China

Operational Plan Report

FY 2010

Operating Unit Overview

OU Executive Summary

The United States Government (USG) HIV program in China has made significant strides in transitioning to a technical assistance model. USG HIV assistance to China now focuses primarily on providing technical assistance and capacity building to the Government of China (GoC), strengthening the GoC's ability to provide oversight and manage its national HIV response in a sustainable manner. While the GoC provides strong leadership and funding for the national HIV program, the quality of HIV interventions is frequently lacking and technical capacity is limited, especially at the provincial and local levels. GoC highly values the technical assistance provided by the USG and the working relationship between the two countries has strengthened over the years. As a result, even with extremely limited resources, USG technical assistance exerts a strong influence on the GoC's HIV response at the national, provincial and local levels. CDC and USAID, the two USG agencies working on HIV in China, effectively use their individual comparative advantages for maximum impact: US CDC's technical assistance relationship with China CDC at the national and provincial levels focuses on best-practice guidance and technical approaches, while USAID's technical assistance relationships with provincial and local CDC and other local implementing partners focuses on developing implementation models for most-at-risk populations (MARPs).

As the largest contributor, USG provides over a third of total support to the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM). USG-China supports GoC in its relationship with GFATM and is one of two bilateral donor representatives sitting as voting members on the Country Coordinating Mechanism (CCM). With a total portfolio of over $900 million, China is currently the largest single recipient of GFATM resources. This includes $532 million for HIV over the next six years under the recently approved Rolling Continuation Channel (RCC) GF program to be launched in January 2010 as a national scale-up of China's HIV programs. Major factors influencing the success of the GoC in winning these grants rests with the ability of the Ministry of Health (MoH)(with USG assistance) to write excellent proposals and China's well-developed health financing system for moving resources from the national to the provincial and local levels. Where China often falls short, however, is in its ability to effectively implement quality interventions at the provincial and, even more, at the local levels. Given the USG's HIV technical assistance-based model, the USG is uniquely positioned to provide technical assistance to the GoC to ensure quality implementation of GFATM HIV grants. However, limited USG HIV resources in China preclude the USG from engaging sufficiently to impact implementation of the GFATM HIV grants on a scale commensurate with their magnitude and importance. The USG/China HIV team estimates that an additional $5-6 million per year for the bilateral program would be all that is necessary to meaningfully impact the quality of GFATM HIV implementation for the life of the RCC.

The USG China team vision is that in five to six years the GoC will have the technical capacity, as well as the financial ability, to provide policy oversight and manage and coordinate the implementation of an effective, high-quality national HIV/AIDS program. To achieve that vision, over the next five years, the USG China team expects to continue to provide intensive targeted technical assistance and capacity building to the GoC, strategically adapting and testing models that have been proven in other settings for use in China and then turning them over to the GoC and other implementers for roll out. USG will support state-of-the-art HIV surveillance efforts, provide critical policy input, build the capacity of targeted health care worker, improve the quality of HIV services and strengthen key elements of the health care system at the national, provincial and local levels. USG will focus its assistance primarily in seven high-burden provinces, while still providing a moderate level of technical assistance to the other eight provinces designated by the GoC. USG will continue to tailor this assistance to the specific needs of each province.

Context

Estimates from the Ministry of Health indicate that approximately 740,000 people were HIV positive and 105,000 people had AIDS in 2009. UNAIDS estimated 700,000 adults and children living with HIV/AIDS in 2008. The HIV/AIDS epidemic in China is concentrated in injection drug users (IDU) and their sex partners, female sex workers (FSW) and male clients, and men who have sex with men (MSM). While overall national prevalence remains low (0.05-0.07%), national prevalence rates among these high risk groups range from 2.1% for female sex workers (2008 data) to 4.9% for urban MSM (2009 data) to 7.5% for IDUs and 30% for female sex workers who inject drugs (2005 data); prevalence rates are significantly higher in hot-spot areas. Given China's large population, these numbers translate into an estimated 4,000 new cases of HIV/AIDS each month. Sexual transmission is now the primary mode of transmission, although drug use is still a major transmission mode in the southwest provinces and in Xinjiang in the northwest. With approximately 2.6 million prevalent tuberculosis (TB) cases, China ranks second after India for number of cases of TB (WHO, 2009); an estimated 5% of the new cases each year are multi-drug resistant and 2% are among HIV positive people.

HIV and AIDS Statistics for China UNAIDS/WHO 2008	**Male**	**Female**
Number of HIV+ adults (15+)	490,000	200,000
Number of HIV+ children	10,000	
HIV prevalence rate: adult (15-49)	0.1%	
HIV prevalence rate: young people (15-24)	0.1%	
Number of deaths due to AIDS: adults and children	20,000	

GoC leads the national response to HIV, working under the Five-Year Plan of Action (2006-2010). GoC investment in the prevention and treatment of HIV/AIDS has increased from US $50 million in 2003 to US $235 million in 2009 and now accounts for an estimated 65% of total HIV funding in China. Local governments (city and county) also contribute a substantial amount of HIV/AIDS funding (over US $60 million annually).

In 2003, GoC initiated the China Comprehensive AIDS Response (China CARES) program that provides free HIV testing and treatment of all infected individuals in 127 severely affected counties. This was complemented by the Four Frees and One Care program that provides free antiretroviral (ARV) drugs to AIDS patients in rural areas and poor urban areas, free voluntary HIV counseling, free drugs for HIV-infected pregnant women and HIV testing of their newborn babies, free schooling for children orphaned by AIDS, and care and economic assistance to the households of people living with AIDS (PLHA). In late 2004, a national methadone maintenance treatment (MMT) pilot program was authorized which formalized the inclusion of drug users in HIV/AIDS prevention efforts.

Additional demographic, socio-economic and health statistics can be found at the following sites:

UN Population Division: http://esa.un.org/unpp/index.asp
WHO: http://www.who.int/whosis/en/
The World Bank: http://web.worldbank.org/WBSITE/EXTERNAL/ COUNTRIES/EAST ASIAPACIFICEXT/ CHINAEXTN/0,,contentMDK:20601872~menuPK: 318976~pagePK:141137~piPK:141127~theSitePK:318950,00.html

UNFPA: http://www.unfpa.org/about/report/2008/en/index.html
UNDP: http://www.undp.org/publications/annualreport2009/index.shtml
UNESCO: http://stats.uis.unesco.org/unesco/TableViewer/document.aspx?ReportId=198&IF_Language=eng&BR_Country=1560

Prevention

Primary prevention is a top priority for GoC and is at the core of USG assistance to the national response. Although the GoC has established HIV prevention interventions with MARPs, many are of inconsistent quality due to different resource and skill levels among implementers. The USG plays a key role in improving the quality of MARPs programming by supporting activities in the 15 provinces with the highest HIV burden and providing a more intense effort in the provinces of Guangxi and Yunnan. The focus is on building capacity and providing models that are evidence-based, highly targeted and non-discriminatory. To build local capacity for prevention, the USG will train local sub-partners, including local China Center for Disease Control (CDC) and non-governmental organization (NGO) staff in behavior change interventions, HIV prevention and working with MARPs.

With FY 2010 funds, the USG will continue to provide technical support to the GoC to improve the quality of the national 100% Condom Use Program (CUP). To complement this program, USG will support social marketing of condoms and lubricants. Efforts to reach FSW will focus on those with lower incomes who are harder to reach and are not reached by other national or donor-supported programs. Based on the results of a February 2009 assessment of service interventions, the USG will refine the Comprehensive Prevention Package (CPP) model in Guangxi and Yunnan to more effectively reach higher risk FSW and will continue development and testing of the CPP for MSM. A planned December 2009 assessment of CPP supportive services will provide additional information for quality improvement. In FY 2010, the USG will continue to support the national 61 city MSM HIV survey, provide technical assistance to prevention projects implemented through GFATM and other sources, and provide support to counties funded under GFATM RCC for scale-up of the popular opinion leaders (POL) behavior change model for MSM. In general, USG support for MSM programs will concentrate on lower-income MSM.

Given the importance of drug use as a driver of China's HIV/AIDS epidemic, the USG will continue to support improvements in the quality of IDU interventions as they are scaled up by the GoC including collaborating with GFATM to increase MMT enrollment. To help address issues of poor adherence among those enrolled in MMT, the USG will refine the CPP model for IDUs, expand a pilot intervention using peers and family members for psychosocial support, and explore the possibility of replication of this model in other sites by local partners. The USG will provide technical assistance to help China CDC evaluate its nationwide needle and syringe program (NSP) as well as strengthen Gejiu and Luzhai as Centers of Excellence for community-based and rural IDU interventions that can be scaled up by the GoC and others.

In FY 2010, the USG will continue to allocate limited funding to assist the GoC reduce mother-to-child-transmission (MTCT). USG funding will improve the quality of MTCT interventions through support at the central level for PMTCT policy and guideline revisions, removal of key policy barriers, development of the national PMTCT data management and reporting system and supportive supervision. At the provincial level, USG will provide technical assistance for expansion of a model pilot program for delivery of PMTCT services. USG will assist in piloting routine syphilis and HIV rapid screening in antenatal care (ANC) clinics in two provinces, provide technical assistance to implement early infant virologic diagnosis by dried blood spots at 6-8 weeks of age in seven provinces and strengthen linkages between MMT, antiretroviral treatment (ART) and PMTCT services.

Care

In FY 2010, USG will continue to support the GoC and GFATM scale up the essential care package model, a comprehensive approach for providing quality care and support services to PLHA including ART adherence, home-based care and support, prophylaxis for opportunistic infections, regular follow-up services for those on ART, clinical monitoring and condom promotion. USG will provide technical assistance to improve implementation of comprehensive care and support services to PLHA and support strengthening linkage mechanisms between voluntary counseling and testing (VCT), prevention, care, and treatment to increase follow-up and referral rates. USG will continue to support the enrollment of PLHA into MMT clinics and the provision of peer psychological support and follow-up services to these IDU.

