PEPFAR Asia Regional Program

Regional Operational Plan 2016

FY17 Strategic Direction Summary

2 May 2016

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Goal Statement

The goal of the PEPFAR Asia Regional Program (ARP) is to catalyze broader, sustained epidemic control by demonstrating more effective approaches to reach, test, treat, and retain priority populations in settings with the greatest burden of HIV in China, Laos, and Thailand.

Based upon extensive analyses of epidemiological and program performance data, ARP has developed a Regional Operations Plan (ROP) for FY17 that remains focused on geographic areas and populations where HIV transmission is highest, while committing to a vision of strong, sustainable national and regional networks and systems for HIV epidemic control.

Working across USG agencies and collaboratively with host-country government counterparts, implementing partners, civil society organizations (CSOs), and multilateral organizations, the FY17 plan will accelerate epidemic control in fourteen provinces with the highest HIV rates and lowest ART coverage among priority populations in China (five of 31 provinces), Laos (three of 17 provinces), and Thailand (six of 77 provinces).

FY17 activities build upon a tradition of successful ARP investments in 1) innovative, scalable, and more effective approaches for HIV epidemic control and 2) technical assistance (TA) that converts successful approaches into national policies and commitments to scale up; reinforces laboratory and strategic information capacity to guide and improve program implementation and quality; and secures the financial, systems, and human resource capacity needed for broader implementation.

ARP will continue to apply this approach in FY17, but with a sharp focus on assisting country efforts to operationalize *test-and-start* policies and explore the use of pre-exposure prophylaxis (PrEP) in priority provinces through patient-centered community and public HIV services that meet quality standards and are cost-effective to deliver and sustain. By doing so, the ARP anticipates it will help national programs maximize the prevention and treatment benefits of antiretroviral medications and optimize the care continuum.

To achieve this with its limited resources, and reflecting its analysis of epidemiological and program data, ARP will focus its investments on settings with the highest HIV infection burdens, concentrate on the key drivers of the epidemic in those provinces, and align USG agency investments to achieve greater impact.

ARP will collaborate with the Government of China (GoC) to achieve sustained epidemic control by focusing its field implementation activities on men who have sex with men (MSM) living in urban areas of Chinese provinces with the country's largest HIV burden.

In Laos and Thailand, ARP will concentrate its efforts on providing TA that facilitates early access to high-quality HIV testing services and antiretroviral medication among MSM and transgender (TG) women in priority provinces, while ensuring that local and national providers have access to data to help them effectively plan programs and make timely clinical care decisions.

While focused on those key and priority populations, ARP activities will have benefits for other populations (e.g., female sex workers and people who inject drugs) in all three countries and across the region.

By demonstrating how cost-effective programming can achieve epidemic control among target populations in priority areas, while helping to strengthen the systems to support replication and scale-up of successful models by the country, ARP will leverage its relatively modest investments, its reputation as a trustworthy, reliable, and knowledgeable partner in the region, and its strong technical relationships to maximize epidemiological impact and sustainability.

In doing so, ARP will enable these countries to take a critical step forward towards achieving the UNAIDS 90-90-90 treatment targets by 2020 – while helping them engage with other countries in the region so as to accelerate HIV epidemic control more broadly.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

China

China is the most populous nation in the world with an estimated 1.36 billion people in 2014[1]. China has the world's second largest economy, and its 2014 GNI per capita (Atlas method) of $7,380, ranks 101 and qualifies it as a middle-income country. As China's economy has grown rapidly, large disparities in wealth have emerged. China now has more than 200 billionaires as well as 70-200 million persons living in poverty, depending on the poverty index used. China's urban-dwelling population has tripled since the late 1970s, including 250 million rural-to-urban migrant workers. Most migrants belong to a "floating population" that lacks local registration status, which generally excludes them from social welfare programs (including free ART and other HIV-related services) where they live for work. Immigrants, whose numbers have also surged during China's economic expansion, are similarly excluded from social services access.

China's most recent HIV epidemic estimate is that there are 825,000 persons living with HIV. As of the end of 2014, 159,000 cumulative deaths among HIV-diagnosed persons had been reported. In 2014, 85,000 HIV-diagnosed persons initiated ART; by the end of the year 295,000 were receiving ART, among 442,000 people living with HIV (PLHIV) who had initiated HIV care (reported CD4 count considered a proxy for care). Of those receiving ART, 195,000 had laboratory evidence of viral suppression at least once within 12 months of starting ART (73% of ART patients had received at least one viral load test). Approximately 15 million women give birth in China each year; in 2014 0.1% of this group was diagnosed with HIV, and the mother-to-child transmission (MTCT) rate was 6.1%.[2]

[1] World Bank- http://www.worldbank.org/en/country/china
[2] 2015 China AIDS Response Progress Report, NHFPC

The ratio of male-to-female new HIV diagnoses in China is approximately 3:1. Most PLHIV in China are adults under 50 years of age; there were fewer than 10,000 children diagnosed with HIV in China in 2011. PLHIV residences are geographically concentrated in five southern and western provinces, as well as in areas of central China affected by the plasma donor HIV outbreak of the 1990s.

Over 110,000 new diagnoses of HIV were reported in China in 2015.[3] Approximately two-thirds of newly-diagnosed HIV cases reported heterosexual sex as their sole HIV transmission risk factor; more than 25% reported male:male sex.[4] The annual total of new HIV diagnoses among persons 15-19 years of age is double what it was five years ago, which suggests that incidence may be on the rise. National sentinel behavioral surveillance data indicate that HIV prevalence among MSM climbed from 1.4% in 2005 to 8.0% in 2015, while remaining stable among injecting drug users at around 3.3%[5].

Since 2010, China's HIV treatment guidelines have included recommendations for treatment of HIV-infected individuals regardless of initial CD4 count for members of sero-discordant couples, pregnant women, or those who have TB or a hepatitis co-infection. In 2014, the GoC issued guidelines that changed treatment eligibility criteria from CD4 <350 to CD4 <500. A draft revision of China's HIV treatment guidelines that eliminates CD4 thresholds for initiation of ART was submitted to the Chinese National Health and Family Planning Commission (NHFPC) in December, 2015 for review, and official approval is anticipated in 2016.

While China has not yet released a revised document that demonstrates full adoption of test and start in China (i.e. removal of CD4 threshold for ART initiation), the National Center for AIDS/STD Control and Prevention (NCAIDS) Division of Treatment and Care has made progress by submitting a proposal in 2015 to the National Health and Family Planning Commission (NHFPC) suggesting this change. They are currently waiting for feedback from NHFPC as of 4/22/2016. Stigma and discrimination against PLHIV both persist throughout China. Media reports in the last year have described numerous instances of PLHIV denied educational and employment opportunities, as well as vital health care services, on the basis of their HIV status. Efforts to mitigate HIV-related discrimination include the Red Ribbon Discussion Forum, which annually brings together leaders of HIV community-based organizations (CBOs) and policy makers for information sharing and advocacy. Further, monthly televised HIV public service announcements have been aired in high-burden counties served by the "China CARES" program[6]. More work remains in this area, particularly for key populations, such as MSM and TG women, including those also living with HIV who often face multiple layers of stigma.

[3] China Daily 11-20-2015 "Gay Men Hit Hard By HIV/AIDS Epidemic"
[4] MSM- and drug use-related stigma may contribute to the number of cases attributed to heterosexual transmission despite a low proportion of female PLHIV.
[5] 2015 China AIDS Response Progress Report
[6] Comprehensive program established by MoH in 2003 in counties with greatest number of HIV/AIDS cases

Table 1.1.1.a China: Key National Demographic and Epidemiological Data

Total			<15				15+			
			Female		Male		Female		Male	
	N	%	N	%	N	%	N	%	N	%
Total Population	1.36 billion		114.9 million	8.4 %	134.0 million	9.8 %	544.4 million	39.8%	574.5 million	*42.0%*
Prevalence (%)		0.06						223000/ 6592880 00 0.034%		557000/ 7085300 00 0.079%
AIDS Deaths (cumulative)	159,000									
PLHIV (only by sex)	825,000						220,275		604,725	
Incidence Rate (Yr)										
New Infections (Yr)	48,000									
Annual births[7]	18,454,700									
% >= 1 ANC visit		95								
Pregnant women needing ARVs[8]	6,800									
Orphans										
TB cases (Yr) for 15+yrs	1,393,000						347,000		1,046,000	
TB/HIV Co-infection	4,700									
Males Circumcised										
Total MSM	3,900,000									
MSM HIV Prevalence[9]	300,300	7.7								
Total FSW	2,520,000									
FSW HIV Prevalence	5,540	0.2								
Total PWID	2,260,000									
PWID HIV Prevalence	135,600	3.3[10]								

Table 1.1.2a China: Cascade of HIV diagnosis, care and treatment (12 months, 2014)[11]

				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Population (#)	HIV Prevalence (%)	Total PLHIV diagnosed (#)	In Care (#)	On ART (#)		Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)

[7] total live births, UNICEF, 2012
[8] National Center for Women and Children's Health, 2012
[9] in 2014 per sentinel surveillance; 2015 China AIDS Response Progress Report
[10] 2015 China AIDS Response Progress Report
[11] Unpublished data, NCAIDS 2014

Total population	1.36 billion	0.06	501,000[12]	441,809	295,358		195,104	127,560,180	103,501	85,274
Population < 15 years										
Pregnant Women	18,454,700		6,800							
MSM	3,900,000	7.7								
FSW	2,520,000	0.2								
PWID	2,260,000	3.3								

Laos People's Democratic Republic (Laos)

Although a lower middle income country, with a GNI per capita of 1,660 (USD) in 2014, the Laos economy has been steadily improving with ~7% GDP growth for several years. Of the estimated population of 7 million, more than half (55%) is below 20 years of age and more than a third (36.5%) live in urban areas. Much of the population lives in poverty, with inadequate access to water, sanitation, and health care. WHO has classified Laos as one of its health workforce crisis countries. Other areas of health system weakness include health financing, health management information systems (HMIS), health infrastructure, and planning and management of health services.

The main causes of mortality and morbidity in Laos are communicable diseases. The HIV epidemic is classified as low prevalence (0.18% in 2014) with an emerging epidemic among MSM. The estimated HIV prevalence in 2014 among MSM was 1.6% followed by PWID (1.5%) and sex workers (1.3%). While more information about the impact of the HIV epidemic among TG women is needed, an IBBS survey among TG women in 2011 found that 4% of individuals were infected with HIV. Around 50% of the estimated 12,529 PLHIV in Laos (in 2014) were men who had multiple partners; mainly men who traveled frequently for work and engaged commercial sex workers.

Until recently, understanding of the epidemic within the military was limited, as the Lao People's Army was only included in the 2000/2001 and 2004 BBSS. Regular alcohol consumption (50%), sex with sex workers (11.5%), inconsistent condom use (81.8%), and other high-risk behaviors were identified in both surveys, however, as were significant rates of gonorrhea and chlamydia (2.9%-10%). Subsequent PEPFAR-supported HIV testing at military bases and routine case reporting at ART sites suggested increasingly identified numbers of infections amongst military personnel, in particular men aged ≥25 years old, although total numbers remain low. A seroprevalence assessment within the Lao People's Army was recently completed, however, with preliminary

[12] NCAIDS, 2011 estimate

results suggesting a prevalence that is less than the 0.29% (UNAIDS 2014) national prevalence among 15-49 year olds.

In 2014, a total of 5,007 adults and children PLHIV had been retained on ART for the previous 12 months, the equivalent to 40% of all estimated PLHIV. Laos/CHAS reports that median CD4 counts upon entry to care in Laos was above 250 cells per mm3 in 2013, an indication that HIV-infected individuals are entering care at earlier stages of infection than in many other countries in the region, and an indication that the HIV epidemic in Laos may be less mature than in surrounding countries. A reported 163 children were on ART in 2012; 49 HIV-positive pregnant women received ARVs to prevent MTCT in 2012.

Although HIV incidence in the general population has been declining, new HIV infections increased from 612 (in 2010) to an estimated 1,057 cases (in 2014), suggesting the epidemic is worsening. With economic growth, increasing employment opportunities, cross-border migration, and an improved transport system, the HIV epidemic in Laos is evolving quickly and beginning to reflect the trends of neighboring countries, namely, broader impact among the general population with greater concentration among key populations.

In 2015 Laos implemented WHO ART guidelines June 2013 to start ART in all PLHIV regardless of WHO clinical stage who have CD4 less than 500 cells/mm3. Starting 1 January 2016 Laos adopted WHO's 2015 new recommendations: ART should be initiated in all adults living with HIV regardless of WHO clinical stage and at any CD4 cell count.

Table 1.1.1b Laos: Key National Demographic and Epidemiological Data (2014)

	Total		<15				15+			
			Female		Male		Female		Male	
	N	%	N	%	N	%	N	%	N	%
Total Population[13]	7,027,006		1,106,177		1,159,120		2,391,448		2,370,261	
Prevalence (%)		0.18		0.04		0.04		0.22		0.27
AIDS Deaths (per year)	468		27		29		172		240	
PLHIV	12,529		440		461		5,305		6,323	
Incidence Rate (Yr)		0.015		0.005		0.005		0.020		0.020
New Infections (Yr)	1,057		54		57		384		562	
Annual births[14]	181,000									
% >= 1 ANC visit	54.2									
Pregnant women needing ARVs	307									
Orphans (maternal, paternal, double)	158,839									
Key Populations										
Total MSM[15]	55,248									

[13] Source for Total Population, Prevalence (%), AIDS Deaths (per year), PLHIV, Incidence Rate (Yr), Pregnant women needing ARVs, and Orphans (maternal, paternal, double) was SPECTRUM 2014

[14] Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2012 Revision, http://esa.un.org/unpd/wpp/index.htm

[15] Source: Size Estimation for key population, using for the AEM, updated in April 2015. This estimation applied for MSM who had anal sexually active. TG with active anal sexual behavior is included.

MSM HIV Prevalence[16]		1.6								
Total TG[17] Women	N/A									
TG Women Prevalence		N/A								
Total FSW	14,490									
FSW HIV Prevalence [18]		1.3								
Total PWID [19]	1,280									
PWID HIV Prevalence [20]		1.5								

Table 1.1.2b: Laos Cascade of HIV diagnosis, care and treatment (12 months, 2014 achievements)

				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate	**HIV Prevalence**	**Total Estimated PLHIV**	**In Care**	**On ART**	**Retained on ART 12 Months**	**Viral Suppression**	**Tested for HIV**	**Diagnosed HIV Positive**	**Initiated on ART**
	(#)	(%)	(#)	(#)	**(#)**	**(#)**	**12 Months**	(#)	(#)	(#)
Total population	7,027,006	0.18	12,529	5,933	5,007	3,336	2,684	58,745	834	
Population < 15 years	2,265,297	0.04	901						36	
Pregnant Women	191,043	0.2	309					27,749	89	
Key Populations										
MSM	54,898	1.6						955	50	
TG Women	N/A	N/A						N/A	N/A	
FSW	14,490	1.3						2,772	25	
PWID	1,280	1.5						70	1	

<u>Thailand</u>

Although an upper-middle income country (with a GNI per capita of 5,780 USD in 2014), Thailand's economic growth has slowed in recent years compared to other developing East Asian countries. Poverty continues to be an important challenge, particularly among the ~50% of the population (65.1 million in 2015) that live in rural areas. Basic health systems infrastructure and access to clean water and sanitation are nearly ubiquitous.

Thailand was home to approximately 446,000 PLHIV in 2014. Overall HIV incidence has decreased, but incidence and prevalence remain high among key populations, particularly MSM and TG women and sex workers in larger urban areas. Based on the Asian Epidemic Model

[16] 2014 IBBS among MSM (RDS sampling)

[17] Source: Data is not available.

[18] 2014 IBBS among venue-based FSW (TLS sampling)

[19] 2014 UNOCD report

[20] 2010 survey in 2 provinces (Phongsalyand Houaphanh)

(AEM), 7,890 new HIV infections will occur during 2016; 44% through transmission among MSM, 10% among sex workers and their clients, and 11% am6ng PWID.

The AEM projects that 29% of new infections in 2016 will be through spousal transmission, especially (21%) from husbands to their wives. While it continues to be high, the proportion of all new infections that occur through spousal transmission is decreasing (down from nearly 38% in 2010) while this proportion is increasing among MSM (up from 33% in 2010).

As of the end of 2014, 349,816 PLHIV had registered for care with the government, 284,578 (81.3%) had started ART, 258,183 (73.8%) were continuing to take ART at the end of September 2014, and 191,920 (54.8%) had viral load results <50 copies/ml. Although the existing Thai health services infrastructure is robust, the quality of care and treatment remains inconsistent and services are directed nationally in an effort to provide access for all.

Validation of Thailand's elimination of mother-to-child HIV transmission is on-going, but leaks persist in the cascade for HIV-infected infants and HIV-infected mothers after delivery. A 2012 evaluation found that 39% of HIV-exposed infants born during 2008-2011 did not receive early infant diagnosis (EID) and only 157 (37%) HIV-infected infants received ART within one year of age. Data from August 2014 through December 2015 showed that the proportion of HIV-infected infants receiving ART within one year of age increased to 79%. However, the infant AIDS-related mortality among these infants was 17%.

Table 1.1.1.c-1 Thailand: Key National Demographic and Epidemiological Data (2014)

	Total		<15				15+			
			Female		Male		Female		Male	
	N	%	N	%	N	%	N	%	N	%
Total Population[21]	64,871,000		5,847,000	9.01	6,107,000	9.41	27,483,000	42.37	25,434,000	39.21
Prevalence (%)[22]		0.8		0.0573		0.0572		0.69		0.99
AIDS Deaths (per year)	20,494		71		74		6,127		14,197	
PLHIV	446,368		3,780		3,959		189,782		248,847	
Incidence Rate (Yr) (Population age 15+)		0.015		0.001		0.001		0.01		0.02
New Infections (Yr)[23]	7,800		51		54		1,944		5,751	
Annual births[24]	776,370									
% >= 1 ANC visit	763,172	98.3					736,997	98.3		
Pregnant women needing ARVs	4,827	0.62								
Orphans (maternal, paternal, double)[25]	301,865									

[21] NESDB, 2013, (Pop projection 2010-2040)

[22] For Prevalence (%), AIDS Deaths (per year), PLHIV, Incidence Rate (Yr), and New Infections: Adult > 15 years: AEM 2014 and Children <15: SPECTRUM 2014

[23] MOI 2013

[24] ANC and ARV data: Department of Health

[25] AIDS Access Foundation Survey report

TB cases (Yr)[26]	86,000									
TB/HIV Co-infection[27]		13								
Key Populations										
Total MSM[28]	504,248	3								
MSM HIV Prevalence[29]	41,299	7.9								
Total TG Women	N/A									
TG Women Prevalence[30]		2.1								
Total FSW	132,897									
FSW HIV Prevalence	2,698	1.99								
Total PWID	40,300									
PWID HIV Prevalence	11,898	29.7								

Table 1.1.2.c Thailand: Cascade of HIV diagnosis, care and treatment (12 months, 2014)

	2014: Estimated population			**HIV Care and Treatment Cascade by Sep 2014**				**2014: HIV Testing and Linkage to ART**		
	Total Population Size Estimate	**HIV Prevalence**	**Total PLHIV alive**	**In Care[31]**	**On ART**	**Alive and retained on ART 12 Months**	**Viral Suppression[32]**	**Tested for HIV**	**Diagnosed HIV Positive**	**Initiated on ART**
	(#)	(%)	(#)	(#)	(#)	(#)	12 Months	(#)	(#)	(#)
Total population	64,871,000	0.80	446,368	349,816	284,578	258,183	191,920	639,209	18,060	14,201
Population < 15 years	11,954,000	0.06	7,739	6,255	4,875	4,498	3,094	18,061	284	195
Pregnant Women	800,000	0.62	4,960	3,761	2,694	1,405	734			
Key populations[33]										
MSM	504,248	7.9	41,299	4,124	2,687	2,090	1,123	8,539	1,710	
TG Women	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	
FSW	132,897	1.99	2,698	503	347	246	146	3,944	77	
PWID	40,300	29.7	10,898	3,401	2,195	1,432	930	1,233	152	

1.2 Investment Profile

<u>China</u>

[26] WHO 2012 (Register 60,000)
[27] TB and HIV concept note (GF) 2014
[28] Total MSM, FSW, and PWID: National Operation Plan for Ending AIDS 2015-2019
[29] MSM, FSW, and PWID HIV prevalence: AEM 2014
[30] Source: AEM 2015 size estimation and estimated TG HIV prevalence. The 2014 IBBS observed from TG who are sex workers at hot spots was 12%.
[31] Cumulative registered to care and had records in NAP-Plus since 2007
[32] Viral Suppression = <50 copies/ml for Thailand
[33] Only those who disclosed themselves or had records as KP since 2007

With the last of the grant money from the Global Fund fully spent in 2014, the GoC now funds 99% of China's national HIV response. Merck Foundation has provided $2 million annually for HIV programs in Chongqing, Fujian, and Sichuan, but this support will phase out by June 2016. The Gates Foundation currently invests USD $1 million to support civil society engagement in China. The objective of PEPFAR funding in China is provision of TA to strengthen the national HIV response. The majority of PEPFAR dollars in China fund staffing costs of technical experts, all of whom work closely with local counterparts at national, provincial, and local levels.

PEPFAR China has two cooperative agreements, one with the HIV division of China's lead public health agency, the China Centers for Disease Control (China-CDC); a second with a Chinese NGO devoted to PLHIV: AIDS Care China (ACC). The goal of the PEPFAR China's cooperative agreement with China-CDC is the provision of programmatic funds to carry out projects that serve the goal of TA for China's HIV response. China-CDC sits within the National Health and Family Planning Commission (NHFPC). Funds are distributed through the China-CDC's national office to various divisions of its lead HIV programming agency, NCAIDS, and implementing partners in the Chinese government in PEPFAR focus provinces/areas.

NCAIDS is responsible for HIV surveillance, prevention programming, care and treatment, monitoring and evaluation, and training of public health professionals throughout China. It has offices at multiple jurisdictional levels: provincial, prefecture/city, and county. HIV treatment services and maternal/child health services are provided by two different agencies within the NHFPC: the Chinese public hospital system and the National Center for Women's and Children's Health (NCWCH). All NHFPC agencies function at the most local level (including provision of ART in some areas) through three-tiered primary health care system (of three different levels based upon the size of the population they serve: county, township, and village) located throughout China.

Table 1.2.1 China: Investment Profile by Program Area (2014)

Program Area	Total Expenditure (USD)[34]	% PEPFAR	% GF[35]	% GoC	% Other[36]
Clinical care, treatment, and support	NA				
Community-based care	NA				
PMTCT	NA				
HTC	NA				
VMMC	NA				
Priority population prevention	NA				
Key population	NA				

[34] Due to the sensitive nature of government spending information, ARP is unable to obtain all exact expenditure amounts by program area from Go; Figures obtained from the NHFPC 2015 China AIDS Response Progress Report.

[35] Global Fund closed out of in China in 2013 and no longer provides any funding for HIV activities. A no cost extension provided funds through 2014 at 2013 levels.

[36] Not including private sector investments reported by NCAIDS (2015 report) as USD$3.17 million in 2014

prevention					
OVC	NA				
Laboratory	NA				
SI, Surveys and Surveillance	NA				
HSS	NA				
Total	USD $964,761,906 (100%)	USD$ 1,500,000 (0.16%)	0	UDS$ 953,015,873 (98.8%)	USD$ 7,071,430 (0.73%)

Table 1.2.3 China: USG Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives[37]

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
NIH	Not available	N/A	N/A	N/A	There are 11 grants active or ending in FY17. They include collaborative research focused on HIV vaccine and HBV/HCV/TB co-infection, with some noted in PEPFAR focus provinces.
Private Sector	Not available	0	0	0	Not available
TOTAL	NA	0	0	0	n/a

Laos

In recent years the policy/political environment in Laos has increasingly supported the national HIV response. The Laos National HIV Program continues to rely heavily on external financial and technical support, and improving the sustainability of that response is a PEPFAR priority.

From 2009-2011, overall HIV expenditure in Laos increased from US$6 million in 2009 to US$11.74 million in 2011, with 7.4% of the response funded by the Government of Laos (GOL) in 2011. While donor funding for HIV was reduced in recent years, domestic funding did not increase to compensate. As a result, overall funding for HIV in Laos declined to approximately US$10 million in 2014.

In 2014, 81.5% of the funding for the National HIV Program came from external sources. Of all non-domestic resources, the Global Fund provided the largest share, at 51.77% in 2014 (followed by bilateral agencies such as Australia and the USG). That year, PEPFAR contributions represented 11.2% of the funding for the National HIV Program. Nearly half (49.6%) of all national HIV program expenditure in 2014 was spent on health systems strengthening, followed by HIV prevention among key populations (25%).

[37] The ARP does not support non-PEPFAR funded initiatives or PEPFAR central initiatives in China

Implementation of HIV funding in Laos is complicated by the centralized nature of the public health system: while the National HIV Program has funding allocated for HIV, provincial governments have limited (or no) HIV program budgets to support control efforts locally.

Table 1.2.1b Laos: Investment Profile by Program Area (2014)

Program Area	Total Expenditure (USD)	% PEPFAR	% GF	% GOL	% Other[38]
Clinical care, treatment, and support	1,394,775	-	92.30	7.70	-
Community-based care					
PMTCT	80,173	48.64	-	-	51.36
HTC	166,396	6.01	42.34	-	51.65
VMMC					
Priority population prevention - Youth					
Key population prevention	2,526,121	38.12	41.10	-	20.78
OVC					
Laboratory					
SI, Surveys and Surveillance	437,467	12.12	75.57	0.00	12.32
HSS	4,961,259	1.05	43.81	35.07	20.08
Other	433,575	0.00	63.94	0.00	36.06
Total	9,999,766 (100%)	1,116,974 (11.17%)	5,176,879 (51.77%)	1,846,957 (18.47%)	1,858,956 (18.59%)

Table 1.2.2b Laos: Procurement Profile for Key Commodities[39]

Table 1.2.3b Laos: Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	$0	N/A	N/A	N/A	N/A
USAID TB	$0	N/A	N/A	N/A	N/A
USAID Malaria	$0	N/A	N/A	N/A	N/A
Family Planning	$0	N/A	N/A	N/A	N/A
NIH	$0	N/A	N/A	N/A	N/A
CDC NCD	$0	N/A	N/A	N/A	N/A
Peace Corps	$0	N/A	N/A	N/A	N/A
DOD Ebola	$0	N/A	N/A	N/A	N/A
MCC	$0	N/A	N/A	N/A	N/A
Private Sector	Not available	0	0	0	N/A

[38] UN/WHO, UNICEF, UNAIDS, and ADB

[39] PEPFAR does not provide procurement in Laos

PEPFAR Central Initiatives	LCI: $280,000 USAID KPCF: $165,000 CDC KPCF: $60,000	CDC KPCF: $60,000	2 (1 CDC, 1 USAID)	USAID LCI: $40,000 KPCF: $240,000 CDC KPCF: $10,000	LCI: 1. To improve technical and organizational capacity of consortium partners to provide effective, cost-efficient, and sustainable TA to enhance, broaden, and expand local and regional civil society advocacy efforts, and; 2. To improve capacity of local and regional CSOs to successfully award and program small grants to advocate for improved programs and policies for key affected populations, as well as increase accountability of national HIV and AIDS responses. KPCF: To help Laos develop, demonstrate, and disseminate enhanced intervention models to intensify HIV, STI, and TB case finding among MSM, TG, and other key populations and to support early and sustained access to prevention, care, and treatment services.
TOTAL	$505,000	$60,000	2	$290,000	

Thailand

Thailand's response to HIV is predominantly funded by the Royal Thai Government (RTG). The RTG funded 92% of the response in 2013. According to the National Operational Plan for Ending AIDS, 2015-2019, total available resources rose from $283 million in 2012 to $341 million in 2014, with domestic public resources comprising 89% of all investments in the HIV response.

