7	42.1				
One	14.8	36.9	1.0	15.2	19.5	35.0	20.9	26.8	29.4	34.6	5.0	23.5				
2-3	11.2	32.0	8.2	14.9	24.1	24.9	3.7	22.0	16.7	27.1	2.5	14.1				
4-10	8.9	14.5	17.1	12.9	15.2	24.2	24.3	20.5	11.4	27.2	13.0	13.6				
11-20	2.8	10.4	6.1	5.6	1.6	7.6	7.0	5.0	0.3	6.4	8.0	3.1				
21+	0.7	6.2	11.3	5.5	0.1	6.6	14.5	4.9	0.2	0.4	12.9	3.6				
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0				
(N)	(174)	(126)	(135)	(435)	(175)	(214)	(48)	(437)	(237)	(58)	(134)	(429)				
<b>Number of partners for oral sex in the past 6 month</b>																
None	12.0	9.0	5.5	9.1	12.1	4.0	4.5	7.5	4.3	5.1	5.2	4.6				
One	42.0	33.1	10.3	29.4	35.9	36.2	13.6	33.3	39.7	31.7	3.7	29.2				
2-3	25.1	30.1	29.2	27.6	32.9	27.1	12.0	27.7	38.5	29.2	11.5	30.2				
4-10	17.1	13.7	33.6	21.8	16.6	24.5	46.5	23.9	15.2	32.9	40.4	24.0				
11-20	2.6	8.5	9.0	6.1	1.4	3.6	8.9	3.4	0.9	0.8	9.4	3.2				
21+	1.2	5.6	12.5	6.0	1.1	4.6	14.5	4.3	1.3	0.4	29.8	8.8				
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0				
(N)	(174)	(126)	(135)	(435)	(176)	(214)	(48)	(438)	(237)	(58)	(134)	(429)				
<b>Number of paid male partners in the past 6 month</b>																
None	89.0	87.4	97.2	91.4	96.9	93.6	82.2	93.6	95.4	94.3	96.9	95.7				
One	0.7	3.9	0.9	1.5	0.3	1.5	13.1	2.4	2.1	0.0	0.0	1.3				
2-3	7.3	2.7	0.5	4.0	2.9	1.6	2.2	2.2	0.5	0.5	0.3	0.5				
4-10	2.0	4.1	0.5	2.0	0.0	2.1	2.0	1.2	1.9	5.1	0.7	2.0				
11-20	0.9	0.6	0.5	0.7	0.0	1.2	0.5	0.6	0.0	0.1	2.2	0.6				
21+	0.3	1.3	0.5	0.6	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0				
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0				
(N)	(174)	(126)	(135)	(435)	(176)	(214)	(48)	(438)	(237)	(58)	(134)	(429)				
<b>Number of female partners in the past 6 month</b>																

	Province A					Province B					Capital City					
	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total
None	66.2	100.0	54.7	70.1	94.2	100.0	72.5	94.3	85.8	100.0	51.5	78.6				
One	18.5	0.0	21.3	15.3	1.1	0.0	13.9	2.1	3.7	0.0	8.4	4.5				
2-3	10.2	0.0	16.2	9.8	3.5	0.0	13.6	3.1	8.7	0.0	13.1	8.8				
4-10	5.2	0.0	7.4	4.7	1.2	0.0	0.0	0.5	1.9	0.0	8.9	3.5				
11-20	0.0	0.0	0.5	0.1	0.0	0.0	0.0	0.0	0.0	0.0	18.0	4.7				
21+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0				
(N)	(191)	(131)	(135)	(457)	(180)	(220)	(48)	(448)	(253)	(62)	(134)	(449)				
<b>Relationship with last woman partner</b>																
Steady partner	54.5	0.0	73.8	63.5	10.9	0.0	12.7	11.9	22.2	0.0	24.7	23.7				
Casual partner	27.6	0.0	18.1	23.2	51.6	0.0	7.6	26.3	31.7	0.0	38.8	35.8				
One night stand	13.7	0.0	3.2	8.8	7.4	0.0	79.8	49.1	42.7	0.0	33.4	37.3				
Acquaintance	4.2	0.0	5.0	4.6	30.1	0.0	0.0	12.8	3.4	0.0	3.1	3.2				
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0				
(N)	(54)	(0)	(57)	(111)	(10)	(0)	(5)	(15)	(24)	(0)	(59)	(83)				

**Table A4.10 Sexual activity of MSM by age group**

	Province A			Province B			Province C		
	Age<25	Age 25+	Total	Age<25	Age 25+	Total	Age<25	Age 25+	Total
<b>Number of partners for receptive anal sex in the past 6 month</b>									
None	51.3	35.5	46.3	21.1	20.7	20.9	32.1	54.6	42.4
One	15.5	14.6	15.2	24.8	29.5	26.8	31.8	13.4	23.3
2-3	11.9	21.1	14.8	19.4	25.5	21.9	16.6	11.0	14.1
4-10	10.2	18.4	12.8	21.8	18.6	20.5	12.4	14.9	13.6
11-20	6.2	4.2	5.6	6.8	2.6	5.0	3.9	2.1	3.0
21+	5.0	6.2	5.4	6.0	3.2	4.8	3.2	4.1	3.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(301)	(136)	(437)	(252)	(187)	(439)	(219)	(211)	(430)
<b>Number of partners for oral sex in the past 6 month</b>									
None	9.4	8.3	9.1	7.6	7.2	7.4	5.9	3.1	4.6
One	27.9	32.3	29.3	31.9	35.1	33.2	33.9	24.5	29.6
2-3	24.9	32.7	27.4	28.1	26.9	27.6	29.2	31.0	30.0
4-10	25.8	15.1	22.4	23.5	24.8	24.0	22.5	25.4	23.8
11-20	5.9	6.3	6.0	3.8	2.8	3.4	2.8	3.6	3.2
21+	6.1	5.4	5.9	5.2	3.1	4.3	5.7	12.5	8.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(301)	(136)	(437)	(252)	(188)	(440)	(219)	(211)	(430)
<b>Number of paid male partners in the past 6 month</b>									
None	97.4	78.5	91.4	96.7	89.0	93.5	98.6	92.2	95.7
One	0.6	3.3	1.5	1.2	4.2	2.4	0.1	2.8	1.3
2-3	0.4	11.5	3.9	1.6	3.1	2.2	0.1	0.9	0.5
4-10	1.3	3.3	2.0	0.3	2.6	1.2	0.1	4.2	2.0
11-20	0.0	2.1	0.7	0.3	1.1	0.6	1.1	0.0	0.6
21+	0.2	1.3	0.6	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(301)	(136)	(437)	(252)	(188)	(440)	(219)	(211)	(430)

	Province A		Province B		Province C	
	Age<25	Age 25+	Age<25	Age 25+	Age<25	Age 25+
<b>Number of female partners in the past 6 month</b>						
None	67.9	76.1	94.4	93.9	82.6	72.9
One	17.3	10.2	0.2	4.8	2.1	6.5
2-3	9.8	9.6	4.7	1.0	3.2	10.4
4-10	5.0	4.1	0.7	0.2	0.5	2.9
11-20	0.2	0.0	0.0	0.0	0.0	7.3
21+	0.0	0.0	0.0	0.0	0.0	0.0
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
<b>(N)</b>	<b>(318)</b>	<b>(141)</b>	<b>(192)</b>	<b>(14)</b>	<b>(231)</b>	<b>(219)</b>
<b>Relationship with last woman partner</b>						
Steady partner	68.3	48.3	3.8	22.2	11.7	25.5
Casual partner	19.1	36.1	35.4	16.6	27.3	23.5
One night stand	7.6	12.4	41.8	57.0	48.4	44.6
Acquaintance	5.0	3.1	19.0	4.2	12.6	6.5
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
<b>(N)</b>	<b>(91)</b>	<b>(20)</b>	<b>(8)</b>	<b>(8)</b>	<b>(16)</b>	<b>(45)</b>

**Table A4.11 HIV prevention behavior of MSM by group**

	Province A					Province B					Capital City				
	General population MSM	Transgender	Male Workers	Sex Workers	Total	General population MSM	Transgender	Male Workers	Sex Workers	Total	General population MSM	Transgender	Male Workers	Sex Workers	Total
<b>Frequency of condom use with non-paying partners</b>															
Every time	58.0	52.8	63.0	57.8	57.8	62.3	49.2	40.7	54.1	54.1	54.9	41.8	71.3	56.0	
Almost every time	20.2	31.5	35.5	26.8	26.8	16.0	20.9	56.7	21.9	21.9	26.5	34.2	11.2	24.9	
Sometime	7.0	5.1	1.2	5.2	5.2	16.7	22.7	2.7	18.4	18.4	7.5	11.7	16.8	9.7	
Never	14.8	10.6	0.3	10.3	10.3	5.0	7.2	0.0	5.6	5.6	11.0	12.3	0.7	9.4	
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
(N)	(145)	(115)	(75)	(335)	(335)	(151)	(189)	(30)	(370)	(370)	(207)	(49)	(61)	(317)	
<b>Condom use with last non-paying partners</b>															
Yes	79.0	79.3	87.0	81.0	81.0	81.0	79.7	98.2	81.7	81.7	80.0	71.4	86.5	79.9	
No	21.0	20.7	13.1	19.0	19.0	19.0	20.3	1.8	18.4	18.4	20.0	28.6	13.5	20.2	
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
(N)	(172)	(125)	(84)	(381)	(381)	(176)	(214)	(34)	(424)	(424)	(238)	(59)	(63)	(360)	
<b>Frequency of lubricant use with non-paying partners</b>															
Every time	38.9	49.8	77.6	52.1	52.1	53.9	39.4	54.4	47.0	47.0	65.1	61.5	89.6	72.0	
Almost every time	9.9	11.9	19.0	12.9	12.9	4.8	3.7	25.7	6.0	6.0	12.1	10.5	5.4	9.9	
Sometime	21.4	20.1	3.5	16.2	16.2	28.9	29.1	19.9	28.3	28.3	10.1	11.5	3.5	8.3	
Never	29.8	18.2	0.0	18.8	18.8	12.4	27.8	0.0	18.7	18.7	12.8	16.6	1.5	9.9	
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
(N)	(150)	(115)	(98)	(363)	(363)	(153)	(192)	(33)	(378)	(378)	(198)	(48)	(121)	(367)	
<b>Type of lubricant used with last non-paying partners</b>															
Not used	48.5	30.2	58.4	47.3	47.3	30.5	33.8	69.3	36.7	36.7	26.2	38.6	55.9	35.3	
Non-water based	5.4	2.5	2.8	3.9	3.9	5.0	4.7	2.6	4.6	4.6	5.9	11.1	2.0	5.5	
Water based	46.1	67.3	38.8	48.8	48.8	64.6	61.4	28.2	58.7	58.7	67.9	50.2	42.1	59.2	
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
(N)	(191)	(131)	(135)	(457)	(457)	(180)	(220)	(48)	(448)	(448)	(253)	(62)	(134)	(449)	