USG will assist the GoC to better implement the national TB and HIV programs, including the TB/HIV co-infection program, by working with a senior TB clinical scientist providing technical assistance and support to the National TB Center and National Center for AIDS/STD Control and Prevention (NCAIDS) on TB/HIV-related policy. In addition, the USG will continue to work with the GoC to promote provider-initiated counseling and testing (PITC) in TB clinics in seven provinces with high HIV prevalence rates. USG will work with the GoC to develop an operations manual with optimal HIV care and treatment models for TB/HIV co-infected IDU.

In FY 2010, USG will continue to provide technical assistance to the GoC to overcome barriers to accessing counseling and testing, which is now available at over 6,000 stand-alone VCT sites. The USG will continue to advocate with the GoC for the use of rapid HIV testing as well as provide technical assistance in quality assurance and quality control and linking HIV counseling and testing with other program components. At the provincial level, the USG will pilot home-based VCT and PITC approaches in several high epidemic areas for early case detection.

Treatment

Most patients with advanced HIV disease in China receive free treatment through the National Free ART Program, also referred to as Four Frees and One Care. In 2009, the GoC announced that second-line ART will be provided free to AIDS patients who have become resistant to first-line ART. Through the Global Fund RCC, the GoC has developed national targets of 80,000 people on ART by 2010 and 150,000 by 2015, with the GoC supporting two-thirds of the cost of treatment. With FY 2010 funding, the USG will provide technical assistance to China CARES and GFATM RCC integrated national programs to better implement the National Free ART program, including strengthening linkages between VCT, prevention, care and treatment to increase follow-up and referrals. USG will assist the RCC to scale up a community- and home-based treatment model in 76 heavily AIDS-affected counties and assist in opening a second Rural AIDS Clinical Training Center in Luzhai, Guangxi, an area with a primarily IDU-driven HIV epidemic. This will help the GoC scale-up ART services to rural and small-city IDU populations and strengthen referral services between MMT clinics, PMTCT and ART programs. Both of these activities will support USG's emphasis on prevention with positives. To improve the quality of HIV care and treatment services, USG will provide technical assistance on integrating a new monitoring and evaluation (M&E) plan into the National Free ART Program.

The USG will work with the National Center for Women's and Children's Health (NCWCH) and NCAIDS systems to strengthen cooperation between PMTCT and pediatric HIV/AIDS programs, supporting the development of a referral mechanism between these two programs, the drafting of technical guidelines for early infant diagnosis (EID) and the implementation of these guidelines. USG will work with GFATM to strengthen the three-tier health network system to improve quality of care for HIV-exposed and infected children including advocating for the use of cotrimoxazole prophylaxis and second-line ART when indicated. USG will provide technical assistance on analysis and utilization of pediatric ART follow-up data

and will assist in the interpretation of the results so that the information is used for program improvement.

Other

USG will work closely with the National AIDS Reference Laboratory (NARL) to strengthen the overall laboratory system in the nation. USG will help NARL obtain the highest international laboratory accreditation (CAP) and to expand domestic proficiency testing programs to provincial and local HIV laboratories. To increase CD4 testing coverage among HIV-infected persons and those on treatment, USG will work with manufacturers to evaluate a new simplified near point-of-care CD4 enumeration method to reduce CD4 sample transportation problems. USG and NARL will evaluate a new specimen collection and test method to simplify viral load (VL) testing and thus to increase VL use in assessing treatment success or failure. USG will collaborate with NARL, NCWCH, Clinton Foundation and UNICEF to establish appropriate testing guidelines and build an efficient and high quality laboratory network to timely identify infected infants using DBS. Two independent easy-to-use polymerase chain reaction assays will be employed to ensure detection accuracy in infants. USG will continue capacity building for drug resistance (DR) testing in several provincial CDCs and assist NARL and NCAIDS Division of Care and Treatment to streamline patient DR determination, data analysis and timely reports to physicians. In addition to the continuation of support in incidence surveys, USG will also provide assistance in the use of novel incidence assays in China. USG will facilitate the appropriate use of rapid tests and testing algorithms at VCT sites and among MARPs to enhance infection identification and quick return of results for timely counseling to prevent secondary transmission. USG will help evaluate the fourth generation antibody and pooled RNA tests to shorten window period (acute or primary HIV infection) and to field-evaluate the acceptability and utility of a domestic oral rapid test in MARPs.

Given the difficulty in reaching MARPs, the USG will continue to support targeted surveillance and behavioral surveys that provide critical input to improve the focus and quality of programs for MARPs. The USG has been supporting sentinel surveillance sites in 15 provinces while working with the GoC in those provinces to build their ability and expertise. Starting in FY 2010, routine surveillance tasks in several of these provinces will be handed over to the GoC which is now able to independently monitor HIV among MARP groups. As efforts in these provinces decline, the USG will increase piloting innovative surveillance methods, demonstrating their feasibility, and encouraging national scale-up. For example, in FY 2010 the USG will support the implementation of a low cost coverage and behavioral monitoring tool for FSW and MSM that will provide information to help guide the design of interventions as well as monitor impact. USG will support special surveillance efforts including the estimation of HIV prevalence among migrant workers, provide technical assistance to the GoC for a large IDU HIV incidence survey, and assist with several projects following upon the 61-city MSM study carried out in FY 2008-2009 with USG technical assistance.

To promote improved access and use of information collected in the national web-based surveillance system, USG will provide technical assistance to the GoC for analysis of routine data. USG will complete a training model, initiated in two provinces in FY 2009, to improve database use. It is anticipated that this model will be scaled up to additional provinces by GoC policy makers.

With FY 2010 funding, USG will provide technical assistance at the national level to assist with the evaluation of the national HIV/AIDS program and the development of the next national Five-Year Action Plan for HIV/AIDS (2011-2016). By focusing on building capacity for policy development and analysis and fostering an enabling environment at the community level, this assistance will help strengthen the overall health system. Similarly, USG will assist seven key provinces to develop their own five-year strategic plans following GFATM guidance under the consolidated Rolling Continuation Channel (RCC).

At the national, provincial and county levels, with FY 2010 funding, USG will continue to strengthen the public health systems through training programs to improve human capacity. At the national level USG

will focus on improving the quality of training; at the provincial level, USG provides the only practical clinical training focused on the rural HIV/AIDS epidemic; and at the county level USG strengthens the capacity of health care providers to provide home- and community-based care and treatment services to PLHA. USG will continue to strengthen the capacity of local community-based organizations through activities such as adapting capacity-building tools to the China context, building advocacy skills, and partnering young organizations with more established and accepted ones.

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV						
Adults 15-49 HIV Prevalence Rate						
Children 0-14 living with HIV						
Deaths due to HIV/AIDS						
Estimated new HIV infections among adults						
Estimated new HIV infections among adults and children						
Estimated number of pregnant women in the last 12 months						
Estimated number of pregnant women living with HIV needing ART for PMTCT						
Number of people living with HIV/AIDS						
Orphans 0-17 due to HIV/AIDS						
The estimated						

number of adults and children with advanced HIV infection (in need of ART)						
Women 15+ living with HIV						

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

Redacted

Public-Private Partnership(s)

(No data provided.)

Surveillance and Survey Activities

Name	Type of Activity	Target Population	Stage
61-city survey	Behavioral Surveillance among MARPS	Men who have Sex with Men	Publishing
Cohort study of HIV transmission among serodiscordant couples	Behavioral Surveillance among MARPS	Other	Implementation
HIV comprehensive sentinel surveillance	Sentinel Surveillance (e.g. ANC Surveys)	Female Commercial Sex Workers, Injecting Drug Users, Mobile Populations, Men who have Sex with Men, Pregnant	Implementation

		Women, Youth, Other	
HIV drug resistance	HIV Drug Resistance	Other	Implementation
HIV incidence surveillance	Recent HIV Infections	Female Commercial Sex Workers, Injecting Drug Users, Mobile Populations, Men who have Sex with Men, Pregnant Women, Youth, Other	Implementation
Laboratory quality control	Laboratory Support	Other	Implementation
Low-fee sex worker risk behavior survey	Behavioral Surveillance among MARPS	Female Commercial Sex Workers	Development
Methadone Maintenance Treatment (MMT) Outcome Study	Evaluation	Drug Users	Implementation
Needle and syringe program (NSP) evaluation	Evaluation	Injecting Drug Users	Data Review
New incidence assay development	Recent HIV Infections	Other	Implementation
Point-of-care technologies for CD4, VL, and EID	Laboratory Support	Other	Planning

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHCS (State)	GAP	GHCS (State)	GHCS (USAID)	
HHS/CDC		3,000,000	1,450,000		**4,450,000**
HHS/HRSA			50,000		**50,000**
USAID			1,500,000	4,000,000	**5,500,000**
Total	**0**	**3,000,000**	**3,000,000**	**4,000,000**	**10,000,000**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency				Total
	HHS/CDC	HHS/HRSA	USAID	AllOther	
HBHC	249,100		469,600		**718,700**
HLAB	379,200				**379,200**
HTXS	185,800	37,500	316,800		**540,100**
HVCT	377,700		264,000		**641,700**
HVMS	2,085,000		863,850		**2,948,850**
HVOP	131,100		861,900		**993,000**
HVSI	377,300		364,355		**741,655**
HVTB	25,600				**25,600**
IDUP	273,200		1,208,500		**1,481,700**
MTCT	66,200				**66,200**
OHSS	155,700		1,150,995		**1,306,695**
PDCS	73,800				**73,800**
PDTX	70,300	12,500			**82,800**
	4,450,000	**50,000**	**5,500,000**	**0**	**10,000,000**

Budgetary Requirements Worksheet

(No data provided.)

National Level Indicators

National Level Indicators and Targets

REDACTED

Policy Tracking Table

(No data provided.)