Available Global Fund resources are expected to drop from $39 million in 2014 to about $14 million in 2015-2016, and to begin phasing out entirely during 2017. ARP resources contributed about 0.8% of the total resources available to the national HIV response in 2013. According to Thailand's National AIDS Spending Assessment, 89% of all expenditures that year were associated with clinical care, treatment, and support. In contrast, only 3.6% of all expenditures were devoted to key population prevention and to HIV testing and counseling, combined. While expenditures on care and treatment were supported almost entirely with domestic public resources, expenditures on key population prevention were dependent predominantly on external resources, with domestic public resources comprising only 14% of total spending in this area.

Table 1.2.1c Thailand: Investment Profile by Program Area (2013)

Program Area	Total Expenditure (USD)	% PEPFAR	% GF	% RTG	% Other[40]
Clinical care, treatment, and support	193,823,307	0.04	1.60	98.36	0.01
PMTCT	2,341,539	1.47	0.00	98.18	0.35
HTC	2,386,610	0.00	0.00	99.99	0.01
Priority population prevention - Youth	3,584,625	1.31	89.31	8.41	0.97
Key population prevention	5,421,317	6.42	78.33	13.75	1.50

[40] UN/WHO

OVC	796,718	0.00	83.67	7.47	8.87
SI, Surveys and Surveillance	930,823	18.60	47.33	34.07	0.00
HSS	9,292,281	11.52	40.95	44.39	3.14
Total	218,577,221 (100%)	1,116,974 (0.80%)	5,176,879 (7.07%)	1,846,957 (91.90%)	1,858,956 (0.23%)

Table 1.2.2c Thailand: Procurement Profile for Key Commodities[41]

Table 1.2.3c Thailand: Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	$0	0	0	0	N/A
USAID TB	$199,000	$0	0	$0	USAID TB activities focused on supporting MDR-TB control; providing technical guidance on MDR-TB management; supporting TB SI; and strengthening national TB surveillance systems (M & E).
USAID Malaria	$358,000	N/A	N/A	N/A	In FY 2014, USAID supported community-based malaria control services in high malaria transmission zones of eastern Burma, along the Thai border, as well as building partnerships with Thailand's Bureau of Vector-Borne Diseases (BVBD) for similar work on the Thai side of the Burmese and Cambodian borders. Supported the integration of malaria services into health promotion hospitals in Thailand.
Family Planning	$0	N/A	N/A	N/A	N/A
NIH	$2,190,000	N/A	0	0	Covers 11 awards to four Thai universities in various areas of research including MDR-TB, HIV, occupational health, dengue, and others
CDC NCD	$312,000	$273,000	1	$0	Thailand MoPH coag one in which multiple non-HIV programs, including NCD, buy into.
Peace Corps	$2,300,000	N/A	0	$0	Thailand, Peace Corps addresses youth development with goal that Thai youth will be prepared for roles as healthy, productive citizens who contribute positively to their communities. The program also improves English teaching with the goal of assisting teachers, students, and community members in gaining access to personal, professional, and academic opportunities through English acquisition.
DOD Ebola	0	N/A	N/A	N/A	N/A
MCC	0	N/A	N/A	N/A	N/A
Private Sector	Not available	0	0	0	N/A
PEPFAR Central Initiatives	LCI: $420,000 USAID KPCF: $500,000 USAID KPIS: $700,000 CDC KPIS: $520,000 CDC KPCF:	CDC KPIS: $500,000 CDC KPCF: $200,000	3 (1 CDC, 2 USAID)	USAID LCI: $60,000 KPCF: $400,000 KPIS: $500,000 CDC KPCF: $270,000	LCI: 1. To improve technical and organizational capacity of consortium partners to provide effective, cost-efficient, and sustainable TA to enhance, broaden, and expand local and regional civil society advocacy efforts, and; 2. To improve capacity of local and regional CSOsto successfully award and program small grants to advocate for improved programs and policies for key affected populations, as well as increase

[41] PEPFAR does not provide procurement in Thailand

	$240,000				accountability of national HIV and AIDS responses. KPCF: To help Thailand develop, demonstrate, and disseminate enhanced intervention models to intensify HIV, STI, and TB case finding among MSM, TG, and other key populations and to support early and sustained access to prevention, care, and treatment services. KPIS: To evaluate the feasibility of a community-based Test and Treat approach that targets MSM and transgender women (TG) populations through a model involving two linked strategies; 1) community-based service delivery settings and 2) enhanced community-based outreach interventions for increasing uptake of services.
TOTAL	$7,739,000	$973,000	3	$1,230,000	CDC NCD and CDC DGHA Thailand contribute to the same IM (MoPH)

1.3 National Sustainability Profile

<u>China</u>

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed annually by PEPFAR teams and partner stakeholders to sharpen the understanding of each country's sustainability landscape and to assist PEPFAR and others in making informed HIV/AIDS investment decisions. Based on responses to 90 questions, the SID assesses the sustainability of the national HIV/AIDS response across 15 critical elements. Scores for these elements are displayed on a color-coded dashboard, together with other contextual charts and information. As the SID is completed over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

Sustainability Analysis for Epidemic Control: China

Epidemic Type: Concentrated
Income Level: Upper-middle Income
PEPFAR Categorization: Technical Collaboration (Asia Regional)
PEPFAR COP 16 Planning Level: 4,000,000

SUSTAINABILITY DOMAINS and ELEMENTS

	2016	2017	2018	2019
Governance, Leadership, and Accountability				
1. Planning and Coordination	8.83			
2. Policies and Governance	7.13			
3. Civil Society Engagement	7.12			
4. Private Sector Engagement	2.15			
5. Public Access to Information	5.00			
National Health System and Service Delivery				
6. Service Delivery	8.33			
7. Human Resources for Health	8.67			
8. Commodity Security and Supply Chain	7.53			
9. Quality Management	7.05			
10. Laboratory	5.42			
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	9.17			
12. Technical and Allocative Efficiencies	8.81			
Strategic Information				
13. Epidemiological and Health Data	9.05			
14. Financial/Expenditure Data	0.00			
15. Performance Data	8.46			

After a series of internal discussions and preliminary review of SID 2.0 alongside available national data/reports, PEPFAR China shared its draft SID with NCAIDS partners. A draft was also shared with civil society representatives (including AIDS Care China), the Health Attaché at the U.S. Embassy, and a UNAIDS country representative. The revised SID with feedback integrated from stakeholders was shared again with NCAIDS for final review.

China's SID highlights national strengths in Domestic Resource Mobilization (9.17, dark green), Epidemiological and Health Data (9.05, dark green), and Planning and Coordination (8.83, dark green). Among identified vulnerabilities, PEPFAR China has set Financial/Expenditure Data (0.00, red), Laboratory (5.42, yellow), Quality Management (7.05, light green, and Civil Society Engagement (7.12, light green) as a few key areas for improvement in FY17-18.

Financial/Expenditure Data: Expenditure evaluation data at the national level has never been disseminated, to some extent because of a lack of capacity for such analyses in the public health sector. Only Dehong Prefecture of Yunnan (one of the areas hardest hit by HIV in China), has conducted a high-quality economic analysis and disseminated the published results in 2010, with support from UNAIDS. PEPFAR China will provide technical consultation on health economic evaluation and cost effectiveness to NCAIDS, and aims to complete an analysis in FY17 in a selected province.

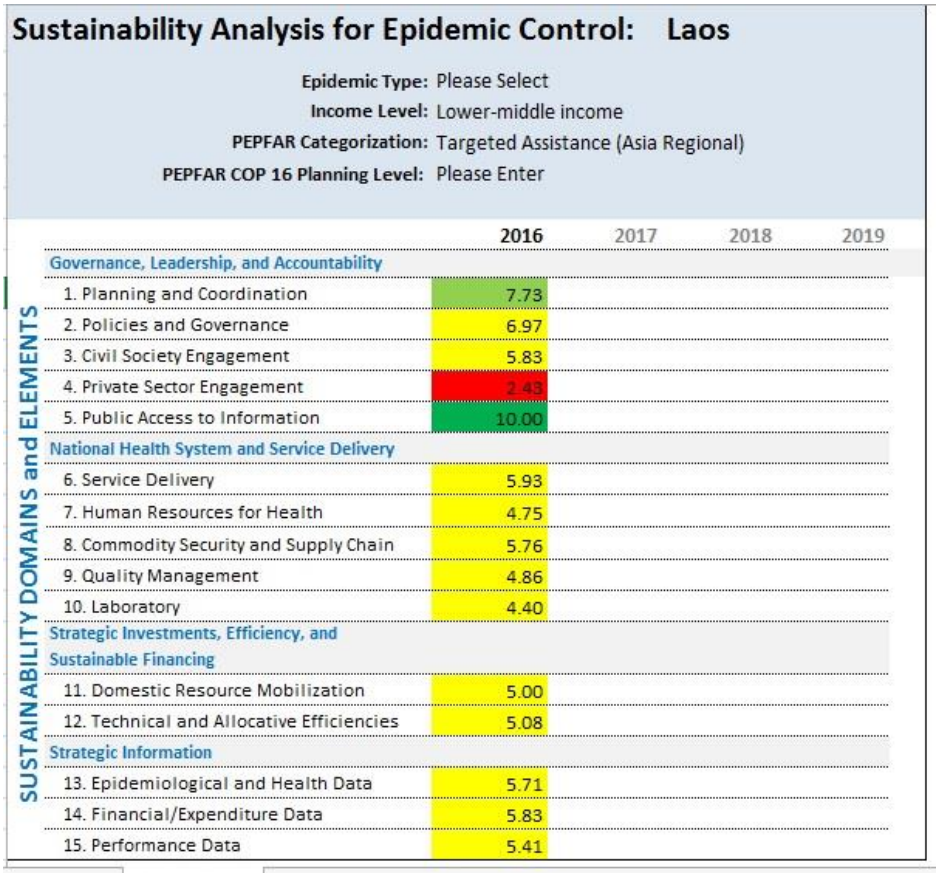
Laboratory: The national laboratory network is facility-based, staffed by professionals, and well-regulated. However the capacity of subnational non-laboratory-staff in health care facilities to carry out point-of-care testing (POCT) is highly variable, and this system is not well-evaluated. Viral load testing infrastructure is weak, especially the quality and delay in returning the results. PEPFAR China will continue to provide TA to improve the capacity of laboratory personnel and quality control at site-level, especially those services implemented by local CBOs, and consideration of the 2015 WHO guidelines to utilize lay counselors in HCT.

Quality Management: The quality of data and services are still weak despite systems in place. Further, data analysis for quality management and improvement are still lacking. PEPFAR China will focus on TA in data analysis and utilization to improve program decision making at all levels (national, provincial, and local). Health systems support in laboratory capacity strengthening is included throughout site-level projects discussed in the following sections, and detailed further in Section 6.

Civil Society Engagement: With inconsistent competencies and service quality, difficulties in official registration as an NGO, and unevenly distributed participation and financial stability, civil society groups remain limited in their opportunities to directly impact national HIV policy, decision making and planning processes. PEPFAR China will continue to provide TA to local CBOs to improve their staff and organizational capacity to engage in and influence HIV policy. At national and provincial levels, and in keeping with priorities to also sustain civil society engagement in the national HIV response, PEPFAR China will continue to encourage CBOs to apply for GoC funding now available annually since a mechanism was established in 2015.

<u>Laos</u>

The Laos 2016 SID was completed under the leadership of the Centre for HIV/AIDS and STI (CHAS), Ministry of Health, with engagement and consultation from development partners including UNAIDS, WHO and CSOs (LAOPHA and Lao Red Cross). The SID dashboard results were endorsed by CHAS (the Ministry of Health). Of the 15 sustainability elements evaluated, only two were found to meet the standard of sustained: Public Access to Information (dark green) and Planning and Coordination (light green). The remaining 13 elements were identified to be sustainability vulnerabilities (yellow and red).



Sustainability Analysis for Epidemic Control: Laos

Epidemic Type: Please Select
Income Level: Lower-middle income
PEPFAR Categorization: Targeted Assistance (Asia Regional)
PEPFAR COP 16 Planning Level: Please Enter

SUSTAINABILITY DOMAINS and ELEMENTS

	2016	2017	2018	2019
Governance, Leadership, and Accountability				
1. Planning and Coordination	7.73			
2. Policies and Governance	6.97			
3. Civil Society Engagement	5.83			
4. Private Sector Engagement	2.43			
5. Public Access to Information	10.00			
National Health System and Service Delivery				
6. Service Delivery	5.93			
7. Human Resources for Health	4.75			
8. Commodity Security and Supply Chain	5.76			
9. Quality Management	4.86			
10. Laboratory	4.40			
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	5.00			
12. Technical and Allocative Efficiencies	5.08			
Strategic Information				
13. Epidemiological and Health Data	5.71			
14. Financial/Expenditure Data	5.83			
15. Performance Data	5.41			

Laos remains dependent on donors for its HIV response including Commodity Security and Supply Chain elements (yellow). SID results show no domestic investment for HIV test kits, ARV drugs, or condoms. There is also limited Private Sector Engagement (red) where public and private health financing schemes do not include HIV services (e.g., HIV testing). Therefore, improving domestic resource mobilization including inclusion of HIV services in health financing schemes is key to establishing a sustained Lao HIV response. In addition, addressing the shortage of Human Resources for Health in HIV service delivery, Quality Improvement, Laboratory Capacity, and Strategic Information (all yellow) as well as mitigating the effects of stigma and discrimination will be integral to sustainably controlling the Lao HIV epidemic. ARP will collaborate with Laos on systems strengthening activities to improve these sustainability vulnerabilities.

<u>Thailand</u>

Thailand's SID was prepared through a consultative process with key stakeholders from the Thai Bureau of AIDS, Tuberculosis and Sexually-Transmission Infections (BATS), the Thai National AIDS Management Centers (NAMC), the Bureau of Epidemiology, and a community-based organization representative (SWING).

Sustainability Analysis for Epidemic Control: Thailand

Epidemic Type: Concentrated
Income Level: Upper-middle Income
PEPFAR Categorization: Targeted Assistance (Asia Regional)
PEPFAR COP 16 Planning Level: Please Enter

SUSTAINABILITY DOMAINS and ELEMENTS	2016	2017	2018	2019
Governance, Leadership, and Accountability				
1. Planning and Coordination	9.33			
2. Policies and Governance	7.64			
3. Civil Society Engagement	7.50			
4. Private Sector Engagement	4.10			
5. Public Access to Information	7.00			
National Health System and Service Delivery				
6. Service Delivery	7.31			
7. Human Resources for Health	7.58			
8. Commodity Security and Supply Chain	10.00			
9. Quality Management	6.19			
10. Laboratory	9.58			
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	8.06			
12. Technical and Allocative Efficiencies	8.65			
Strategic Information				
13. Epidemiological and Health Data	8.45			
14. Financial/Expenditure Data	8.33			
15. Performance Data	6.70			

A desk survey was also conducted through various government websites to review publically reported national information, and data from national HIV systems. On February 4, 2016, the preliminary results were presented to the national consultation workshop to prepare a report on Thailand's National AIDS Spending Assessment (NASA) and annual GARPR 2015.

Of the 15 elements that were evaluated for Thailand, twelve were found to be "sustained" (light or dark green), with the Planning Coordination, Commodity, Security and Supply Chain and Technical Allocative Efficiencies elements considered particularly sustained (dark green).

No elements were determined to be red (unsustained), however, three elements (Private Sector Engagement, Quality Management and Performance Data) were found to be yellow. ARP is confident that the yellow score for Quality Management, and Performance Data particularly indicate room for improvement and therefore will invest in these areas in ROP 2016. There is a gap in performance data as currently HIV cascade data at provincial and subgroup by key population are not available. Even though Thailand's SID results show overall high sustainability, in domestic funding for civil society had a low score and this is a risk for maintaining a key population program.

1.4 Alignment of PEPFAR investments geographically to disease burden

China

By the end of 2014, 12 provinces (in order: Yunnan, Sichuan, Guangxi, Henan, Guangdong, Xinjiang, Chongqing, Guizhou, Hunan, Zhejiang, Jiangsu and Beijing) reported over 10,000 cases of people living with HIV/AIDS individually and accounted for 83.5% of the total number of cases of people living with HIV/AIDS reported nationwide. Even within the most heavily affected Chinese provinces, there is substantial geographic variability in PLHIV residence at the time of diagnosis. This fact, combined with the rapid, ongoing urbanization and mobility of the Chinese population, continue to challenge the identification of China's geographic HIV "hotspots".

Serial cross-sectional biobehavioral surveys point to steadily increasing HIV seroprevalence among MSM in China, with level or slightly declining HIV seroprevalence in recent years among PWID and FSW. Because most MSM in China reside in urban areas, the ongoing geographic focus of HIV interventions is urban gay men, especially in cities within provinces that have historically held the highest concentration of PLWH. Since FY2015, PEPFAR-China has increasingly focused its support for field activities on urban MSM, with FY2017 support focused on 16 urban communities with a combined population of 60 million. With the exception of Tianjin, these communities are located in 5 of the high HIV prevalence Chinese provinces noted earlier: Yunnan, Guangxi, Guizhou, Xinjiang, and Hunan. Thirteen of the communities have a recent HIV seroprevalence measurement drawn from a sample of MSM, which range from 7% to 25% (Table 1.4.1). A 2015 analysis of expenditures found that nearly 50% of non-M&O PEPFAR expenditures in China were applied at the subnational level. This level of subnational support will continue in FY17.

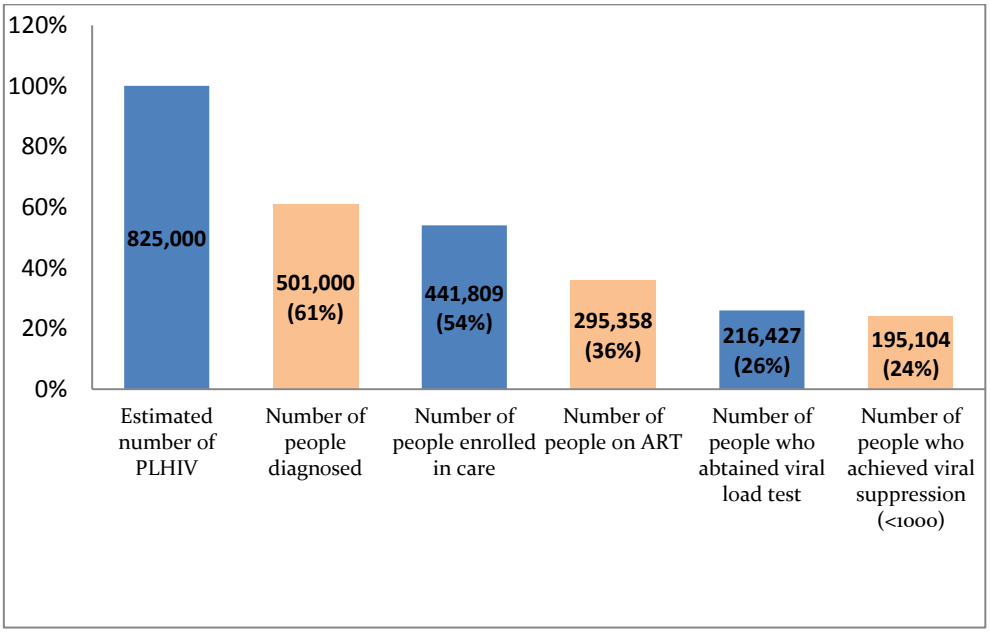
Table 1.4.1 –Distribution of PEPFAR China resources in high HIV burden priority areas[42]

SNU	Site	Total population	Total # PLHA	MSM HIV sero-prevalence
Yunnan	Kunming	3,285,935	80,000	11%
	Dali	667,408		7%
	Honghe	330,306		7 %
Guangxi	Nanning	2,840,000	65,000	12%
	Liuzhou	1,160,300		12%
	Beihai	690,000		10%
Xinjiang	Urumqi	586,100	35,000	12%
	Kashi	571,100		12.5%
	Yining	535,700		13%

[42] Population size and MSM HIV seroprevalence estimates are unpublished and obtained from either data publicly available online or subnational counterparts in Q2FY16.

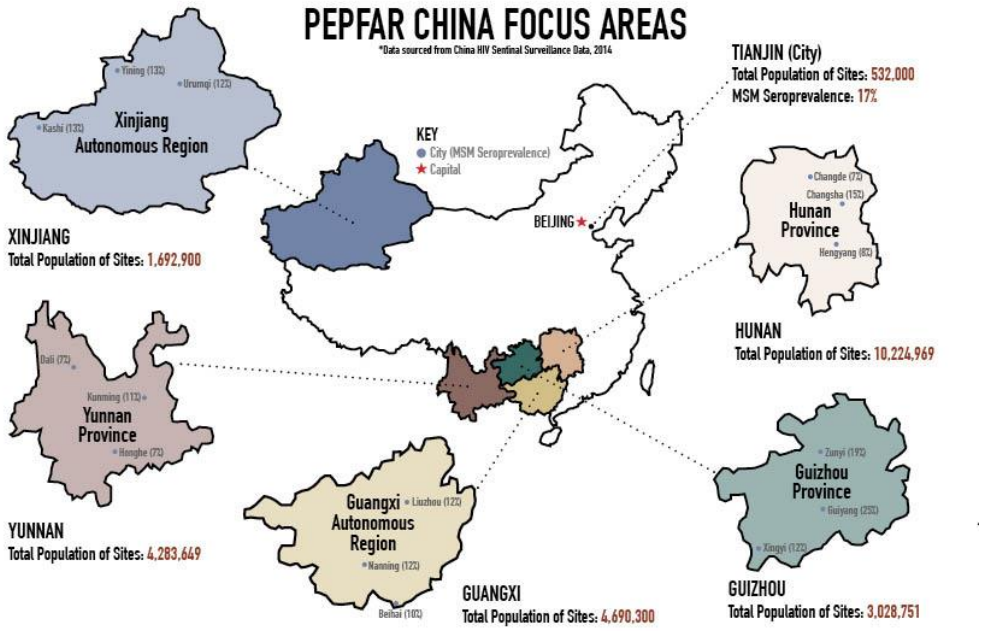
Guizhou	Zunyi	656,725	17,000	19%
	Xingyi	320,000		12%
	Guiyang	2,052,026		25%
Tianjin city	Tianjin	532,000		17%
Hunan	Changsha	3,654,686	16,000	15%
	Hengyang	3,653,182		8%
	Changde	2,917,101		7%

Figure 1.4.2 – China: National HIV cascade data, 2014[43]



[43] PLHIV estimate unpublished; Data is provisional per WHO China, Red Ribbon Forum ARV strategy seminar, Nov 2015: "Ending the AIDS epidemic by 2030"; 73% of ART patients had received at least one viral load test

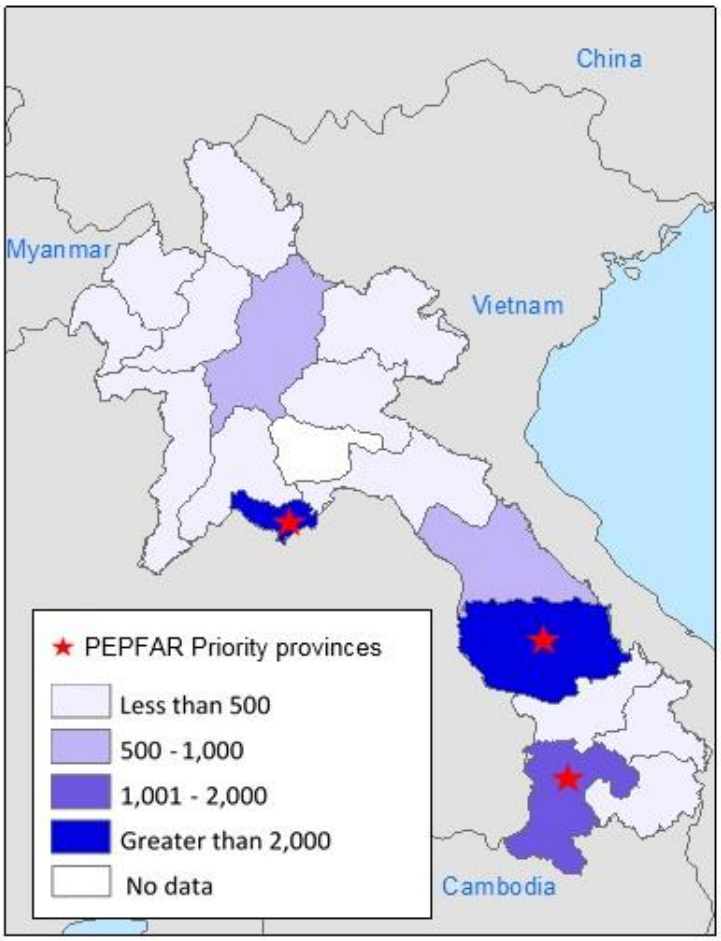
Figure 1.4.3 – PEPFAR China geographic focus areas[44]