	Province A				Province B				Capital City						
	General population MSM	Transgender	Male Workers	Sex	Total	General population MSM	Transgender	Male Workers	Sex	Total	General population MSM	Transgender	Male Workers	Sex	Total
<b>Condom use with last female partners</b>															
Yes	77.1	0.0	73.1	75.2	75.2	90.0	0.0	76.0	81.9	81.9	65.6	0.0	76.6	72.0	
No	22.9	0.0	26.9	24.8	24.8	10.0	0.0	24.1	18.1	18.1	34.4	0.0	23.5	28.0	
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(54)	(0)	(57)	(111)	(111)	(10)	(0)	(5)	(15)	(15)	(24)	(0)	(59)	(83)	
<b>Consistent condom use with all partners</b>															
Yes	57.0	52.0	60.4	57.1	57.1	62.6	49.2	44.6	54.1	54.1	55.3	41.7	70.0	58.1	
No	43.0	48.0	39.6	42.9	42.9	37.4	50.8	55.4	45.9	45.9	44.7	58.3	30.0	41.9	
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(165)	(116)	(135)	(416)	(416)	(155)	(189)	(47)	(391)	(391)	(218)	(50)	(131)	(399)	

**Table A4.12 HIV prevention behavior of MSM by age group**

	Province A			Province B			Province C		
	Age<25	Age 25+	Total	Age<25	Age 25+	Total	Age<25	Age 25+	Total
<b>Frequency of condom use with non-paying partners</b>									
Every time	54.1	66.3	58.2	51.9	57.6	54.1	46.0	68.4	56.0
Almost every time	30.3	19.0	26.5	24.2	18.4	21.9	28.4	20.5	24.9
Sometime	5.7	3.9	5.1	18.4	18.3	18.4	10.9	8.2	9.7
Never	9.9	10.8	10.2	5.6	5.7	5.6	14.7	2.9	9.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(223)	(114)	(337)	(217)	(154)	(371)	(164)	(153)	(317)
<b>Condom use with last non-paying partners</b>									
Yes	80.8	81.9	81.2	82.1	81.0	81.7	73.5	87.9	80.0
No	19.2	18.2	18.8	17.9	19.0	18.3	26.5	12.1	20.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(258)	(125)	(383)	(248)	(177)	(425)	(191)	(170)	(361)
<b>Frequency of lubricant use with non-paying partners</b>									
Every time	49.5	58.4	52.5	38.1	60.2	47.1	58.5	88.1	72.0
Almost every time	15.1	8.1	12.8	6.3	5.6	6.0	14.2	4.7	9.9
Sometime	16.3	15.4	16.0	35.4	17.8	28.2	12.0	3.7	8.3
Never	19.1	18.1	18.7	20.2	16.4	18.7	15.3	3.4	9.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(249)	(116)	(365)	(217)	(63)	(380)	(180)	(187)	(367)
<b>Type of lubricant used with last nonpaying partners</b>									
None	50.2	40.4	47.3	37.5	35.6	36.7	42.7	27.3	35.7
Non-water based	3.2	5.7	3.9	3.1	6.6	4.6	7.0	3.7	5.5
Water based	46.6	53.9	48.8	59.3	57.8	58.7	50.3	69.0	58.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(318)	(141)	(459)	(258)	(192)	(450)	(231)	(219)	(450)
<b>Condom use with last female partners</b>									
Yes	73.6	80.2	75.2	88.6	73.7	82.2	66.1	73.2	70.1
No	26.4	19.8	24.8	11.4	26.3	17.9	33.9	26.8	29.9



**Table A4.13 HIV prevention behavior of MSW with clients by group**

	Province A		Province B		Capital City	
	General population MSW	Transgender MSW	General population MSW	Transgender MSW	General population MSW	Transgender MSW
<b>Frequency of condom use with clients</b>						
Every time	74.7	82.1	77.8	66.9	78.5	74.2
Almost every time	24.3	11.0	16.4	33.1	18.5	23.9
Sometimes	1.1	7.0	3.6	0.0	3.0	1.9
Never	4.0	0.0	2.3	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(68)	(59)	(127)	(10)	(35)	(45)
<b>Used condom with last client</b>						
Yes	95.7	96.4	96.0	100.0	96.0	97.5
No	4.3	3.6	4.0	0.0	4.0	2.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(12)	(43)	(55)
<b>Used lubricant with last client</b>						
Yes	73.0	71.1	72.3	58.6	60.8	60.0
No	27.0	28.9	27.7	41.4	39.2	40.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(11)	(43)	(54)
<b>Used condom with last client</b>						
Yes	95.7	96.4	96.0	100.0	96.0	97.5
No	4.3	3.6	4.0	0.0	4.0	2.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(12)	(43)	(55)
<b>Used lubricant with last client</b>						
Yes	73.0	71.1	72.3	58.6	60.8	60.0
No	27.0	28.9	27.7	41.4	39.2	40.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(11)	(43)	(54)
<b>Used condom with last client</b>						
Yes	95.7	96.4	96.0	100.0	96.0	97.5
No	4.3	3.6	4.0	0.0	4.0	2.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(12)	(43)	(55)
<b>Used lubricant with last client</b>						
Yes	73.0	71.1	72.3	58.6	60.8	60.0
No	27.0	28.9	27.7	41.4	39.2	40.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(11)	(43)	(54)
<b>Used condom with last client</b>						
Yes	95.7	96.4	96.0	100.0	96.0	97.5
No	4.3	3.6	4.0	0.0	4.0	2.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(12)	(43)	(55)
<b>Used lubricant with last client</b>						
Yes	73.0	71.1	72.3	58.6	60.8	60.0
No	27.0	28.9	27.7	41.4	39.2	40.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(11)	(43)	(54)
<b>Used condom with last client</b>						
Yes	95.7	96.4	96.0	100.0	96.0	97.5
No	4.3	3.6	4.0	0.0	4.0	2.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(12)	(43)	(55)
<b>Used lubricant with last client</b>						
Yes	73.0	71.1	72.3	58.6	60.8	60.0
No	27.0	28.9	27.7	41.4	39.2	40.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(11)	(43)	(54)
<b>Used condom with last client</b>						
Yes	95.7	96.4	96.0	100.0	96.0	97.5
No	4.3	3.6	4.0	0.0	4.0	2.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(12)	(43)	(55)
<b>Used lubricant with last client</b>						
Yes	73.0	71.1	72.3	58.6	60.8	60.0
No	27.0	28.9	27.7	41.4	39.2	40.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(11)	(43)	(54)
<b>Used condom with last client</b>						
Yes	95.7	96.4	96.0	100.0	96.0	97.5
No	4.3	3.6	4.0	0.0	4.0	2.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(12)	(43)	(55)
<b>Used lubricant with last client</b>						
Yes	73.0	71.1	72.3	58.6	60.8	60.0
No	27.0	28.9	27.7	41.4	39.2	40.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(11)	(43)	(54)
<b>Used condom with last client</b>						
Yes	95.7	96.4	96.0	100.0	96.0	97.5
No	4.3	3.6	4.0	0.0	4.0	2.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(12)	(43)	(55)
<b>Used lubricant with last client</b>						
Yes	73.0	71.1	72.3	58.6	60.8	60.0
No	27.0	28.9	27.7	41.4	39.2	40.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(11)	(43)	(54)
<b>Used condom with last client</b>						
Yes	95.7	96.4	96.0	100.0	96.0	97.5
No	4.3	3.6	4.0	0.0	4.0	2.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(12)	(43)	(55)
<b>Used lubricant with last client</b>						
Yes	73.0	71.1	72.3	58.6	60.8	60.0
No	27.0	28.9	27.7	41.4	39.2	40.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(11)	(43)	(54)
<b>Used condom with last client</b>						
Yes	95.7	96.4	96.0	100.0	96.0	97.5
No	4.3	3.6	4.0	0.0	4.0	2.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(12)	(43)	(55)
<b>Used lubricant with last client</b>						
Yes	73.0	71.1	72.3	58.6	60.8	60.0
No	27.0	28.9	27.7	41.4	39.2	40.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(78)	(60)	(138)	(11)	(43)	(54)

**Table A4.14 HIV prevention behavior of MSW with clients by age group**

	Province A			Province B			Capital City		
<b>Frequency of condom use with clients</b>									
Every time	73.9	88.8	77.8	77.3	70.9	73.6	82.8	90.4	86.9
Almost every time	18.9	9.4	16.4	20.1	27.8	24.5	5.6	8.9	7.4
Sometimes	4.2	1.8	3.6	2.6	1.3	1.9	8.5	0.0	3.9
Never	3.1	0.0	2.3	0.0	0.0	0.0	3.2	0.7	1.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(99)	(28)	(127)	(21)	(25)	(46)	(51)	(73)	(124)
<b>Used condom with last client</b>									
Yes	97.0	93.1	96.0	97.9	97.2	97.5	94.7	99.4	97.0
No	3.0	6.9	4.0	2.1	2.8	2.5	5.3	0.7	3.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(107)	(31)	(138)	(26)	(30)	(56)	(58)	(78)	(136)
<b>Used lubricant with last client</b>									
Yes	72.1	72.9	72.3	48.4	69.3	60.2	82.1	96.5	89.4
No	27.9	27.1	27.7	51.6	30.7	39.8	18.0	3.5	10.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(107)	(31)	(138)	(25)	(30)	(55)	(58)	(78)	(136)