Technical Areas

Technical Area Summary

Technical Area: Adult Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	718,700	
HTXS	540,100	
Total Technical Area Planned Funding:	**1,258,800**	**0**

Summary:
Context and Background In 2003, in response to the urgent needs of patients with advanced HIV disease, the GoC issued the Four Frees and One Care policy. This program provides free HIV testing and ART for socioeconomically disadvantaged PLHA, schooling for AIDS orphans, provision of PMTCT and social support for PLHA. While the initial policy provided only 1st line ART, 2nd line regimens are now available in 15 of the 31 provinces. Initially, the need for ART was confined primarily to former plasma donors (FPD) in rural communities in east-central China and to certain high-risk populations such as IDU and their sex partners along well-known drug-trafficking routes. However, approximately 45% of new HIV cases in China were attributed to heterosexual transmission in 2008, and the proportion of women infected has doubled in the past decade. Preliminary 2009 estimates from the GoC indicate that approximately one-third of new infections in China occur among MSM. The needs and target populations for ART have changed substantially in the past six years (Bulterys et al. Chin Med J 2009; 122:1352-55). Through the GFATM RCC, the GoC has developed national targets of 80,000 people on ART by 2010 and 150,000 by 2014, with the GoC supporting one-half of the cost of treatment and GFATM and other international partners supporting the rest. However, the GoC faces several challenges in implementing the Four Frees and One Care policy for both care and treatment of adults. 1. Coordination Coordination between hospitals, NCAIDS and maternal child health (MCH) can improve as well as coordination among the three-tiered county, township and village health system network in rural areas. Referral mechanisms between prevention (MMT, NSP, PMTCT, and CUP) and care and treatment can be strengthened. Patients need to be identified earlier so they can start ART and HIV care and support. 2. Staffing The HIV/AIDS epidemic_s spread across China increases the challenge of coordinated health care delivery and required human resources. Many areas that are highly affected by HIV/AIDS are areas with high rates of poverty and large ethnic minority populations. There are few health care providers in these rural and remote areas and those providers often lack experience providing quality HIV-related treatment, care and support. 3. Support services Historically, there has been a strong focus on ARV distribution but less on adherence, psychological counseling, social support or care. 2nd line ARV drug availability is still limited. There is often a lack of funds for laboratory testing and clinical monitoring beyond CD4 testing. OI diagnosis and treatment is not free for patients (except in two provinces) and there is low coverage of cotrimoxazole prophylaxis. Few patients on ART are given viral load tests, though a major scale-up in viral load testing is now underway (see also Laboratory Support narrative). There is a lack of appropriate ART adherence models for different HIV epidemic settings. 4. Community involvement PLHA, community and family involvement is underutilized. Stigma and discrimination towards PLHA exists among health providers and communities. Few areas have income-generating activities for PLHA. Accomplishments since last COP An important component of the USG strategy in the past year has been to shift away from direct implementation support to provision of TA for model replication and scale-up. To accomplish this,

USG has continued to develop and strengthen the Continuum of Prevention to Care and Treatment (CoPCT) programs for IDU and FSW at sites in Yunnan and Guangxi. These are demonstration sites where strengthened GoC institutional care and treatment, CBO/NGO and PLHA support services are woven into an integrated services package which can and is being replicated by other GoC- and GFATM-supported projects. As part of the model rollout, USG developed and distributed model documentation and lessons learned for program replication and provided funding for study tours and participation in internship courses provided at the model sites. USG successfully leveraged funding from the GoC and other donors to support project offices and staff. Cost sharing for TA and training provided for GoC and GFATM project staff in other Yunnan and Guangxi sites has been forthcoming. USG continued to support GoC and the GFATM RCC scale up the Essential Care Package (ECP) model. ECP is a comprehensive approach for providing quality care and support services to PLHA including ARV adherence, home-based care and support, OI prophylaxis, regular ART follow-up services, clinical monitoring and condom promotion. This package is delivered through the rural three-tier village, township, and county health network system while including community and PLHA family members. In FY09, USG placed increased focus on a PwP strategy for early case finding and case management. USG focused on strengthening links between case finding (VCT, PITC) and case management (prevention, care, and support) by assisting in setting up referral mechanisms between prevention programs and care and treatment services. The capacity of rural health staff to improve investigation rates, lost-to-follow-up rates, CD4 testing and coverage of care and support services was improved through trainings and TA. USG assisted the GoC strengthen the three-tier health network services using home- and community-based care and support including income-generation activities for PLHA. Care included OI prophylaxis, clinic OI management, follow-up services such as CD4 testing, condom promotion and referral services to TB/HIV/HCV, PMTCT, and STI screening and treatment. This program was carried out in Anhui and Henan provinces. A pilot to improve ARV adherence was carried out in FY09 using directly observed therapy (DOT). HIV ARV adherence counseling and support services were distributed through rural DOTs volunteers and village doctors. USG will continue to provide technical and management support to help build capacity among village, township and county-level physicians, strengthening the current ART referral system. Family members and PLHA are recruited as DOTs volunteers to improve 1st and 2nd line ART adherence. They support county CDCs that provide HIV-positive patients with prevention and follow-up services including quarterly CD4 monitoring and, since 2009, annual viral load tests. To address the challenges related to treatment, in FY09 USG assisted GoC in revising its National Free ART Program manual. In FY08, a pilot evaluation of virologic outcomes among adult AIDS patients receiving ART through the National Free ART Program in 24 counties in 8 provinces was carried out with partial support from USG. The results demonstrated that virologic suppression was achieved in the majority of adult patients. However, virologic response was poorer among those who started ART earlier (before 2005) and those who started on a ddI- containing 1st line regimen. In addition, county hospitals (or above) generally had better virologic outcomes than smaller township hospitals or rural village clinics. Males were at higher risk of treatment failure than females. These results were analyzed in FY09 and will be published in an international journal by the NCAIDS. In addition, five-year outcomes of the China National Free ART Program (among 48,785 adult patients) were published in the August 18, 2009 issue of the Annals of Internal Medicine (Zhang F et al.). These results showed that the Program reduced mortality among adult patients with AIDS to rates similar to those of other low- or middle-income countries. The cumulative immunologic treatment failure rate of 50% after 5 years (based on WHO criteria), however, is of great concern. This detailed follow-up analysis, carried out in close collaboration with USG, has led to the current GoC push to provide 2nd line ART to patients in need in all provinces. In FY09, USG provided TA, in collaboration with Clinton Foundation, for the new 2nd line ART guidelines and related treatment adherence guidance in China. Development of national implementation guidelines for the 2nd line ARV program is ongoing. While strengthening sites to serve as models, USG continued to build institutional capacity of local health systems through the provision of ongoing TA and training as well as the development and distribution of standard operating procedures and training manuals for clinical and home-based care and treatment services for PLHA. USG supported efforts to improve referral linkages between the disparate providers within the existing health system, and supported comprehensive

HIV quality assurance and quality improvement (QA/QI) systems in Yunnan and Guangxi, which help to ensure the institutionalization of not only specific health systems improvements but also of the systems strengthening process in those provinces. USG supported the development of community-based models of livelihoods strengthening interventions to help improve quality of life of PLHIV and their families. The growing numbers of PLHA who can lead relatively healthy lives because of the availability of ART obtain support on adapting their livelihoods strategies to their health status and staying productive and self-reliant. In 2009 four new partnerships were developed in COPCT sites; these include 3 interventions with hospital based PLHA support groups and one intervention with a support group of MMT clinic clients living with HIV. USG supported the development of community-based PLHA support services in Guangxi and Yunnan. Activities include training of PLHA as counselors for home & hospital visits, peer psycho-social support/counseling, PLHA support group, positive prevention, and family support groups. An important component includes clinic and hospital based peer-led ART adherence support interventions. These services are linked to existing services such as HIV counseling and testing, medical care and ART treatment and MMT, to encourage project cost-effectiveness and sustainability. USG assisted NCAIDS to develop a tool for improving adherence among IDU. Given the lack of experienced health workers providing ART services to MSM, IDU, pregnant women and TB patients, USG assisted GoC to develop and evaluate appropriate ART service models for these populations using the existing health services infrastructure in rural and urban settings. In this activity, USG collaborated with the Bill and Melinda Gates Foundation, which is focusing its assistance on 14 urban areas of China. In eight provinces where MSM HIV prevalence is growing rapidly, USG assisted in the development of self-help groups among MSM PLHA networks that include web-based support, telephone hotlines, and peer support, particularly in VCT, MSM-friendly STI services, ART, and OI prophylaxis services. USG is in the process of helping to expand this model to 280 GFATM RCC-supported areas. USG continued to assist the Lixin Rural AIDS Clinical Training Center in Anhui province build capacity among county-level physicians to manage ART and OI treatment for PLHA. The center provides additional training to graduates back in their home counties. By 2008, 72 physicians were trained through this Center, in collaboration with Clinton Foundation. Of these, 90% are providing ART and OI services to PLHA in their home counties. These Lixin-trained rural physicians have provided ART and HIV care services to over 15,000 HIV/AIDS patients in 15 provinces. Goals and Strategies In FY10 and 11, USG will provide TA to China CARES and GFATM RCC integrated national programs to better implement the National Free ART program. If short-term gains achieved from 1st line therapy are to be sustained and improved, a comprehensive approach to HIV/AIDS that incorporates both efforts to initiate treatment earlier and provide 2nd line ART is necessary. USG will assist the RCC scale-up of a community- and home-based treatment model in 76 heavily AIDS-affected counties. This will incl ude strengthening the three-tier village, township and county health network system to provide quality ART services to patients. USG will provide TA to China CARES and RCC to better implement comprehensive care and support services to PLHA, including serodiscordant couples. To support the GoC develop the second Rural AIDS Clinical Training Center in FY10, USG will provide TA for an assessment of the site in Luzhai, Guangxi province. The placement of a new training center in this high-HIV prevalence area will help define best practices for ART services to rural and small-city IDU populations and strengthen referral services between MMT clinics, PMTCT and ART programs in addition to instructing physicians in HIV care and treatment for IDU. USG will continue to support ART adherence interventions at four CPP sites and add a fifth site. In addition, USG will continue to support the enrollment of PLHA into MMT clinics and the provision of peer psychological support and follow-up services to these IDU. USG will also assist in the use of IDU peers to improve ART adherence among PLHA. USG will continue to assist NCAIDS, China CARES and RCC improve planning and operation of quality care and support services for PLHA. In FY10, USG will continue to assist GoC scale up MMT clinics as a platform for care and support to HIV-positive IDU as well as promote the integration of care and support with ART services in seven IDU-driven HIV epidemic provinces. Activities will include establishing PLHA self-help groups for improving enrollment, follow-up and adherence, setting up DOTS in MMT clinics, conducting quarterly CD4 testing, providing cotrimoxazole for OI prevention and setting up referral services to ANC, ARV and TB clinics. USG will continue to work to strengthen links between VCT, prevention, care, and treatment to increase follow-up

and referral rates and develop comprehensive care packages. The revision of the physician training curriculum in the 13 national HIV/AIDS training centers will help to strengthen these links. USG will continue to provide TA to NCAIDS to scale up 2nd line ART to additional provinces and will assist 15 provinces in quality assurance of CD4 and viral load testing based on the national guidelines (see also Laboratory section). To help improve the quality of HIV care and treatment services, USG will provide TA and support to NCAIDS on integrating the new M&E plan into the National Free ART Program. USG will support the AIDS Care China CBO database used to monitor ART adherence. USG will support NCAIDS pilot HIV/HBV and HCV co-infection programs in Guangdong and Guangxi provinces. In addition, USG will assist NCAIDS develop national guidelines for the treatment of Hepatitis B and HIV co-infected patients. USG staff working on adult care and treatment include a portion of a Senior Project Officer and a vacant Care & Treatment Project Officer.