Laos

According to an analysis conducted of FY2015 ARP expenditure in Laos, more than half (56%, 603,231 USD) was applied at the national level. Expenditures at the national level were primarily invested in KP-MSMTG, HTC, FBCTS, and cross-cutting PM to SI (in that order), reflecting a focus on MSM and TG women as priority populations, coverage and quality of HIV testing and treatment, and on strategic information and health systems strengthening. Other national-level PEPFAR investments in Laos were distributed across other

Figure 1.4.b.1 Estimated Number of PLHIV, Laos, 2015

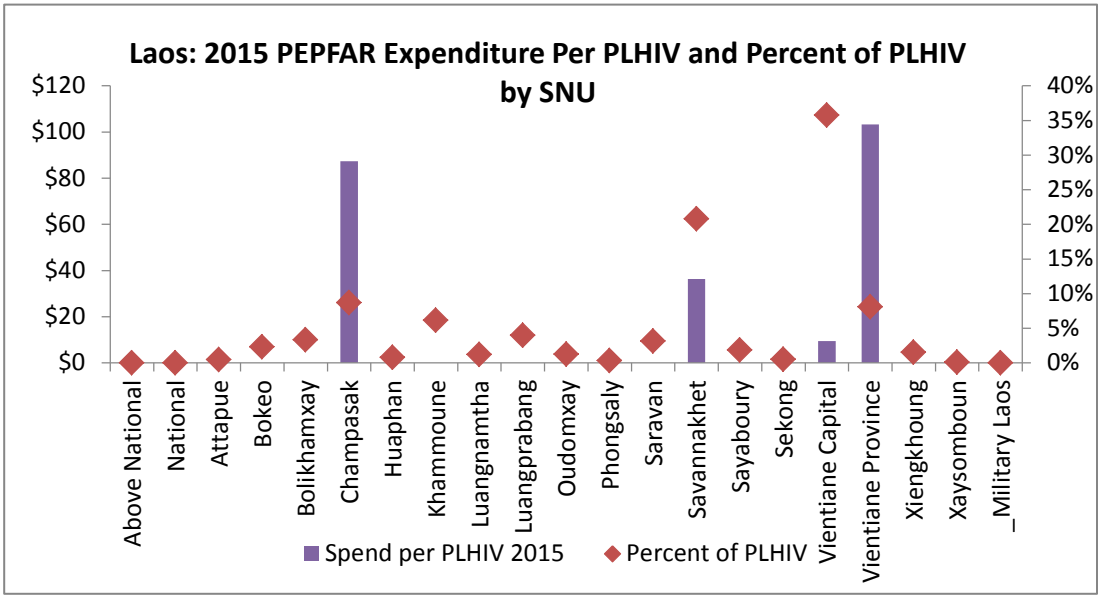


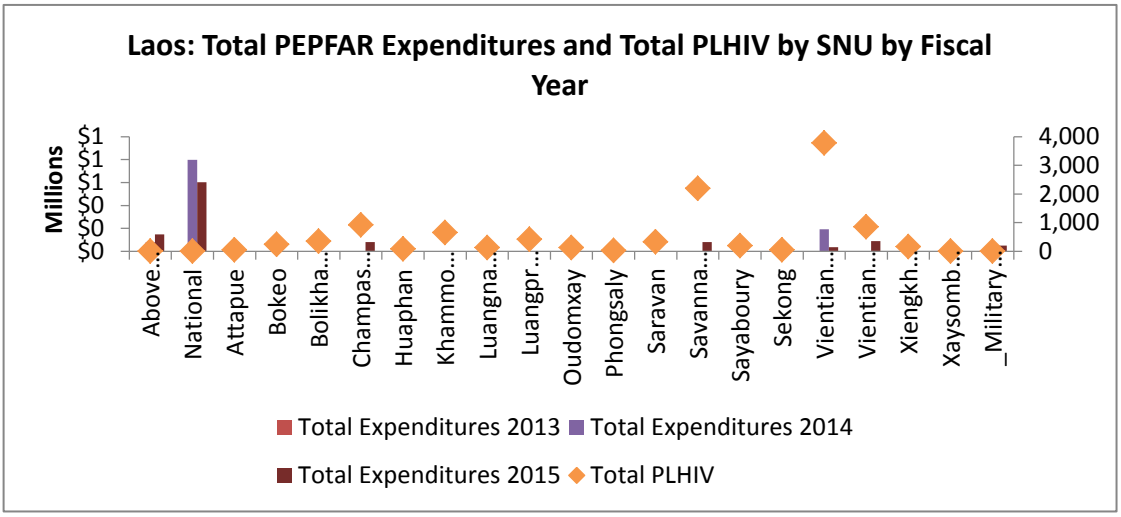
[44] China HIV sentinel surveillance data, 2014

areas including CBCTS, PMTCT, Lab, and SURV.

Approximately one-third (31%, 334,190 USD) of PEPFAR FY2015 expenditures in Laos were at the sub-national (provincial) level. As with national-level expenditures, the majority of the expenditures were invested in KP-MSMTG, HTC, FBCTS, CBCTS, GP-PREV, and SURV (in that order). Geographically, all (100%) of the sub-national investment was made in four areas and the military (Vientiane Province, Champasak, Savannakhet, Vientiane Capital, and Military). With the exception of the military, most areas have the largest estimated numbers of PLHIV, largest estimated numbers of MSM and TG women, and largest combined numbers of key populations (e.g., MSM and TG women) in Laos. ARP demonstration pilots (i.e., Key Populations Challenge Fund/KPCF) include some of these provinces within their geographic scope. An additional 14% (148,794 USD) was invested in country-to-country technical collaborations between Thailand and neighboring national HIV programs or at the Above National level.

Thailand



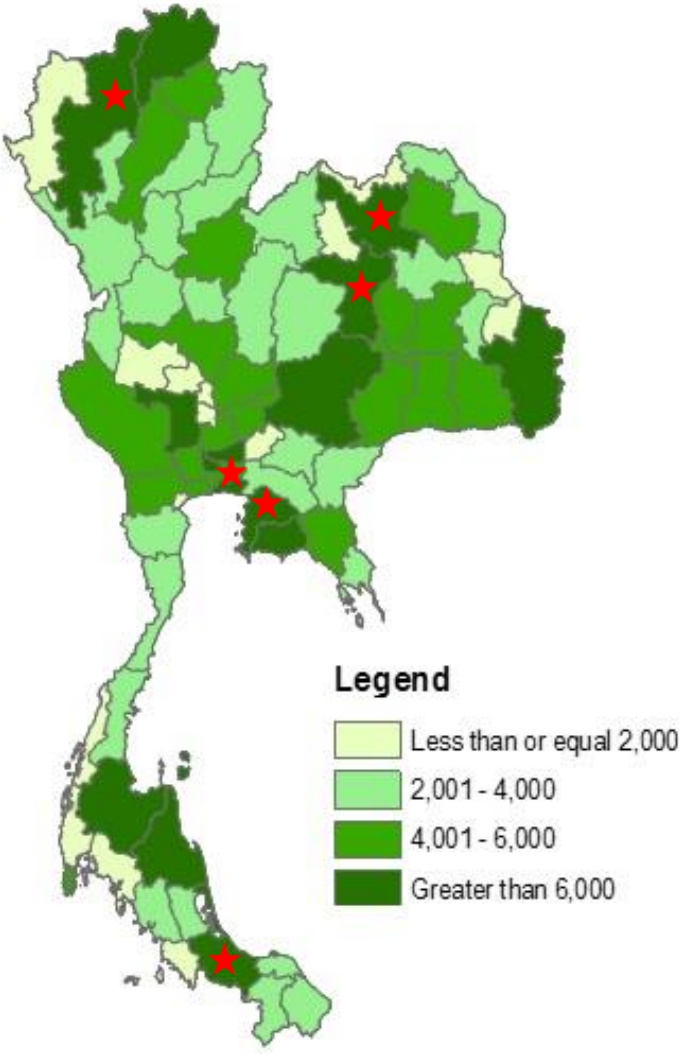


According to an analysis conducted of FY2015, ARP expenditures in Thailand showed that about one-third (32%, 2.2 million USD, or 2,341,944) was applied at the national level. These were primarily invested in HTC, KP-MSMTG, FBCTS, CBCTS, and PP-PREV, reflecting an emphasis on broadly expanding coverage and quality of HIV testing and treatment including a focus on MSM and TG women as priority populations. Other national-level PEPFAR investments in Thailand were distributed across six other areas: Surveillance, Cross-cutting Program Management to SI, Lab, Cross-cutting Program Management to HSS, HSS to SI, KP-FSW, IC, and PMTCT.

More than half (60%, 4.4 million USD or 4,359,411) of PEPFAR FY2015 expenditures in Thailand were at the sub-national (provincial) level. As with national-level expenditures, the majority was invested in HTC, FBCTS, KP-MSMTG, GP-PREV and CBCTS. Geographically, 89% of the sub-national investment was made in four provinces (Bangkok, Chonburi, Chiang Mai, and Songkhla); most of which have the largest estimated numbers of PLHIV, largest estimated numbers of MSM and TG women, and largest combined numbers of key populations (i.e., FSW, MSM, TG women, and PWID) in Thailand.

ARP demonstration pilots (i.e., Key Populations Challenge Fund) include these provinces within their geographic scope. An additional 8% was invested in CCTC collaborations between Thailand and neighboring national HIV programs or at the Above National level.

Figure 1.4.c.1. Estimated Number of Thailand PLHIV, 2015



★ = PEPFAR Priority Province

Figure 1.4.c.2. Estimated Number of High Risk MSM, 2015

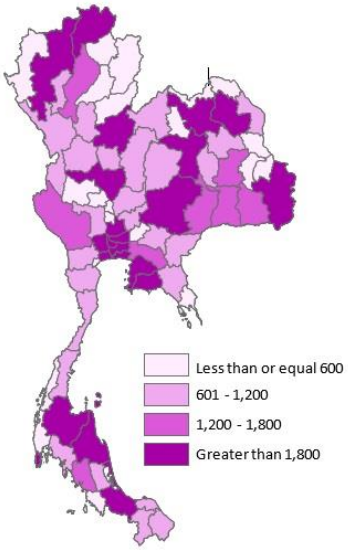
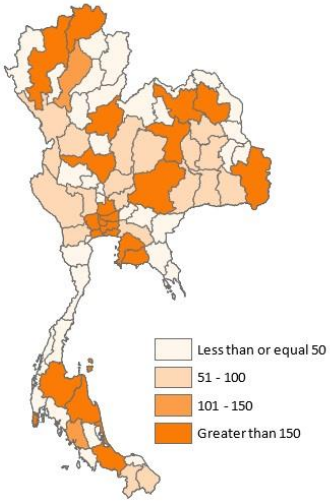
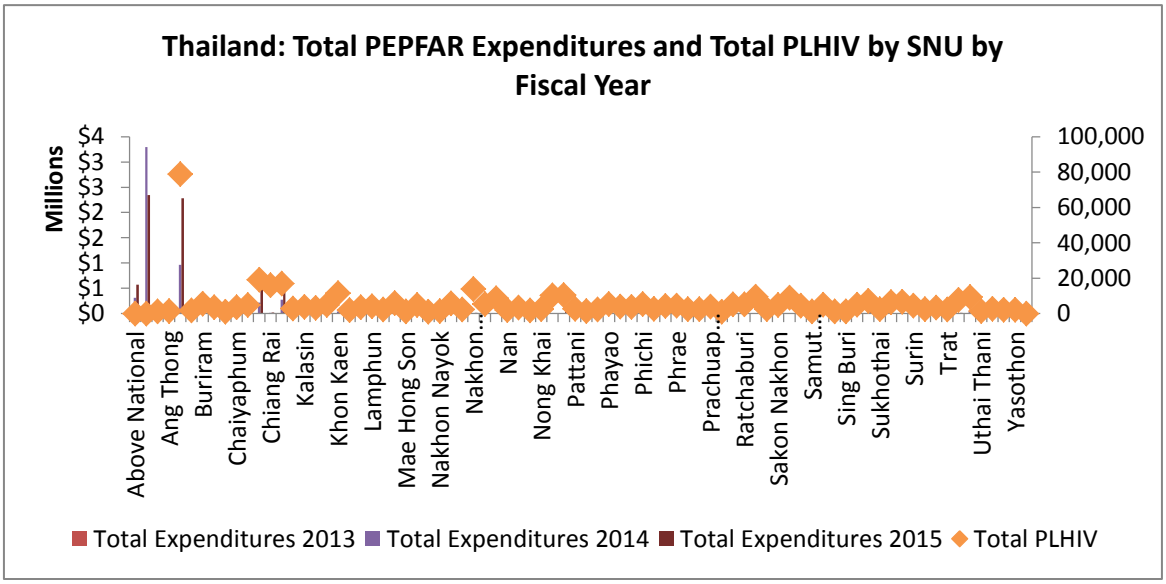
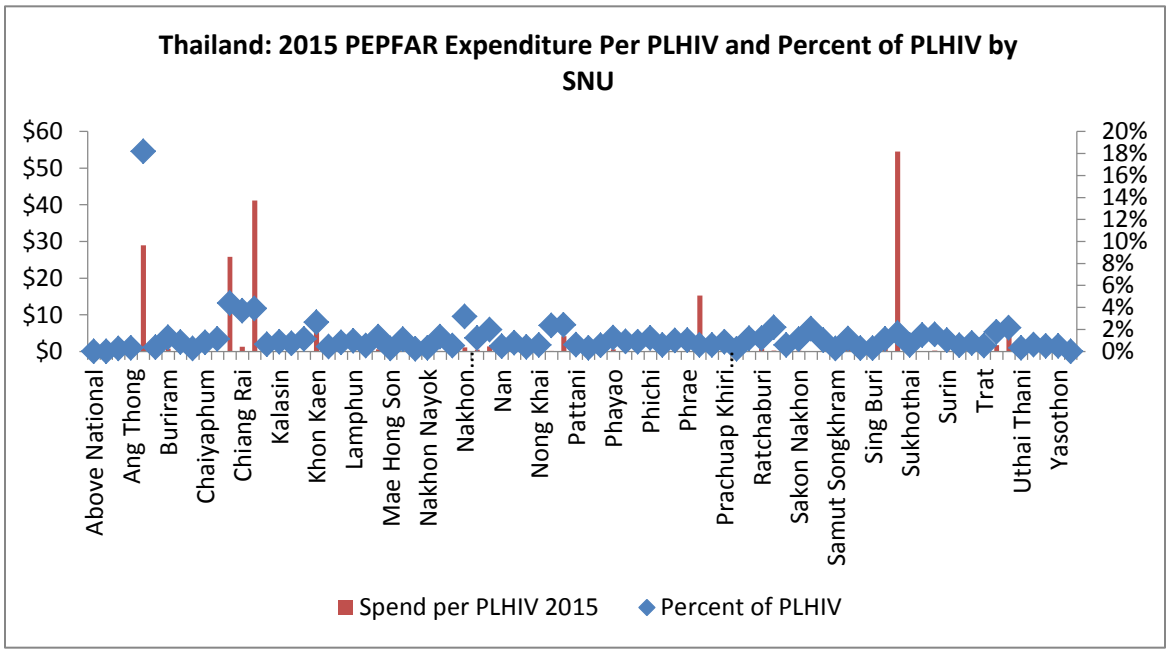


Figure 1.4.c.3. Estimated Number of High Risk TG Women, Thailand, 2015







1.5 Stakeholder Engagement

The U.S. CDC has been the only PEPFAR agency in China since 2013. PEPFAR China's primary stakeholder, the China-CDC and NHFPC, was fully engaged in the process of the 2016 ROP development via monthly meetings with PEPFAR China leadership during FY16, along with frequent phone contact by program officers between meetings. PEPFAR China also fully engaged with civil society groups and UNAIDS on the operational plan. Several community based health organizations (CBOs) who target MSM in focus provinces were in contact with program officers

to provide input. PEPFAR China's NGO implementing partner, ACC, was also an active participant in FY 2017 planning.

In Laos and Thailand, ARP plans and implements all of its activities in collaboration with Laos and Thai government institutions, multilaterals, international agencies, civil society, and domestic and international NGOs responding to the HIV epidemic in the two countries.

To that end, in 2016 ARP continued to regularly consult with stakeholders through formal and informal, ad hoc and regular, project-specific, and national strategic meetings and discussions. In China, Laos, and Thailand, the ARP also held special stakeholder planning sessions (with civil society, communities, government, and multilaterals/international agencies): first to discuss and gather stakeholder input on proposed strategic directions and initiatives for PEPFAR in FY17 and, later, to review and finalize those plans together. Careful effort was made to actively engage these stakeholders in strategy setting and project design, implementation, and review efforts. The plans and priorities described in this ROP reflect these exchanges and consensus that was reached.

Furthermore, as a voting member of the Global Fund CCM in Laos and a donor observer on the CCM in Thailand, ARP plans are aligned with and designed to work in concert with the Global Fund.

Associated to the FY17 ROP is a concept note for a plan to advance Thailand's regional and global leadership in ending AIDS by demonstrating sustainable solutions to finance and improve the community response to HIV as support from the Global Fund to Thailand comes to an end in December 2016. For more information about this plan, see Appendix C.

Concept-note development was guided by a task force comprised of representatives from civil society, CBOs, the principal recipients of both the government and the civil-society Global Fund HIV and TB grants, UNAIDS, and the Thai Ministry of Public Health. Three formal task force meetings were held to generate consensus on concept-note objectives and activity areas during a three-week period prior to submission.

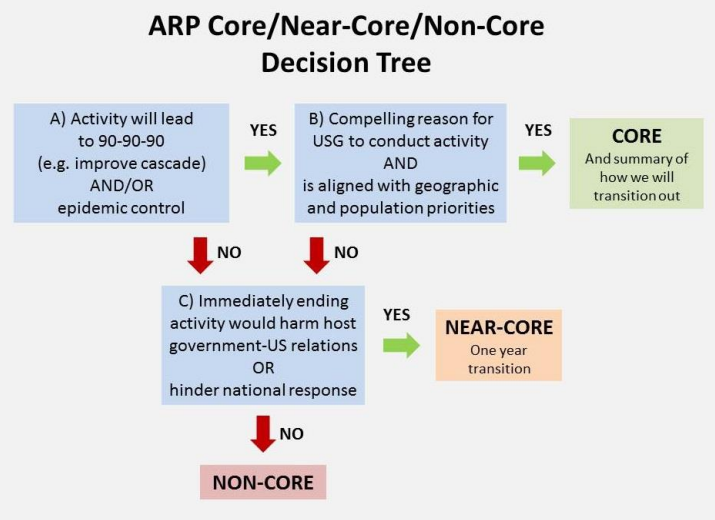
Between these meetings, a number of other distinct consultations took place with representatives from civil society and community organizations to solicit their direction, as well as with the Global Fund principal recipients to identify potential key populations coverage gaps and establish prospective service delivery coverage targets for initial incentive fund activities.

In late 2015, PEPFAR staff also played an active role in consultations with civil society networks in the development of a regional concept note focusing on "Sustainable HIV Financing in Transition" (SHIFT) in Indonesia, Malaysia, the Philippines, and Thailand. This proposed work led by regional civil society networks will focus on advocacy for sustained financing of civil-society HIV programming, and would complement the efforts proposed in this concept note to advance systems and policies to support these investments while optimizing practice to improve value for money in these investments.

2.0 Core, Near-Core and Non-Core Activities

During the ARP Portfolio Review in 2016, participants from PEPFAR implementing agencies discussed PEPFAR's vision, analyzed country contexts and epidemics, and reviewed the alignment and effect of its ROP 2015 investments with the epidemics in those countries. Agencies then reached consensus on priority strategies, populations, and geographical locations for FY17 activities.

In 2015—after reviewing available guidance on *core*, *near-core*, and *non-core* activities—participants developed and reached consensus on a tool to facilitate this classification of activities (see insert). For the group, the tool reflected PEPFAR priorities through the lens of TA and TC programs.



In 2015, this tool led to several major ARP pivots, including a concentration on improving the cascade for MSM and TG women in priority geographic areas and the determination to end several activities that were considered non-core or redundant to other agency efforts.

Throughout 2016, agencies regularly reviewed near-core activities to monitor the progress of transition plans. For new activities included in ROP 2016, agencies used the core-/near-core/and non-core tool to classify them.

Among 16 sites supported in China, 1 site (Beihai) will be handed over to central government (see Sec. 5.2). In addition to project/site and subnational level activities towards HIV control locally, PEPFAR also focuses its TA at the national level to disseminate its learning globally; in FY17 this will include joint publications, presentations, policy and guideline revisions, and south-to-south collaboration.

Details for ARP elements classified as *core*, *near-core*, or *non-core* appear in Appendix A.

3.0 Geographic and Population Prioritization

<u>China</u>

China's estimated national HIV prevalence (0.06%) is low both relative to the world and to several of the 15 nations with which it shares a border. Geographic disparities in HIV prevalence in China are extremely large, with 12/31 provinces accounting for 83.5% of all reported PLHIV. The 12

provinces reporting the greatest number of PLHIV as of the end of 2014 are (in order from greatest to least): Yunnan, Sichuan, Guangxi, Henan, Guangdong, Xinjiang, Chongqing, Guizhou, Hunan, Zhejiang, Jiangsu and Beijing. The five provinces in which PEPFAR-China's field sites are located are included among this group: Yunnan, Guangxi, Xinjiang, Guizhou and Hunan.

Like other low HIV prevalence countries, China's PLWH are concentrated among key populations at high risk of HIV whose size and HIV prevalence are notoriously challenging to measure due to social marginalization. Even given those limitations, the available public health data suggest that MSM are emerging as the highest-risk key population. Figure 3.2 summarizes annual cross-sectional seroprevalence among key populations in China, as measured through China's national HIV sentinel surveillance system. These data indicate a steady rise in the HIV seroprevalence among MSM, from 1.3% in 2004, to 7.7% in 2014. Among female sex workers, prevalence has been comparatively low in recent years (0.22% in 2014). HIV seroprevalence among drug users (both injecting and non-injecting drug users may participate) has declined from approximately 7% in 2006 to 3.3% in 2014.

Figure 3.3 summarizes the most commonly reported transmission modes reported by HIV case-patients in China over the last several years. Notable trends include a steady decline in injecting drug use from 34% in 2006 to 6% in 2014 mirrored by an increase in the proportion attributed to male homosexual from 2.5% to 25.8% during the same time period. Although heterosexual sex remains the most commonly reported HIV transmission risk among reported cases, China's persistent 3:1 ratio of male:female HIV case reports along with the social desirability of reporting only heterosexual sex behaviors point to an HIV epidemic driven by MSM transmission.

Figure 3.1 - Geographic Distribution of People Living with HIV/AIDS in China (NCAIDS 2014)

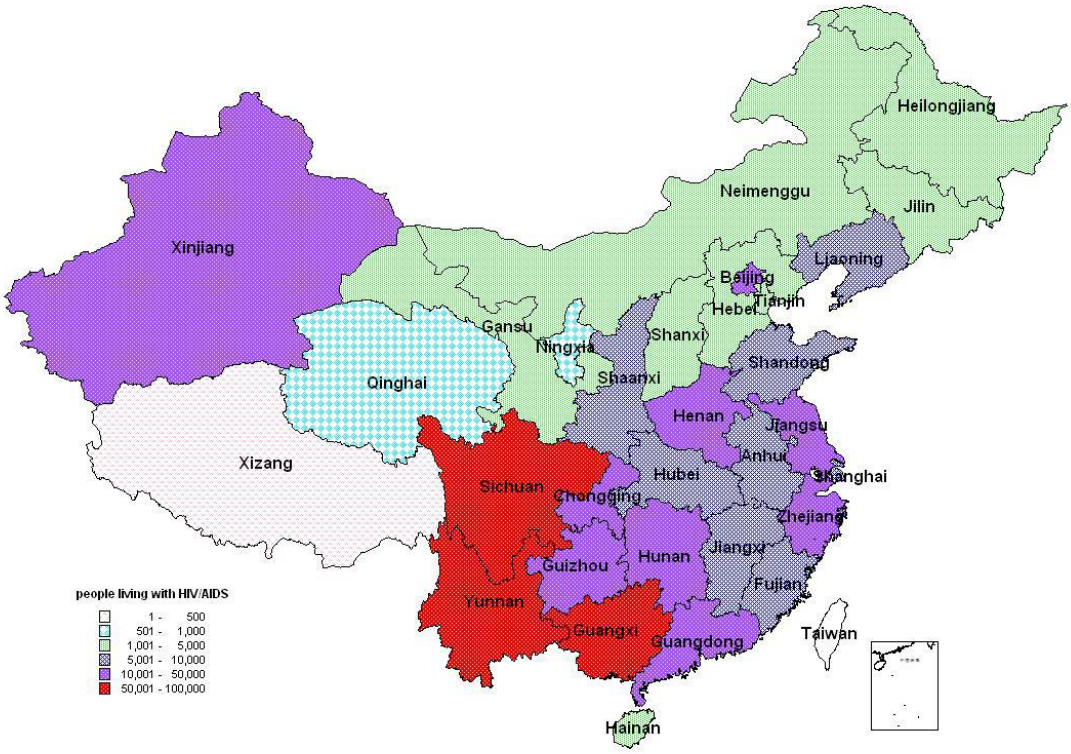


Figure 3.2 - Trends in HIV prevalence among Different Groups in China, AIDS Sentinel Surveillance Data, 2003 -2014

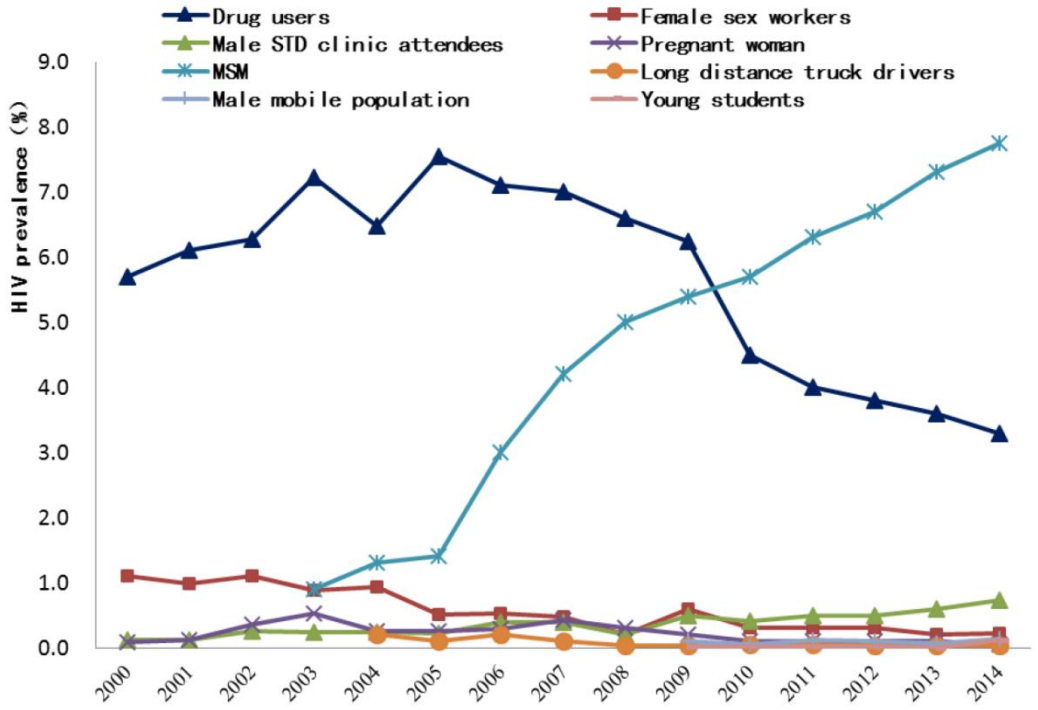
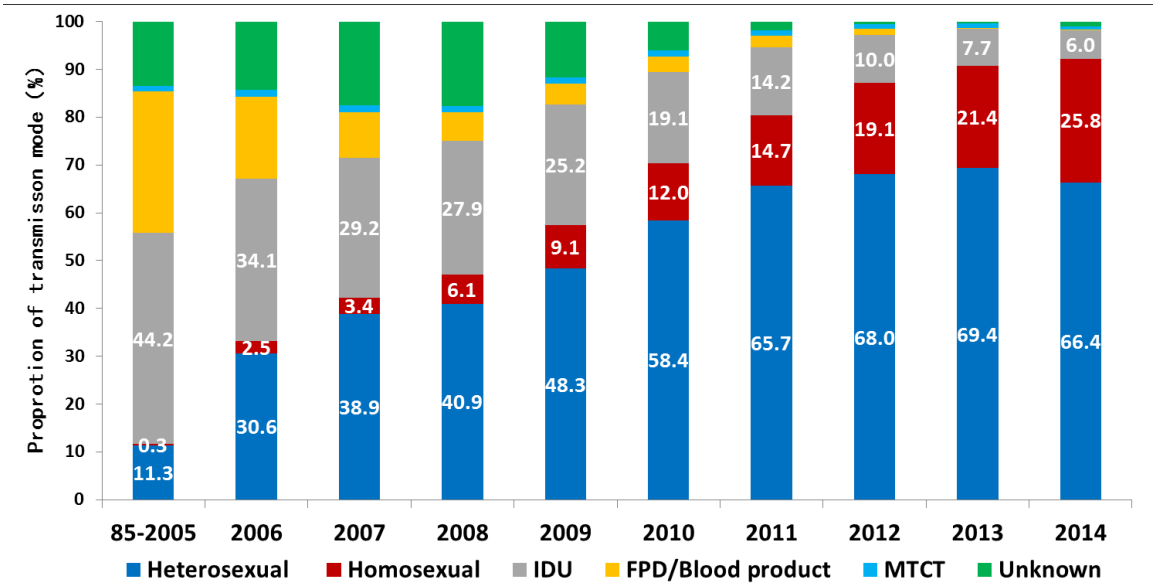


Figure 3.3 - Transmission Modes of Newly Diagnosed Cases of HIV/AIDS by Year, NCAIDS 2014



Laos and Thailand

In both Laos and Thailand, the HIV burden is concentrated among MSM and TG women in urban areas. According to official government estimates based on the AEM, 44% of new infections in Thailand in 2016 are forecast to occur among MSM and TG women – with proportional increases in new infections occurring among these populations over time.