**Table A4.15 Coverage of HIV prevention services by MSM group**

	Province A				Province B				Bangkok			
	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total
Talked to a peer educator in the past 12 months	11.5	27.9	18.4	17.3	32.8	39.2	30.8	35.5	18.5	27.7	69.6	32.8
Went to drop-in center in the past 12 months	2.5	11.2	6.7	5.7	8.1	11.9	6.4	10.9	8.8	13.9	41.3	17.7
Received a free condom in the past 12 months	31.1	47.8	46.8	39.4	83.5	86.5	80.3	84.5	36.8	53.8	78.3	49.5
Received free lubricant in the past 12 months	39.4	72.2	70.3	56.5	39.7	50.5	49.3	46.0	19.1	27.5	75.1	34.3
Went for STI screening in the past 12 months	2.3	6.7	5.9	4.4	9.6	3.7	18.1	7.9	5.5	4.4	14.1	7.6
Went for HIV counseling and testing in the past 12 months	13.2	15.9	19.0	15.6	34.1	28.9	49.0	33.5	33.5	34.2	37.1	34.5
Went for HIV counseling and testing and got results in the past 12 months	12.4	15.6	18.8	15.1	32.2	28.2	46.3	32.1	33.0	34.2	37.1	34.2
(N)	(191)	(131)	(135)	(457)	(180)	(220)	(48)	(448)	(253)	(62)	(134)	(449)

**Table A4.16 Coverage of HIV prevention services for MSM by age group**

	Province A			Province B			Bangkok		
	Age <25	Age 25+	TOTAL	Age <25	Age 25+	TOTAL	Age <25	Age 25+	TOTAL
Talked to a peer educator in the past 12 months	16.8	18.2	17.2	30.8	42.1	35.5	25.3	41.2	32.6
Went to drop-in center in the past 12 months	6.1	4.5	5.6	7.6	15.4	10.8	12.9	23.2	23.2
Received a free condom in the past 12 months	37.3	45.8	39.9	82.4	87.3	84.4	42.8	58.0	49.8
Received free lubricant in the past 12 months	54.6	61.1	56.5	40.0	54.4	46.0	26.7	43.4	34.3
Went for STI screening in the past 12 months	6.4	1.8	5.0	9.0	6.3	7.9	5.3	10.1	7.5
Went for HIV counseling and testing in the past 12 months	11.8	24.6	15.5	27.8	41.4	33.4	22.0	48.9	34.3
Went for HIV counseling and testing and got results in the past 12 months	11.1	24.6	15.0	26.4	40.0	32.0	21.3	48.9	34.0
(N)	(318)	(141)	(459)	(258)	(192)	(450)	(231)	(219)	(450)

**Table A4.17 Source of STI screening referral, site for STI screening and satisfaction with STI services for MSM by group**

	Province A					Province B					Capital City					
	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total
<b>Got STI referral where</b>																
1 Outreach/DIC	0.0	1.2	1.3	0.7	0.8	0.0	0.0	0.4	0.1	0.0	0.0	0.4	0.1	0.0	4.7	1.3
2 No referral	100.0	98.8	98.7	99.3	99.2	100.0	100.0	99.7	99.9	100.0	100.0	99.7	99.9	100.0	95.3	98.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(191)	(131)	(135)	(457)	(180)	(220)	(48)	(448)	(253)	(62)	(134)	(449)	(253)	(62)	(134)	(449)
<b>Got STI where</b>																
1 None	97.7	93.3	94.1	95.6	90.5	96.3	82.0	92.1	94.6	95.6	85.9	92.4	94.6	95.6	85.9	92.4
2 Government	1.5	3.8	3.9	2.8	4.9	1.1	10.5	3.8	1.7	0.0	5.2	2.4	1.7	0.0	5.2	2.4
3 MSM-special	0.0	1.7	0.6	0.6	1.3	2.5	7.6	2.6	3.0	0.3	4.0	3.0	3.0	0.3	4.0	3.0
4 Private	0.8	1.3	1.5	1.1	3.4	0.1	0.0	1.4	0.7	4.2	4.9	2.2	0.7	4.2	4.9	2.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(191)	(131)	(135)	(457)	(180)	(220)	(48)	(448)	(253)	(62)	(134)	(449)	(253)	(62)	(134)	(449)
<b>Got enough info STI</b>																
1 Yes	87.4	85.5	69.6	79.3	80.5	84.2	94.2	85.0	72.2	100.0	83.5	79.5	72.2	100.0	83.5	79.5
2 No	12.6	14.5	30.5	20.7	19.5	15.8	5.8	15.0	27.8	0.0	16.5	20.5	27.8	0.0	16.5	20.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(5)	(9)	(11)	(25)	(23)	(12)	(7)	(42)	(20)	(3)	(26)	(49)	(20)	(3)	(26)	(49)
<b>Were you provided with opportunities to ask questions about STIs and their treatment at your last STI</b>																
1 Yes	33.5	71.9	91.3	70.4	90.4	69.7	92.8	86.6	95.0	100.0	88.2	92.1	95.0	100.0	88.2	92.1
2 No	66.5	28.1	8.7	29.6	9.6	30.3	7.2	13.5	5.0	0.0	11.8	7.9	5.0	0.0	11.8	7.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(5)	(9)	(11)	(25)	(23)	(12)	(7)	(42)	(20)	(3)	(26)	(49)	(20)	(3)	(26)	(49)
<b>Were the explanations provided easy to understand?</b>																
1 Yes	100.0	68.2	100.0	86.5	98.7	100.0	100.0	99.4	93.4	100.0	96.7	95.4	93.4	100.0	96.7	95.4
2 No	0.0	31.8	0.0	13.5	1.3	0.0	0.0	0.7	6.6	0.0	3.3	4.6	6.6	0.0	3.3	4.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(1)	(6)	(7)	(14)	(20)	(9)	(6)	(35)	(19)	(3)	(24)	(46)	(19)	(3)	(24)	(46)



	Province A					Province B					Capital City					
	Transgender		Male Sex Workers		Total	Transgender		Male Sex Workers		Total	Transgender		Male Sex Workers		Total	
	General population MSM					General population MSM					General population MSM					
<b>Very confident in confidentiality STI</b>																
1 Yes	74.5	52.7	26.0	47.0	83.9	76.9	36.3	69.4	85.5	6.6	72.4	73.8				
2 No	25.6	47.3	74.1	53.0	16.1	23.1	63.7	30.6	14.5	93.4	27.7	26.3				
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0				
(N)	(5)	(9)	(11)	(25)	(23)	(12)	(7)	(42)	(20)	(3)	(26)	(49)				
<b>Not treated differently at STI</b>																
1 Yes	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0				
2 No	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0				
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0				
(N)	(5)	(9)	(11)	(25)	(23)	(12)	(7)	(42)	(20)	(3)	(26)	(49)				

**Table A4.18 Source of STI screening referral, site for STI screening and satisfaction with STI services for MSM by age group**

	Province A		Province B		Province C		Total	Age <25	Age 25+	Total
	Age <25	Age 25+	Age <25	Age 25+	Age <25	Age 25+				
<b>Got STI referral where</b>										
1 Outreach/DIC	0.9	0.0	0.7	0.3	0.4	0.4	0.4	0.7	1.9	1.3
2 No referral	99.1	100.0	99.4	99.7	99.6	99.7	99.7	99.3	98.1	98.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(318)	(141)	(459)	(258)	(192)	(450)	(450)	(231)	(219)	(450)
<b>Got STI where</b>										
1 None	93.6	98.2	95.0	91.0	93.8	92.1	94.7	89.9	89.9	92.5
2 Government	4.1	1.8	3.4	5.5	1.4	3.8	2.7	2.0	2.0	2.4
3 MSM-special	0.8	0.0	0.5	2.3	3.2	2.6	0.5	5.8	5.8	2.9
4 Private	1.5	0.0	1.1	1.2	1.7	1.4	2.1	2.4	2.4	2.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(318)	(141)	(459)	(258)	(192)	(450)	(450)	(231)	(219)	(450)
<b>Got enough info STI</b>										
1 Yes	66.1	90.9	68.7	82.2	91.0	85.0	81.1	78.6	78.6	79.5
2 No	33.9	9.1	31.3	17.8	9.0	15.0	19.0	21.4	21.4	20.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(23)	(3)	(26)	(25)	(17)	(42)	(19)	(30)	(30)	(49)
<b>Were you provided with opportunities to ask questions about STIs and their treatment at your last STI</b>										
1 Yes	72.4	90.9	74.4	85.1	89.5	86.6	88.2	94.5	94.5	92.1
2 No	27.6	9.1	25.6	14.9	10.5	13.5	11.8	5.5	5.5	7.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(23)	(3)	(26)	(25)	(17)	(42)	(19)	(30)	(30)	(49)
<b>Were the explanations provided easy to understand?</b>										
1 Yes	62.3	100.0	68.1	99.0	100.0	99.4	100.0	92.7	92.7	95.4
2 No	37.8	0.0	31.9	1.0	0.0	0.7	0.0	7.3	7.3	4.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(13)	(2)	(15)	(20)	(15)	(35)	(18)	(28)	(28)	(46)
<b>Very confident in confidentiality STI</b>										
1 Yes	44.5	9.1	40.7	58.0	93.1	96.4	56.9	84.2	84.2	73.8
2 No	55.5	90.9	59.3	42.0	6.9	30.6	43.1	15.8	15.8	26.3

	Province A		Province B		Province C	
	Age<25	Age 25+	Age<25	Age 25+	Age<25	Age 25+
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(23)	(3)	(25)	(17)	(19)	(30)
<b>Not treated differently at STI</b>						
1 Yes	100.0	100.0	100.0	100.0	100.0	100.0
2 No	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(23)	(3)	(25)	(17)	(19)	(30)