Technical Area: Biomedical Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
IDUP	1,481,700	
Total Technical Area Planned Funding:	**1,481,700**	**0**

Summary:

IDUP Context and Background Drug use is an important driver of the HIV/AIDS epidemic in China. It remains the major transmission mode in China_s southwestern provinces and Xinjiang in the northwest. According to the 2008 China Report on Narcotics Control, there were 1.1 million registered drug users. The estimated number of total drug users is 2-3 times higher the registered number; 77.5% use heroin and 55.7% inject. In Guangxi, there are approximately 55,000 drug users; 52,000 in Yunnan (registered and non-registered). Guangxi and Yunnan are among seven provinces where the number of PLHA infected through IDU is over 10,000. While HIV prevalence among IDU nationally averages around 7.5%, 2006 sentinel surveillance found an IDU HIV prevalence of 34% in Guangxi, 25% in Yunnan and 20% in Xinjiang. Based on a joint assessment of HIV/AIDS prevention, treatment and care conducted by the State Council AIDS Working Committee Office (SCAWCO) and the UN Theme Group on AIDS, the cumulative number of reported HIV cases in China was 276,335 in 2008 with 33% infected via IDU. IDU transmission accounted for 42% of the 50,000 estimated new HIV infections in 2007. In Gejiu, one of four USG-supported CPP sites in Yunnan, IDU make up 65% of all HIV/AIDS cases. In behavioral surveys, 40% of IDU reported sharing needles prior to entering detoxification centers. In addition to needle and syringe sharing, sexual transmission plays an increasingly important role among IDU and their sexual partners. In Yunnan, 21% of female IDU reported selling sex for money or drugs in the previous month. FSW may also inject drugs, increasing transmission risk. In Sichuan, 2.5% of FSW reported injecting drugs. Among street- based sex workers the proportion who reported injecting was twice as high. The HIV infection rate among IDU FSW is 18.3% in Geiju and 14.5% in Kaiyuan, two sites in Yunnan province where the USG is piloting the CPP model for IDU. A recent behavioral study in Yunnan and adjoining provinces showed that male IDU often buy sex, potentially infecting FSW. In Sichuan, 22% of male IDU reported buying sex and only a minority reported condom use at last commercial sex. Male IDU may also have male to male sex. China has made great strides in addressing the issue of HIV transmission via IDU. It is one of the first countries in the world to make MMT a national priority in its response to HIV/AIDS and drug use. The MMT program was piloted from 2004-2005. Since 2006, MMT has been a formal national program, co-managed by MoH, the Ministry of Public Security (MoPS), and the State Food & Drug Administration. By May 2009, a total of 625 MMT clinics had been set up in 23 of 31 provinces. The GoC has set a target of 1,000 operational MMT clinics by the end of 2009. As of May 2009, 204,165 clients had ever been enrolled in MMT with 104,239 currently on treatment. The average number of clients per clinic was 167, with an annual retention rate of 66%. In light of the rapid expansion of the

national MMT program, a number of challenges need to be addressed including the limited capacity of implementing staff, insufficient psychosocial support and lack of care and support services for IDU resulting in low enrollment and retention at MMT sites. Anecdotal evidence from IDUs in program hotspots indicate that having a job and receiving rehabilitation support can reduce the risk of relapse and therefore HIV transmission, yet few MMT sites offer such services. As a complement to the MMT program, GoC launched a nation-wide needle and syringe program (NSP) to reduce HIV transmission risk among IDU. By the end of 2008, 897 NSP sites were set up in 26 of 31 provinces, covering 526 counties. The average monthly coverage of the program is 36,000 IDU. While MMT and other interventions aimed at IDU are being scaled-up, coverage remains hampered by police crack downs and regular incarceration in _rehabilitation centers._ Recent developments suggest that the need to preve nt HIV/AIDS is moving China_s policy environment to take small but significant steps towards a less retributive response to drug users. A new _anti-drug_ law, which came into effect on June 1, 2008, introduced the concept of _community-based drug rehabilitation_ delivered through neighborhood committees and designated grassroots organizations. This concept paves the way for a broader social response to drug use that does not simply treat it as a crime. The latest version of the GoC guidelines for implementing the MMT program dispense with the eligibility requirement of two failed detoxification center detentions for registered IDU and allow non-registered IDU (i.e., users who have never been arrested) enroll directly into clinics without referral from the Public Security Bureau (PSB). To complement these policy changes, there is a strong political concern on adherence rates within the MMT program leading to a greater willingness to explore new interventions to reduce program drop-out rates. Together, these four factors _ the need to act quickly to halt the HIV/AIDS epidemic among IDU, a new more tolerant anti-drug law, a loosening of the entry requirements for the MMT program and a strong concern about the MMT program_s outcomes _ create an opportunity to further develop existing IDU services and implement new ones that push for improved access to drug treatment. Accomplishments since last COP To support the GoC scale-up and improve the quality of the national MMT program, USG provided TA in several critical areas including the development of the Methadone Clinic-Based Comprehensive Prevention, Support, and Treatment Model to address enrollment and lost-to-follow-up issues of MMT clinics; training to improve MMT staff capacity in 15 provinces; and the first mobile MMT clinic in Yunnan in 2006. Currently, there are 23 mobile MMT clinics funded by GoC. In FY09, USG collaborated with GFATM Round 4 provinces using peer educators and outreach workers to increase MMT enrollment in 15 provinces Referral mechanisms from drug detoxification centers to MMTs were expanded. A model using PSB staff to follow-up and improve IDU enrollment in MMT upon release from detoxification centers was field tested. Psychosocial support through peers and MMT staff to improve MMT retention rates was provided. HIV+ IDU were preferentially recruited to improve the prevention effectiveness of MMT. USG supported smart card MMT management system pilot in Guizhou province aimed at improving MMT data management and referral of clients from one MMT clinic to another. This system is gradually being scaled up nationally by GoC. In 2009, USG continued to support the development of a community-based MMT adherence support program initiated in 2008 in response to the findings of a 2008 assessment conducted by the Yunnan CDC and Yunnan Institute of Drug Abuse. The study found low adherence rates in China_s MMT program, noting the system concentrated mainly on dispensing methadone and failed to address the individual client_s psychological process of giving up heroin and adjusting to a new way of life. The USG-supported intervention uses peers and family members to provide the missing psychosocial support component. The intervention was designed to operate alongside and enhance the effectiveness of GoC-funded MMT clinic services. A primary focus of USG assistance for IDU has been the development of a CPP model for IDU as a demonstration project/replicable model for delivering high quality, targeted prevention interventions linked with care and treatment services provided by local government and CBOs (refer to HVOP narrative on CPP model for FSW and MSM). The CPP model for IDU is being implemented in sites in Guangxi (Luzhai, Nanning, Ningming,) and Yunnan (Gejiu and Kunming) provinces. The model includes peer education, drop-in centers, targeted interpersonal community outreach activities, community events, VCT, support groups, STI management and health service referrals. BCC interventions for IDU a im to normalize and promote correct and consistent condom use with all partners and decrease needle sharing. The drop-in centers, run by local partners, allow IDU to meet and learn about HIV prevention as well as