In addition, population size estimates and IBBS data indicate that the HIV burden among MSM and TG women is greatest in specific provinces. For example, the RTG estimates the number of at-risk MSM in Bangkok is at least four times larger than the number in Chonburi, the province with the second-highest MSM population size estimate. While the national HIV prevalence estimate among MSM in Thailand is 9.2%, the estimated prevalence among MSM in Bangkok is more than 24%. In Laos, MSM size estimates are not available, but the government estimates that the population sizes are greatest in Vientiane Capital, Champasak, and Savannakhet, provinces and the estimated HIV prevalence among MSM in these provinces (i.e., 1.8% in Vientiane Capital, 0.8% in Savannakhet, and 0.3% in Champasak) are the highest in the country.

In Thailand, only 31% of MSM are estimated to have had an HIV test and received their result in the past year – a testing rate that is lower than for any other key population. Low testing rates in this population signify particularly low treatment coverage in a population in which antiretroviral-based prevention strategies could have great benefits. Furthermore, once diagnosed with HIV infection, only 45% of MSM in Thailand are registered for care, a registration rate that is lower than people who inject drugs and female sex workers.

In light of these data, and consistent with the vision articulated in the PEPFAR 3.0 Blueprint, the PEPFAR Laos and Thailand aim to consolidate and refine its focus for FY16 on activities to produce measurable improvements in "three 90s" cascade outcomes among MSM and TG women in priority settings.

In Thailand, ARP will collaborate to improve the quality and efficiency of clinical and community programming targeting MSM and TG women in Bangkok, Chiang Mai, Chonburi, Songkla, Khon Kaen, and Udonthani (see *Figure 1.4.1b-1*). These settings are consistent with the constricted geographical focus of ARP activities approved in the 2015 ROP. In Laos, ARP will similarly collaborate to improve cascade outcomes for MSM and TG women in clinical and community settings in Vientiane Capital, Champasak, and Savanakhet (see *Figure 1.4.1b-3*).

PEPFAR Laos and Thailand anticipates that this sub-national focus will achieve improvements in cascade outcomes for MSM and TG women in these priority settings within the next three years.

ARP will re-focus TA to improve the quality of HIV testing among MSM and TG women in priority provinces, including Bangkok, and ensure that systems are in place to monitor those who are HIV-infected through the cascade of HIV care.

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

4.1 Targets for scale-up locations and populations

China

PEPFAR China's targets in FY17 continue to reflect its program orientation of technical collaboration with GoC. As such, targets typically reflect the estimated outputs of field activities where a strategy, like "test and start," is being piloted among MSM and in coordination with local partners, ART clinics, and their CBO partners. Outputs reported, such as the number of persons tested and number on ART by site, thus reflect the scope of smaller, site-level pilot projects where the intent is not (for example) ART coverage, but the demonstration of the feasibility and impact of a new strategy for increased access or utilization, expanded and improved case finding, and stronger care linkages to improve the cascade. While PEPFAR China utilizes required PEPFAR indicators to monitor the output of its support, the team emphasizes accountability and learning by also examining outcomes using qualitative indicators, analyses, and evaluations in order to assess any measureable impact on national HIV policy, health systems, quality of service delivery, and, ultimately, the three 90's.

The approaches at scale-up sites in China are supported by PEPFAR in order to help the GoC demonstrate and scale up successful "test and start" interventions among MSM, and, ultimately, prevent new infections. A one-stop strategy (defined as consolidation of usually disparate HIV services in one place, at one time) is promoted to reduce loss-to-follow-up during referral processes. Treatment as prevention among MSM is also promoted, and in 2014, the GoC raised the CD4 count threshold eligibility criteria for initiating ART from 350 to 500 copies/ml to allow earlier treatment initiation. To meet the 2015 WHO recommendations, China's guidelines will also integrate "Test and Start" ART regardless of CD4 count. At the time of ROP16 writing, these updated guidelines are awaiting approval by the NHFPC; approval is anticipated in FY16. Additional pilots from FY16 that will continue into FY17 to address cascade entry include - promotion of contact tracing and partner notification, self-sample collection for HCT, and the Tianjin bathhouse HCT model.

Assumptions made to determine resources required include: capacity of local health care authorities to provide case finding and care services (e.g., CD4, VL); local resource availability and interest in co-investing in pilot field activities, and recent epidemic and population trends that impact HIV case-finding, such as migration and urbanization.

Challenges, some discussed further in Section 6, that continue to hinder PEPFAR China and its partners from reaching its targets are: inadequate communication and linkage coordination among local CDC, clinics and CBOs; stigma and discrimination against MSM and PLHIV that limit access; low CBO capacity in service and care delivery; poor quality control in laboratory

management; lack of trained lay providers to assist with point of care HCT; and limited HIV surveillance because of hard to reach, remote, and migrant PLHIV.

With respect to data quality, local key population size estimates are variable and often challenged by their administrative linkage to public health employee performance reviews in which higher HIV testing coverage is rewarded, thereby incentivizing down-estimation of the key population size that serves as the denominator in the testing coverage ratio. Further, HIV testing and counseling in China is counted by tests performed, not the number of individuals tested; testing records are not standardized and few facilities digitize them. In FY17, USG will continue to provide necessary TA in key population size estimation, and attempt to forge a partnership in 1-2 areas to conduct high-quality RDS data collection and analysis to enable a local MSM population size estimate that could serve as a model for other localities wishing to do the same.

The following tables highlight FY17 targets for HIV prevention, treatment and care at PEPFAR supported sites.

Table 4.1.1: China: ART Targets in Scale-up Sub-national Units for Epidemic Control[45]

Subnational Unit (SNU)	**Total PLHIV**	**Expected current on ART (2016)**	**Additional patients required for 80% ART coverage**	**Target current on ART (FY17)** ***TX_CURR***	**Newly initiated (FY17)** ***TX_NEW***
Ruili County	3,513	200	N/A	150(Ruili Better Clinic)	20
Mengsheng Township	673[46]	50	N/A	240(Mengsheng Better Clinic)	40

Table 4.1.2: China: MSM Newly Initiating ART linked to care in Sites with TA support via the NCAIDS IM (FY 17)

Entry Streams for ART Enrollment	**Tested/Couns for HIV (in FY17)**	**Identified Positive (in FY17)**	**Linked to care (75-80%)**
Beihai City	300	24	18
Nanning City	1200	120	96
Liuzhou City	1000	100	80
Honghuagang District	500	60	48
Guiyang City	600	100	80
Xinyi City	400	32	26

[46] Estimated 24,000 people in Mengsheng township per ACC, Q2FY2016

Changde City	800	35	28
Changsha City	1600	130	104
Hengyang	400	20	16
Hongqiao District	1000	60	48
Kashi City	300	15	12
Yining City	400	20	16
Tianshan District	1200	96	75
Dali	600	42	**32**
Kunming City	1000	66	53
Honghe	600	42	32
Total	11,900	962 (8.1%)	764 (79%)

Table 4.1.4: China: MSM Prevention Interventions to Facilitate Epidemic Control

SNU	MSM Population Size Estimate[47]	KP_PREV FY17 Target	KP Coverage Goal
Beihai City	4200	371	9%
Nanning City	16050	1700	11%
Liuzhou City	6300	1500	24%
Honghuagang District	3370	1000	30%
Guiyang City	11872	1300	11%
Xinyi City	2640	700	27%
Changde City	16429	1800	11%
Changsha City	21108	2000	9%
Hengyang	19461	500	3%
Hongqiao District	3032	3000	99%
Kashi City	3125	500	16%
Yining City	2937	500	17%
Tianshan District	3218	2000	62%
Dali	3728	960	26%
Kunming City	19221	1580	8%
Honghe	1880	960	51%
Total	138,571	20,371	14.7%

[47] Unpublished estimates in Q2FY16 with provincial partners and compared to 1.5% of males 15-64 years and total population in site/area.

Laos

We calculated targets based on estimated number of PLHIV by sub-national units (provinces) and the estimated number of key populations (i.e., MSM and TG women) using the AEM and the number of PLHIV in care and treatment from the HIV Care and ART Program Monitoring System (HIVCAM-Plus). The three priority provinces identified for FY16 were selected based on high PLHIV burden and are continued as priority provinces for FY17. These provinces remain where we are implementing PEPFAR key population prevention and care programs to support national prevention activities. In alignment with the 90x90x90 goals, we will continue targeting areas where key populations and PLHIV are likely to receive HIV care and estimate target population sizes in those areas. We will do targeted TA in sites in the three provinces to cover at least 25% of PLHIV in each province. The targeted interventions will be focused on key populations to promote HIV testing and care and treatment. PEPFAR will do targeted cascade monitoring for retention, viral suppression and quality improvement of all PLHIV receiving care in the priority provinces (Q1-2).

We will focus our targets to reach 29% of key populations (ranging from 23-45%) in the 3 provinces based on high HIV burden and resource availability. The FY17 targets to identify HIV-infections in key populations are similar to the results reported in FY15 (approximately 617). We targeted 75% of newly identified PLHIV to be on ART using HTC activities to increase testing (Q3-5). We analyzed 2015 results to identify low yield of HIV-infection in high risk key pop MSM/TG. Our assumption on the number of high risk MSM/TG to be reached in 2017 is based on available data of key populations by province and program performance in FY15 (Q6). Challenges in meeting the targets might be related to fear of HIV testing in health care settings in the target population because of perceived stigma and discrimination, health care worker capacity, and differences in health insurance policies which may affect the ability to access care (Q7). We know the ART data in the HIVCAM-Plus database has some limitations as it is just being fully implemented. This may result in under reporting of newly diagnosed persons which may limit the tracking of these populations once they are registered in care. We will work with health facilities and the Lao Centre for HIV/AIDS and STI (CHAS) to train HCWs for more complete data entry and definitions to increase coverage of registration and accuracy of data to monitor the completeness of the care cascade.

As a TA/TC country, a primary TA target is to increase HIV testing in key populations in response to country needs. The Laos National HIV Strategy and Action, Plan 2016-2020 (NSAP) outlines the country plan to target "access to HIV Testing and Counselling Services (HTS), access to ART, scale-up of coverage, improving the quality of interventions, ensuring financial and organisational sustainability of HIV services, and increasing the capacity of implementing partners, etc. (Laos NSAP)." Additionally, strengthening the laboratory infrastructure and monitoring and evaluation systems is needed to ensure the availability of both accurate and timely test results for care and treatment management as well as the availability of high-quality data for program improvement and evidence-based decision-making. We will work with CHAS on these activities.

Table 4.1.1b: Laos: ART Targets in Priority Sub-national Units for Epidemic Control

SNU	Total PLHIV (AEM)	Expected Current on ART end of Sep 2015*	Additional patients required for 80% ART coverage (80% coverage currently on ART)	PEPFAR Site Targets (in FY17) *TX_CURR*
Champasak	1,020	460	356	458
Savannakhet	2,383	1,103	803	967
Vientiane Capital	4,154	1,898	1,425	970
Total	**7,557**	**3,461**	**2,854**	**2,395**

*AEM updated February 2016

Table 4.1.2c Entry Streams for newly initiating ART Patients in Priority Provinces (FY17)

Areas & Populations	Test	Identified Positive MSM, TG*	Enrolled on ART All PLHIV**
Champasak	958	23	100
Savannakhet	958	23	182
Vientiane Capital	2,146	58	335
Total	**4,062**	**104**	**617**

*Targeted MSM, TG only (assumed 5% positive)

**Included all PLHIV identified in routine HTC program

Table 4.1.3c Laos: Target Population for Prevention Intervention of Facilitate Epidemic Control

	Target high risk MSM,TG	Coverage goal	FY17 target
Champasak	2,313	43%	1,005
Savannakhet	3,381	30%	1,005
Vientiane Capital	8,007	25%	2,010
Total	**13,701**	**29%**	**4,020**

Thailand

We calculated targets based on estimated number of PLHIV by sub-national units (provinces) using the AEM, estimated number of key population from Thai National AIDS Operational Plan (2015-2019), the number of PLHIV in care and treatment from the National AIDS Program Reports (NAP). The six priority provinces identified for FY16 were selected based on high PLHIV burden. These provinces remain where we are implementing PEPFAR key population prevention and care program to support RTG and Global Fund activities. According to the 90-90-90 goals, we will continue targeting areas where key populations and PLHIV are likely to receive HIV care and estimate target population size in those areas. We will do targeted TA in high volume hospitals in the six provinces (9 hospitals in Bangkok and 6 hospitals for the other 5 provinces) to cover at least 25% of PLHIV in each province. The targeted interventions for recruitment will be focused on key populations to promote HIV testing. For treatment and retention will be for all PLHIV receiving care in BMA hospitals and specific interventions for key populations in the targeted area. PEPFAR will do targeted cascade monitoring for retention, viral suppression and quality improvement of all PLHIV receiving care in the priority provinces (Q1-2).

We will focus our target to reach key population for 36% (ranging from 11-49%) in these 6 provinces which in the past our targets were based on high HIV prevalence provinces and resource availability only. The FY17 targets to identify HIV-infections in key populations are similar to the results reported in FY15 (approximately 2,864). We targeted 75% of newly identified PLHIV will be on ART using the marketing campaign of Test and Start for community and Ending AIDS for HCWs (Q3-5). We analyzed 2015 results to identify low yield of HIV-infection in high risk key pop MSM/TG. We assume that we can reach more high risk MSM/TG in 2017 resulting from recently available data of key population by province and program performance in FY15 (Q6). Challenges in meeting the targets might be related to fear of target population to receive HIV testing in health care setting because of past perception of stigma and discrimination and differences in health insurance policies which affect the ability to access to care (Q7). We know the data in the NAP database has some limitations. This database does not cover private or self-payment services, may be under registered newly identified and incomplete data entry of type of populations (e.g. general vs. key pop). This prevents tracking of these populations, inability to track sub-group of key populations once they were registered in care. We will work with health

facilities and the NHSO to train HCWs for more complete data entry and definitions to increase coverage of registration and accuracy of data to monitor the complete of care cascade. In addition the estimated number of key populations were updated in 2015. We plan to continue working with the national estimation working group to verify SNU data if more data are available. (Q8).

As a TA/TC country our primary TA targets are the model to improve RTTR in key populations in response to country needs. Thailand has approved Ending AIDS plan in late 2015 and has developed the national and sub-national operation plan. To prove the effective model and strong SI, a comprehensive single M&E system is highly needed. TA work from our prioritized provinces will demonstrate how to expand coverage to key and priory populations. We will work with central technical departments, regional, provincial management team and clinicians by creating provincial networks. These networks will analyze their own situation, develop QI plan and implement with health facilities. Strong HMIS and M&E systems that we have developed in prior years will be the foundation of targeted interventions with key populations. We will also provide TA to the provincial networks to develop plan and mobilize local funds for HIV epidemic control. The model if effective will be good practice for the other provinces and operate under the Ending AIDS plan of the RTG.

Table 4.1.1b: Thailand: ART Targets in Priority Sub-national Units for Epidemic Control

SNU	Total PLHIV (AEM)	Expected Current on ART end of Sep 2015*	Additional patients required for 80% ART coverage (80% coverage - currently on ART)	PEPFAR Site Targets (in FY17)** *TX_CURR***
Bangkok	78,843	41,876	21,198	9,280
Chiangmai	18,150	10,808	3,712	450
Chonburi	16,169	12,817	118	610
Khonkaen	11,389	7,474	1,637	25
Songkhla	6,650	5,680	(360)	75
Udonthani	9,496	5,736	1,861	85
Total	**140,698**	**84,391**	**18,580**	**10,525**

*AEM updated in 2015

**Target for MSM, TG only except for Bangkok included all PLHIV

Table 4.1.2c Entry Streams for newly initiating ART Patients in Priority Provinces (FY17)

Areas & Populations	Test	Identified Positive	Enrolled on ART
Bangkok	10,950	2,111	2,131
Chiangmai	2,400	312	277
Chonburi	2,400	360	318

Khonkaen	450	45	25
Songkhla	700	49	43
Udonthani	600	120	85
Total	**17,500**	**2,997**	**2,879**

Table 4.1.3c Thailand: Target Population for Prevention Intervention of Facilitate Epidemic Control

	Target high risk MSM,TG	Coverage goal	FY17 target
Bangkok	38,511	37%	14,190
Chiangmai	6,561	49%	3,200
Chonburi	8,036	40%	3,200
Khonkaen	3,672	12%	450
Songkhla	3,982	25%	1,000
Udonthani	2,906	21%	600
Total	**63,668**	**36%**	**22,640**

Table 4.1.34 Thailand: Incentive Funding

Province	KP_PREV	HTC_TST	HTC_POS	Tx_NEW (TA)	PrEP_NEW	KP_MAT
Thailand	62,845	42,629	4,957	4,461	250	6,976
Bangkok	27,831	18,674	2,801	2,521	170	4,860
Nonthaburi	2,932	2,052	185	166	0	0
Pathum Thani	2,916	2,041	184	165	0	0
Samut Prakarn	4,280	2,976	268	241	0	178
Chonburi	2,516	1,601	144	130	15	0
Nakhon Ratchasima	4,491	3,144	283	255	0	0
Khon Kaen	3,091	2,164	195	175	0	0
Udon Thani	2,264	1,585	143	128	0	0
Ubon Ratchathani	3,018	2,113	190	171	0	0
Chiang Rai	174	104	9	8	0	157
Chiang Mai	3,822	2,336	210	189	40	1,620
Phuket	1,551	1,086	98	88	0	0
Songkhla	3,957	2,752	248	223	25	161

4.2 Priority population prevention

China

In FY17, in keeping with TA towards improving HIV cascade outcomes in the right places, PEPFAR China will continue to promote dissemination of and implementation of "test and treat" guidelines and prevention guidelines for MSM. This is all with the goal of promoting a national recommended standard package of evidenced-based HIV prevention services for MSM. PEPFAR China will also collaborate with NCAIDS and local CBOs on pilot projects to strengthen its reach to MSM for HIV testing, early diagnosis, and linkages to care, treatment, and sustained viral suppression.

Though the national response targets priority populations, not all prevention methods and services are accepted and used widely by the intended beneficiaries. A more vibrant CBO sector that is engaged in HIV prevention and control is still needed. While China's CBO sector is relatively weak and its activities have been disrupted by the withdrawal of the Global Fund, the GoC has established a new mechanism for sustaining the efforts of HIV-focused CBOs. In 2015, the central GoC allocated total USD$ 8 million to purchase prevention and care services from NGOs and CBOs. A total of 766 proposals were finally approved through this new mechanism.

PEPFAR China will continue to promote the role of local CBOs in outreach, HTC, and care and adherence support since their "peer educators" (e.g., MSM, former FSW, PLHIV) are trusted by the hard-to-reach populations. USG also encourages its GoC partner, NCAIDS, to use portions of the PEPFAR funds to conduct HIV interventions through existing CBOs.

Laos and Thailand

In FY2017, ARP will work with the RTG and civil society to achieve epidemic control in Laos and Thailand by doing the right things, in the right places, right now.

Focusing activities among MSM and TG women in priority provinces, ARP will support government efforts to broaden the implementation of PrEP and *test-and-start* using innovative models that can be expanded nationwide. In recognition of the need to demonstrate sustained support for people across the cascade of HIV prevention to care to treatment services, ARP will continue to pilot confidential service linkage and referral systems in Thailand and Laos in FY17. These systems will be deployed in quality-assured and marketed service coalitions of MSM- and TG women-friendly community and clinical providers that are promoted through targeted social and other media. Real-time referrals and confirmation of successful linkages across providers; automated client reminders; community and clinical health worker tasking, and tracking of pay-for-performance incentives for contributions to cascade outcomes will be achieved through the use of cell-phone based communication technologies. SIMS visits conducted in the past year demonstrated opportunities to improve making and tracking of successful referrals from community prevention activities to clinical HIV services. These new systems will produce

community-level dashboards that will allow partners and stakeholders to track and improve meaningful beneficiary outcomes across the HIV cascade routinely and collaboratively.

With these more robust linkage, referral, and performance improvement systems in place, ARP will continue to pilot outreach and demand generation activities to increase uptake of testing and other HIV services among individuals facing the greatest risks, while reducing unit costs. Traditional peer outreach roles and responsibilities will be expanded across the HIV cascade to prioritize linkages to HIV testing and counseling while incorporating adherence support, retention, and other community care and support functions. Using the linkage and referral systems referenced above, participating clinics will use a reduced, more skilled, cadre of outreach workers – redubbed community-based supporters – to assist in addressing client loss to follow up, late entry to care and treatment, and improving successful referrals across clinical sites.

The community-based supporters will be trained to mobilize beneficiaries as "peer motivators" to refer their peers and partners to HIV testing with simple voucher systems inspired by respondent-driven sampling techniques. For each successful referral of an individual who is a newly tested in the past six months the referring individual will receive a small incentive. Peer mobilizers who make no successful referrals will receive no incentives. The performance of the community-based supporters will be evaluated and incentivized in part on the basis of the number of newly identified and newly engaged in care HIV-infected individuals they are able to reach though their peer mobilizers. This will encourage the community-based supporters to seek partnerships with peer mobilizers situated in networks with elevated HIV infection burdens, and to routinely swap out peer mobilizers who do not help to link HIV-infected individuals to services for those who do. Community-based supporters and HIV counseling staff will also be trained in the use of simple risk assessment tools that will help them to make appropriate HIV service referrals, and to identify and counsel HIV-uninfected individuals who might benefit from PrEP. PrEP is available commercially in Thailand, and the ARP will support access to free PrEP for up to 1,000 clients annually in Thailand made possible through a generous donation from HRH Princess Soamsavali. The ARP will also explore platforms to reach key populations though social media online and facilitate documented referrals of these individuals to offline HIV testing and other services.

To mitigate stigma and discrimination that may serve as barriers to HIV service uptake among priority populations, ARP will provide training to health care providers in priority geographic settings. These efforts will feature "south-to-south" collaboration between the Laos and Thai programs – based upon foundations established through previous ARP activities in these areas.

ARP will partner to demonstrate more effective and efficient service approaches for priority populations in priority settings, and disseminate results to improve the quality of programming for other populations and settings with other donor and domestic resources in Laos and Thailand. Through its work with CBOs, ARP will generate evidence of the value for money of investments in civil society in terms of improved cascade outcomes and reduced unit costs, and will advocate for increased host-country and other donor investments in the sector.

With limited resources and as a designated "technical assistance / technical collaboration" platform, ARP will leverage remaining Global Fund, other donor, and host-country resources in Thailand and Laos to ensure that beneficiaries in PEPFAR direct service delivery sites have access to HIV education, condoms and lubricant, sexually transmitted infection screening and treatment, HIV testing commodities, and HIV treatment.

ARP will also work with priority provinces to build local capacity to collect and examine HIV care cascade data and will provide TA to the RTG to implement a revised IBBS and online behavioral surveillance among key populations in priority provinces.

ARP will work with MOPH and the Bangkok Metropolitan Administration (BMA) to ensure quality rapid HIV testing for MSM and TG women as described in section 4.5, and will work with MOPH, BMA and others to expand access to PrEP services as described in section 4.8.