**Table A4.19: Source of HCT referral, site for HCT and satisfaction with HCT services for MSM by group**

	Province A			Province B			Capital City					
	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total
<b>Got HCT referral where</b>												
1 Outreach/DIC	0.0	1.2	0.2	0.3	0.5	0.0	0.0	0.2	0.9	0.0	10.0	3.2
2 No referral	100.0	98.8	99.8	99.7	99.5	100.0	100.0	99.8	99.1	100.0	90.0	96.8
Total (N)	(191)	(131)	(135)	(457)	(180)	(220)	(48)	(448)	(253)	(62)	(134)	(449)
<b>Got HCT where</b>												
1 None	87.8	85.0	82.0	85.4	66.4	71.1	55.1	66.7	66.5	65.8	63.4	65.6
2 Government	8.2	6.4	14.4	9.7	22.8	12.5	28.8	18.8	10.3	3.4	10.6	9.6
3 MSM-special	0.0	4.4	0.2	1.0	7.8	9.1	14.6	9.2	11.3	13.8	15.2	12.6
4 Private	3.9	4.2	3.4	3.8	3.0	7.3	5.6	5.3	12.0	17.0	10.9	12.3
Total (N)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(191)	(131)	(135)	(457)	(180)	(220)	(48)	(448)	(253)	(62)	(133)	(448)
<b>Got enough info at HCT</b>												
1 Yes	59.3	66.7	87.9	71.9	83.0	73.5	59.5	75.1	59.6	72.9	83.5	67.8
2 No	40.7	33.3	12.1	28.1	17.0	26.5	40.5	24.9	40.4	27.1	16.6	32.2
Total (N)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(26)	(22)	(26)	(74)	(68)	(65)	(27)	(160)	(78)	(19)	(63)	(160)
<b>Were you provided with opportunities to ask questions about HIV, the testing procedure and other issues</b>												
1 Yes	91.1	74.4	86.8	85.7	87.3	81.1	66.2	81.1	78.7	92.1	96.3	85.1
2 No	8.9	25.3	13.2	14.3	12.8	19.0	33.8	18.9	21.3	7.9	3.7	14.9
Total (N)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(26)	(22)	(26)	(74)	(68)	(65)	(27)	(160)	(78)	(19)	(63)	(160)
<b>Were the explanations provided easy to understand</b>												
1 Yes	95.6	100.0	100.0	98.1	99.4	97.7	100.0	98.8	94.2	98.1	97.7	95.8
2 No	4.4	0.0	0.0	1.9	0.6	2.3	0.0	1.2	5.8	1.9	2.3	4.2
Total (N)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	(24)	(15)	(20)	(59)	(56)	(50)	(23)	(129)	(64)	(15)	(59)	(138)

	Province A			Province B			Capital City					
	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total	General population MSM	Transgender	Male Sex Workers	Total
<b>Very confident in confidentiality at HCT</b>												
1 Yes	40.3	52.9	49.9	46.8	81.6	66.0	58.4	71.3	75.7	55.4	90.1	77.4
2 No	59.7	47.1	50.1	53.2	18.4	34.0	41.6	28.7	24.3	44.6	9.9	22.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(26)	(22)	(26)	(74)	(67)	(65)	(27)	(159)	(78)	(19)	(63)	(160)
<b>Did you feel that the staff at the testing and counseling clinic treated you with respect?</b>												
1 Yes	100.0	97.2	89.8	95.5	100.0	100.0	97.9	99.6	99.5	100.0	100.0	99.7
2 No	0.0	2.8	10.2	4.5	0.0	0.0	2.1	0.4	0.6	0.0	0.0	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(26)	(22)	(26)	(74)	(68)	(65)	(27)	(160)	(78)	(19)	(63)	(160)
<b>Not treated differently at HCT</b>												
1 Yes	100.0	93.0	94.0	96.1	100.0	100.0	90.8	98.4	96.2	100.0	99.2	97.5
2 No	0.0	7.0	6.0	3.9	0.0	0.0	9.3	1.6	3.8	0.0	0.8	2.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
(N)	(26)	(22)	(26)	(74)	(67)	(65)	(27)	(159)	(78)	(19)	(63)	(160)



## A5 PWID Tables

**Table A5.1. HIV risk behaviors of PWID by site**

	Province C	Capital City		
	Total	Male	Female	Total
<b>Shared injection equipment in the past 12 months</b>				
Yes	14.8	21.8	21.5	20.8
No	85.2	78.2	78.5	79.2
Total	100.0	100.0	100.0	100.0
(N)	(173)	(264)	(58)	(322)
<b>Shared injection equipment last time injected</b>				
Yes	2.6	9.9	10.5	9.7
No	97.4	90.1	89.5	90.3
Total	100.0	100.0	100.0	100.0
(N)	(173)	(264)	(58)	(322)
<b>Number of sexual partners in the past 12 months</b>				
None or One	94.2	NA	NA	98.2
Two or more	5.8	NA	NA	1.8
Total	100.0			100.0
(N)	(111)			(322)

**Table A5.2. Condom use by type of partner for PWID**

	Province C	Capital City		
<b>Frequency of condom use with regular partner</b>				
Always	16.1	39.2	27.2	37.4
Usually or sometime of Never	83.9	60.8	72.8	62.6
Total	100.0	100.0	100.0	100.0
(N)	(81)	(121)	(88)	(149)
<b>Used condom last time with regular partner</b>				
Yes	26.5	35.8	38.8	36.7
No	73.5	64.2	61.2	63.3
Total	100.0	100.0	100.0	100.0
(N)	(111)	(186)	(37)	(223)
<b>Used condom last time with casual partner</b>				
Yes	5.8	13.2	2.7	11.7
No	94.2	86.8	97.3	88.3
Total	100.0	100.0	100.0	100.0
(N)	(111)	(186)	(37)	(223)

**Table A5.3. Coverage of HIV prevention services for PWID**

	Province C	Capital City		Total
		Male	Female	
<b>Peer Education</b>				
Yes	26.7	54.3	53.5	54.3
No	13.3	45.7	46.5	45.7
Total	100.0	100.0	100.0	100.0
(N)	(173)	(264)	(58)	(322)
<b>Drop-in center</b>				
Yes	27.5	58.2	63.0	45.7
No	72.5	41.8	37.0	40.6
Total	100.0	100.0	100.0	100.0
(N)	(173)	(264)	(58)	(322)
<b>Received free injecting equipment</b>				
Yes	28.6	53.4	54.6	53.8
No	71.4	46.6	45.4	46.2
Total	100.0	100.0	100.0	100.0
(N)	(173)	(264)	(58)	(322)
<b>Received free condom</b>				
Yes	21.6	43.6	49.4	44.7
No	78.4	56.1	50.6	55.3
Total	100.0	100.0	100.0	100.0
(N)	(173)	(264)	(58)	(322)
<b>Testing and know result</b>				
Yes	54.7	58.9	70.0	60.8
No	45.3	41.1	30.0	39.2
Total	100.0	100.0	100.0	100.0
(N)	(173)	(264)	(58)	(322)
<b>Coverage of the HIV prevention program</b>				
Yes	24.3	21.8	17.2	19.6
No	75.7	78.2	82.8	80.4
Total	100.0	100.0	100.0	100.0
(N)	(173)	(264)	(58)	(322)