receive peer support and encouragement to quit using drugs. These centers act as a base of operations for outreach workers and the project team. Outreach teams go into the community to engage IDU where they socialize or engage in risky behavior. On-site counseling services are provided at the drop-in-centers, while testing is done at local CDC offices. GFATM and GoC_s China CARES program provide funding for needle and syringe programs (NSP) situated proximate to the drop-in centers and linkages are made to local MMT clinics. No USG funding is used to purchase needles or syringes per PEPFAR policy. In February 2009, the USG carried out an assessment of the overall CPP program. For the IDU CPP model, the review recommended increasing activities focusing on job skills, employment opportunities and income generation for IDU since employability, skills, and job placement interventions can improve retention rates. This finding confirmed the results of a USG-funded needs assessment in Guangxi province which identified a strong need for job placement and other economic strengthening programs for clients of MMT clinics. In response, in 2009, USG identified and supported a partner organization, Xingcheng Ltd., as a business model for replication via MMT clinics. In FY09, USG supported a study tour of the Kunming drop-in center for partner officials. The tour served as part of an advocacy effort to convince GFATM sites and others to adopt the successful IDU drop-in center CPP model. USG supported local partners as technical assistance providers. A local partner in Gejiu, the Jin Hudong Community, is providing systematic technical assistance to Jianshui County (a GFATM site in Yunnan) on IDU outreach and creating effective linkages among outreach, NSP and MMT. USG supported systematic technical assistance to selected GFATM sites in FY09. In FY09, USG partners worked closely with the Yunnan PSB to ensure successful development of the newly mandated Provincial IDU Community Outreach Program. This Program is a result of a new law instructing local authorities not to forcibly take IDU to detoxification centers if urine tests show they have been using drugs. The law allows for offenders to remain within their communities provided they regularly report to a designated community contact person. However, many officials remain unclear about how this law may be implemented. USG sees this as an opportunity to expand the rehabilitation approach to drug use. Efforts in Yunnan have the potential to influence the way the law is enacted throughout China. In previous years, USG partners supported training peer educators in compulsory detoxification centers in 29 sites (17 under GFATM, eight under USG, and four under the Australian government). This essential work continued in FY09. Given that at any one time many active IDU are incarcerated, this is an effective way to reach this otherwise hidden population and establish links for subsequent follow-up upon their release. The peer education model in detoxification centers was expanded in FY09 to operate in most CPP sites. New Community Rehabilitation outreach efforts were conducted in collaboration with PSB and the local community unit via peer educators in Kunming and Mengzi. In FY09, USG and its partners continued strong collaboration with national and local government partners, GFATM, and the Australian government-funded highly active antiretroviral therapy project (HAARP), encouraging these other implementers to replicate successful USG models of targeted prevention interventions. Goals and Strategies With FY10 funding, the USG will continue to focus on developing models for expanding and improving the quality of MMT services, refining the CPP model for IDU, and advocating for replication of successful models. The USG will refine its community-based MMT adherence support model, assessing impact on MMT adherence rates, supporting further development of the program around two MMT clinics in Nanning and exploring the possibility of replication in other sites by local partners in 2010. USG will continue to strengthen Gejiu as a _center of excellence_ for community-based IDU interventions while transitioning direct provision of service costs to GoC funding. Similar support to the IDU project in Luzhai, initiated in partnership with GoC, will increase staff capacity and build effective linkages between services to establish a _center of excellence_ for a model which is replicable in small towns and rural areas. These sites will serve as models for scale-up at other GoC, GFATM and AUSAid-supported IDU sites. USG will support provincial MMT clinics and associated community groups train outreach workers and female IDU peer educators on condom promotion and behavior change among female IDU in 15 provinces. For FSW who also inject drugs and are reached through the CPP sites in Guangxi and Yunnan, USG will ensure that appropriate messages and behavior change interventions for the dual risk of sex work and injecting drug use are included. Evidence suggests higher doses of methadone and remaining longer in treatment are effective in preventing HIV infection among IDUs. However, MMT clinics in China often do not provide

internationally recommended doses of methadone. Moderate methadone dosing may predispose patients to drop out of the MMT program resulting in a higher likelihood of continued injection drug use and other high risk behaviors for contracting HIV. A public health evaluation (PHE) will look at the effectiveness of currently used moderate dosages versus internationally recommended higher dosages of methadone, with and without the inclusion of additional psychosocial services, on MMT retention; HIV, HCV and STI incidence; self-reported high-risk behaviors; and quality of life measures among IDUs attending 54 MMT clinics in three provinces. Given China_s leadership in initiating and scaling up MMT, in FY10 USG will support GoC in developing a technical assistance program aimed at sharing China_s MMT experience with other countries that have an IDU-driven epidemic, such as Vietnam, Ukraine, Kazakhstan and other Central Asian countries. The program will consist of convening workshops, sending Chinese experts abroad as consultants, and receiving study tours from other countries. To measure the effectiveness of NSP funded by GoC, USG will provide technical assistance to China CDC to conduct an evaluation on the program in FY10. USG will provide support to GoC in assessing the national MMT program to provide information for program improvements and generate data for decision making. USG staff working on IDU include a portion of a Senior Project Officer, a PHE coordinator and a vacant Local Project Officer.

Technical Area: Counseling and Testing

Budget Code	Budget Code Planned Amount	On Hold Amount
HVCT	641,700	
Total Technical Area Planned Funding:	**641,700**	**0**

Summary:

Context and Background Counseling, testing and knowing one_s HIV status are critical to behavior change and the main entry point for care, support, and treatment. Of China_s estimated 740,000 PLHA as of 2009, only about 30% knew their HIV status despite GoC expansion of free voluntary counseling and testing (VCT) service centers. GoC has now made counseling and testing one of the major components of its national comprehensive AIDS program. By the end of 2008, more than 6,000 stand-alone VCT sites had been established nationwide. More than half of the VCT sites have been set-up in provincial and local CDC and STIs clinics and approximately 1,300 of these are special counseling and testing clinics in hospitals. In spite of this progress, there are significant barriers to expanding access to counseling and testing services and improving uptake. These include a lack of awareness of the benefits of testing, concerns about privacy, and fears of discrimination by health care staff and others. In addition, some government policies _ including a regulation requiring identification for confirmatory testing _ limit uptake, especially among MARPs. Testing at VCT sites is hampered by the national testing algorithms, which require confirmatory Western Blot testing for positive screens obtained via ELISA or rapid testing. In addition, due to the inconsistent quality of some of the domestic rapid test kits, they are not believed to be reliable by VCT staff. The tests require a 2 week or longer waiting period before results can be provided to patients, translating into many MARPs being lost to follow-up. Recently, the National AIDS Reference Laboratory (NARL) presented operational challenges to using HIV rapid tests in China and sought broad input to facilitate the revision of the national HIV testing policy. Another challenge is that the quality of data collected through the VCT reporting system needs improvement. It is not clear how many HIV tests are done through VCT services and how many tests are not linked with counseling.

Accomplishments since last COP To address barriers to VCT access and uptake, USG is advocating for multiple testing and counseling models to facilitate case finding, case management and to strengthen HIV prevention efforts, As an alternative to the stand-alone VCT model, in FY09 the USG continued to advocate for linking HIV counseling and testing with other program components such as surveillance, health education, peer education, STI services, care, outreach and behavior change interventions. Where feasible, these alternatives should be placed within NGO facilities targeting MARPs. USG supported the

establishment of linkage mechanisms to bridge VCT sites with local CDCs and provided counselor training and quality assurance/quality improvement (QA/QI) guidance. In addition, USG began advocating for provider initiated testing and counseling (PITC) for high-prevalence areas and service points that attract high numbers of MARPs. Since increasing numbers of HIV positive cases are being detected via the medical care system in China, integration of HIV testing and counseling into routine medical care is important. In FY09 USG actively advocated PITC in targeted areas in China. As a result, the GoC has come to consider PITC an important supplement to VCT. Since June 2008, USG has also supported several PITC pilots in a number of hospital settings through the NCAIDS in three provinces with lower HIV prevalence, Guangdong, Shandong and Liaoning, in order to influence PITC national guideline development. Pilot results show it is feasible to integrate PITC into routine medical care in China. Experiences learned from these pilots will provide a strong base for developing national Chinese PITC technical and implementation guidance. USG also provided technical assistance to GFATM Round 3, 4 and 5 to conduct PITC pilots in their project provinces in FY09. In FY09, USG also continued to advocate for making HIV testing routine an d simple through rapid HIV testing models. USG participated in the revision of the National HIV Laboratory Testing Guidelines, which will be issued soon. National testing algorithms will be adopted based on these revisions, and HIV rapid testing quality control guidance will be developed. Goals and Strategies In order to achieve the goal of universal knowledge of HIV status, in FY10 USG will continue to pilot multiple counseling and testing models in China. Study data show couples_ testing and counseling reduces HIV transmission, promotes behavior change and facilitates communication. PEPFAR re-authorization legislation mentions interventions with discordant couples as a high priority. In FY10, USG will pilot couples_ testing and counseling among HIV discordant couples in USG funded provinces with high HIV prevalence. A targeted workshop on couples_ counseling will be conducted by Dr. Elizabeth Marum specifically on couples_ testing among sex partners of MARPs. With NCAIDS, counseling techniques will be developed for married couples where the husband also has sex with men. In MSM surveys, approximately one-half of the MSM over the age of 30 are married. USG will support model development of MSM, FSW and IDU community based outreach with referrals to VCT integrated in community-based drop-in centers in Yunnan and Guangxi, as well as pilot testing and counseling models provided by MSM organizations using local MSM community counselors from Sichuan province. In the Sichuan model, the _first-counselor responsible_ mechanism has played an important role in pre-test counseling, result informing, post-test counseling, and referral to PLHA organizations. During the two years of the pilot, 2,218 MSM were counseled and tested, and post test counseling rate reached 100% in the last year. USG will continue to pilot and promote the community based special VCT model for MARPs in USG supported provinces. In addition, in FY10, USG will continue to advocate the scaling-up of PITC pilots in low and high prevalence provinces, so as to accumulate more evidence for the Chinese national PITC technical and implementation guidelines. In FY10, USG will continue to advocate and support the use of rapid testing in China to improve uptake of VCT services and reduce loss to follow-up. USG will strengthen technical assistance for quality assurance and quality control of rapid tests. In addition, other types of rapid tests, such as oral fluid rapid tests, will be piloted to evaluate their feasibility and acceptability, especially among IDUs and MSM. Continuous efforts, with involvement of local implementing governments and non-governmental partners, will be made to strengthen linkage between testing and knowing one_s HIV status, and linkage between testing and other services such as care, treatment, and support. In the coming year USG will support NCAIDS develop a VCT data quality assurance & control protocol and conduct a VCT data quality evaluation in China. In FY10, USG will support GoC build counseling and testing capacity at all levels by providing training to improve counseling skills; providing training to local CDC, hospital, and detoxification facility staff; and assisting GFATM to better target MARPs for VCT at the national, provincial, and local levels. USG staff working on counseling and testing include a portion of a Senior Project Officer and a currently vacant Counseling and Testing Project Officer.