4.3 Voluntary medical male circumcision (VMMC)

N/A

4.4 Preventing mother-to-child transmission (PMTCT)

<u>China</u>

As the national PMTCT program becomes increasingly effective, PEPFAR China is maintaining support only at the national level, and in support of data analysis efforts to help inform the overall understanding of the HIV epidemic in China. In FY17, PEPFAR China will provide technical consultation to Beijing-based staff at the National Center for Women's and Children's Health. This collaborative review of data will strengthen PMTCT data management and utilization for monitoring and strengthening the implementation of option B+, while providing necessary inputs for national HIV epidemic estimates.

<u>Laos</u>

An estimated 150 HIV-infected infants are born to HIV-infected pregnant women in Laos annually; however, the uptake of antenatal services and HIV counseling and testing by pregnant women is low. In addition, there are a limited number of HCWs in MCH settings who have the knowledge and skill to provide PMTCT services and link HIV-infected pregnant women to HIV care in a timely manner. During 2014-2015, ARP worked closely with Laos Maternal and Child Health staff to conduct HIV PITC, couples HIV testing and counseling (CHTC), and PMTCT SOP trainings and to supervise and monitor services at hospitals in Vientiane Capital, SVK, and CPS. Data from CHAS showed increased uptake of HIV testing among pregnant women in Vientiane Capital from 70% in 2014 to 99% in 2015 (national coverage was 20% in 2014). Although coverage of HIV testing among pregnant women has increased in SVK (10% in 2014 to 28% in 2015) and CPS (17% in 2014 to 24% in 2015) coverage remains low. Coverage of partner HIV testing increased from 18% in 2014 to 25% in 2015 in Vientiane Capital, from 1% to 5% in SVK and from 4% to 8% in

CPS. ARP will train staff on CHTC and the PMTCT SOP for hospitals in SVK and CPS provinces in 2016. In 2017, ARP will continue to monitor uptake and coverage of HIV testing among pregnant women, partners, and the linkage of HIV+ pregnant women to PMTCT services. Supervision and monitoring visits will be provided for sites with low coverage as part of routine services.

Limited ARP investments in PMTCT occur at the above site level of support. In FY17, ARP will use data from an operational assessment of Laos HIV sentinel surveillance and PMTCT services to concentrate program improvement in priority provinces. ARP will work with MCH and CHAS to provide supervision to sites with low uptake of services according to national guidelines and provide TA to MCH and CHAS to strengthen the PMTCT monitoring and evaluation system. Couples HIV testing and counseling training will be conducted at sites in priority provinces.

Thailand

In Thailand, the MTCT rate remains above 2%. In 2016, with TA from ARP, the Thai Government will publish 'Thailand National Guidelines on HIV/AIDS Treatment and Prevention 2016'. The new guidelines recommend ART for HIV-infected adults including pregnant women regardless of CD4 count (option B plus) and ARV prophylaxis based on mother-to-child HIV transmission risk (AZT x 4 weeks or AZT+3TC+NVP x 6 weeks) and EID for infants born to HIV-infected mothers including HIV DNA PCR at birth for high MTCT risk infants.

Limited ARP investments in PMTCT occur at the above site level of support. In FY16, working with support from ARP the MOPH implemented a national active case management system to identify HIV-infected infants early, determine the cause of HIV infection, and ensure infants receive care according to national guidelines. In FY17, while reducing its overall investment in PMTCT activities, ARP will support MOPH to integrate active case management into the national PMTCT and HIV treatment and care system. ARP will provide TA to MOPH to prepare for a WHO elimination of MTCT validation assessment and the GARP report

ARP is also working with MOPH Department of Health and the Thai Red Cross (TRC) to develop a model to ensure that migrant HIV-infected pregnant women and infants receive PMTCT services according to national recommendations. Funding is provided by the Princess Soamsawali Fund and TRC.

4.5 HIV testing and counseling services (HTS)

China

In line with the first "90", expanding HTC among MSM is increasingly a GoC priority and a core area for FY17 PEPFAR support. This includes an emphasis on increasing the number of persons who know their HIV status, continue to prevent HIV, and access timely ART. China has relied on provider-initiated counseling and testing (PITC) for case detection in areas with higher HIV disease burden and delays in case finding, but rarely employed tailored, innovative interventions

targeting key populations, particularly among MSM. In FY17, PEPFAR China will collaborate with the GoC to improve HIV testing yield by exploring current HIV testing strategies, and strengthening its approach in focus regions.

For example, PEPFAR China will work with subnational (provincial, city, county level) partners to expand testing by developing and demonstrating innovative HIV testing and counseling interventions among MSM in Yunnan, a province hit hard by HIV. This includes "WeChat"/web-based social and dating applications that are increasingly popular among MSM, especially young MSM. PEPFAR China, together with NCAIDS, will work with Blued, the most popular social networking application company, to pilot its mobile app for HTC outreach and linkages to care and treatment. Three CBOs will provide offline HTC services along with risk behavior surveys. If successful, this project has the potential for scale-up and to replace traditional venue-based outreach. It will also strengthen coordination among local CDCs, clinics, and CBOs, and improve capacity in HIV service delivery, data utilization, and financial sustainability.

PEPFAR China will continue to encourage involvement of CBOs in HTC and referrals, contribute to improving service delivery quality, and utilize web-based outreach for MSM to access regular (every 3-6 months) HTC, including supervised oral/finger-prick rapid test by trained CBO staff. Meanwhile, PEPFAR will also help local CDC and CBOs to set quality assurance mechanisms for rapid testing and apply it in routine HCT. PEPFAR support also includes the promotion of contact tracing and partner notification, and self-sample collection for HCT among partners in Guizhou.

Laos and Thailand

Achieving epidemic control through enhanced use of antiretroviral medications is contingent on increasing HTC coverage in the key populations most likely to acquire or transmit HIV. In both Thailand and Laos, the largest proportions of new HIV infections in the coming years are forecast to occur in the MSM and TG women populations, while rates of HIV testing uptake in these populations have remained low. As HIV testing is a gateway to HIV treatment among infected individuals and to PrEP as part of a broader combination of HIV prevention services for uninfected individuals, ARP aims to increase HTC uptake among MSM and TG women in priority areas in FY16 while maintaining high rates of case identification.

Performance data from ARP partners engaged in prevention outreach activities in Thailand indicate that 10-20% of individuals referred to HTC services are infected with HIV. However, with notable exceptions, the proportion of individuals reached who were referred to HTC by these partners has typically not exceeded 33%, suggesting that partners may be working in the right places, but need to employ more effective strategies to increase demand and remove barriers to HTC uptake.

To improve HTC program performance and reduce unit costs, ARP will support the following activities in Thailand and Laos in FY16:

- ARP will support peer recruitment strategies at existing testing sites to encourage those seeking testing to refer their peers and partners. By providing small incentives to HIV testing clients for referrals, ARP hopes to increase rates of testing and case identification. Initial experiences with revised peer recruitment strategies in Chiang Mai are resulting in high proportions of individuals reached receiving HIV testing services, as well as high case finding yields.

- ARP will assist the targeted expansion of access to HTC through mobile testing, as well as with same-hour screening and same-hour testing administered by community partners and same-day confirmation by Government-run facilities. Partners who offer prevention outreach and education services will be trained to offer quality-assured HTC at targeted community testing events. In Laos, community-based civil society partners will be trained to provide HIV screening using oral-fluid HIV tests on an outreach basis, and will provide referrals of individuals who screen reactive for confirmation using the national HIV testing algorithm and care. With the support of the Thai MoPH, we hope to pilot the use of the oral fluid HIV test as a screening test in Thailand as well, later in the year. While the oral fluid test has a high unit procurement cost compared to other kits, the ability to use the one kit to "screen out" individuals with non-reactive results should reduce overall unit testing costs. ARP will also support training and quality assurance for delivering rapid (same-hour) HIV screening and testing, and some branding and marketing support for participating providers.

- ARP will support targeted demand generation efforts using social media, including web-based recruitment, counselling, education, and referral sites, and community events to raise awareness of the valuable and lifesaving benefits of testing and early access to HIV treatment. We have seen evidence of increases in testing uptake in community sites associated with mobile HIV testing, promotion via social media in Thailand, and targeted promotional events. In FY16 we will seek to employ low-cost events and communication channels to cultivate norms supporting regular testing among MSM and TG women.

- Achieving and demonstrating substantial increases in HIV testing uptake in priority settings and populations will be bolstered by new investments in 1) mobile technology-based linkage and referral systems and 2) enhanced outreach approaches, detailed in section 4.2, "priority population prevention." Per the SIMS requirements, all individuals who are diagnosed with USG support will receive follow-up and assistance in accessing HIV care and treatment services. In Thailand, the national program will procure HIV testing kits generally, and we have helped establish mechanisms for community testing partners to receive test kits from public sector hospitals, who then apply for reimbursement with the National Health Security Office to recuperate their costs. In Laos and Thailand, ARP will procure oral-fluid test kits to support the pilot application of oral fluid screening through community partners to accelerate rates of testing uptake and diagnosis among MSM and TG women and blood-based HIV test kits to support PrEP implementation where government supported HIV testing (i.e., two times/year) does not completely cover HIV testing for PrEP.

- The RTG issued guidelines for HIV testing with same-day result in health facilities nationwide in 2013. ARP will work with and support RTG to implement robust quality assurance and improvement systems to ensure quality HIV test results are provided to PLHIV in Thailand.

- Current, HIV testing is available in District and Provincial Hospitals in Thailand. To increase access to HIV testing, ARP will work with the RTG to develop a training package, quality assurance and improvement systems, and a certification process to provide HIV testing in primary health care settings, and explore the feasibility of HIV self-testing.

4.6 Facility- and community-based care and support

China

To meet the challenges of the 2nd and 3rd "90", PEPFAR-China will continue technical support in FY17 with subnational partners on projects that strengthen case detection, access to services for PLHIV and their partners, and care linkages. This includes select areas for contact tracing, partner notification, and early initiation of ART. PEPFAR China will continue to monitor the approval of "test and start" in national guidelines, including adherence at subnational levels via consultation, mentoring, and an HIV nursing handbook. With USG support, AIDS Care China (ACC) will continue to provide care and adherence support through HIV-positive peer educators in Yunnan province. Based on FY15 SIMS findings, PEPFAR will support ACC in FY17 to monitor progress in implementing new operational policies for data quality control, patient referral tracking tools, and service delivery improvement plans. Support will also help to identify factors and barriers to care and treatment in Guiyang in order to increase coverage and retention.

Laos

In Laos, at the end of 2014, 6,381 people had been diagnosed with HIV and 3,848 were on ART. ARP is working with the Lao government to improve the quality of HIV testing, care, and PLHIV follow-up in the care cascade in four ART clinics in three priority provinces. In addition, ARP will consider reasonable PEPFAR investments in national systems, protocols, and capacity – such as targeted TA for laboratory or SI efforts – where they are needed to achieve measurable outcomes in priority populations and settings or broader epidemic control.

Thailand

As of September 2014, 369,408 people had been diagnosed with HIV and 284,578 (77.0%) were on ART. Despite this strong response, gaps in HIV testing, adherence to ART, and retention in care remain particular challenges among MSM, TG women, and other key populations. In FY17 ARP will work with local and national partners to expand HIV testing among key populations, improve the quality of care across the continuum of care cascade, ensure accurate and complete cascade data are available to providers and public health officials, and address stigma and discrimination using community meetings, peer outreach, and a web presence with a goal of bringing more

people in for HIV testing, keeping HIV-infected persons in care, and reducing HIV-related morbidity and mortality. ARP will provide TA and work with RTG and local providers to implement quality improvement (QI) programs for care and laboratory services (e.g., HIV, CD4, VL, STIs, TB), ensuring laboratory results are available and used by providers by improving communication among laboratories and health care providers, and by strengthening laboratory networks to ensure results are available to providers as soon as possible. Where appropriate and at the request of the RTG, ARP will provide TA to develop external quality assessments and laboratory accreditation.

ARP will work with the RTG to transition from CD4 count to HIV viral load to monitor HIV treatment and to assess the service delivery package in Thailand including follow-up of schedules of stable PLHIV to ensure the efficient use of scarce resources.

ARP is also working with local partners to ensure HIV-infected Lao migrants have access to ART and care services and HIV-infected pregnant women migrants have access to PMTCT services.

4.7 TB/HIV

China

Given the scale of the TB burden in China, inadequate attention to TB/HIV co-infection issues could jeopardize optimal timing of ART initiation among TB-infected PLHIV. A common issue found during SIMS visits was suboptimal TB/HIV co-infection case management. TB/HIV patients either do not receive ART during and after TB treatment due to referral delays, or they cannot access free TB treatment due to atypical TB manifestations. In FY17, PEPFAR China support in TB/HIV will be directed at a national level with NCAIDS counterparts to analyze the impact of co-infection on ART efficiency.

Laos and Thailand

In FY16, ARP will continue to help pilot, with PEPFAR/Vietnam, an enhanced TB infection control intervention for healthcare facilities in Thailand and Vietnam that provide services to both HIV and TB clients. Other TA will focus on establishing operational and informational linkages between national HIV and TB management information systems, supporting data analysis and technical writing, and working in Bangkok to improve the quality of TB/HIV testing and treatment. ARP will provide limited and targeted TA as requested by MOPH to help respond to outbreaks of MDR-TB and to assist with the evaluation of GeneXpert to diagnose TB in Thailand. As a modest investment with substantial impact, ARP will provide TA in Laos to introduce HIV testing in TB clinics in its three priority provinces.

4.8 Adult treatment

China

In addition to promoting "test and start," PEPFAR China will continue to support provincial governments' efforts for optimizing treatment coverage of newly detected HIV positive MSMs by piloting a comprehensive model to ensure 90% of PLHIV have achieved undetectable viral load after 6 months of treatment. PEPFAR China supports high-quality training and management of peer educators in local CBOs to conduct peer accompanied HIV confirmatory testing services, link those diagnosed to care with prompt initiation of ART regardless of CD4 count, and supports adherence and viral load monitoring. Harnessing mobile technology-based linkages to maximize testing, treatment, care, and referrals is also a key area of support for FY17 in select PEPFAR provinces.

Laos and Thailand

ARP works closely with the RTG and other stakeholders in Thailand to maximize PLHIV access to ART, and retention in the continuum of care cascade, while ensuring that quality services are delivered in a sustainable fashion in priority provinces. The 'Thailand National Guidelines on HIV/AIDS Treatment and Prevention 2014' recommend ART for HIV-infected adults regardless of CD4 count and PrEP for people at high risk of HIV infection, signaling a major change in Thailand's posture towards HIV treatment and prevention, with Thailand becoming a leader in Asia in providing PLHIV early access to ART. In FY16 ARP worked with the RTG on new National Guidelines that will include additional second line ART regimens and recommendations to use VL monitoring, instead of CD4 count testing, for stable PLHIV.

In FY17, ARP will continue to work with the MOPH and CBOs to ensure that MSM, TG women, and other key populations in key provinces can access HIV services including ART regardless of CD4 count and that HIV services are implemented consistent with WHO recommendations. Following successful ARP-supported pilot and scale-up, the MOPH adopted HIVQUAL-T as a standard national QI tool for health facilities that can also be used for hospital accreditation. ARP ended financial support for the program in 2016. ARP will continue to provide targeted TA to build the QI capacity of local leadership and health care providers to retain PLHIV in the continuum of care cascade. ARP will also provide TA to build the capacity of HCWs, CBO staff, and GF peers to expand HIV rapid testing using mobile clinics, peer referrals, and testing events, and to link those who test positive to services, using HIV case managers where possible. Disease specific certification (DSC), a national accreditation program developed to recognize health facilities that meet defined administrative and clinical care criteria, including disease prevention activities, for specific diseases (e.g., stroke), will be developed for HIV with TA from ARP in FY17. DSC activities to support PLHIV in the care cascade will include: adherence and retention support, HCW stigma and discrimination training, PrEP implementation, STI screening and treatment, risk reduction counseling, and the development of navigators to help PLHIV access mental health and social services and health plan referrals and DSC coaches to support and provide ongoing training to HCWs.

In FY15 and FY16, ARP worked with the government of Bangkok and local CBOs to launch and support MSM clinics in 12 hospitals in four provinces of Thailand including 8 hospitals in Bangkok. The clinics aim to provide HIV services free of stigma and discrimination, increase HIV testing among MSM, and support HIV-infected MSM to stay in the continuum of care cascade. In FY17, ARP will continue efforts to increase community awareness and support for the activity including peer outreach, a website, and community meetings and build the capacity of the clinics and community-based health clinics in Bangkok to provide PrEP to MSM and TG women. ARP will also work with the local government of Bangkok to improve retention in care by enhancing the quality of HIV and STI services, laboratory systems, and establishing effective referrals in the Bangkok health care system.

ARP has historically provided TA to the RTG to improve the quality of HIV and STI screening services nationally. In FY17, ARP will provide TA for HIV and STI services for priority populations and provinces as requested by RTG.

The USG PEPFAR team was awarded a KPIS grant to assess an HIV test, treat, and prevent HIV model among MSM and TG women in facility and community-based settings in Thailand. The intervention works with local partners in facilities and communities to launch innovative peer-driven efforts to increase demand for HIV testing among MSM and TG women. At the community-based sites, peers provide HIV testing in community-based drop-in centers and clinicians provide ART at the same sites in an effort to overcome the stigma and discrimination barriers that exist in some public sector ART sites.

At the facility-based sites, peers have been integrated with hospital staff to coordinate services. ARP is working with staff at 5 hospitals in 4 priority provinces to strengthen communication between laboratories, clinicians, counselors, and PLHIV to ensure PLHIV are counseled appropriately and offered ART regardless of CD4 count, those who are HIV-uninfected but at risk are offered PrEP, and services are provided in a setting free of stigma and discrimination. ARP developed the educational tools used in the hospitals with MOPH staff. In FY 17, we will assess the effectiveness of the tools, make modifications if necessary and the MOPH will use the tools to scale up test, treat, and prevent HIV activities nationwide. We will also examine preliminary results on acceptance, adherence and other implementation issues from the study and share the results with the government and local providers.

An estimated 40-50% of new HIV infections in Thailand in 2015 occurred among MSM and 55% of these MSM are thought to be under the age of 25.[48] Although there are several models to provide services to MSM and TG women in Thailand (e.g., the Silom Community Clinic, the Thai Red Cross), few resources have been directed to young MSM and TG women. In addition, the Thai Medical Council has approved HIV testing without parental consent for people <18 years old, but

[48] Pannee Chaiphosri, Suvimon Tanpradech, Kanokrat Lerdtripop, et al., HIV/AIDS Epidemic and Status of Prevention and Alleviation Effort, Bangkok, 2010-2014, p.1

testing of these youth is not widely practiced. ARP will coordinate with the RTG, CBOs, and other stakeholders to develop models for HIV care and treatment of young MSM and TG women.

Thailand's national HIV treatment and care guidelines recommend PrEP (tenofovir-emtricatibine) for those at high risk of HIV infection. However, the FDA approved the use of tenofovir-emtricatibine for PrEP, but only for those ≥18 years old. During the 2017-2020, ARP will collaborate with UNICEF, BATS, TRC, Siriraj Hospital (with funding from UNICEF) to assess the feasibility of implementing PrEP among young MSM in Thailand.

In 2016, Path to Health (P2H) received funding from UNICEF to develop an online virtual clinic (I-USE) to reach and recruit young people to receive HIV/AIDS counseling, prevention messages and access HIV testing through 46 network clinics including Siriraj Hospital and 8 BMA hospitals. In 2017, ARP will work with BMA, UNICEF, P2H, and Siriraj Hospital to develop web-based education and demand creation materials to promote HIV testing among young MSM/TG and link HIV positive young MSM/TG in Bangkok to treatment and care services using I-USE and other media resources (e.g., banners on websites, outreach activities at schools, Facebook, Line group, Stickers posted in schools, Post I-USE web on Gay websites: yentafo, Dek-D, Postjung).

Migrant registration data in October 2014 showed that there were 213,689 registered Lao migrant workers with 9,150 dependents in Thailand and surveillance among Lao migrants found an HIV prevalence of 0.8%. As of 2015, 599 Lao PLHIV have registered to receive ART in Thailand. With support from the Global Fund and the Government of Laos, ten clinics in Laos are able to provide ART, CD4, and viral load testing. In FY16, ARP will help establish and assess the success of the first system for cross-border HIV patient referral along the Laos-Thai border.

In Laos, ARP will concentrate on improving the quality of adult care at four ART sites in three priority provinces in Lao, working with the Government of Laos to strengthen the quality of HIV care from HIV testing to viral suppression and ensuring complete accurate data are available to providers and public health officials.

In addition, HIV-infected migrants need to be educated about HIV prevention to ensure that HIV is not transmitted to others. ARP will assist a network of hospitals that provide ART along the Lao-Thai border and other national borders to increase HIV testing, implement quality improvement systems for ART use, and maintain PLHIV in the continuum of care cascade at those sites.

4.9 Pediatric Treatment

China and Laos

N/A

Thailand

The Thailand National Guidelines on HIV/AIDS Treatment and Prevention 2016 recommend ART for all children regardless of CD4 count giving the priority to infants <1 year old, for children 1-5 years old with CD4<25%, and for children 5-15 years old with CD4<500 (unpublished).

In FY16, while transitioning away from pediatric-specific activities, ARP worked with the Thai MOPH and four regional pediatric HIV case management sites to establish an Active Case Management Network. The project will promote early infant HIV diagnosis, identify newly HIV-infected infants, determine the reason for HIV infection, assure they are linked to an HIV care program, and initiate ART as soon as possible according to the national guidelines. Preliminary results showed that the proportion of HIV-infected infants who initiated ART during the first year of life increased from 52% in 2012 to 79% in 2015. Although HIV-infected infants received ART earlier, the mortality rate was high (17%), more than 40% of infants who received ART for ≥6 months had virologic failure (VL>1,000 copies/mL), and some infants were lost to follow-up. ARP is uniquely positioned through its strong relationships with the RTG, the MOPH, and the four regional sites that have network connections with pediatric clinics in all 77 provinces to strengthen HIV treatment and care cascade among these infants, ensure HIV-infected infants receive care according to national guidelines, and continue the to transfer these life-saving activities to the RTG in a sustainable manner.

In 2013, 75% of HIV-infected children and adolescents in pediatric HIV clinics were ten years old or older and 20% were 15 years or older. Comprehensive models to transition HIV-infected youth to adult HIV care services are lacking and data from resource-constrained settings on the unique challenges HIV-infected adolescents and youth face such as ART adherence, retention in care, risk behavior, viral load suppression and life choices are limited. ARP, working with local partners, developed guidelines and tools for providers to use to help HIV-infected youth transition from pediatric to adult HIV care services. These activities, implemented in Bangkok, address important health, psychological, and prevention-with-positives challenges HIV-infected youth. ARP will provide targeted TA to assess the impact of the model and tools on a cohort of perinatally HIV-infected youth as they transition to adult HIV care.

4.10 OVC

N/A

4.11 Regional Support for HIV Epidemic Control

Leveraging the lessons learned and expertise from ARP countries to accelerate and strengthen HIV epidemic control throughout the region is an ARP priority. The ARP implements this work both as a part of and in addition to its in-country efforts. Such efforts fall broadly into three categories: (A) regular contributions to regional networks; (B) advocacy, support, and participation in regional consultations; (C) facilitation of country-to-country collaboration and cross-border cooperation.

Through such approaches, the ARP China, Laos, and Thailand programs will promote practical, immediate improvements to HIV program planning, implementation, and monitoring in countries across Asia (and in other regions, where possible) as well as improved national policies and regional collaboration for sustained financial support and expanded and more effective responses—with an emphasis on key populations.

High-level priorities for ARP regional work are increased access by populations to high quality services and the improvement of HIV cascade outcomes. It addresses these priorities through regional work that optimizes service delivery, creates enabling environments (including both sufficient sustainable financing and human capacity), and promotes the use of high quality data for program monitoring and improvement.

Illustrative examples of ARP regional support include the sharing of approaches and lessons learned from modeling of key population sizes; incentivized outreach/case finding; planning and delivery of PrEP; task shifting for HIV testing (e.g., oral fluid rapid testing) and treatment services; SI/economic analyses for increased/sustainable funding for HIV both broadly and specifically from government to civil society; applications of ICT to improve 90-90-90 outcomes among MSM and other KP while reducing costs; the "investment case" for community- and KP-led service delivery; accelerated scale-up of high-quality rapid testing for HIV and VL testing through participation and support for laboratory networks; building upon partnerships with APCOM on regional PrEParing Asia consultation; APCASO/APCOM on regional Global Fund SHIFT proposal; and support for and providing key inputs to SI networks for surveillance and monitoring of HIV cascades across the region; addressing key population mobility, and reaching adolescent and young key populations.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services in sustained support locations and populations

China

Since a UN High-Level Special Meeting in 2003, the GoC has implemented its 'Four Frees and One Care' policy since 2004; a standard package of services includes the following-

(1) free anti-retroviral drugs to AIDS patients;
(2) free voluntary counselling and testing;
(3) free drugs for PMTCT, and HIV testing of newborn babies;
(4) free schooling for AIDS orphans and children from HIV infected families; and
(5) economic assistance and care to the households of PLHIV.

Laos

Supported largely with donor resources, the GOL offers a basic package of HIV-related services in a limited number of sites and provinces in the country. This includes VCT services with low-cost HIV testing, care and treatment (ART), testing and treatment of STI, PMTCT, provision of male and female condoms and lubricant, needle and syringe programs, screening and treatment for opportunistic infections, peer counselling, self-help groups, and home-based care. Even where available, however, these services often suffer from stock-outs and shortages of medicines and supplies, lack of healthcare worker capacity, and high out-of-pocket expenses for clients as a result of (among other things) the need to travel long distances to reach service centers.

Thailand

Thailand established a universal health care system in 2002 that provides ~99.5% of Thai nationals with health protection and nearly free access to a wide range of health services, including a comprehensive package of HIV testing, treatment, care, and support services. In 2014, Thailand became the first country in Asia to offer HIV treatment to every person living with HIV. In addition, the government also funds key laboratory services, including EQA for HIV serology and CD4 testing, VL testing, HIV prevention services such as outreach and STI services, a pediatric HIV care network, molecular testing for EID, and HAART for PMTCT.