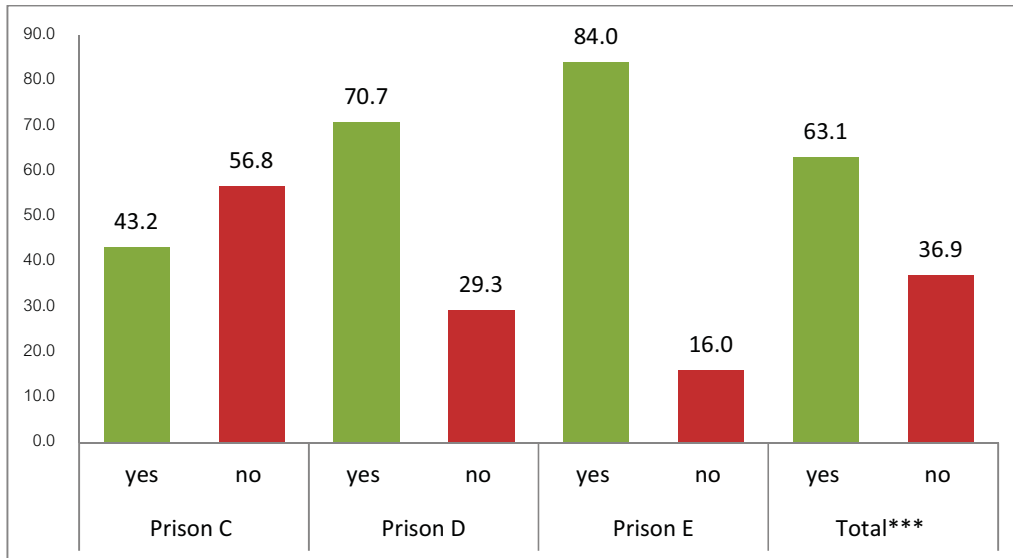


**Table A5.4. Risk behaviors of PWID in the past 12 months based on whether talked to an outreach worker**

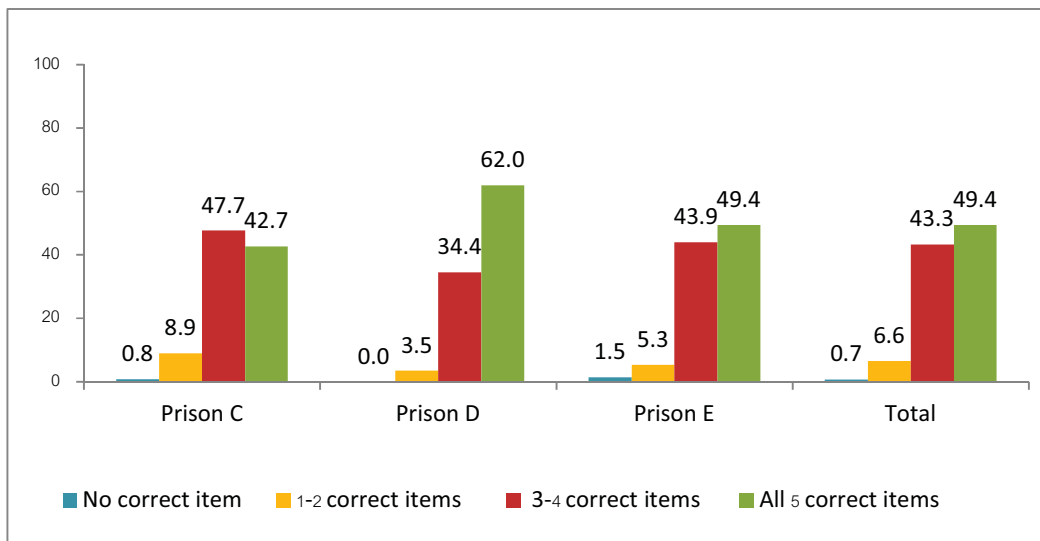
	Province C		Capital City	
	PE	No PE	PE	No PE
<b>Shared injection equipment in the past 12 months</b>				
Yes	9.3	20.3	13.5	31.6
No	90.7	79.5	86.5	68.4
Total	100.0	100.0	100.0	100.0
(N)	(68)	(105)	198	124
<b>Shared injection equipment last time injected</b>				
Yes	NA	NA	3.8	20.7
No	NA	NA	96.2	79.3
Total			100.0	100.0
(N)			198	124
<b>Number of sexual partners in the past 12 months</b>				
None	NA	NA	97.9	97.6
One	NA	NA	2.1	2.4
Total			100.0	100.0
(N)			130	93
<b>Frequency of condom use with regular partners</b>				
Always	NA	NA	48.7	19.5
Usually, Sometimes, Never	NA	NA	51.3	80.5
Total			100.0	100.0
(N)			130	93
<b>Used condom last time with regular partner</b>				
Yes	30.5	25.3	43.7	28.2
No	69.5	74.7	56.3	71.8
Total	100.0	100.0	100.0	100.0
(N)	(46)	(65)	130	93
<b>Used condom last time with casual partner</b>				
Yes	NA	NA	12.9	11.8
No	NA	NA	87.1	88.2
Total	100.0	100.0	100.0	100.0
(N)	(xxx)	(xxx)	(130)	(93)

## A6 Prisoner Tables

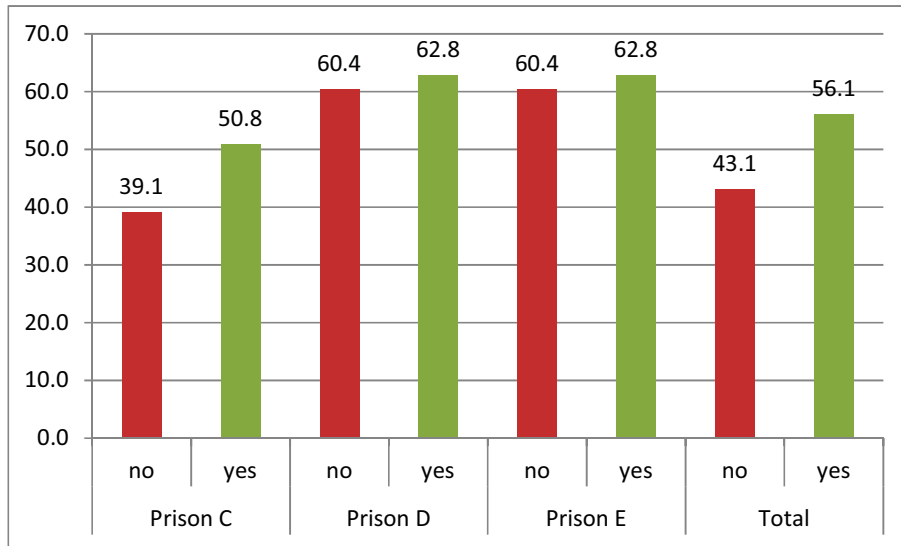
**Figure A6.1 Correctly assess ALL the four STI knowledge items by whether met with PE**



**Figure A6.2 Ability to correctly assess the five GARPR AIDS knowledge items by prison**



**Figure A6.3 Correctly assess ALL the five GARPR AIDS knowledge items by meeting with PE**



**Table A6.1 Percent of prisoners by risk behavior before and during incarceration**

Risk Behavior	Prison C		Prison D		Prison E		Total	
	before	during	before	during	before	during	before	during
No risk behavior	17.6	39.5	6.7	25.7	15.7	44.5	14.2	36.8
1-3 behaviors	54.8	45.5	63.4	56.1	66.9	45.9	59.8	48.5
4-6 behaviors	24.8	14.3	26.6	16.9	16.6	9.3	23.5	13.9
7-9 behaviors	2.8	0.8	3.3	1.4	0.9	0.3	2.5	0.8
<b>Total</b>	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<b>Average number of risk behaviors</b>	2.4	1.5	2.8	1.9	2.0	1.2	2.4	1.5
<b>N</b>	778	778	421	421	344	344	1,543	1,543

Risk behaviors assessed: (1) sharing razor blades; (2) tattooing; (3) sharing tattooing equipment; (4) using drugs; (5) injecting drugs; (6) sharing injection equipment; (7) implanting beads in the penis foreskin/scaring; (8) having anal sex; and (9) (not) using condoms for every episode of sex.

**Table A6.2 Level of risk for HIV/AIDS as measured by risk behavior change before and during incarceration by behavior and prison**

	Prison C	Prison D	Prison E	Total
<b>Sharing razor blades</b>				
Same level (yes→ yes)	26.5	36.1	19.5	27.5
Reduced (yes→ no)	6.8	6.4	5.8	6.5
Increased (no→ yes)	12.6	17.1	9.6	13.2
No risk (no→ no)	54.1	40.4	65.1	52.8
<i>N</i>	<b>778</b>	<b>421</b>	<b>344</b>	<b>1543</b>
<b>Tattooing</b>				
Same level (yes→ yes)	26.2	34.2	22.4	27.5
Reduced (yes→ no)	25.6	23.3	18.3	23.3
Increased (no→ yes)	5.9	10.2	7.8	7.5
No risk (no→ no)	42.3	32.3	51.5	41.6
<i>N</i>	<b>778</b>	<b>421</b>	<b>344</b>	<b>1543</b>
<b>Sharing tattooing equipment</b>				
Same level (yes→ yes)	23.1	35.8	17.4	25.3
Reduced (yes→ no)	35.8	38.3	40.5	37.5
Increased (no→ yes)	4.5	6.7	4.2	5.0
No risk (no→ no)	36.7	19.3	37.8	32.2
<i>N</i>	<b>758</b>	<b>405</b>	<b>333</b>	<b>1496</b>
<b>Using addictive drugs</b>				
Same level (yes→ yes)	11.5	29.0	12.8	16.5
Reduced (yes→ no)	49.3	50.9	51.7	50.3
Increased (no→ yes)	1.2	0.5	0.0	0.7
No risk (no→ no)	37.9	19.6	35.6	32.5
<i>N</i>	<b>746</b>	<b>397</b>	<b>329</b>	<b>1472</b>
<b>Using addictive drugs</b>				
Same level (yes→ yes)	11.5	29.0	12.8	16.5
Reduced (yes→ no)	49.3	50.9	51.7	50.3
Increased (no→ yes)	1.2	0.5	0.0	0.7
No risk (no→ no)	37.9	19.6	35.6	32.5
<i>N</i>	<b>746</b>	<b>397</b>	<b>329</b>	<b>1472</b>
<b>Injecting drugs</b>				
Same level (yes→ yes)	1.9	2.7	0.9	2.0
Reduced (yes→ no)	9.2	5.1	8.7	7.8
Increased (no→ yes)	0.9	1.8	0.0	1.0
No risk (no→ no)	88.0	90.4	90.4	89.3
<i>N</i>	<b>465</b>	<b>334</b>	<b>218</b>	<b>1017</b>
<b>Sharing injection equipment</b>				
Same level (yes→ yes)	-	-	-	80.0
Reduced (yes→ no)	-	-	-	5.0
Increased (no→ yes)	-	-	-	10.0
No risk (no→ no)	-	-	-	5.0
<i>N</i>	<b>9</b>	<b>9</b>	<b>2</b>	<b>20*</b>
<b>Implanting beads to penis foreskin/scarring</b>				
Same level (yes→ yes)	10.9	7.9	11.2	10.2
Reduced (yes→ no)	16.5	23.8	10.9	17.3

	Prison C	Prison D	Prison E	Total
Increased (no→ yes)	10.3	6.9	10.9	9.5
No risk (no→ no)	62.3	61.4	66.9	63.1
<i>N</i>	<b>769</b>	<b>420</b>	<b>338</b>	<b>1527</b>
<b>Having anal sex</b>				
Same level (yes→ yes)	10.7	5.7	3.8	7.8
Reduced (yes→ no)	15.4	9.7	10.5	12.7
Increased (no→ yes)	3.8	2.1	0.9	2.7
No risk (no→ no)	70.1	82.4	84.8	76.8
<i>N</i>	<b>767</b>	<b>421</b>	<b>342</b>	<b>1530</b>
<b>Condom use during anal sex</b>				
Same low level (no→ no)	4.9	4.3	15.4	5.9
Reduced (no→sometimes)	0.0	4.3	0.0	0.8
Reduced (no→every time)	2.4	0.0	7.7	2.5
Same high level (sometimes → sometimes)	17.1	34.8	23.1	21.2
Increased (sometimes→ no)	8.5	8.7	7.7	8.5
Reduced (sometimes → every time)	12.2	4.3	15.4	11.0
Increased (every time→ no)	3.7	0.0	0.0	2.5
Increased (every time→sometimes)	2.4	4.3	0.0	2.5
No risk (every time→every time)	48.8	39.1	30.8	44.9
<i>N</i>	<b>82</b>	<b>23</b>	<b>13</b>	<b>118</b>

Note: \* = percentage distribution not shown due to small N

## 9. APPENDIX

### 9.3 Request for Proposals

#### Final Request for Proposals (RFP) 24 September 2010

#### Evaluation of the national HIV-Prevention among Most at Risk Populations, Prisoners and Migrant workers in Thailand

(Project period: October 2010 – June 2014)