Technical Area: Health Systems Strengthening

Budget Code	Budget Code Planned Amount	On Hold Amount
OHSS	1,306,695	
Total Technical Area Planned Funding:	**1,306,695**	**0**

Summary:

Context and Background Strengthening the health systems within China is essential for addressing the HIV/AIDS epidemic before it becomes generalized. The Chinese health infrastructure operates vertically through the national, provincial and county levels. China CDC, MCH and hospital administration systems each operate in their own silos independent of each other, from national down to local levels. At the local level, China_s three-tier health network system (county, township and village) plays an important role providing prevention, care and treatment services to PLHA. Through these systems, USG-supported HIV/AIDS activities work closely with GoC at all levels to improve capacity and strengthen cooperation to provide quality prevention, care and treatment services Accomplishments since last COP Following a multi-year effort to change the national MMT policy of NCAIDS, USG advocacy to preferentially enroll PLHA in national MMT programs began to influence policy, as evidenced by GoC issuing national-level HIV/AIDS indicators measuring the number of PLHA enrolled in MMT and the number of PLHA receiving palliative care and support. USG assisted NCAIDS develop national guidelines for the implementation of rapid testing and PITC, 2nd line ART (revising), TB/HIV co-infection treatment and ARV adherence. China adopted some of the methods developed by USG on size estimations for the purpose of GFATM planning at provincial levels. USG contributed to improving implementation of the Four Frees and One Care policy by improving linkages to care and treatment. USG efforts at the community level focused on facilitating linkages between indigenous organizations and provincial and county CDCs and health bureaus, particularly in Guangxi and Yunnan provinces where USG supports many CBOs. USG has encouraged CBOs to engage in increased dialogue with provincial and local CDCs and health bureaus to influence the policy process. By providing small grants to regional PLHA networks to work with their national member organizations and develop policy analysis skills, USG increased the ability of county networks to participate in national policy dialogue activities. To complement this activity, USG assisted newly-formed networks establish steering committees and provided training to these groups in advocacy, organization and financial management, and HIV/AIDS awareness. USG emphasizes the bottom-up approach to build advocacy skills among local PLHA networks and MARP peer groups. Progress has been made on training and mobilizing, and ensuring buy-in and support from local governments to sustain indigenous organizations and link services they provide to current government and other donor-provided services. USG addressed the lack of trained management and operational personnel in underserved areas through practical internship and in-services training programs at the Lixin Rural AIDS Clinical Training Center for physicians and the Provincial Program Management Training Program (PPMTP) for provincial and more local managers of HIV/AIDS programs.. USG promoted a variety of intentional spillovers to strengthen collaborations between vertical systems,(e.g., TB, MCH, STI, Lab, PSB, MMT clinics). While collaboration across these systems is important for quality HIV/AIDS programming in China, they vary across prevention, case finding, case management, and care and treatment. China has its own laboratory accreditation system USG supported the initiation of the two-year process for the international College of American Pathologists (CAP) accreditation of the national AIDS reference laboratory (NARL). Goals and Strategies For a USG program with limited resources to have maximum impact on health system reform and health systems strengthening as they relate to HIV, strategic focus is required. The USG focuses on policy and advocacy, strengthening community-based organizations_ linkages to government, and training of health car e professionals, paraprofessionals, and community health workers providing HIV/AIDS prevention, treatment and care. In FY10 and FY11, USG will support targeted new and continuing efforts to strengthen China_s health system at the national, provincial, county, and community levels. USG will continue its work on reducing stigma and discrimination against MARPs and PLHA by measuring the extent to which national policies are known and understood. USG will employ MARPs and

PLHA to measure discrimination by health care providers after this year_s implementation of the stigma and discrimination curriculum in Guangxi. USG will also measure discrimination among health care providers who have not been trained, and the range and effectiveness of current incentives and sanctions for health care providers and public service personnel when discrimination does occur. Results of this analysis will be incorporated into policy dialogue and advocacy activities. USG will focus on improving operational policies to support access to services, protection of rights, and harmonization of HIV legal frameworks and policies that support community participation, including registration of NGOs. Importantly, USG will reposition MARPs and PLHA to enable them to meaningfully participate in the policy process by strengthening their advocacy capacity, supporting community mobilization, and consolidating community structures. All activities are underpinned by a commitment to ensure the best quality data is driving decision making, and data is used for policy analysis, advocacy, and public consumption. USG aims to demonstrate, document, and disseminate successful approaches to policy making and implementation that are supportive of MARP and PLHA. USG works with the Chinese government to advocate that successful approaches to HIV policy be replicated beyond Guangxi and Yunnan provinces. Strengthening local CBOs will continue to be a focus of the USG China program. Adaptation of CBO capacity tools to the China context is being carried out, and USG will use the CBO analysis toolkit to assess group development needs, analyze group capacity, and assist groups in devising work plans focused on building capacity. Given the unique situation in China where it is not possible for CBOs and NGOs to register unless they are affiliated with a government partner or agency, USG will simultaneously build the capacity of government partners to enable them to effectively support these groups, which will require a similar assessment and capacity building process as well as development of tailor-made tools for these partners. Given the relative newness of CBOs among MARPs, many groups lack the expertise that could make them more sustainable and improve the quality of life for their members. To address this situation, USG will begin building their expertise around savings-led, income- generation options, micro-finance group mobilization and development, business planning, and simple marketing and accounting skills. USG will also work with local PSBs with FY10 funding to improve their treatment of IDU and foster partnerships between local PSBs and CDCs to increase referrals of IDU to MMT, thus complementing and building on the PwP work. USG will create opportunities for PSBs and CDCs to engage in dialogue and harmonize public health and policing practices. Building on past regional meetings, USG will convene groups of police and public health officials from the model communities to share emerging _best practices_ on interagency coordination and communication. Through joint efforts with GF-RCC, USG will support activities to reduce stigma and discrimination specifically among MSM. In the area of commodity and procurement systems support, USG will continue providing medical products support to 15 provinces to conduct workshops on PITC, supporting 2nd line ARV usage, helping develop an electronic medical records system for HIV, developing new surveillance and lab guidelines, adopting newer lab technologies (EID, BED, CD4 and VL) , implementing comprehensive intervention, care and treatment programs, and strengthening program planning and management and M&E. in order to build provincial capacity for better implementation of national and international HIV/AIDS control and prevention programs. With FY10 funding, USG will continue to be involved in a variety of activities related to leadership/governance. At the national level, USG will assist in developing the China Five-Year Action Plan for HIV/AIDS (2011-2016), to accelerate and complement an effective national response, which includes supporting government policy development, building capacity for policy analysis, and fostering an enabling environment at the community level as well as setting up strategies, targets and national M&E systems. In F10 and FY11, USG will continue to support capacity building activities such as assisting NCAIDS divisions with annual work plans and providing program management training. In addition, USG supports NCAIDS_ efforts to pay close attention to capacity development at the lower levels. Institutional capacity building of government partners is supported through the development of management skills which are more participatory, inclusive, and respectful of the community_s contributions. USG will assist the Guangxi and Anhui health bureaus and CDCs to conduct workshops on how to develop strategy and action plans for local response to the HIV/AIDS epidemic. USG will also provide TA support to 15 provinces in developing implementation plans for RCC counties. USG will support ongoing staff development activities and capacity building of local implementing partners in the areas of advocacy, effective use and dissemination

of data, and public relations. USG will support the brokering and provision of grants to establish _twinning_ relationships between young organizations and more established and accepted ones. USG will also monitor developments in the formation of NGOs as the 10-year national poverty alleviation plan explicitly calls for increased NGO involvement in anti-poverty activities. With FY10 funding, USG plans to expand the use of technical tools and training materials, while applying lessons learned from Guangxi province, to strengthening ARV management in Yunnan. Specific proposed activities for Yunnan province include conducting a stakeholders meeting, a workshop to assist national and provincial staff in introducing standard operating procedures and tools for ARV management, and a training- of-trainers (TOT) workshop. USG will also provide follow-up support. USG will also continue to assist local policy makers, planners, and public officials in applying strategic information in planning and advocacy for adequate HIV/AIDS resources with the A2 project. These types of activities are having tremendous impact, as noted during a recent MoH presentation in Yunnan province where a decision to realign the HIV/AIDS budget was made after receiving technical assistance from USG in this area. To complement this effort, in FY10 USG will initiate dialogue with NCAIDS to discuss how HIV/AIDS is financed in China and develop a plan for policy advocacy to increase the amount of public financing. Through this effort, a better understanding of total resource mobilization towards HIV/AIDS programming at the national, provincial, and county levels will result. USG will continue to assign technical advisors to GoC in FY10 to better integrate USG efforts with the Chinese national and provincial needs, ensure USG participation in HIV/AIDS annual provincial planning meetings, participate in strategic planning with the NCAIDS, support NCAIDS_ efforts to implement the _Three Ones_ principle in every province, assist in the acceptance of rapid testing at the lower levels, and support national lab policy and improve lab quality. All USG Project Officers spend part of their time working on Health Systems Strengthening.