5.2 Transition plans for redirecting PEPFAR support to priority locations and populations

As China, Laos, and Thailand are technical collaboration/TA model countries, PEPFAR support has historically maintained a consistent focus on a limited number of priority locations and populations. In ROP 2016, these focus provinces are fourteen provinces in China (5/31), Laos (3/17), and Thailand (6/77) with the highest HIV incidence and lowest ART coverage among priority populations in order to accelerate epidemic control.

PEPFAR support for the Lao military has focused on addressing HIV knowledge and stigma/discrimination within the military, combination prevention (TA), and HTS (DSD), and the recently concluded seroprevalence (SABERS) survey. Based on the results of the seroprevalence survey, PEPFAR support for Lao military will begin responsible transition out now, with transition to be completed by end of quarter two FY17, focusing in the interim on above-site technical assistance with the goal of: 1) phasing out HIV testing support by PEPFAR; 2) focus on starting the development and implementation of a written HIV policy that addresses routine standardized HIV testing, linkage processes for positives, stigma, and discrimination; 3) facilitate a collaborative relationship between MoD and MoH to encourage future Laos government support of the MoD HIV program; and 4) military-specific HIV lecture series by a DoD Infectious Diseases physician in Q1 FY17 to foster discussions about HIV policy.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

Regional

Table R.1. Key Programmatic Gap #R1: Sharing of Lessons Learned/Best Practices for HIV Epidemic Control in the Region is Not Optimal					
Regional Priority	**Proposed venue(s) / activities**	**Target populations**	**1 year milestones**	**2 year milestones**	**3 year outcomes**
Policy development and implementation (e.g. test and start, community-led approaches, self-testing) for key populations	ASEAN, APEC, UN high-level meetings	MSM, TG	Agreement in principle to test and start, community-led approaches, self-testing at high-level meetings	Adoption of formal test and start community-led approaches, self-testing, policy in the region - Regional discussion about implementation needs	Implementation of test and start, community-led approaches and self-test policies in the region
Optimizing, integrating, and scaling up more efficient HIV service models in both facility and community settings	Regional networks and workshops, regional TA and capacity building activities for both GO and CSOs	MSM, TG	Sharing a proof-of-concept of HIV service optimization strategy in regional fora	Piloting of HIV service optimization strategy in additional country(ies)	Adaptation and/or scale-up of HIV service optimization strategy in additional country(ies)
Sustainable funding mechanisms, capacity building, and accreditation for CSO/CBOs	Regional workshops, study tours	MSM, TG	Intra-Regional capacity-building TA through CBO networks	Establishing a funding mechanism for CBO in Thailand	Sustainably (i.e. domestically) funded CBOs in multiple countries. -CSO/CBOs able to provide quality KP services without external technical assistance in

					multiple countries.
Application of ICT, innovative approaches and best practices for data quality and use (analysis) for program planning, service delivery and cascade monitoring	Regional technical assistance, regional training institute, Conferences, dissemination meetings	Cross-border migrants, MSM, TG	Sharing a data application or analysis method in a regional forum Development of HIV cascade monitoring tools	Piloting of data application or analysis method in additional country(ies) Sharing of HIV cascade monitoring tools to other countries in the region	Adoption or routine use of data application or analysis method and tools in additional country(ies)

China

Table 6.1.1 Key Programmatic Gap #1: High numbers of undiagnosed MSM PLHIV in 6 geographic focus areas in China.							
Key Systems Barrier	**Expected milestones 1-2 years**	**Outcomes expected after 3 years**	**Proposed ROP16 activity**	**Budget Code(s)**	**Budget (USD)**	**Associated IM ID**	**SID Element/Score?**
Limited capacity of and coordination among local CDCs and CBOs to reach more MSM for HIV testing and counseling,	40 CBO/CDC staff from PEPFAR focus provinces trained in MSM comprehensive interventions (e.g. Tianjin bathhouse, new media applications, CBO-CDC	Improved KSA in HTC, prevention, care and ARV adherence support among staff from 16 MSM CBOs in PEPFAR supported provinces	Pilots on MSM bathhouse projects and test and treat	HVOP	45000	China CDC/ NCAIDS 16622	B-6. Service delivery C-12. Technical and Allocative Efficiencies

prevention, care and treatment adherence support	capacity development. CBO/CDC training curriculum and materials drafted with USG technical support. 2 annual meetings held with NCAIDS include experience sharing on MSM strategy and include provincial and site level MSM-oriented CBOs in attendance.	16 CBOs from 11 provinces report on having replicated bathhouse models Tiantong, a provincial-level MSM CBO, demonstrating TA support to other CBOs. Revised MSM Intervention guideline that incorporate lessons learned from Tianjin and subnational trainings for CDC/CBOs. 3 protocols and related publications shared for USG review reflect improvements in more sound, rigorous methodology or data analysis.	Various trainings and technical support to MSM CBOs, and protocols designs	OHSS HBHC HTXS	60000	China CDC/ NCAIDS 16622	B-9. Quality Management
Stigma and discrimination preventing MSM PLHIV access to HIV services	HTC, prevention, care and ARV adherence support handbook with anti-stigma content. MSM youth focused HIV advocacy materials drafted.	CBO HTC, prevention and care and ARV adherence support handbook produced in Hunan, disseminated, and regularly used in trainings in PEPFAR provinces	Development of HIV advocacy materials for MSM youth (middle, high schools and universities)	OHSS	10000	China CDC/ NCAIDS 16622	A-5. Public access to info

	2 planning meetings held with NCAIDS, UNAIDS, and Chinese Association of STD/AIDS Control for developing the Stigma index survey. Draft Stigma Index report produced with USG input and TA on data analysis.	60% of MSM surveyed report increased access to HIV prevention, care and treatment over the last 3 years. At least 1 Stigma Index survey is completed by the Chinese Association of STD/AIDS Control and Prevention, or its designee, with USG technical support on protocol/tools/analysis that include respondents from key populations.	Support Chinese Association of STD/AIDS Control and Prevention on development of CBO HTC, prevention and care and ARV adherence support handbook, advocacy on technologies and policies, and experience exchanges	OHSS	30000	China CDC/ NCAIDS 16622	A -3. Civil society engagement

Table 6.1.2 Key Programmatic Gap #2: Lack of reliable national and subnational HIV epidemic data to guide timely, comprehensive quality programming in 6 geographic focus areas in China.

Key Systems Barrier	Expected milestones 1-2 years	Outcomes expected after 3 years	Proposed ROP16 activity	Budget Code(s)	Budget (USD)	Associated IM ID	SID Element/Score?
Low level of experience in KP size estimation methods, and in designing and managing HIV treatment & prevention programs targeting MSM	50 local staff trained in RDS for population size estimation. RDS data collection in 1-2 PEPFAR areas generates a more reliable MSM population size estimate by end of year 2, including cohort study enrollment per protocol. 17 SIMS visits conducted to PEPFAR supported sites and above sites highlight improvements in data	Local CDCs in PEPFAR focus areas reported at time of annual meeting more timely, quality, reliable MSM size estimates, including thorough methods explanation (e.g. adheres to published STROBE criteria) 7 work plans/implementation plans from IPs (NCAIDS/ACC) reflect utilization of past	MSM size estimation using RDSA	HVSI	10,000	China CDC/ NCAIDS 16622	B-9. Quality Management D-13 Epi and Health data
			Monitor and train staff on utilization of data collection system and improve data quality	HBHC HTXS HVSI	19,277	AIDS CARE CHINA 16576	D-15. Performance Data D-13 Epi and Health data
			Program planning and experience exchange meetings	HVSI OHSS	30000	China CDC/ NCAIDS 16622	B-9. Quality Management D-13 Epi and Health data

	quality and utilization. Finalized M&E handbook with provincial staff and NCAIDS for PEPFAR areas.	implementation year's public health data in formulating the following years' activities. 2 experience exchange meetings hosted annually by NCAIDS to share best practices domestically and regionally for improved data quality, reliability and utilization.	Monitoring and evaluation visits and handbook development	HVSI	50000	China CDC/ NCAIDS 16622	D-15. Performance Data D-13 Epi and Health data

Table 6.1.3 Key Programmatic Gap #3: Limited laboratory capacity (workforce, quality) to match the services required for PLHIV in 6 geographic focus areas in China.

Key Systems Barrier	Expected milestones 1-2 years	Outcomes expected after 3 years	Proposed ROP16 activity	Budget Code(s)	Budget (USD)	Associated IM ID	SID Element/Score?
Limited lab staff capacity at national and subnational levels in quality control and management	20 local staff trained by the end of year 1 on QC in accordance with international standards.	International quality control standards for HIV diagnostic testing performed outside of laboratory settings by non-lab staff are implemented in project field sites doing diagnostic testing	Training on laboratory network quality control (including MSM acute infection diagnosis and management)	HLAB	5,000	16622	B-6. Service delivery B-10. Laboratory
Limited lab capacity in alternate methods for HIV prevention among MSM	50 local staff in at least 3 PEPFAR focus areas trained on lay provider and quality self-testing kit administration, in compliance with WHO 2015 guidelines. 100 HIV testing kits collected and analyzed in 3 PEPFAR areas (600 total).B13 Molecular tracing data protocol developed, and data analysis on MSM HIV transmission completed with USG technical	Expansion of legal options in China for HIV testing that are convenient, patient-centered, and in a stigma-reduced environment, e.g. CFDA approval of HIV diagnostics kits; lay and self-testing kits promoted in HTC efforts by a local health department. Report/publication documenting findings on feasibility and impact of HCT expansion among	DBS and exploration on urine self-sample collection for HCT through different methods (pharmacy, volunteer, CBOs) among MSM	HLAB	30000	16622	B-6. Service delivery B-9. Quality Management B-10. Laboratory C-12. Technical and Allocative Efficiencies

	support.	MSM using different methods (pharmacy, volunteer, CBOs).					
		Incorporation of routine HIV diagnostic testing in STD clinics in PEPFAR project sites that conforms to quality control standards	Exploration and evaluation on the use of molecular tracing data to study HIV transmission among MSM	HLAB	20000	16622	B-10 Laboratory

Laos

Table 6.1.1b: Laos: Key Programmatic Gap #1: 1. Implementation of Test & Start Policy					
Key Systems Barrier	**Outcomes/ milestones expected during 3 years**	**Proposed ROP16 activity**	**Budget Code(s)**	**Budget (USD)**	**Associated IM ID**
1. 1 National approaches to HIV prevention and testing are not designed/nuanced/ targeted for young MSM. Stigma and	Year1: Expanded health facilities/community groups participating in the EPM activities and received training on RRTTR model Year1: Completed and implemented SOP and capacity building activities Year2: Number of health facilities/	1.1.a1 Implement and expand enhanced peer mobilizer model in all priority provinces 1.1.a2 Establish health-community HIV service provider network to support RRTTR/continuum of HIV services	HVCT HVOP OHSS	101,639 90,113 40,000	17860 (BMA_HTS) 17859 (PrEP2Start) 17309

discrimination towards KP still persists, limiting their accessibility to services	communities implemented innovative outreach models in 3 priorities provinces and expanded to the incentive fund implementation sites : Ongoing data collection and analysis for dissemination at national level for policy advocacy Year3: Effective innovative outreach models expanded and scaled up in the incentive fund implementation sites	1.1.a3 Capacity building of peer mobilisers 1.1.a4 Development of SOP 1.1.a5 Analysis of effectiveness of the model			LINKAGES
	Year1: Oral fluid HIV testing SOP developed : Developed oral fluid as a self- testing option materials and manuals : Draft policy and guidelines on oral fluid HIV test, follow up counselling measures appropriate for preventing adverse effects of self testing Year2: Oral fluid HIV testing SOP, guidelines integrated in national HIV management protocol : Policy on oral HIV testing launched	1.1.b1 Self testing approaches developed with an aim to increase HIV testing uptake among KPs 1.1.b1 Implementation of peer-supervised lay screening, self-screening using OraQuick in 3 provinces (Vientiane, Savannakhet and Champasak) to identify acceptable self-testing approaches for KPs 1.1 b3 Support policy development discussion in national fora through developed SOP, tools, QA/QI systems and relevant training for self-testing 1.1 b4 Conduct ongoing discussion among civil society organizations to inform development of SOPs, tools and guidelines for self-testing	HCVT OHSS	50,000 50,000	17309
	Year1: Developed S&D materials and site level policy and SOP addressing S&D : Completed baseline assessment in selected health facilities : Developed and implemented capacity building package for health facility and community providers Year2: Defined and packaged intervention model : Implemented S&D interventions	1.1.c1 S&D reduction assessment tools adapted for Laos 1.1.c2 Conduct S&D assessment using the adopted tools in selected facilities 1.1.c3 Generate ongoing dialogues among the health-community HIV service provider network at provincial level for integration of S&D reduction intervention model in national strategic plan 1.1.c4 Capacity strengthening activities for	OHSS	50,000	17815

	Year3: Stigma and discrimination reduction approaches developed and integrated in HIV service facilities	health facilities and community service providers			

Table 6.1.2b: Laos: Key Programmatic Gap #2: Newly established HIV program HMIS and surveillance systems for effectively used for program monitoring and planning and need maintenance for high quality data

Key Systems Barrier	Outcomes/ milestones expected during 3 years	Proposed ROP16 activity	Budget Code(s)	Budget (USD)	Associated IM ID
2.1 Newly established HIV information/data systems that require data quality assurance for optimal use of data related to HIV cascade for KPs and general PLHIV (CHAS3_MIS)	Year1: Drafted DQA protocol : Data review and QI workshop were conducted as planed (at least 2 times/Year) : Trained public health officers and HCWs on data use for program monitoring and QI plan development Year2: DQA protocol implemented : Improved data quality in HMIS (HIVCAM, MER) : Regular data reviewed conducted with stakeholders and data used for program/policy planning Year3: High data quality of HMIS systems designed to monitoring HIV cascade under Laos MOH system and made it available for public health care providers, technical officers, CBOs and related stakeholders access for program M&E and QI	2.1.a1 Monitor and develop DQA protocol for HIV data systems and tools to monitor HIV cascade across the KP and general PLHIV cohorts (link community recruitment and health facility services data) 2.1.a2 Establish regular data review and quality improvement plan on HIV programming and HMIS to enhance coordination for data management system and information sharing 2.1.a3 Provide capacity building and technical assistance to provincial public health staff, HCWs and community workers for how to access and use data for program monitoring and QI	HTXST HVCT HVSI OHSS	5,000 5,000 4,000 6,000	17858
2.2 Lack of right data and strategic information to support HIV service cascade	Year1: Expanded of eCascade system to better understand the social and behavioral characteristics of high risk individuals and to focus and improve client support across the continuum of care Year2: Expanded the eCascade system to make the social and behavioral risk data more representative of KP in the 6 priority provinces	2.2.a1 Expand of eCascade system to better understand the social and behavioral characteristics of high risk individuals and to focus and improve client support across the continuum of care	HVSI OHSS	80,000 20,000	17309

	Year3: Increased availability of data and other SI at local levels to fully understand reasons for drop-offs and for tailoring response to the populations and their needs and circumstances				
2.3 The national surveillance system needs to be strengthen	Year1: National surveillance protocols developed : Number of public health officers trained/participated to surveillance activities Year2: Data from surveillance used for policy/program planning (e.g. national strategic plan development) Year3: Available of effective national surveillance system to monitor HIV epidemics with provision of key evidences for policy and program planning at national and sub-national level : Laos MOH technical officers have capacity to maintain and effectively use data from the system for program planning	2.3.a1 Implement the revised IBBS model among MSM/TG/MSW 2.3.a2 Implement an innovative on-line behavioral surveillance among MSM/TG and young adults 2.3.a3 Build capacity on translation and utilization of surveillance data for impact analysis and program planning	HVSI	30,000	17858

Table 6.1.3b: Laos: Key Programmatic Gap #3: Lack of quality control and improvement for HTC and ART services					
Key Systems Barrier	**Outcomes/ milestones expected during 3 years**	**Proposed ROP16 activity**	**Budget Code(s)**	**Budget (USD)**	**Associated IM ID**
3.1 Quality of HIV counseling and testing service (HTS)	Year1: Number of HCWs trained on HTC and QI for HTC : Number / documentation of QI activities related to HTC, retesting before ART initiation Year2: Number of HCWs trained on HTC and QI for HTC : Number / documentation of QI activities related to HTC, retesting before ART initiation Year3: improved quality of HCT in facility	3.1.a1 Conducted QI workshop for HCT services staffs in priorities provinces 3.1.a2 Conducted HCT lesson learn workshop for staffs in priorities provinces 3.1.a3 Conducted HCT coaching and monitoring at sites in priorities provinces 3.1.a4Technical working group meeting	HBHC HVCT	30,000 30,000	17858

	based with National HIV quality system by provide technical support for capacity building on quality improvement of HIV counseling : Promote the capacities of re-testing at facilities before starting ART to get along with National policy				
3.2 Quality of HIV treatment and care in 11 ARV sites	Year1: Number of HCWs trained on ART coverage and viral suppression : Number / documentation of QI activities related to ART coverage and viral suppression Year2: Increased coverage of ART, retention and viral suppression in PLHIV Year3: Increased coverage of ART, retention and viral suppression in PLHIV	3.2.a1 Increase the rate of start ARV at any CD4 to all HIV positive patients diagnosed 3.2.a2 Skills-transfer coaching for HIV quality improvement and update knowledge for CHAS staffs and 11 ARV staffs for program sustainability 3.2.a3 Build capacity of participating ARV staffs on HIV QI program 3.2.a4 Share lesson learned and best practice for HIV QI project	HTXS	60,000	17858
3.3. Lack of reliable data to monitor the cascade of HIV prevention and care	Year1: Number of HCWs, public health officers participated to MIS training (data quality, data use) : SOP on data use developed : At least 60% ART sites and VCT sites reported on HTC and ART services through HIVCAM, MERS MIS Year2: At least 80% ART sites and VCT sites reported on HTC and ART services through HIVCAM, MERS MIS : Improved data quality and data use to monitor service performance at VCT and ART sites Year3: Available of an integrated system with reliable information used for monitoring of HIV related mortality and morbidity and the outputs and outcomes of hospital-based interventions (Focusing on	3.3.a1 MIS (MERS and HIVCAM) assessment (Data quality, system infrastructure and key factors for long-term sustainability) 3.3.a2 Revised SOP to improve data quality and sustainable system implementation) 3.3.a3- Provide training and field coaching for the revised SOP and the data quality improvement process. 3.3.a4 Develop and implement SOP on data use for monitoring of service deliveries and determination of areas needed for quality improvement 3.3.a5 Scaling up MERS for TB/HIV services and the linked data with HIVCAM for TB/HIV program monitoring	HTXST HVCT HVSI OHSS	5,000 5,000 4,000 6,000	17858

	VCT, care, ART and TB/HIV interventions in 3 priority provinces)				
3.4 Capacity of provincial leadership on HIV program management and the utilization of monitoring data to improve HIV interventions	Year1: Workshops/ training on data utilization led by Laos technical lead officers Year2: Improved in HIV cascade data in participating provinces : Provincial staff are capable to conduct regular performance data review Year3: Provincial public health officers, leaders and HIV program managers have capacity to use evidence-based decision and program planning to achieve 90x90x90	3.4.a1 Review and revise training curriculum of HIV program management for local leadership 3.4.a2 Organize training courses - Conduct post-training assessment to review the trainees' needs and factors related to their capabilities on utilization of SI for provincial program planning	OHSS	40,000	17858

Thailand

Table 6.1.1c Thailand: Key Programmatic Gap #1: 1. Implementation of Test & Start Policy					
Key Systems Barrier	**Outcomes and milestones expected during 3 years**	**Proposed ROP16 activity**	**Budget code(s)**	**Budget amount**	**IM**
1. 1: National approaches to HIV prevention and testing are not designed/nuanced/ targeted for young MSM. Stigma and discrimination towards KP still persists, limiting their accessibility to services	Year 1 - Expanded health facilities/community groups participating in the EPM activities and received training on RRTTR model Year 1 - Completed and implemented SOP and capacity building activities Year 2 - Number of health facilities/ communities implemented innovative outreach models in 6 priorities provinces and expanded to the incentive fund implementation sites Year 2 - Ongoing data collection and analysis for dissemination at national level for policy advocacy Year 3 - Effective innovative outreach models expanded and scaled up in the incentive fund implementation sites	- Implement and expand enhanced peer mobilizer model in all priority provinces - Establish health-community HIV service provider network to support RRTTR/continuum of HIV services - Capacity building of peer mobilisers - Development of SOP - Analysis of effectiveness of the model	HVCT HVOP OHSS	101,639 90,113 40,000	17860 (BMA_HTS) 17859 (PrEP2Start) 17309 LINKAGES
	Year 1 - Oral fluid HIV testing SOP developed	- Self testing approaches developed	HVCT	72,500	17309

	Year 1 - Developed oral fluid as a self- testing option materials and manuals Year 1 - Draft policy and guidelines on oral fluid HIV test, follow up counselling measures appropriate for preventing adverse effects of self-testing Year 2 - Oral fluid HIV testing SOP, guidelines integrated in national HIV management protocol Year 2 - Policy on oral HIV testing launched Year 3 - Self testing approaches developed with an aim to increase HIV testing uptake among KPs (USAID)	with an aim to increase HIV testing uptake among KPs - Implementation of peer-supervised lay screening, self-screening using OraQuick in 3 provinces (Bangkok, Chiangmai and Chonburi) to identify acceptable self-testing approaches for KPs - Support policy development discussion in national fora through developed SOP, tools, QA/QI systems and relevant training for self-testing - Conduct ongoing discussion among civil society organizations to inform development of SOPs, tools and guidelines for self-testing	OHSS	72,500	
	Year 1 - Expanded number of HCWs/hospitals/CBOs received sensitivity training in other provinces outside of the 6 focused provinces Year 1 - Provincial health facility-community service provider network forum/relationship established and formalized and regularly convened performance data review, situation analysis and implemented QI activities Year 2 - Increased skilled of HCWs, CBOs in working with KPs Year 2 - Increased in provincial network capacity in effectively monitored RRTTR implementation and QI activities (expanded in the incentive fund implementation sites in 13 provinces) Year 3 - Expanded provincial facility-community network model for effective RRTTR in priority provinces with evidence of improving KPs HIV treatment and care cascade and expanded in the incentive fund implementation sites in 13 provinces	- Conduct RRTTR and sensitivity training for HCWs and CBOs responsible in high HIV burden districts in priority provinces and network - Strengthen provincial network activities among communities, CBOs, health facilities, PHO, local government, and private sector - Collect and evaluate KP cascade data	OHSS HVSI	23,312 51,525	17860 BMA (BMA_Network) 17859 MOPH (PeEP2Start)
	Year 1 - Developed S&D materials and site level policy	- S&D reduction intervention models			

	and SOP addressing S&D Year 1 - Completed baseline assessment in priority provinces Year 1 - Developed and implemented capacity building package for health facility and community providers Year 2 - Defined and packaged intervention model Year 2 - Implemented S&D interventions Year 3 - Stigma and discrimination reduction approaches developed and integrated in HIV service facilities	developed to support improved access to HIV services among KPs - Generate ongoing dialogues among the health-community HIV service provider network at provincial level for integration of S&D reduction intervention model in community-led test and treat activities - Conduct S&D assessment in the priority provinces to determine S&D issues associated with leakages across the cascade - Capacity strengthening activities for health facilities and community service providers	OHSS	95,500	17815
	Year 1 - Established and formalized linkage and network between HTC and STI services in priority provinces Year 1 - Installed POC STI in all priority provinces Year 1 - Capacity building on application of POC STI Year 2 - Continued capacity building activities Year 2 - Analysis of effectiveness of referral networks from successful rate of STI treatment of those referred Year 2 - Disseminated results of analysis for advocacy Year 3 - Successful demonstration of community-led STI services for improving HIV cascade among KPs	- POC STI made available for STI control linked to HIV services - Capacity building for CBOs for the use of POC STI to strengthen STI diagnosis and treatment among KP - Support linkages across the HIV continuum of services from STI screening, diagnosis, STI treatment, HTC, PrEP and ARV treatment	HVOP	219796	17309
	Year 1 - Webpage/ website developed for MSM, TGW community are online and accessed Year 1 - Page viewed, number of participation to online activities Year 2- Increased in number of webpage/ website viewed developed for MSM, TGW community are online and accessed Year 2 - Page viewed, number of participation to	- Demonstrate of an online recruitment to offline recruitment and testing model, particularly focused on younger MSM and those who use social media (CDC+USAID) - Promote of young MSM, TG using virtual clinic online as a reach/recruit strategies	HVOP HVCT HVCT OHSS	11,209 13,451 152,250 65,250	17859 MOPH (Young MSM) 17309

	online activities Year 2 - Increased uptake of HTC among those reached online Year 3 -Improved marketing of HIV testing services that are designed for target populations (e.g. young MSM/TG)				
1.2: No system in place for certification of HIV rapid testing and QA/QC for mobile and community-based HTC settings	Year 1 - HIV rapid testing (POCT) by community health workers training curriculum developed Year 1 - One pilot training conducted Year 1 - Certification criteria and program for HIV POCT by community health workers developed Year 1 - EQA program developed Year 2 - Increased capacity and competency among community-based sites to perform HTC services Year 2 - Established ToT network (regional DMsc trainers) Year 2 - Increased number of community-based setting certified for conducting HIV clinical services, including HTC Year 2 - All community-based sites supported by PEPFAR be part of the evaluation of the Medical Science and National Health Security Office Year 3 - All community-based sites supported by PEPFAR certified by relevant bodies to enable them to reimburse associated costs	- Develop training program for community health workers to perform qualified rapid HIV testing in mobile or community-based settings (DiCs) - Improve quality of POCT rapid HIV testing - Develop certification program for community-based HIV testing - Prepare the EQA program toward laboratory accreditation - Identify relevant evaluation bodies (Medical Science Department and National Health Security) and engage them for establishing certification processes for community-based sites - Develop training curriculum for community health workers to perform HIV rapid testing with same day result - Conduct training for community health workers in priority area - Train regional laboratory science center to provide coaching support to community health workers in their responsible area	HLAB	10,000	17859 MOPH (Lab_policy)