1	Date RFP issued	16 <sup>th</sup> of September 2010
2	Issuing Office	The National AIDS Management Center (NAMC) on behalf of National AIDS Committee and Country Coordinating Mechanism (CCM) Thailand
3	A. Proposal to be submitted to	Dr. Petchsri Sirinirund The National AIDS Management Center Department of Disease Control, Ministry of Public Health Tiwanon Road, Nonthaburi 11000 Tel: 66-2-590-3829 Fax: 66-2-965-9153 Email: <a href="mailto:spetchsri@gmail.com">spetchsri@gmail.com</a> And  Thai National AIDS Evaluation Secretariat Email: <a href="mailto:Thai.AIDS.NES@gmail.com">Thai.AIDS.NES@gmail.com</a>
	B: Instructions are included in the request for proposal	Dr. Petchsri Sirinirund The National AIDS Management Center Department of Disease Control, Ministry of Public Health Tiwanon Road, Nonthaburi 11000
4	Questions	Questions may be submitted to the National AIDS Evaluation Secretariat via email <u>only</u> no later than 5.00 PM 22 <sup>th</sup> September 2010.  Should the National AIDS Evaluation Secretariat choose to respond, all questions and all responses will be shared to all interests by the 27 <sup>th</sup> of September 2010
5	Proposals Due	No later than 24.00 hrs on 5 <sup>th</sup> October 2010 (Bangkok time)
6	Submission Method	By electronic via email to Dr. Petchsri Sirinirund Email: <a href="mailto:spetchsri@gmail.com">spetchsri@gmail.com</a> and Thai National AIDS Evaluation Secretariat Email: <a href="mailto:Thai.aids.nes@gmail.com">Thai.aids.nes@gmail.com</a>  <u>Seven copies</u> are required by hand or regular mail (CD with electronic file) to Dr. Petchsri Sirinirund The National Management Center The first floor, Building 7 <sup>th</sup> Department of Disease Control, Ministry of Public Health Tiwanon Road, Nonthaburi 11000

## I: Purpose of the proposal

The National Evaluation Task Force and National AIDS Management Center on behalf of the National AIDS Committee and Country Coordinating Mechanism (CCM) Thailand requests proposals for evaluating the *National HIV-Prevention among Most at Risk Populations, Prisoners and Migrant workers in Thailand*. Through this contract, the National AIDS Evaluation Task Force aims to develop methodologies and measurement tools, and implement an evaluation of National HIV prevention intervention targeting most at risk populations (MARPs), prisoners and migrant workers. This evaluation study will identify strengths, address gaps in HIV prevention programming knowledge, and bolster the evidence base for improving and scaling up effective HIV prevention programs in Thailand. Finally the study will estimate new HIV infections averted after Thailand implemented the HIV national prevention targeting MARP.

The successful offeror will assess current HIV prevention targeting MARP, prisoner, and migrant worker approaches in Thailand and make recommendations to address barriers to access and for increased effectiveness of national HIV prevention targeting most-at-risk populations (MARPs) and migrant workers (MW). Results from the baseline evaluation will be used to inform the development of the Global Fund Round 8 phase II implementation as well as national strategy and operational plan. In addition, the successful offeror will promote the utilization of evaluation results and transfer program evaluation skills thereby improving the capacity in evaluation among program staff (government and civil society) and fostering a “culture” of data and evidence-driven programming decision-making.

## II: Goal and Objectives

### A. Goal:

Improve access to, quality of, and effectiveness of HIV prevention services targeting MARP, prisoners and migrant workers through program evaluation.

All activities will contribute towards accomplishing this goal through the following objectives;

### B. Objectives:

1. Design and implement an evaluation study that aims to improve the quality, coverage, and effectiveness of HIV prevention programs targeting MARP, prisoners and migrant workers (MW). MARP refers to men who have sex with men (MSM), male sex workers, transgenders, injecting drug users (IDU), and venue and non-venue-based female sex workers (FSW).
2. Promote the interpretation and use of evaluation findings and data in HIV prevention program design, implementation and revision of ongoing the Global Fund Round 8 prevention efforts and national strategic planning

## III: Collaboration, Project period, Funding and Geographic Coverage

### A: Collaboration with other programs and partners

The successful offeror will work closely with the technical team appointed by the National Evaluation Task Force to finalize evaluation protocol and instrument(s), conduct data analysis, and report on the findings. Where appropriate, the successful offeror will work in close collaboration with a broad range of

the Global Fund principle recipients (PRs), sub-recipients (SR) and sub-SRs, bilateral and multilateral organizations and other key stakeholders to design and implement evaluation activities.

The successful offeror will have access to, and work in close collaboration with other studies that are on-going. These include an impact evaluation that is being implemented by the Bureau of Epidemiology (BoE) (supported by the World Bank) and a cost-effectiveness study that will be implemented by the Health Intervention and Technology Assessment Program, Department of Health, MOPH. Prisoner evaluation will be conducted by the Thai Ministry of Public Health –US CDC collaboration (TUC).

#### **B: Period of Performance**

The period of performance is from October 2010 to June 2014, subject to the contractor's performance and availability of funds. Since core activities are contingent upon the availability of funding through NAMc and PR-DDC supported by the Global Fund Round 8, funds will be divided into two phases according to Global Fund grant management.

Phase I will cover the award of the grant through June 2012, while Phase II will cover the period of July 2012 to the end of June 2014. To ensure the use of findings to inform the development of the Global Fund Round 8, the preliminary results of *the first part* of the Phase I is required by the end of January 2011.

#### **C: Funding**

This contract will be funded by the Global Fund Round 8, subject to availability of funds. The cost of Phase I activities, to be implemented between October 2010- and June 2012, shall not exceed 13,000,000 THB or 419,354.83 USD (31 THB/USD). The cost of Phase II activities will be determined.

#### **D: Geographic coverage**

By the end of June 2014, the Global Fund Round 8 will be supporting the implementation of interventions in 44 provinces in Thailand. The number and selection of the provinces to be included in this program evaluation will depend on appropriateness of the technical and management approaches that have been proposed. The final list of provinces to be included will be made in agreement with the contractor and the technical team and NAMc.

It is important to note that, at the selected sites, all HIV prevention efforts and activities will be included in the study design, not limited to only activities supported by the Global Fund Round 8.

### **IV: Country and program Context**

#### **A: HIV epidemic context:**

Thailand's national program has been recognized for its past success in controlling HIV among FSW, through the 100% condom use program and, more recently, for the expansion of ARV treatment program on a national scale. Despite these successes, in recent years there have been signs that the country is vulnerable to a resurgence of the HIV epidemic. HIV rates among several MARP continue to be high or are increasing. Recently, integrated biological and behavioral sentinel surveillance surveys (IBBS) revealed an alarming increase in HIV prevalence among MSM in Bangkok from 17% in 2003 to



28% in 2005<sup>i</sup>, 31% in 2007 and 24% in 2009, and in Chiang Mai from 15% in 2005 to 17% in 2007.<sup>ii</sup> Sentinel surveillance among male sex workers (MSW) in four provinces showed decreasing prevalence from 16% in 1997 to 8% in 2002 and 2003, followed by increased prevalence ranging between 9% and 12% during 2004-2007.<sup>iii</sup> The MOPH surveys above included MSW in 2005 and 2007. HIV prevalence in Bangkok was 19% in 2005 and 27% in 2007, and 11% in Chiang Mai in 2005 and 16% in 2007. Most alarmingly, there is evidence showing that HIV incidence among MSM under aged 22 is 10%. HIV continues to be a serious problem among the estimated 40,000 IDU<sup>iv</sup> although the prevalence in Bangkok has declined steadily since 2003 (from 40%-50% for the previous decade to 29% in 2007).<sup>v</sup>

HIV prevalence among direct (brothel-based) FSW and indirect FSW (entertainment venue-based, street-based, and call girls) in Thailand declined steadily from the mid-1990s, reaching 5% among direct FSW and 2% among indirect FSW in 2006, and then increasing slightly to 6% among direct FSW and 3% among indirect FSW in 2007.<sup>vi</sup> Several changes in the way sex work is practiced and the national response have created the potential for a resurgence of HIV in this group. FSW increasingly meet clients in indirect settings (now accounting for at least 92% of all FSW),<sup>vii</sup> placing sex workers at a disadvantage in negotiating condom use. Sexually transmitted infection (STI) clinics have been relocated from community locations to hospitals, where sex workers are reluctant to go. The volume of outreach activities and condom supplies have decreased, due in part to budget cuts. Street-based FSW may be at particularly high risk: a recent US government supported respondent-driven sampling (RDS) survey of primarily street-based FSW in three areas of Bangkok found that 20% were HIV-positive.<sup>viii</sup> As of June 2009, 1,768 prisoners have been infected with HIV out of a total of 209,427 inmates in throughout Thailand. Based on HIV case reports, 63% of transmission was through sex as the route of transmission and 34% by injecting drug use. Finally, migrant workers coming to Thailand in large numbers from Myanmar, Laos and Cambodia are similarly characterized by prevalence of HIV around 2.5%, a rate that is much higher than that in the general population and reflects poor linkages with these populations to prevention programs and health services.

## **B: HIV prevention targeting MARP and migrant worker context**

In early of 2009, Thailand received USD106 million from the GF Round 8 to revitalize HIV prevention among FSW, IDU, MSM and migrant workers (MW). The grant provides a remarkable opportunity for Thailand to reinvigorate HIV prevention. After a decisive and successful campaign to prevent HIV transmission among FSW, clients and their sexual partners in the late 1980s, preventing an estimated 80% of a projected 6 million HIV infections, Thailand has not focused on HIV prevention among MARP for the past two decades. There is clear evidence that MARP are responsible for most HIV infections in Thailand. A renewed focus on prevention is a critical component of the National Universal Access plan (UA plan) that aims to reduce by 50% the number of new infections in Thailand by 2011.

The Global Fund Round 8 is a 5-year project and was initiated in July 2009. The implementation has been divided into 2 phases: Phase I from July 2009 to June 2011, and Phase II from July 2011 to June 2014. The Department of Disease Control (DDC), under the Ministry of Public Health, is the PR for MSM and FSW, and works with three NGO SRs: Rainbow Sky Association of Thailand (RSAT), the Planned Parenthood Foundation of Thailand (PPAT), and Thanyarak Institute for Drug Abuse (TIDA), and 3 governmental SRs: Bureau of AIDS, TB and STI (BATS), Department of Corrections (DOC) and the Office of Narcotics Control Board (ONCB). Raks Thai Foundation serves as PR for the MW programs, in

collaboration with SRs including the BoE, the World Vision Foundation of Thailand (WVFT), the AIDS Network Development Foundation (AIDSNet), the Pattanarak Foundation, Foundation for AIDS Rights (FAR), and the Department of Health Service Support (DHSS). Finally, Population Services International (PSI) serves as PR for IDU programs, working with three SRs: the Raks Thai Foundation (Raks Thai), the Community Pharmacy Organization of Thailand (CPAT), and the Asian Harm Reduction Network (AHRN).