Technical Area: Laboratory Infrastructure

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	379,200	
Total Technical Area Planned Funding:	**379,200**	**0**

Summary:

Context and Background The USG_s China 5-Year Strategic plan for HIV/AIDS (2006-2010) aims to assist GoC in maintaining the HIV prevalence below 0.1% or 1.5 million infected persons in the nation by 2015. By 2009, there were an estimated 740,000 HIV-positive persons in the total population of 1.34 billion (prevalence=0.06%). Laboratories play an important role in the diagnosis and identification of HIV infected persons, prevention of HIV infection, surveillance, estimation of the magnitude of new infections, emergence of drug resistance, immunologic and virologic monitoring of patients on ART and identification, care and treatment of HIV-infected infants by EID. China has an extensive, tiered HIV laboratory system. The management, inspection, regulation, testing, specimen archival, function, supervision, staffing, and accreditation of HIV laboratories are thoroughly delineated in the 2006 National HIV Detection Management Guidelines. The National AIDS Reference Laboratory (NARL) in NCAIDS of China CDC oversees the testing, training, coordination, evaluation and quality management of all laboratory tests related to HIV, HCV and syphilis. NARL provides quality assurance programs for more than 8,000 HIV laboratories through 35 confirmatory central laboratories. USG provides technical and logistic support to China_s laboratory infrastructure and capacity building by strategically working with NARL to maximize USG_s impact. Accomplishments since last COP In mid-2009, a senior laboratory staff member was added to the USG team specifically to attend to USG_s laboratory efforts. In line with the USG_s TA model, technical experts in laboratory methods, epidemiology and statistics were brought in from Atlanta to assist NARL with many aspects of laboratory-related programming including strategic planning, quality assurance, guideline writing, EID, DR and HIV incidence determination. USG actively

participated in the revision of the 2004 National HIV Detection Technical Guidelines (to be published in October 2009) and the establishment of an electronic reporting system to keep NARL abreast of the strength, quality, and weakness of the HIV laboratory network. There were more than 45 million HIV antibody, 156,000 CD4 and 33,550 VL tests performed nationally in 2008. Laboratory quality assurance is monitored through a tiered supervision approach. The frequency and coverage of direct on-site inspections of screening laboratories by provincial supervisory authorities varied greatly from province to province. Twenty-two provincial CDCs performed clinical evaluations of reagent kits including rapid tests used in their provinces. USG supported NARL_s participation in international proficiency testing (PT) programs and conducting domestic PT. In 2008, all 35 central confirmatory laboratories participated in NARL_s EIA, WB and RT PT programs with passing grades of 100, 100, and 94%, respectively. In addition to the use of CD4 to determine ART eligibility and monitor treatment, annual VL testing was added in the 2009 revised ART treatment guidelines which now incorporate 2nd line treatment. Considering the number of persons with known infection status (about 230,000) and the number of persons receiving ART (about 50,000), the coverage of CD4 and VL is low. Thirty (30) confirmatory central laboratories participated in CD4 PT and all passed. Twenty six (26) participated in VL PT where 2 laboratories failed (8%). NARL experts provided needed timely technical support to laboratories with suboptimal performance. China and US are the two countries that use BED assay extensively to measure HIV incidence to inform public health prevention policy making. Long-term collaboration between US CDC Atlanta GAP laboratory and NARL in this area has resulted in the advancement of incidence determination capability in China. BED-based incidence determination has been used in various at-risk populations (MSM, FSW, IDU etc) in Xinjiang, Yunnan and other provinces. A BED assay-experienced NARL staff is currently on training at GAP laboratory (from August 2009 to February 2010) to study a novel and simplified incidence assay and to do technology transfer to NARL. All 15 laboratories participating in the US CDC BED PT program in 2009 passed. NARL recently demonstrated that archived DBS specimens collected from VCT sites could be used for incidence determination. USG also supported the semiannual publication and dissemination of NARL_s Newsletter of the AIDS Laboratory Network to update laboratory and managerial staff on national testing policies, reagent quality, training opportunities, and novel techniques developed domestically and internationally. This newsletter is distributed to all 8,000 HIV laboratories and plays a significant role in updating and educating managerial and bench laboratory staff. The EID laboratory program in China was initiated in 2005 and was mostly research-based. Deficiencies of the program included the weak integration of laboratory operations with the PMTCT program, suboptimal EID detection algorithms used by the National Center for Woman and Child Health (NCWCH), required confirmation of infection status at 18 months of age in national technical guidelines, and inadequate linkage of infected infants to HIV care and treatment. All these contributed to the profound confusion in rural MCH staff and delay of care and treatment of infected infants. USG supported NARL in DBS specimen collection and DNA PCR training in Xinjiang, Yunnan, Henan, Guangxi and Jiangsu, and the development of training materials including a DVD demonstrating the correct way to collect and transport DBS samples in Chinese. USG also actively participated in an integrated PMTCT/EID pilot supported by Clinton Foundation (CHAI), NARL, Bureau of Health, Yunnan CDC and Mother and Child Health (MCH) Department in 5 high prevalence sites in Honghe prefecture, Yunnan. USG proactively promoted information sharing and consensus building of the lessons learned from the pilot with all stakeholders to maximize their use in the upcoming PMTCT/EID scale-up program in 2010-2011. USG also promoted quality assurance for rapid tests by implementing a new laboratory logbook in 15 prefecture-level hospital and MCH facilities. This logbook (originally designed by GAP Atlanta) was specifically designed to accommodate Chinese HIV testing regulations and to allow early identification of operational errors. China has the most extensive DR activities among all PEPFAR countries. Two laboratory staff from Shandong CDC and NARL received 6-month training at the GAP Atlanta DR laboratory. USG assisted with DR capacity building in Guangdong CDC. A DBS-based DR detection training course was conducted in 2009 with emphasis on DR mutation data analysis and interpretations. Three major DR laboratories received WHO DR certification in 2009. Two independent DR PT programs are currently run by NARL and the Division of Retrovirology and Immunology Laboratory in NCAIDS with anticipated consolidation in 2010. USG will collaborate with the Division of Care and

Treatment in NCAIDS to facilitate the seamless flow of specimen collection from patients with ART failure to the timely return of comprehensible DR mutation results to ART caregivers. Through the assistance of China-US collaborative CIPRA program, NIH and USG, a Chinese-language-based laboratory specimen and data management system was launched in 2009. This system was specifically designed for NARL to manage its HIV specimen inventory using unique specimen identification numbers and bar codes. The system stores specimen source, test history, test results, sample type, residual volume and storage locations. This simple and secure system keeps NARL abreast of its inventory and the quality of its achieved specimens. NARL is able to easily retrieve achieved specimens to conduct specific serosurveys such as BED incidence or to evaluate new technologies such as fourth generation EIA and rapid t ests. Goals and Strategies USG_s FY10 laboratory infrastructure strategy in China is to continue to build on successes and mutual trust to influence to the Chinese laboratory network and to provide high quality service to prevention and treatment programs. USG will work with the appropriate Chinese and provincial government agencies, international organizations and GAP Atlanta to ensure the establishment of sound laboratory guidelines, regulations and testing algorithms as well as the timely delivery of quality-assured laboratory results to all prevention and care/treatment programs. USG will bring in technical assistance from Atlanta GAP laboratory to augment needed areas of serologic testing: incidence, DR, EID, VL, CD4, LIS and laboratory accreditation by internationally recognized agencies. NARL will upgrade its laboratory quality management systems and attain CAP accreditation (a 1.5-2 year process), the highest clinical laboratory performance standard in the world. A CAP-accredited NARL will be able to exert its influence on the other domestic laboratories in a rapid manner and lead to a positive transformation of the laboratory quality system in the nation. One NARL staff is currently receiving CAP training in GAP laboratory. Additional US staff with rich CAP experience will provide on-site TA to NARL. There are numerous challenges, outlined above, associated with the implementation of the PMTCT/EID program in China. Chinese PMTCT/EID program is fundamentally different from that in sub-Saharan PEPFAR countries in several aspects. The number of HIV-positive pregnant women is relatively small (7,000-8,000 per year). There is a well-established Chinese maternal health care system, and most women seek prenatal care. However, HIV positive pregnant women and their exposed infants are widely distributed geographically and thus are hard to reach. USG will collaborate with UNICEF, WHO and Clinton Foundation to assist NCWCH and NARL in establishing a sound China-specific EID testing algorithm, guidelines and laboratory capacity. Considering the critical need of highly complex laboratory skills and equipment, it would be advisable to establish a small but high-quality EID laboratory network and use DBS as the primary means for specimen collection and transportation. In addition to the current manual Roche DNA PCR method, USG will assist NARL to evaluate and implement automation of qualitative, low-cost, real-time commercial assays in China to provide additional confirmatory tests and QA. Commitment from one of the international manufacturers with FDA approved real-time technology and successful EID evaluation (in South Africa) has been obtained. Initially, this real-time assay(s) will be used as a quality assurance measure and will be strategically placed in NARL with the hope to eventually establish dual independent assays to assure quality and shorten the turn-around time for identifying and referring infected infants to care and treatment. In the meantime, USG will continue working with Yunnan BoH and CDC, Clinton Foundation and other stakeholders including international organizations in China to monitor and analyze the ongoing PMTCT/EID pilot program and identify solutions to encountered barriers and challenges. USG will continue providing training to NARL personnel and provide TA in the area of incidence estimation and evaluation of new laboratory methods to detect recent infections. The new methods include 2 avidity-based approaches and a rapid incidence test. USG and NARL will also implement new laboratory methods (e.g., non-infectious dried tube materials as a mean to circumvent transportation/biosafety barriers) to enhance the extension of serologic PT programs. To overcome the low coverage of CD4 count tests for ART eligibility and post-treatment monitoring, USG and NARL will collaborate with PointCare to evaluate CD4 technology in NARL and several prefecture locations. One issue is the necessity of specimen transportation and the requirement that CD4 tests be completed within 2-3 days of sample collection. Likewise, to increase the coverage of VL use for ART monitoring, a new, simple collection method using plasma samples and cotton swabs prior to transportation will be evaluated by NARL and tested in remote areas. The rural laboratory staff is sophisticated enough to engage this

novel approach and there has been a previous successful attempt in China using cotton for qualitative HIV identification. A productive collaboration is anticipated and a positive outcome could greatly broaden the use of VL to determine treatment success or failure as stipulated by the national treatment guidelines. This approach will also potentially be useful for DR surveillance. USG is in the process of securing participation of commercial manufacturers (BioMerieux and Abbott) in this project. USG will facilitate the appropriate use of rapid tests and testing algorithms at VCT sites and among MARPs to enhance infection identification, timely return of confirmed HIV test results and to prevent secondary transmission. USG will work with NCAIDS to field-evaluate the acceptability and sensitivity/specificity of an SFDA-approved oral rapid test (Aware TM HIV-1/2, manufactured locally by Beijing Marr Biopharmaceutical Co with the technical support by Calypte). USG will continue working with NARL to evaluate the utility of 4th generation EIA, 4th generation rapid tests and pooled RNA tests in shortening the window period. With the expansion of care and treatment programs and the increasing number of HIV/AIDS patients on ART, China is facing an urgent challenge to expand DR monitoring services without reducing quality. Working with NARL and NCAIDS Division of Care and Treatment, USG will assist in streamlining patient DR determination. USG will provide TA when necessary and will continue to strengthen laboratory capacity building, data analysis and publication of DR results in provincial CDCs including Shandong and Guangdong. To efficiently meet the increased USG laboratory activities in China, USG will intensify its efforts with NARL and draw direct technical support from both program and laboratory experts from GAP Atlanta, CHAI, and commercial entities with proven quality products. Close collaboration will continue with the US CDC Division of Laboratories and their ongoing programs to improve lab quality in China. In addition, a new HIV laboratory-experienced FSN will be hired in November 2009 to meet our increased laboratory needs and work with the Laboratory Chief.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	2,948,848	
Total Technical Area Planned Funding:	**2,948,848**	**0**

Summary:
(No data provided.)