1.3 Delay in/disruption of HIV services including treatment services due to limitations in eligibility criteria by geographic locations where clients are registered under the national insurance schemes	Year 1 - Gathering of data to support the magnitude of service disruption, and key barriers Year 1 - Working group formed to develop policy/ recommendation for addressing services gaps due to insurance issue Year 1 - Assessment results of "case manager" on getting service costs (for pre-ART) reimbursed Year 2 - Policy paper developed to allow access to HIV services for all regardless of their designated geographic location Year 2 - Policy dialogue initiated to explore possible approaches to resolve costs not currently covered under the current insurance scheme (lab and x-ray costs for pre-ART) Year 3 - Available mechanisms for lab screening cost reimbursement and/or policy change to support baseline checkup cost reimbursement	- Systematically collect and analyze data and good practices (SOPs, tools, training packages for community-based HIV service providers) from priority provinces to support national insurance policy improvement i.e. national universal coverage, social security insurance scheme (SSS) - Establish/support 'Case Manager' system both within the health facilities or/and community organizations to facilitate and support insurance coverage or/and financial support for KPs across sites/provinces	HVSI HVSI OHSS	38,571 35,000 35,000	17859 17860 MOPH (PrEP2Start) BMA_Cascade, BMA_HTS 17309
1.4: Lack of effective funding mechanism for community led activities or CBO	Year 1 - Working group on funding mechanism established Year 1 - Data on barriers of funding to CBOs were compiled Year 1 - Proposed funding mechanism were drafted and tested Year 2 - Expansion of effective mechanism training to other provinces or revisit proposed mechanism to assess the success Year 3 - Available funding mechanisms for CBOs, NGO to conduct RRTTR for KP communities at provincial level	- Engage stakeholders and policy champions through different channels including site visits, policy dialogues (e.g. NHSO, SSS, PHO, health facilities, CBOs, PLHIV rep) for developing and adoption of mechanisms to sustainably address issues of health coverage - Synthesis of provincial best practices and explore possibilities of local resource mobilization - Engage provincial and central stakeholder to develop mechanism, protocol to pilot test the mechanism and evaluate outcomes - Strengthen provincial network among PHO, CBOs, health facilities, local government, private business through	OHSS HBHC HVTB HVSI	37,000 25,929 4,321 50,606	17859 17860 MOPH CARE Policy MOPH (PrEP2Start) MOPH (PrEP2Start) MOPH (PrEP2Start) BMA Network

		provincial AIDS committee, provincial coordinating mechanism etc.			
1.5 Low rate of ART initiation in HIV-positive infants and high death rate	Year 1 - Routine data report to the quarterly advisory committee meeting by MOPH staff Year 1 - 70% of HIV-infected infants start ART within 6 month Year 2 - Routine data report to the quarterly advisory committee meeting by MOPH staff Year 2 - 75% of HIV-infected infants start ART within 6 month Year 3 - Maintained active case management system for HIV-positive infants and immediately start ART >80% of HIV by routine MOPH system	- Active Case Management Network for early antiretroviral treatment in HIV-infected infants aiming for cure	OHSS PDCS PCTX	19200 22400 22400	17859 MOPH(Care_ACC)
1.6 Lack of comprehensive clinical service models appropriate for TG population	Year 1 - Completed needs assessment Year 1 - Defined intervention health service package for TG Year 1 - Routine dashboard for data presentation of TG service coverage Year 2 - Ongoing analysis of clinical data of TG clients Year 2 - Expanded capacity building activities to other sites for appropriate services for TG Year 2 - Dissemination of service model to other provinces and countries Year 3 - Increased access to HIV and health services among TG populations Year 3 - HIV services model developed for TG populations	- Conduct a needs assessment on health seeking behaviors among TG populations at the TANGERINE Clinic - Identify appropriate services for TG that contribute to improved HIV cascade among TG - Package proven models to be shared and disseminated nationally and internationally	HVOP HVCT HBHC HTXS OHSS	40,500 40,500 40,500 40,500 40,500	17309

Table 6.1.2c Thailand: Key Programmatic Gap #2: Need for harmonized HIV program HMIS system and high quality and reliable surveillance systems for effective program planning, monitoring, and QI					
Key Systems Barrier	**Outcomes and milestones expected during 3 years**	**Proposed ROP16 activity**	**Budget code(s)**	**Budget amount**	**IM**
2.1 Several information/data systems in place that require harmonization for optimal use of data related to HIV cascade for KPs	Year 1 - Linkage of disparate KP clinical reporting systems, including viral load, ART, HIV testing, into the national HIV reporting system Year 1 - Piloted the approach in Bangkok Year 2 - Expanded the system linkages to other priority provinces Year 2 - Utilized KP clinical data from the national HIV system to support HIV cascade monitoring Year 3 - Available of routine and integrated HMIS system for monitoring of HIV related mortality and morbidity, 90x90x90 and the outputs and outcomes at hospital-based services deliveries, sub-national and national level for Thai and non-Thai population Year 3 - Minimize duplicated workload of hospital staff on reporting of data to multiple public health programs and surveillance	- Consolidate and design data systems and tools to monitor HIV cascade across the KP and PLHIV cohorts - Strengthen provincial single plan/coordination mechanism on HIV programming and HMIS to enhance coordination for data management system and information sharing - Provide capacity building and technical assistance to provincial public health staff, HCWs and community workers for how to access and use data for program monitoring and QI	HVSI OHSS	115,715 12,857	17859 17860 MOPH SI_MIS_utilization BMA (BSI) MOPH (SI_MIS_CARE) BMA (BSI)
2.2 Lack of data about barriers to ART retention and treatment failure at national and sub-national level	Year 1 - Number of HCWs/hospitals trained on QA/QI process focused on ART retention and treatment failure Year 1 - Number of QI activities conducted to address ART retention and treatment failure Year 2 - Expansion of hospitals implementing QA/QI Year 2 - Improvement of retention and treatment failure outcomes Year 3 - Available of monitoring system and increased capacity of public health technical teams at regional and provincial level to use data and manage their	- Analyze patient charts and patient data to assess barriers to ART retention and treatment failure - Establish and build capacity of regional and provincial technical team to coach health and community care providers to improve data quality and utilization to increase ART retention and prevention of HIVDR - Support conduct of QA/QI process focused on ART retention and			

	responsible program to achieve 90x90x90 goal	treatment failure			
2.3 Lack of right data and strategic information to understand the true risk and yield of different MSM/TG (hard-to-reach) populations	Year 1 - Expanded the eCascade system to make the social and behavioral risk data more representative of KP in the 6 priority provinces Year 2 - Expanded the eCascade system to make the social and behavioral risk data more representative of KP in the 6 priority provinces and the incentive fund provinces Year 2 - Expanded the coverage of services to capture the high risk populations identified in the eCascade system Year 3 - Increased availability of data and other SI at local levels to fully understand reasons for drop-offs and for tailoring response to the populations and their needs and circumstances	- Expand of eCascade (formerly CommCare) system to better understand the social and behavioral characteristics of high risk individuals and to focus and improve client support across the continuum of care	HVSI OHSS	50,000 50,000	17815
2.4 Insufficient number of skilled public health officers to maintain national HMIS, surveillance system(s) and regular update size estimation/projecti on for number of PLHIV and KPs	Year 1 - Revised IBBS protocol/manual Year 1 - Number of public health officers trained on revised IBBS protocol Year 2 - Implementation of revised IBBS Year 2 - Data available for program planning for national and sub-national level Year 2 - Update data on KP size estimation Year 3 - Increased number of skilled public health officers and capacities to maintain national surveillance system(s) and use epidemiological data for policies/programs planning and improvement Year 3 - Available of data for monitoring of HIV epidemics, outcome and impact indicators in priority provinces and at national level Year 3 - Availability of KP estimation data at national and sub-national level	- Implement the revised IBBS model among MSM/TG/MSW and male military conscripts - Implement an innovative on-line behavioral surveillance among MSM/TG and young adults - Build capacity on translation and utilization of surveillance data for impact analysis and program planning - Support and train junior Thai public health officers to perform size estimation projection for KPs and PLHIV for national and sub-national level	HVSI OHSS	90,000 10,000	17859 MOPH SIMIS_Surveillance
2.5 Incomplete viral load test result data	Year 1 - Identified linkage of viral load data with individuals from the lab databases and routine HIV	- Strengthen and promote laboratory quality improvement program and	HLAB	41,742	17859 17860

in the current national database system due to delay in result entry may bias the interpretation of treatment outcomes at national and sub-national level	reporting system of different hospitals Year 1 - Pilot the information systems linkage approach in Bangkok Year 2 - Increased complete list of viral load data with other HIV data at national level Year 2 - Expanded the linkage system to other priority provinces Year 2 - Utilized viral load data to support HIV cascade monitoring Year 3 - Increased viral load test results in the national HIV monitoring system and viral load data is available/ more reliable to monitoring HIV treatment outcomes and evaluation of impact	laboratory network among laboratories and key stakeholders within each province to support HIV care and treatment - Strengthen laboratory quality management system among laboratories within the province for laboratory accreditation - Promote and improve utilization of laboratory data among laboratory network to improve HIV services - Strengthen laboratory program monitoring and evaluation			MOPH(Lab_CARE) BMA(BMA_Lab)

6.2 Critical Systems Investments for Achieving Priority Policies

China

Table 6.2.1 Key Policy 1: Test and Start							
Key Systems Barrier	**Expected milestones 1-2 years**	**Outcomes expected after 3 years**	**Proposed ROP16 activity**	**Budget Code(s)**	**Budget (USD)**	**Associated IM ID**	**SID Element/Score?**

Delays in national level approval for Test and start guidelines with NHFPC for final approval	Test and start guidelines formally approved by National Health and Family Planning Commission by end of 2016. Revised test and start policy announced in China, and dissemination to PEPFAR provinces as evidenced by NCAIDS and provincial level discussion of policy implementation at annual meetings.	Evaluation of policy implementation illustrates notable increase in number of MSM PLHIV initiated onto ART by providers regardless of CD4 (Increase in # of MSM PLHIV initiated on ART with CD4>500) at PEPFAR supported ACC Better Clinics. 90% of beneficiaries at PEPFAR sites report increased access to ARVs immediatley after diagnosis and regardless of CD4 count.	Train staff on national treatment guidelines and service skill	HBHC, HTXS	6400	AIDS CARE CHINA 16576	A-2. Policies and Governance B-6. Service delivery
	80% of local CDC and CBO staff report awareness and use of test and start guidelines, supported by SIMS observations at PEPFAR supported provinces.		Training on data analysis/use, and protocol development (NCAIDS);	HVSI	50000	China CDC/ NCAIDS 16622	B-9. Quality Management C-12. Technical and Allocative Efficiencies D-15. Performance Data

Table 6.2.2 Key Policy 2: New and Efficient Service Delivery Models in PEPFAR Supported areas

Key Systems Barrier	Expected milestones 1-2 years	Outcomes expected after 3 years	Proposed ROP16 activity	Budget Code(s)	Budget (USD)	Associated IM ID	SID Element/Score?
Limited coordination and staff capacity among CBOs, local CDC, and ART clinics for timely implementation and evaluation of MSM comprehensive	CDC and CBO staff at national and subnational levels can articulate a clear mechanism for engaging feedback in planning, implementation, and evaluation of MSM	Improved coordination observed and reported among supported CBOs with CDCs and clinics applying models Increase in median CD4 at diagnosis among	Pilots on MSM comprehensive interventions, including early test and start, use of STD clinic platform, contact tracing and partner notification services, and ICT/new media	HBHC	75,000	China CDC/ NCAIDS 16622	B-6. Service delivery B-9. Quality Management

intervention package	comprehensive HIV interventions in PEPFAR areas as evidenced by end of year 2 via China CARES program annual meeting. At least 2 CBO-CDC partnerships for test and start with co-funding established, with documented referral mechanism (SOP) to local STD and ART clinics. Annual planning meetings at local CDC level demonstrate CBO participation. Local CDC implementation plans mention coordination and funding mechanisms for engaging CBOs.	persons newly-diagnosed with HIV, esp MSM, in project areas Increased proportion of HIV-diagnosed linked to care compared to baseline Increased proportion of persons on ART retained in care 12 months after initiation compared to baseline Increased % of persons with viral suppression at first viral load test conducted.	Comprehensive care and support service for PLHA at 8 RRC in Yunnan and Sichuan	HBHC	88549		B-6. Service delivery B-9. Quality Management
			Provide HIV/STI/OI diagnosis and treatment, care and management of PLHA at 2 Better Clinics in Yunnan	HBHC	48457	AIDS CARE CHINA 16576	B-6. Service delivery B-9. Quality Management

2.2 Lack of technical capacity to fully deploy PrEP in Thailand; PrEP is not free in Thailand	2.2.1: Successful demonstration of a cost-effective model for PrEP with results broadly disseminated; 2.2.2: PrEP drugs are free in national health insurance scheme 2.2.3: SOP, tools and guidelines for PrEP criteria (eligibility criteria for PrEP, screening tool to exclude acute HIV infection etc.)	- Demonstration of service models for PrEP in demonstration sites - Economic evaluations for PrEP scale-up - Implementation of community-led PrEP services and Princess PrEP (CBO led and public health led) - Evaluation on feasibility and acceptability (e.g. populations, risk factors) of PrEP services - Policy development for PrEP, STI and strengthen STI and HCV services for KPs	- Launch of PrEP provision among KPs in community-based sites - Community forum convened prior to piloting, and throughout the implementation - Training package and coaching strategy developed and implemented - Implemented PrEP provision at community-based sites in 1-2 provinces - Routinely collected uptake, acceptability and factors influencing uptake of PrEP among KPs	- Expanded community-based sites in other priority provinces – Ongoing capacity building and coaching - Evaluated feasibility of PrEP provision by community-based sites - Disseminated results for broader implementation and integration of PrEP into the national system

Laos

Table 6.2.2b Laos: Key Policy 2: Optimization of service delivery model					
Key Systems Barrier	**Outcomes and milestones expected during 3 years**	**Proposed ROP16 activity**	**Budget Code(s)**	**Budget Amount (USD)**	**IM**

2.2.1 Current policy and practices do not fully follow current WHO for optimizing treatment services	Year 1 - Technical working group to revise national guidelines convened Year 1 - Draft revised national guidelines developed, reviewed and approved Year 2 - Revised national guidelines that integrated WHO optimization services has adopted and published/disseminated Year 3 - New policy launched/revised national HIV management guidelines to recommend less frequent ART pick up, CD4 at entry and annual viral load thereafter Year 3 - SOP, guidelines and tools for health/community care providers to classify stable clients for less frequent ART pick up	1. Work with Laos MOH to revise the national guidelines to recommend less frequent ART pick up: pilot less frequent ART pick-up, CD4 at entry and annual viral load thereafter with POC VL in community-based settings	HTXS	10,000	17858

Thailand

Table 6.2.1c Thailand: Key Policy 1: Optimization of service delivery model by less frequent ART pick up and more effective PrEP programming					
Key Systems Barrier	**Outcomes and milestones expected during 3 years**	**Proposed ROP16 activity**	**Budget code(s)**	**Budget amounts**	**IM**
2.1 Current practices do not fully follow current WHO/Thai national guidelines for optimizing treatment services	Year 1 - A set of criteria identified for potential clients as part of a strategy and SOP/guidelines development for less frequent visits to collect ART Year 1 - Installed POC VL in all community-based sites in priority provinces Year 1 - Capacity building package developed and implemented Year 1- Piloted the strategy in 1-2 sites Year 1 Communication strategy developed for dissemination of the findings and lessons learned at national level	- Demonstration of quarterly or less frequent and community dispensing: pilot less frequent ART pick-up with POC VL in community-based settings - Generate more contextual evidence/data to support review of existing identification and criteria of 'stable clients' for less frequent ART follow up for SOP and tool developments to support acceptability of treatment optimization approaches/practices	OHSS HTXS HVOP OHSS HVOP	$20,000 633,811	17859 MOPH (Policy) (PrEP2Start) 17309

	Year 2 - Expanded pilot sites in other priority provinces Year 2 - Evaluated factors contributing to successful implementation of the strategy Year 2 - Cost-saving analysis conducted to support broader implementation Year 2 - Supported policy dialogues for scale up of the strategy Year 3 – Obtained contextual evidence to support less frequent visit, community ART dispensing and POC VL in community-based settings Year 3 - New policy launched/revised national HIV management guidelines to recommend less frequent ART pick up and community-based dispensing of ART Year 3 – Completed SOP, guidelines and tools for health/community care providers to classify stable clients for less frequent ART pick up				
2.2 Lack of technical capacity to fully deploy PrEP in Thailand; PrEP is not free in Thailand	Year 1 - Launch of PrEP provision among KPs in community-based sites Year 1 - Community forum convened prior to piloting, and throughout the implementation Year 1 - Training package and coaching strategy developed and implemented Year 1 - Implemented PrEP provision at community-based sites in 1-2 provinces Year 1 - Routinely collected uptake, acceptability and factors influencing uptake of PrEP among KPs Year 2 - Expanded community-based sites in other priority provinces – Ongoing capacity building and coaching Year 2 - Evaluated feasibility of PrEP provision by community-based sites Year 2 - Disseminated results for broader implementation and integration of PrEP into the national system	- Demonstration of service models for PrEP in demonstration sites - Economic evaluations for PrEP scale-up - Implementation of community-led PrEP services and Princess PrEP (CBO led and public health led) - Evaluation on feasibility and acceptability (e.g. populations, risk factors) of PrEP services - Policy development for PrEP, STI and strengthen STI and HCV services for KPs	HBHC HTXS HVCT HVOP HVOP	19,393 19,393 38,786 38,786 150,000	17859 MOPH (PrEP2Start) MOPH (Policy) 17309

	Year 3 - Successful demonstration of a cost-effective model for PrEP with results broadly disseminated; Year 3 - PrEP drugs are free in national health insurance scheme Year 3 - SOP, tools and guidelines for PrEP criteria (eligibility criteria for PrEP, screening tool to exclude acute HIV infection etc.)				

6.3 Proposed system investments outside of programmatic gaps and priority policies.

China

Table 6.3.1 China: Other Proposed Systems Investments							
Activity	**1st 90; 2nd 90; 3rd 90; or Sustained Epi Control?**	**Expected milestones 1-2 years**	**Outcomes expected after 3 years**	**Budget (USD)**	**Budget Code(s)**	**Associated IM ID**	**SID Element/Score?**
HRH - Systems/Institutional Investments							
PPMPT training and personnel development support	1,2,4	At least 16 health care workers trained in PPMTP by NCAIDS with USG TA.	All PEPFAR focus provinces can report having at least 3 staff who have received PPMTP training from NCAIDS. Increase in KSA of PPMTP trainees in comprehensive HIV program design, management and M&E	8,500	OHSS, HBHC, HTXS, HVSI, HLAB	China CDC/ NCAIDS 16622	B-7. Human Resources for Health

Personnel salary (program assistants) and office supplies	4	CDC staff in 4 of 5 PEPFAR focus areas and NCAIDS divisions are trained in project implementation and supervison, and can articulate understanding of PEPFAR planning and reporting requirements and tools, including program management database, SIMS, and MER.	Increase in KSA of staff trained and supported at site and above sites	100,000	OHSS, HBHC, HTXS, HVSI, HLAB	China CDC/ NCAIDS 16622	B-7. Human Resources for Health
Inst & Org Development							
Trainings to strengthen HRH and disseminate of China's experiences, including south to south collaboration, leadership, and provincial program management training program (PPMTP)	4	2 annual trainings conducted that address prioritized technical needs on size estimation, data utilization, contact tracing, and self testing quality control from NCAIDS and subnational CDCs. 3 stakeholders meetings held on south to south, including NCAIDS communication and documentation of proposed plans and USG technical support needs.	Demonstrated increase in KSA of trainees and progress on south to south collaboration through partnership and planning meetings with NCAIDS	30,000	OHSS	China CDC/ NCAIDS 16622	B-9. Quality Management C-12. Technical and Allocative Efficiencies D-15. Performance Data
Strategic Information							
Qualitative data analysis Training	4	80 health care workers from 1-2 focus provinces and national level receive 6 days training using available qualitative data.	Improved HIV response based on utilizatin of quantitative and qualitative data in the five project provinces	50,000	HVOP	TBD	B-7 Human Resources for Health D-13 Epi and Health Data

Review on death cases of children who were exposed to HIV	2,4	3 PMTCT-related discussions and meetings held, and review of staff time includes technical consultation for reviews, data analysis, utilization and reports with NCWCH.	Data analysis complete and findings utilized towards measureable revisions in national policy	5,000	MTCT	China CDC/ NCAIDS 16622	A-2 Policies and Governance D-13 Epi and Health data D-15. Performance Data
Systems Development							
Collect feedback from facility partners of RRC and coordinate linked services	2,3,4	Supported staff report 25% of time spent on site meetings/visits and technical consultation to improve HIV services (referrals, linkages to care, and coordiantion with CDC) at 10 field sites.	Feedback collected and integrated into documented improved referrals and coordinated services at 2 facility sites	22,890	HBHC HTXS HVSI	AIDS CARE CHINA 16576	B-6 Service delivery B-9 Quality Management

Laos

Table 6.3.1 Laos: Other Proposed Systems Investments						
Systems Category	Outcomes expected after 3 years	Activity	1st 90; 2nd 90; 3rd 90; or Sustained Epi Control?	Budget (USD)	Budget Code(s)	Associated IM ID
Laboratory						

Strengthen the quality of HIV testing and quality assurance program (WHO1_Lab)	Year1: A manual on Preparation of HIV serology EQA program drafted : 25% of HIV testing facilities participate in HIV EQA program Year2: A manual on Preparation of HIV serology EQA program finalized : 50% of HIV testing facilities participate in HIV EQA program Year3 50% of HIV testing facilities participate in HIV EQA program : Available information of the performance of laboratories through the results of HIV EQA program for program intervention and improvement	* Increase the coverage of HIV EQA program to all testing facilities within the focused provinces * Skills-transfer coaching and quality monitoring of transferred knowledge and technology for the NCLE staff to operate the national HIV EQA program for program sustainability * Develop a manual of preparation of HIV serology EQA program * Build capacity of participating laboratory staff on effective use of EQA data to monitor and improve the quality of laboratory diagnostics through training and site supervision * Improve EQA information system using a database management system	3rd 90	HLAB	$20,000	17092
Strengthen system on HIV/TB co-management (Active HIV Case Finding and HIV/TB Treatment) (WHO2_TB)	Strengthen system on TB/HIV co-management	• Improved screening for HIV among TB patients • Improved TB screening among HIV patients • Improved co-treatment for TB and HIV among TB/HIV co-infected persons	3rd 90	HVCT HVTB	$8,100 $5,400	17092

Thailand

Table 6.3c Thailand: Other Proposed Systems Investments						
Systems Category	Outcomes / milestones expected during 3 years	Activity	1st 90; 2nd 90; 3rd 90; or	Budget Code(s)	Budget	Associated IM ID

			Sustained Epi Control?			
HRH - Systems/Institutional Investments						
Integration of the International Training Center (ITC) to International Disease Control Academy (IDCA)	Year1: Government integration, and budget plan developed Year1: Availability of training curricula related to HIV policy advocacy, stigma and discrimination reduction and the other HIV/STI related program management Year2-3: Personnel and management system under government system and self-sustained by own funding	Develop transition plan to establish the international disease control academy to be a training center under regular government system (Office of International Cooperation, DDC, MOPH) for HIV and other infectious diseases for Asian and Pacific country	Sustain HIV epidemic control	OHSS	30,000	17859
Laboratory						

Strengthening and improve the quality of national External Quality Assessment programs (LAB_TB_EQA)	Year1: Protocol for TB EQA program : Government TB staff trained on TB EQA program Year2: TB reference lab conducted TB EQA program : 50% TB lab participated to TB EQA program Year3: 100% of TB lab participated to TB EQA program : Sustainable and high quality national EQA programs for TB	• Capacity building MOH staff on establishment and operating a national TB EQA program • Build capacity of participating laboratory staff on effective use of EQA data to monitor and improve the quality of laboratory diagnostics • Strengthen and improve the quality of EQA program management in compliance with the international quality standards • Strengthen and improve Laboratory quality management system for accreditation	3rd 90	HLAB	20,000	17859
Improving the HIV cascade through stronger laboratory quality improvement and management systems (LAB.Network.CNBR)	Year1: Laboratory network for QM/QA developed : Conduct lab assessment and QI activities : Implement QI plan in at least 60% of participating Year2.: Implement QI plan in at least 80% of participating laboratories Year3: At least 80% of laboratory in CB network certified through national lab accreditation system	•Strengthen laboratory program management within Chonburi province on HIV testing, care and treatment through a provincial laboratory committee and technical working group to monitor and manage program activities •Strengthen and improve Laboratory quality management system for accreditation •Strengthen laboratory network to facilitate program implementation and quality improvement activities through site assessment and supervision •Capacity building and strengthening laboratory quality	90-90-90	HLAB	12,000	17859 MOPH

		improvement and data utilization to improve efficiency of HIV care and treatment •Coordination among laboratories and VCT clinics within the hospital to promote 90-90-90 goals •Efficient use of laboratory data to increase efficiency and coverage of HIV treatment and care •Strengthen program monitoring at site level to improve quality of laboratory information system to improve HIV services				
Strengthening and improve the quality of national External Quality Assessment programs (STI) (CARE_LAB.EQA)	Year1: Lab EQA for STI protocol developed and implemented Year2: Expand STI EQA program in at least 50% of STI laboratories Year3: Sustainable and high quality national EQA programs	•Capacity building MOH staff on establishment and operating a national Syphilis EQA program •Strengthen and improve the EQA program management through a national Syphilis EQA program committee and technical working group to monitor and manage program activities •Improve information and EQA database system through a web base EQA program •build capacity of participating laboratory staff on effective use of EQA data to monitor and improve the quality of laboratory diagnostics •Strengthen and improve the quality of EQA program management in compliance with the international quality	3rd 90	HLAB	12,800	17859

		standards				
Quality improvement systems						
Quality Improvement systems	Year1: National coaching team composed and trained on how to coach RRTTR Year2: More than 80% of requested coaching to participating hospitals have accomplished Year 3: HIV QI integrated into routine hospital QI team/ accreditation system : 70% of participating hospitals received coaching and certification : National coaching teams to support RRTTR implementation	3.1.a1. Work with Thailand Health Facilities Accreditation Institute (HAI) and BATS to promote HIV CQI and RRTTR approach in the hospital accreditation system (so call Disease Specific Certification, DSC) 3.1.a2. Train and support national coaching teams to provide support to hospitals to be able to implement effective RRTTR and get certification through HAI system	Sustained epidemic control (Quality improvement)	HBHC HVCT HVSI OHSS	30,000 15,000 5,000 50,000	MOPH_Care_Coach

7.0 Management, Operations, and Staffing Plan

An analysis of the ARP staffing footprint via tools developed internally and by OGAC confirmed that ARP's staffing is, for the most part, a sufficient mix of business and programmatic positions, focused on priority technical areas while ensuring that PEPFAR priorities are achieved. Changes did occur among all agencies, resulting in an overall decrease of the staffing footprint from ROP 15.