Besides the Global Fund Round 8, there are number of existing HIV prevention efforts targeting these populations such as HIV prevention supported by National Task Force on HIV Prevention, the MARP HIV Prevention Program supported by USAID, TUC and other donors and, lastly, HIV prevention efforts supported by the Thai government regular budget.

In the National HIV prevention program targeting MARP, prisoners and MW, there are two outcomes expected from the implementation strategy: 1) increased prevention behavior among MARP and MW and; 2) a reduced burden of sexually-transmitted diseases. To achieve these outcomes, the implementation strategy includes four Intermediate outcomes:

- Increased access to HIV prevention and intensity of exposure
- Increased STI, VCT and opioid substitution therapy (OST) overage and intensity of use of services
- Increased HIV/AIDS knowledge
- Increased access to condoms/lubricant and sterile needles/syringes

The needs of most-at-risk populations, prisoners and migrant workers are complex. Learning from past successes in HIV prevention programming, the implementation strategy is designed to include an integrated package of services that is tailored to individual needs. The key strategy for achieving the HIV prevention goal is to target those most at risk of HIV infection, reach them in sufficient numbers, and provide them with broad and effective HIV prevention services. To ensure MARP, prisoners and MW have access to comprehensive and quality services; linkage between services, creating an enabling environment, and promoting effective management of services need to be included in the evaluation framework. The evaluation should take these factors into account during the design and analysis.

With HIV prevention intervention scale-up still in its early stages, it is especially important to aim program evaluation at improving programs. The findings generated during this evaluation activity will be very useful to ensure intervention design and service delivery for the 2<sup>nd</sup> phase of the Global Fund Round 8 and new national strategic plan are evidence-based.

## **V: Statement of Work (SOW)**

The main task of this Request for Proposal (RFP) is to evaluate performance of national HIV prevention targeting MARP, prisoners and MW including programs funded by the Global Fund Round 8. The evaluation should address inputs, processes, outputs and intermediate outcome, outcomes and impact. In addition, the program evaluation covered within the scope of this RFP includes the continuum from assessment of existing prevention programs, identification of needs and gaps and development of appropriate evaluation approaches through a variety of methodologies, analysis, documentation, dissemination and utilization of findings.

Key methodologies and approaches to achieve objectives are as follows;

**Objective 1:** Design and implement an evaluation study that aims to improve the quality, coverage, and effectiveness of national HIV prevention programs targeting MARP, prisoners and MW.

There are 5 key target populations in the RFP;

- MSM, male sex workers and transgenders;
- IDU;;
- Venue and non-venue-based FSW;
- Prisoners; and
- MW (from Myanmar, Laos and Cambodia)

### **A: Key evaluation questions**

The study should address, but is not limited to, the following questions:

### **A: Evaluation questions related to operation of HIV prevention targeting MARP, prisoners and MW**

#### **Part I: Measuring inputs and processes at *the early phase***

- 1) Are key HIV services or interventions on HIV prevention targeting MARP available in the implementation area?
  - a. If not, what are the barriers?
  - b. If yes, are they functioning, performing consistently and regularly provided?
- 2) Are interventions taking place at right locations where MARP can be reached?
- 3) Are logistics and supply systems such as condom, lubricants, needles and syringes established to provide MARP with means to prevent HIV?
- 4) Are available human resources (e.g. peer educators, outreach workers, project staff and program management, local and national coordination, etc.) adequate to deliver high-quality integrated packages of HIV prevention services?
- 5) Are there any identifiable human resource gaps (capacity and competence) which pose an obstacle to the implementation of high quality prevention services?
- 6) Does performance across SRs, sub-SRs and different sites within the activities supported by the Global Fund Round 8 meet a minimum standard including analysis of factors affecting its performance?
- 7) To what extent collaboration and integrated efforts is made leading to better performance among PR, SR and S-SR under the GF round 8 and across funding sources?
- 8) Is the monitoring system adequate in tracking progress of performance, gaps or failures such that timely corrections can be made?

#### **Part II-A: Measuring inputs and processes at *the full implementation phase***

- 9) Are all interventions being implemented as planned?
- 10) Are interventions reaching the intended and right clients?
- 11) Are interventions being implemented according to:
  - a. an integrated, defined package of HIV prevention services; and
  - b. defined standards/good quality (quality and intensity)?If not what is missing and why?
- 12) To what extent do the key interventions appropriately address stigma and discrimination toward MARP?

- 13) To what extent is gender integrated into program planning, implementation, and capacity building of key interventions?
- 14) Are members of the target population satisfied with the intervention and services provided? How is the program design and actual service delivery informed by clients' needs and satisfaction?
- 15) What are appropriate tools and mechanisms, particularly provincial coordinating mechanism (PCM) for implementers to monitor regularly both the coverage and the behavior change reached through prevention services?
- 16) Is the technical and allocative efficiency of financial resources adequate to reach the defined health outcomes in the round 8 proposal?
- 17) What is the extent of participatory involvement of MARP in planning and evaluating services?

#### **Part II-B: Evaluation questions related to intended results (intermediate outcome and outcome)**

- 18) What is the coverage of people reached by defined HIV prevention packages?
- 19) What is the effect of the package of services that may be attributed to the interventions?
  - a. increasing the proportion of the population who know their HIV status?
  - b. decreasing HIV-related risk behaviors?
  - c. decreasing STIs?
  - d. increasing early access to anti-retroviral therapy and prophylaxis for opportunistic infections?

#### **Part III-A: Evaluation questions related to impact at the national level**

- 20) Are the programs implemented on large enough scale to have a positive impact on the HIV epidemic?
- 21) What is the effect of the package of services that may be attributed to the interventions decreasing new HIV infection?

#### **Part III-B: Evaluation questions related to learning for scaling up, health system and sustainability**

- 22) Are interventions being implemented as a combination of HIV prevention approaches (a multifaceted context of behavioral influences, community, and policy and environment interventions)?
- 23) What are the most promising HIV prevention models and approaches for each MARP and MW?
- 24) What are alternatives which the national program needs to consider for policy, strategy, operations and financial systems to sustain promising models for post-Global Fund grants?

#### **B: Methodology and evaluation design**

The Evaluation design should examine inputs, processes, outputs and outcomes wherever possible. The methodology can be any design that is appropriate to answer the key evaluation questions and that fits within the context of rapid scale-up of HIV prevention interventions for MARP, prisoners and MW. Various methods that can be considered include experimental or quasi-experimental designs, cohort studies, and pre-post measures among the target populations. Data on the input, process, and outputs of prevention interventions or service delivery approaches may be obtained through secondary data analysis of program monitoring data. In addition, qualitative methodologies should be considered to complement quantitative efforts and to provide for a better understanding of program context. The

evaluation design will be finalized in collaboration with the technical team appointed by the national evaluation task force and NAMc.

With recognition that Thailand is in a urgent need of evidence-based data to support development of the Global Fund phase II implementation plan, Offeror(s) should focus the study design on collecting data among SRs and sub-SRs (as appropriate) across different areas to answer evaluation questions nos. 1-7 (Part I) to assess details of their performance and the monitoring system.

Finally, in order to measure the effect of programs on decreasing new infections, offeror(s) should consider using triangulation and modeling methods to answer the evaluation questions (Part III-A).

### **C: Measurement**

Measurement issues that often pose challenges to HIV prevention evaluations include the measurement of exposure to or use of targeted prevention interventions and services, the validation of self-reported behavior change, and the appropriate use of biomarkers to measure outcomes. Offeror(s) should propose strategies to address these issues.

### **Objective 2: Promote the interpretation and use of evaluation findings and data in HIV prevention program design, implementation and revision of ongoing the Global Fund Round 8 prevention efforts and national strategic planning**

The successful offeror will expand beyond a dissemination meeting to communicate findings to key stakeholders. Innovative approaches to promote the use of critical evaluation findings among key stockholders at national, sub-national and civil society are needed. In particular, activities should be proposed for translating the evaluation findings into action so that promising program models can be replicated and scaled-up in the second phase of the Global Fund program Round 8 and addressed in the new national strategic and national operational plan.

## **VI: Key Deliverables**

The key deliverables required are as follows:

### **1) Phase I: October 2010 – June 2012 (21 months)**

#### **• Phase I-I October 2010 – January 2011**

- 1) Protocol for evaluating national HIV prevention targeting MARP, prisoners and MW by October 2010
- 2) Measurement tools ( In English and Thai) by November 2010
- 3) Passed IRB and ethical review by November 2010
- 4) Undertake data collection Part I key evaluation questions nos. 1-8
- 5) Presentation of preliminary results by January 2011 (Part I key evaluation questions nos. 1-8)
- 6) Undertake promoting the interpretation and data use activity.

- **Phase I-II : February 2011 – June 2012**

- 7) Undertake the data collection by June 2011 (Part II (A and B) key evaluation questions nos. 9-17)
- 8) Presentation of preliminary results from Part I and II by December 2011
- 9) Final the first round data collection, analysis and report (In English and Thai) by June 2012
- 10) Undertake promoting the interpretation and data use activity.

**2) Phase II: July 2012 –June 2014** (*specific date for each deliverable will be determined when the Global Fund Phase II implementation plan is approved*)

- 11) Undertake the follow-up round of data collection (Part II B evaluation questions) by December 2013
- 12) Undertake Part III (A and B evaluation questions) by March 2014
- 13) The final report ( In English and Thai) by June 2014
- 14) Undertake promoting the interpretation and data use activity by June 2014
- 15) Dataset with data dictionary in English and Thai
- 16) A report of activities and approaches to promote use of findings
- 17) A report of activities and approaches to build local counterpart capacity related to evaluation.

The quarterly progress report is required through the contract period.

**Special considerations:**

The initial contract will be awarded for the time period between October 2010 and June 2012. After successful implementation of *the Phase I contract* and subject to the contractor's performance and availability of funds, *the Phase II contract* will be either directly awarded to the contractor of Phase I, or opened for competitive bidding.

### VII: Qualification of Offeror(s)

1. Institutions or organizations should have experience in managing HIV/AIDS research and evaluation studies for at least 2 years
2. The Principle Investigator (PI) should have experience in managing HIV/AIDS research and evaluation studies for at least 2 years
3. The Global Fund Round 8 SRs are not eligible to respond to this RFP
4. Thai and/or international teams and institutions are eligible to reply

### VIII: Selection Process

1. Proposals will be reviewed and evaluated by the Technical Review Panel (TRP) consisting of 3-5 members and appointed by the National Evaluation Task Force
2. TRP evaluation results and comments of all applications will be submitted and reviewed by the National Evaluation Task Force
3. The National Evaluation Task Force will make the final decision on selection of the successful Offeror.

**IX: Timeline of RFP**

Key step of RFP	Date
1. Advertisement request for proposal (RFP)	16 <sup>th</sup> September 2010
2. Obtain questions related to RFP	22 <sup>nd</sup> September 2010
3. The National Evaluation Secretariat responds to questions	27 <sup>th</sup> September 2010
4. Close date for request for proposal	5 <sup>th</sup> October 2010
5. Technical Review Panel reviews proposals	6 <sup>th</sup> -13th October 2010
6. Technical Review Panel meeting	14 <sup>th</sup> of October 2010
7. Short-listed candidate(s) make presentation to the National Evaluation Task Force	15 <sup>th</sup> of October 2010
8. The National Evaluation Task Force selects a successful offeror	15 <sup>th</sup> of October 2010

**X: Instructions to offerors****1. Technical Proposal**

The technical proposal must be specific, complete and presented concisely. The technical proposal must demonstrate the offeror's capabilities, expertise, and commitment with respect to achieving the goal and objectives of the project. The proposals must take into account the technical selection criteria and evaluation procedures described below. The technical portion of the proposal must not exceed **20 pages**, excluding attachments.

Proposals must be on pages of 8-1/2 inch by 11-inch paper, single-spaced, 12-point or larger type in a single column, with one-inch margins on all sides, with tabs to distinguish each section. An outline format using lists and/or matrices, whenever possible, is recommended. Offerors must include resumes of proposed key personnel (four pages maximum per resume) and other proposed staff (three pages maximum per resume, with no more than 4 examples of potential consultants and staff per proposed position/area of expertise) in an annex. Cover pages, dividers, table of contents, and attachments (i.e., key personnel resumes, and letters of commitment) do not count against the 20-page limitation.

To facilitate efficient review of proposals, offerors must organize the technical proposal in the format specified below

**Technical Proposal Format**

**Cover Page** – Title, names of organization(s) submitting proposal, contact person, telephone and fax numbers, address and email. This page is not included in the 20-page maximum.

**Executive Summary** (not to exceed 2 pages) – Briefly describe the proposed activities, goals, purpose, technical strategies and methodologies, and anticipated results. Briefly describe the technical and managerial resources of your organization. Describe how the overall program will be managed and how the program will meet the overall goal and objectives of the project.

**Narrative** (not to exceed 18 pages) - The narrative section of the proposal should address the project goals and objectives and reflect the tasks outlined in Section V and contain the following elements:

**A. Technical Approach (not to exceed 15 pages)**

A1: Objective 1: Conduct program evaluation that aims to improve quality, coverage and effectiveness of HIV prevention program targeting MARP (not to exceed 12 pages)



A2: Objective 2: Promote the interpretation and use of evaluation findings and data in HIV prevention program design, implementation and revision of ongoing the Global Fund Round 8 prevention efforts and national strategic planning (not to exceed 3 pages)

### **B. Staffing and Management (not to exceed 3 pages)**

**Staffing:** Offerors should provide a summary description of roles, responsibilities and qualifications of all key personnel to be funded under the project. Offerors should specify qualifications and abilities of proposed key personnel relevant to successful implementation and include resumes for key candidates. Resumes should not exceed three pages in length and should be in chronological order starting with most recent experience.

**Management:** Offerors should demonstrate their organizational ability to plan, implement and support programming in the range of activities outlined in the RFP. They should propose an organizational structure to address the breadth, depth and technical areas required to successfully undertake prevention research and evaluation tasks. The management plan should describe the management and administrative arrangements for implementation of the task order, including organizational structure, personnel management, and timely institutional review for the protection of human subjects. Offerors should describe how lines of authority will be managed within their own organization and between the prime contractor and any sub-contractors. Include a plan for how to minimize costs on centrally funded and mission support activities. Offerors are encouraged to include an organizational chart in an annex. Offerors should describe their approach to rapid start-up of activities in the field.

### **2. Cost Proposal**

The Cost Proposal must be completely separate from the applicant's technical proposal. There is no page limitation on the Cost Proposal. Offerors shall submit a Cost Proposal for a 45-month operating period, and divide implementation and budget into 2 phases:

Phase I: October 15, 2010- June 30, 2012 (21 months)

Phase II. July 1, 2012- June 31, 2014 (24 months)

### **Cost Proposal Format**

To support the proposed costs, please provide adequate detail. The following provides guidance on what is needed:

- a. Salary and Wages: Direct salaries and wages should be proposed in accordance with the Offeror's personnel policies;
- b. Fringe Benefits: If the Offeror has a fringe benefit rate that has been approved by an agency of the U.S. Government, such rate should be used and evidence of its approval should be provided;
- c. Travel and Transportation: The proposal should indicate the number of trips, domestic and international, and the estimated costs. Specify the origin and destination for each proposed trip, duration of travel, and number of individuals traveling. Per diems should be based on the Offeror's normal travel policies;
- d. Field office costs: Costs associated with running a field office excluding personnel, indirect costs and fringe benefits.
- e. Equipment: Estimated types of equipment (i.e., model #, cost per unit, quantity);
- f. Supplies: Office supplies and other related supply items related to this activity;
- g. Contractual: Any goods and services being procured through a contract mechanism;
- h. Grants under Contracts (field support/ Mission funding only): The amount for grants under contracts.



- i. Other Direct Costs: This includes communications, report preparation costs, passports, visas, medical exams and inoculations, insurance (other than insurance included in the applicant's fringe benefits), equipment, office rent abroad, etc.
- j. Indirect Costs For example, a breakdown of labor bases and overhead pools, the method of determining the rate, etc.).

## **XI: Evaluation Criteria**

These technical evaluation criteria have been tailored to the requirement of this RFP to allow NAMC to choose the highest quality proposal. The criteria serve as a standard against which the Technical Review Panel (TRP) shall evaluate all proposals.

### **A. Technical Approach (80%)**

#### A1. Overall Technical approach (10 %)

Extent of understanding of, and framing a response to the overall goals and objectives of the project technical aspects of program evaluation, results dissemination and utilization, and local capacity building. Overall merits (responsiveness, technical clarity, analytic depth, technical knowledge, developing country knowledge, program relevance, strategic vision, collaboration, and feasibility) of approaches and strategies to achieve the goals and objectives of the project

#### A2.1 Technical approaches to achieve Objective 1 (50%)

Technical merit of approaches and strategies used for developing evaluation tools and methodologies, testing service delivery models, and evaluating program quality and outcomes. Technical merit of approaches and strategies for carrying out activities, and methodologies for capturing, synthesizing and promoting lessons learned in the field. Overall feasibility to undertake program evaluation as proposed.

#### A2.2 Technical approaches to achieve cross-cutting issues such as stigma & discrimination, gender and health system (10%)

Offeror's awareness and understand to cross-cutting issues such as stigma & discrimination, gender and health system in prevention program research, and feasibility of proposed approaches to assess these factors.

#### A3. Technical approaches to achieve Objective 2 (10%)

Offeror's awareness and understanding of program research utilization needs in specific contexts; challenges in enhancing research utilization in these contexts; and the extent to which the proposed solutions are innovative, feasible and technically appropriate for those contexts. Extent to which the proposed data use activities are likely to succeed in meeting the objective at various stages of the program planning-implementation-evaluation-refinement continuum.

### **B: Staff and Management (20%)**

Demonstrated technical experience and expertise of key staff in HIV prevention program research and evaluation, management, design and implementation of research programs. Ability of key staff to assume program research and evaluation technical leadership roles and effectively manage program research efforts including coordination and collaboration with implementing partners at all levels. Optimal mix and configuration of required skills (demonstrated in the organizational chart) for a functional team approach and for maximizing efficiency, collaboration, capacity building, and minimizing

cost. Feasibility of management structure for implementation of task order requirements, including technical oversight, personnel management, financial management, and logistic support; offerors' proposal for rapid start-up of task order activities in the field.

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- i MMWR. HIV Prevalence among populations of men who have sex with men – Thailand, 2003 and 2005. August 11, 2006. Reported by: F van Griensven A Varangrat, W Wimonasate, JW Tappero, C Sinthuwattanawibool et al.
  - ii Plipat T, Kratsawad K. HIV prevention among men who have sex with men. Bureau of Epidemiology, Department of Disease Control, Ministry of Public Health, 2008.
  - iii Bureau of Epidemiology. Reporting of HIV infection situation in Thailand, 2007. Department of Disease Control, Thailand Ministry of Public Health, 2007.
  - iv Family Health International and Bureau of AIDS, TB, and STI, Department of Disease Control, Ministry of Public Health, Thailand. Summary Technical Report for the Asian Epidemic Model (AEM) Projections for HIV/AIDS in Thailand: 2005-2025. Bangkok: 2008.
  - v Bureau of Epidemiology. Reporting of HIV infection situation in Thailand, 2007. Department of Disease Control, Thailand Ministry of Public Health, 2007.
  - vi Bureau of Epidemiology. Reporting of HIV infection situation in Thailand, 2007. Department of Disease Control, Thailand Ministry of Public Health, 2007.
  - vii Buranasajji P., et al. Summary results. Sex establishment survey annual report. First ed. (August 2006): 16. STI Cluster, Bureau of AIDS, TB and STI, Department of Disease Control, Thailand MOPH.
  - viii Manopaiboon C, Whitehead SJ, Subhachaturas W, et al. Unexpectedly high HIV prevalence among Thai sex workers in a respondent-drive sampling survey. Australasian Society for HIV Medicine, Perth, 2008.