Adjustments were made to align staffing with technical and administrative priorities while recognizing the limited fiscal environment. PEPFAR China will drop 12 partially funded administrative positions (shared with other CDC China programs to ensure logistics support) and also cut the HIV Advocacy position, vacant since August, 2015. USAID will hire two additional 100% FTE FSNs to fulfill PEPFAR requirements and business processes. CDC Thailand is dropping three 100% FTE FSNs, vacant for some years.

As for current vacancies, China's Epidemiology & Strategic Information Chief position, vacant since 2012, has been difficult to fill due to low salary. The position will be key to leading the MSM cohort study, an important part of China's ROP. It will be filled by promotion or repeated recruitment. USAID will fill the two new FSN positions mentioned above. They will provide both technical and program management support/USAID also has a partially-funded FSM admin position vacant and non-PEFPAR funded USDH, both to be filled this FY.CDC Thailand will fill three vacant FSN positions- an SI Senior Epidemiologist, a Special Populations Coordinator and a Performance Monitoring and Reporting Coordinator. The latter is awaiting CAJIng at the Embassy, while the other two will go for CAJing and announcement in the coming months of FY 16. CDC Thailand filled two of its vacant positions from ROP 15.

Within the TA/TC ARP context, PEPFAR China's USG staff will provide continual TA to the national level, joint TA with national staff to priority geographic areas and quarterly monitoring to field. As in the past, there will be three staff leading SIMS and SIMS 2.0 visits will be integrated with regular travel to sites. As for USAID, TA to GF programs, other regional PEPFAR programs and host country governments will be provided through USG staff while TA in other areas, to varying degrees, will be provided by both USG staff and implementing partners. CDC Thailand/Laos uses its technical cadre of primarily FSN staff to deliver TA in priority technical and geographic areas. Thai government staff (IM partner) also provides ad hoc TA to other regional governments. Existing USG staff from USAID and CDC Thailand/Laos will conduct required SIMS visits.

There are minor changes to agencies' CODBs from ROP 15. PEPFAR China has a net decrease of $150k, due to a moderate cut in institutional contractor and ICASS costs to offset the increase in 1) salaries and benefits for existing USG staff and 2) grant funding level to the primary implementing partner, NCAIDS/China CDC, for the new collaborative MSM cohort study. USAID's CODB is expected to be increase ($102k) due to the addition of two new staff while CDC Thailand/Laos has a reduced CODB ($255k) from ROP 15, due to dropping three FSN positions and reducing travel.

APPENDIX A

China

Table A.1: China: Program Core, Near-core, and Non-core Activities for ROP16/FY17			
Level	**Core**	**Near-core**	**Non-core**
SITE	Preventing new cases of HIV and improving access and linkages to care and treatment by supporting the Tianjin MSM bathhouse project in Tianjin and Xinjiang		
	Strengthening MSM population size estimation using RDSA in Guangxi (training and implementation)		
	Piloting MSM comprehensive interventions, including early test and early treatment services in Hunan and Guizhou; using STD clinic platforms for MSM testing and intervention in Xinjiang; Contact tracing and notification services for MSM in Guizhou, Guangxi and Hunan	Piloting MSM comprehensive interventions, including early test and early treatment services in Beihai, Guangxi	
	MSM Cohort analysis to longitudinally follow and estimate key population size, HIV seroprevalence, HIV incidence, and factors associated with HIV cascade entry and retention		
	Training on laboratory network quality control (for improvement of MSM acute infection management) in Guangxi		
	Exploration and evaluation on the use of molecular tracing data to study HIV transmission among MSM, CD4 dried power reagents in Yunnan, incidence rapid test in Yunnan		
	Expanding HTC services and building laboratory capacity via dried blood spot and urine self-sample collection through different models (e.g. pharmacy, volunteer, and CBOs) among MSM in Yunnan, Guangxi, Hunan		
	Identifying factors and barriers to inform a tailored approach for MSM cascade entry in Guiyang (formative assessment)		
	Strengthening HIV surveillance and partner capacity for data analysis and utilization, particularly in program planning		
SUB-NATIONAL	Various trainings and technical consultation to strengthen MSM CBO capacity, including pilots using web-based technology for advocacy, web-based HCT reservation and confirmation in Xinjiang, communication skills improvement in Guizhou, and a pilot on comprehensive MSM intervention in Yunnan. This includes the development of MSM positive people mobilization implementation plans, protocol design, and strengthening care linkages via PLHIV follow up files in Yunnan		
	Training on laboratory network quality control (for improvement of MSM acute infection management) in Guangxi		

	Program planning and experience exchange annual meetings to strengthen local CBO-CDC learning, communication, and coordination for MSM outreach and HIV control		
	Development of HIV advocacy materials for middle and high schools, and universities among MSM in Guizhou		
	Exploration and evaluation on the use of molecular tracing data to study HIV transmission among MSM, CD4 dried power reagents in Yunnan, incidence rapid tests		
	Expanding HTC services and building laboratory capacity via dried blood spot and urine self-sample collection through different models (e.g. pharmacy, volunteer, and CBOs) among MSM in Yunnan, Guangxi, Hunan		
	Strengthening HIV surveillance and partner capacity for data analysis and utilization, particularly in program planning		
NATIONAL	Surveys in various areas, including analysis on concerns and the use of new media with MSM CBOs through web-based questionnaires; status of TB/HIV coinfection via different transmission modes, including impact on efficiency of ART; key factors for HIV transmission among MSM through contact tracing and drug resistance evaluation in focus provinces		
	Monitoring and evaluation visits and handbook development		
	Program planning and experience exchange annual meetings to strengthen local CBO-CDC learning, communication, and coordination for MSM outreach and HIV control		
	Trainings to strengthen HRH and disseminate of China's experiences, including south to south collaboration, leadership, and provincial program management training program (PPMTP)		
	Review death cases of children who were exposed to HIV to analyze associated factors and strengthen PMTCT policy and programs		
	Exploration and evaluation on the use of molecular tracing data to study HIV transmission among MSM, CD4 dried power reagents (National AIDS Reference Lab)		
	Support to the Chinese Association of STD/AIDS Control and Prevention on development of comprehensive service handbooks, advocacy on technologies and policies, experience exchanges to improve participation, capacity of and coordination with MSM CBOs		

Table A.2: China: Program Area Specific Core, Near-core, and Non-core Activities for ROP16/FY17

	Core	Near-core	Non-core
PREVENTION	Preventing new cases of HIV and improving access and linkages to care and treatment by supporting the Tianjin MSM bathhouse project in Tianjin and Xinjiang		

	Piloting MSM comprehensive interventions, including early test and early treatment services in Hunan and Guizhou; using STD clinic platforms for MSM testing and intervention in Xinjiang; Contact tracing and notification services for MSM in Guizhou, Guangxi and Hunan		Piloting MSM comprehensive interventions, including early test and early treatment services in Beihai, Guangxi
	Program planning and experience exchange annual meetings to strengthen local CBO-CDC learning, communication, and coordination for MSM outreach and HIV control		
	Development of HIV advocacy materials for middle and high schools, and universities among MSM in Guizhou		
	Review death cases of children who were exposed to HIV to analyze associated factors and strengthen PMTCT policy and programs		
CARE AND TREATMENT	Surveys in various areas, including analysis on concerns and the use of new media with MSM CBOs through web-based questionnaires; status of TB/HIV coinfection via different transmission modes, including impact on efficiency of ART; key factors for HIV transmission among MSM through contact tracing and drug resistance evaluation in focus provinces		
	Various trainings and technical consultation to strengthen MSM CBO capacity, including pilots using web-based technology for advocacy, web-based HCT reservation and confirmation in Xinjiang, communication skills improvement in Guizhou, and a pilot on comprehensive MSM intervention in Yunnan. This includes the development of MSM positive people mobilization implementation plans, protocol design, and strengthening care linkages via PLHIV follow up files in Yunnan		
	Identifying factors and barriers to inform a tailored approach for MSM cascade entry in Guiyang (formative assessment)		
	Support to the Chinese Association of STD/AIDS Control and Prevention on development of comprehensive service handbooks, advocacy on technologies and policies, experience exchanges to improve participation, capacity of and coordination with MSM CBOs		
HSS	Strengthening MSM population size estimation using RDSA in Guangxi (training and implementation)		
	Strengthening HIV surveillance and partner capacity for data analysis and utilization, particularly in program planning		
	Monitoring and evaluation visits and handbook development		
	MSM Cohort analysis to longitudinally follow and estimate key population size, HIV seroprevalence, HIV incidence, and factors associated with HIV cascade entry and retention		

	Training on laboratory network quality control (for improvement of MSM acute infection management) in Guangxi		
	Exploration and evaluation on the use of molecular tracing data to study HIV transmission among MSM, CD4 dried power reagents in Yunnan, incidence rapid test in Yunnan		
	Expanding HTC services and building laboratory capacity via dried blood spot and urine self-sample collection through different models (e.g. pharmacy, volunteer, and CBOs) among MSM in Yunnan, Guangxi, Hunan		
	Trainings to strengthen HRH and disseminate of China's experiences, including "south to south" collaboration, leadership, and provincial program management training program (PPMTP)		

Table A.3: China - Transition Plans for Near and Non-core Activities[49]					
Transitioning Activities	**Type**	**Funding in ROP 16**	**Estimated Funding in ROP 17**	**# of IMs**	**Transition End**
Beihai	Central support	10,000	TBD	1	31 March 2017
Totals		10,000	TBD	1	

Laos

Table A.2a Laos: Program Core, Near-core, and Non-core Activities for COP 16

Level	**Core Activities**	**Near-core**	**Non-core**
Site level	Strengthening system on HIV/TB co-management (Active HIV Case Finding and HIV/TB Treatment)		
	Strengthen the quality of HIV counseling and testing service (HTS)		
Sub-national level	Strengthen the quality of HIV testing and quality assurance program		
	Strengthen the quality of HIV treatment and care in 11 ARV sites		
National level	Strengthen the national surveillance system		
	Strengthen the quality management information system for monitoring of facility-based VCT, care, ART and TB/HIV interventions in Laos		
	Build capacity of provincial leadership on HIV program management and the utilization of monitoring data to improve HIV interventions		

Table A.3b Laos: Transition Plans for Non-core Activities

[49] Sites closed in FY16 will be discussed further in the next semi-annual and annual program results reporting cycles

Transitioning Activities	Type of Transition	Funding in COP 16	Estimated Funding in COP 17	# of IMs	Transition End date	Notes
There are no non-core activities planned for Laos.						

Thailand

Table A.1c Thailand: Program Core, Near-core, and Non-core Activities for COP 16

Level	Core Activities	Near-core	Non-core
Site level	Strengthening HIV treatment and care services for increased viral suppression among MSM/TG living with HIV		
	Increasing access by MSM and TG women to HCT, STI screening, and PrEP in BMA health centers		
	Increasing HIV testing among young MSM and TG women through virtual clinics and other reach-recruit strategies		
	Starting PrEP and immediate ART to reduce HIV transmission among MSM/TG in Thailand		
	Strengthening systems and capacity for improved laboratory quality in priority provinces to improve the HIV cascade		
Sub-national level	Enhancing HIV testing and data use among BMA laboratories to improve the HIV cascade		
	Increasing MSM and TG women access to HCT and STI screening in BMA health centers		
	Enhancing cascade monitoring capacity and systems for MSM and TG women in Bangkok		
	Improving and expanding quality assurance of HIV and HIV-related diagnosis/baseline assessments in Bangkok health centers		
	Scaling up evidence-based pre-exposure prophylaxis as a comprehensive HIV intervention model		
	Strengthening systems for HIV monitoring, supervision, and coaching		
	Improving the HIV cascade through stronger laboratory quality improvement and management systems		
		Strengthening an active case management network for early ART among HIV-infected infants, aiming for an HIV cure	
National level	Promoting and building capacity among policy makers and public health leaders to support sustainable pre-exposure prophylaxis policy and financing		
	Strengthening and improve the quality of national External Quality Assessment programs (STI)		
	Improving the quality of rapid, point-of-care HIV testing		

	Strengthening and improve the quality of national External Quality Assessment programs (TB)		
	Expanding and enhancing the national HIV surveillance system for MSM, TG women, and other key populations		
	Enhancing cascade monitoring capacity and systems for MSM and TG women in Thailand		
	Strengthening utilization of routine hospital data for surveillance and monitoring of facility-based HIV services among Thai and migrants		
	Securing sustainable HIV informatics and data management capacity		
		Strengthening and promoting an ASEAN center of excellence for international disease control training and HIV/AIDS capacity building	

Table A.3c Thailand: Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 16	Estimated Funding in COP 17	# of IMs	Transition End date	Notes
There are no non-core activities planned for Thailand.						

APPENDIX B

B.1 Planned Spending in 2016

Asia Regional Program

Country	Applied Pipeline (USD)	New Funding (USD)	Total Spend (USD)
China	N/A	4,000,000	4,000,000
Laos	121,408	1,382,725	1,504,133
Thailand	221,804	10,804,063	11,025,867
Total	343,212	16,186,788	16,530,000

China

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$US 0	**$US 4,000,000**	**$US 4,000,000**

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	5,000
HVAB	Abstinence/Be Faithful Prevention	
HVOP	Other Sexual Prevention	728,117
PWIDP	Injecting and Non-Injecting Drug Use	
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	506,274
HBHC	Adult Care and Support	456,535
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	
HTXS	Adult Treatment	330,705
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	
HVTB	TB/HIV Care	
HLAB	Lab	270,048
HVSI	Strategic Information	425,570
OHSS	Health Systems Strengthening	253,170
HVMS	Management and Operations	1,024,580
TOTAL		**4,000,000**

Laos

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
$US 101,408	**$US 1,402,725**	**$US 1,504,133**

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	
HVAB	Abstinence/Be Faithful Prevention	
HVOP	Other Sexual Prevention	$ 240,770
PWIDP	Injecting and Non-Injecting Drug Use	
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	$ 344,420
HBHC	Adult Care and Support	$ 156,484
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	
HTXS	Adult Treatment	$ 180,984
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	
HVTB	TB/HIV Care	$ 23,500
HLAB	Lab	$ 37,650
HVSI	Strategic Information	$ 168,641
OHSS	Health Systems Strengthening	$ 280,193
HVMS	Management and Operations	$ 71,493

Thailand

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
$US 1,730,390	**$US 9,295,477**	**$US 11,025,867**

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$ 12,600
HVAB	Abstinence/Be Faithful Prevention	
HVOP	Other Sexual Prevention	$ 1,487,314

PWIDP	Injecting and Non-Injecting Drug Use		
HMBL	Blood Safety		
HMIN	Injection Safety		
CIRC	Male Circumcision		
HVCT	Counseling and Testing	$	1,643,254
HBHC	Adult Care and Support	$	1,180,480
PDCS	Pediatric Care and Support	$	71,005
HKID	Orphans and Vulnerable Children		
HTXS	Adult Treatment	$	1,324,269
HTXD	ARV Drugs		
PDTX	Pediatric Treatment	$	43,234
HVTB	TB/HIV Care	$	91,798
HLAB	Lab	$	438,671
HVSI	Strategic Information	$	922,730
OHSS	Health Systems Strengthening	$	1,485,110
HVMS	Management and Operations	$	2,325,403

B.2 Resource Projections

Projected resources were based on multiple data sources and methods for estimating resource needs as described below. Some methods were utilized by all Asia Regional Program countries while other methods were applied by some county offices. Target-based and lump sum budgeting approaches were employed while pipeline was applied as required. The PEPFAR Budget Allocation Calculator (PBAC) was used to generate target-based, lump sum, M&O costs, and pipeline. It was also used to determine achievement of the care and treatment earmark. The final PBAC output provides the total new resources needed.

Target-based Budgeting

Thailand

Unit Expenditures (UEs) for Community and Facility-based activities and related program areas (i.e., CBCTS, HTC, and KP_PREV) are generated from the FY15 Expenditure Analysis (EA). Applied UEs were calculated from an average UE at the Sub-national Unit (SNU) without the Implementing Partner (IP) PSI. The UEs for PSI are excluded as the activities ended in FY15. In addition, the cost of rapid test kits from LINKAGES was removed from the HTC UE and projected as a Lump Sum cost. As a result, separate UEs were generated for the two USG agencies as activities and costs differed. The HTC UE for one agency is $43.54 while the UE for the other agency is $10.66.

Laos

For one IP, activities were delayed due to the execution of the MoU between the Government of Laos and the IP. Development and approval of the sub-agreement with a local organization and key planned activities needed to initiate the project were also delayed. The implementation of the key activities started mid-July 2015. As a result, the UEs (i.e., KP_PREV, HTC) for the FY15 EA were high but did not reach the level of an outlier. The UEs may not reflect the actual cost of each activity. However, the majority of the costs were included: program management, coordination, preparation, and training. Therefore, Lump Sum Budgeting methodology was used to plan the budget for FY17 for this IP. For a second Laos IP, UEs could not be generated from the EA data. Lump sum costs were estimated from the approaches below.

Lump Sum Budgeting

Thailand and Laos

To generate lump sum costs for Thailand and Laos, several methods were used. Costs were estimated from partner work plans, and proposed budgets. Additionally, the proposed costs were based on previously completed program costs that are similar to the current requirement. The team also considers leveraging fund from associated activities and other sources.

The lump sum budget calculation is split into two parts. For USG Management and Operations (M&O), resources required for FY17 were based on historical expenditures, plus future plans, including additional travel costs for SIMS visits. Resource projections were calculated for each activity and for each Implementing Mechanism (IM) based on previous and current project budgets and work plans (as appropriate), program descriptions, expected activities, outcomes, outputs, and results, considering the remaining funds after subtracting M&O and target-based budgets. The estimates of each budget-code category was based on the percentage of specific work required by each IM's activity under that budget code multiplied by the total estimated budget of each mechanism. The cost categories of M&O are based on historical data, travel costs, personnel costs including estimated cost of living increases, time allocated to budget code based on projected activities and estimates from the Technical Assistance Monitoring System (TAMS). TAMS is a business management tool used to monitor and track staffing resources for technical assistance activities including staff time spent, travel and per diem, and alignment with programmatic goals and objectives.

China

Lump sum budgets for FY17 were calculated based on previous expenditures (trainings/workshops, travel to field sites, staff salary), audits, new cost estimates for proposed plans based on anticipated activity outputs, and UEs from FY15 EA (i.e., HTC and KP_PREV). Further clarification by activity has been added into the final PBAC lump sum tab.

Applied Pipeline

Pipeline was applied for Thailand and Laos budgets. The applied pipeline was derived from historical and projected expenditures, planned activities as well as current pipeline to determine the applied pipeline as of September 30, 2016. There was an unexpected performance issue for one IP. As a result, the project is being scaled down. The remaining funds, after scope revision, will be reprogrammed to

another mechanism next year. To consider potential pipeline under the Cost of Doing Business, the team is revisiting their current expenditures and applying the potential excess.

Outlier Analyses

All ARP country teams conducted outlier analyses to determine the main factors affecting costs, to ensure efficiency of resources, programmatic output, and to better understand reasons for outliers. The analysis also offers the opportunity to adjust UEs if the analysis and discussions demonstrate a need for adjustments based on the results (e.g., high UE with expected programmatic changes in the next fiscal year). Country teams also used the opportunity to review data quality, to review the potential impact on outliers, and to consider the need to adjust UEs. As a result of the analyses, UEs were adjusted (see examples above). The new UEs were applied to ensure needed FY17 resources are efficiently utilized. Outlier mitigation plans describing the strategies for monitoring the factors resulting in the outliers were also developed. Quarterly monitoring activities will be utilized. The plans will help ensure improved and continued efficiency of resource utilization.

APPENDIX C: PEPFAR/Thailand Incentive Fund Concept Note

Executive summary

Community leadership has been at the core of historical progress in the fight against HIV, and enhancing this leadership is critical to achieving the ambitious global vision to "fast track" an end to AIDS as a public-health threat over the next five years. As external donor financing declines, sustained support for the community response to HIV is particularly vulnerable in many countries in the absence of institutionalized systems to facilitate domestic investments in community leadership.

This concept note seeks $20 million in additional PEPFAR incentive funding over a three-year period to advance Thailand's regional and global leadership in ending AIDS by demonstrating sustainable solutions to finance and improve the community response to HIV as support from the Global Fund to Fight HIV, Tuberculosis and Malaria (Global Fund) to Thailand comes to an end in December 2016. In particular, collaborative activities will:

- establish policies and systems that advance and institutionalize domestic investments in the community response at the national and sub-national levels; and,
- facilitate continuous improvements in community and other HIV services to maximize the health and economic returns on these investments.

Incentive funding will provide a temporary bridge to ensure continued support for key populations currently benefiting from Global Fund-supported HIV services in 31 priority provinces, while establishing domestic mechanisms and systems to finance and enhance the community response to HIV. Since unexpended Global Fund "savings" will sustain some community activities for one additional year beyond the scheduled end dates of the current grants, PEPFAR incentive funding will focus year-one efforts on community engagement and financing, and service delivery and enhancements for men who have sex with men (MSM), transgender (TG) women, male and female sex workers (SW) and people who inject drugs (PWID), in 13 provinces and at the national level. During this initial period, PEPFAR support will also provide technical assistance to the remaining 18 priority provinces in preparation for their transition from Global Fund support at the end of 2017.

Annual PEPFAR incentive-fund disbursements will be contingent on the achievement of key milestones documenting policy commitments to "test and start" and increased utilization of domestic systems and financial resources to support the community response to HIV. PEPFAR support for the introduction of service optimizations will contribute to savings in current domestic HIV investments that can be reinvested to accelerate achievement of these financing milestones.

In year two, incentive-fund support for community service delivery may expand beyond 13 provinces, but by the end of year three, *all of the targeted key-population beneficiaries of Global Fund support will receive support through community-based organizations receiving domestic funding through domestic systems*. As Thailand demonstrates solutions to sustain and improve the community response to HIV with domestic resources, PEPFAR will continue to support platforms for Thailand to provide regional and global leadership necessary to accelerate an end to AIDS as a public-health threat.

Overarching goal and specific objectives

This concept note constitutes a request for $20 million in PEPFAR incentive funding over a three-year period commencing October 1, 2016. This funding will be programmed through the PEPFAR Asia Regional Program (ARP) and will contribute to the *overarching goal* of enhancing Thai leadership in epidemic control locally, regionally, and globally by advancing the following *specific objectives*:

- demonstrating and disseminating sustainable policies and systems for domestic investments in the community response to HIV; and,
- demonstrating and disseminating enhancements and innovations that improve the effectiveness and efficiency of investments in community and clinical services.

As enhancements are introduced that demonstrate the returns on investments in community partners, systems and policies will be introduced that provide expanded opportunities for community engagement and financing. In return, community partners will benefit from increasingly stable platforms and foundations to support the pursuit of further innovations and contributions to epidemic control.

Anticipated results

The anticipated results of PEPFAR incentive fund-supported activities will be:

- institutionalized domestic systems exist to sustain meaningful, equitable partnerships with community and civil-society organizations to end AIDS;
- institutionalized domestic systems exist for the accreditation, continuous quality improvement (CQI) and financing of community-based services;
- measurable progress towards the achievement of “90-90-90” and other “fast track” objectives for accelerating an end to AIDS in key populations; and,
- measurable reductions in unit costs for the achievement of “90-90-90” and other key epidemic control outcomes.

Milestones for success

Annual PEPFAR incentive-fund disbursements will be contingent on the achievement of key milestones to be negotiated and specified in a bilateral Thai-U.S. Memorandum of Understanding (MOU). Provisionally, these will include:

- increased funding flows to community partners through public systems;
- increased overall domestic investments in the community response to HIV;
- policy commitments to differentiated care and other key elements of the 2015 WHO Consolidated Guidelines relevant to “test and start”; and,
- policy commitments to “test and start” for all HIV-infected individuals in Thailand – regardless of provincial or national origin – anywhere.

Geographic coverage

Focus provinces for year-one incentive fund support are listed below. Initial efforts will concentrate on provision and optimization of services, and on establishing community engagement and financing models, in these priority geographic areas. As civil-society and public-sector partners introduce solutions in these areas, incentive funding will support their leadership in providing technical assistance to build the capacity of others to adopt these solutions in the remaining national priority provinces.

Province	**National ranking by total burden of PLHIV**	**Notes**
Bangkok	1	Expand current MSM, MSW, TG sites; add FSW, PWID
Chiang Mai	2	Expand current MSM, MSW, TG sites; add FSW, PWID
Chon Buri	3	Expand current MSM, MSW, TG sites; add FSW, PWID
Chiang Rai	4	New PEPFAR; cover MSM, MSW, TG, FSW, PWID
Nakhon Ratchasima	5	New PEPFAR; cover MSM, MSW, TG, FSW, PWID
Khon Kaen	6	Expand current MSM, MSW, TG sites; add FSW, PWID
Pathum Thani	7	New PEPFAR; part of greater Bangkok; same KP as Bangkok
Nonthaburi	8	New PEPFAR; part of greater Bangkok; same KP as Bangkok
Udon Thani	10	Expand current MSM, MSW, TG sites; add FSW, PWID
Samut Prakan	11	New PEPFAR; part of greater Bangkok; same KP as Bangkok
Ubon Ratchathani	13	New PEPFAR; cover MSM, MSW, TG, FSW, PWID
Songkla	14	Expand current MSM, MSW, TG sites; add FSW, PWID
Phuket	31	New PEPFAR; cover MSM, MSW, TG, FSW, PWID

Service delivery targets

In the above-referenced provinces, PEPFAR incentive-fund activities in year one will reach 62,845 individual members of key populations with individual or small group education; will provide HIV testing services and results to 42,629 individuals. As a result PEPFAR will help to identify 4,957 HIV-infected individuals, and to link 4,461 (90%) of these to HIV treatment. Incentive-fund activities will also support access to HIV pre-exposure prophylaxis (PrEP) among 250 individuals; and will provide medication-assisted therapy to 6,976 people who inject drugs (PWID). These incentive-fund targets specified are *in addition to* core targets specified in the PEPFAR FY 16 Regional Operational Plan:

Population:	**KP_PREV:**	**HTC_TST:**	**HTC_POS:**	**TX_NEW:**	**PrEP_NEW:**	**KP_MAT:**
MSM and TG	48,807	33,264	3977	3,579	160	
FSW	6,287	4,715	50	45		
PWID	7,751	4,650	930	837	90	6,976
Total	62,845	42,629	4,957	4,461	250	6,976

Budget

The total incentive-fund budget request is $20 million, with $7 million for year one, $10 million for year two, and $3 million for year three.