Technical Area: Pediatric Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
PDCS	73,800	
PDTX	82,800	
Total Technical Area Planned Funding:	**156,600**	**0**

Summary:
Context and Background The first HIV-infected patient under the age of 15 in China was diagnosed in 1996. Between 1996 and 2003, only a total of 376 pediatric patients were diagnosed; however, the number of newly diagnosed pediatric patients has risen steadily since 2004. By the end of August 2009, there were over 4,400 cumulative pediatric HIV/AIDS cases reported in China. Of these, 75% came from six provinces (Anhui, Guangxi, Henan, Shanxi, Xinjiang, and Yunnan). Pediatric HIV/AIDS care is

provided through the Four Frees and One Care policy. Due to limited capacity for implementing this policy at the village, township, and county levels, in 2005 the GoC initiated the National Free HIV/AIDS Pediatric Treatment Program. By 2009, this program covered 22 provinces, and approximately 1,350 infected children (ages 0-14 years) were receiving ART. The majority of children on ART (approximately 50%) are from one province: Henan. Nearly all HIV-infected children in China come from economically underdeveloped rural regions of the country. The Clinton Foundation in China is dedicated to providing and promoting high-quality treatment and care for Chinese children living with HIV/AIDS. In recent years, the USG has collaborated with Clinton Foundation and the NCAIDS Division of Care and Treatment in capacity building and increasing the number of pediatric patients receiving ART and optimal care. The national pediatric HIV treatment program in China has shown an undetectable viral load in 60% of previously treatment-naïve pediatric patients one year after starting ART, leaving room for further improvement (Zhang F et al, JAIDS 2007). Challenges faced by the GoC in rolling out pediatric HIV/AIDS care and treatment include: 1) poor integration of pediatric HIV treatment with local pediatric health services including limited cooperation between PMTCT and pediatric HIV treatment programs ; 2) delays in case finding, late diagnosis and lack of follow-up for HIV-infected children resulting in many dying before they are put on ART; 3) poor ARV drug adherence for children in certain rural areas with minimal resources for supervision and support; 4) limited local clinical capacity; and 5) stigma and discrimination among communities and families. Accomplishments since last COP To help address these challenges, USG works with NCWCH and NCAIDS to strengthen cooperation between the PMTCT and pediatric HIV/AIDS programs and supports the development of referral mechanisms. USG assisted GoC to develop technical guidelines for EID and transport of DBS specimens, and is assisting with the implementation of EID in pilot areas and the 333 PMTCT program counties [see Laboratory Support]. Since the Clinton Foundation is providing regular monitoring, mentoring, and direct program support for pediatric HIV/AIDS care and treatment in five of the most heavily affected provinces, USG works closely with the Clinton Foundation to address gaps and barriers in pediatric HIV care and infant diagnosis. Regular meetings on pediatric HIV/AIDS care and treatment have been instituted together with the Clinton Foundation, UNICEF, and GoC. USG trains rural physicians in pediatric HIV care and treatment through the Lixin Rural HIV Clinical Training Center. Physicians from rural areas throughout China are trained in HIV care and treatment, including pediatric diagnosis, ART formulation, adherence and OI prevention, diagnosis and treatment. So far 72 graduates provide facility-based care and support, including cotrimoxazole prophylaxis, to HIV-positive children in their respective provinces. The 2nd line ARV program has expanded to several provinces and is providing Abacavir (ABC), lamivudine (3TC), Kaletra, and Tenofovir. Over 220 children in six provinces are now on 2nd line therapy. Since resistance to NRTI/NNRTI among HIV infected children on 1st line ARV therapy is quite high in China, USG assisted in efforts to improve ARV drug adherence among HIV-infected children. A special difficulty is that a number of children were started on adult ARV drugs in the early years and these children have often developed a complex pattern of ARV drug resistance. Together with Clinton Foundation, USG has helped to develop guidance on the best course of treatment for these children. Goals and Strategies USG will work with Global Fund RCC and GoC to strengthen the three-tier health network system and involve families in quality pediatric HIV care, including OI management and medication adherence support for HIV exposed and infected children. At the provincial level, USG will pilot home-based VCT and PITC approaches in several high-epidemic areas (Xinjiang, Guangxi, and Yunnan) for early case detection and enrollment of young children and infants into care and treatment. USG will assist the 15 USG-supported provinces to implement the PwP strategy and improve case management mechanisms for families of HIV-infected children in order to increase follow-up rates. In FY10, additional physicians will graduate from the Lixin center to add to the cadre of physicians trained in HIV care and treatment supplying pediatric treatment and support in rural areas. The focus of the Lixin training center will shift especially towards 2nd line ART in line with national program needs and the increasing numbers of patients on 1st line ARVs who are starting to fail their therapy after several years. A second USG-supported Rural AIDS Clinical Training Center will open in Luzhai, in northern Guangxi province, focusing on the needs of HIV-infected IDU, especially among local ethnic minority populations. Their families and children will also be covered by services. In addition, USG will assist in improving the curriculum for the 13 national HIV/AIDS clinical

training centers to include the most current pediatric treatment guidelines. USG will provide technical assistance to NCAIDS on analysis and utilization of nationwide pediatric ART follow-up data. Emphasis will be placed on streamlining the guidance and policies surrounding EID. USG will collaborate with UNICEF, WHO and Clinton Foundation to assist NCWCH and NARL in establishing a sound China-specific EID testing algorithm, guidelines and laboratory capacity and establish a small but high-quality EID laboratory network using DBS as the primary means for specimen collection and transportation [see also Laboratory Support]. Current national HIV guidance is confusing to many physicians regarding the acceptability of DNA PCR to confirm an HIV diagnosis. As a result, HIV treatment may be delayed. USG has been working with others on changes to national policies and guidance to clarify acceptable methods of diagnosis for infants and will focus on publicizing the new guidance so that many more infants and young children will be treated earlier. USG will also continue to provide technical assistance for pilot projects for EID, in collaboration with Clinton Foundation and UNICEF. For cotrimoxazole prophylaxis, although the national guidance allows and recommends its use for HIV-exposed infants and confirmed HIV-infected children, some physicians decline to prescribe it due to fears of side effects; several national textbooks for general pediatric care also discourage the use of cotrimoxazole in children. USG will continue to work with NCAIDS to encourage the use of cotrimoxazole prophylaxis when indicated for both adults and children and will champion collection of this information in the web-based reporting system. Efforts will be made to increase the links between the NCWCH and NCAIDS to ensure that children identified as HIV infected through EID and PMTCT programs are provided the proper care and treatment services including regular clinical, CD4, and viral load monitoring. No USG staff works exclusively on pediatric care and treatment.

Technical Area: PMTCT

Budget Code	Budget Code Planned Amount	On Hold Amount
MTCT	66,200	
Total Technical Area Planned Funding:	**66,200**	**0**

Summary:

Context and Background Efforts by the Government of China (GoC) to prevent mother-to-child transmission of HIV (PMTCT) began in earnest in 2003. In accordance with the general principle of piloting, implementing and gradually expanding, GoC rolled out PMTCT services as part of its Four Frees and One Care policy. Early partners, including the United Nations Children_s Fund (UNICEF), conducted pilot demonstrations in health facilities in a limited number of target counties. Current GoC partners include Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), UNICEF, World Health Organization (WHO), USG, Clinton Foundation and Médecins Sans Frontières (MSF). The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), with private funding, also provides support in 20 high HIV prevalence counties in Yunnan province. These partners play a pivotal role by providing primarily technical support but also limited financial support. Starting in 2009, a portion of PMTCT supplies and commodities for rapid expansion of services is being provided through UNITAID. China is large and the overall HIV prevalence among pregnant women is low, albeit with great regional variation. By the end of 2008, the Chinese population totaled approximately 1.3 billion, including 637 million (48.5%) females. China has an estimated 740,000 people living with HIV/AIDS (PLHA), 0.05% (0.04-0.07%) of the total population, including 31% females and 41% infected through heterosexual transmission. There were 88,000 AIDS patients, 20,000 AIDS-related deaths, and an estimated 50,000 new infections in 2008. HIV prevalence among pregnant women ranges from <1/10,000 to 1-5% in the most affected areas. Perinatally acquired HIV infections have been rising each year, resulting in increased infant and pediatric infections. Among newly identified HIV infections in China, the proportion infected perinatally has increased from 0.1% in 1998, to 0.5% in 2003 and 1.6% in 2008. The annual number of deliveries in

China is estimated at 17,309,000. Although national antenatal clinic (ANC) coverage and hospital delivery rates were 90.7% and 91.7%, respectively in 2007, great disparities continue to exist between rural and urban areas. PMTCT was piloted by the GoC from 2003 until 2007, covering 4,158,190 pregnant women in 271 cities and counties. Among all pregnant women receiving ANC, 79% received both antenatal care and an HIV test; 73% of HIV-positive pregnant women received antiretroviral (ARV) drugs, and 82% of their children received ARV prophylaxis. Besides the National Centre for Women and Children_s Health (NCWCH), private health care facilities and some local CDCs also implement PMTCT services. Data from these interventions are not well communicated to NCWCH, which is accountable for all PMTCT interventions in China. Both NCWCH and the National Center for AIDS/STD Control and Prevention (NCAIDS) are part of the China Centers for Disease Control and Prevention (CDC) under the Ministry of Health (MoH). A global interagency task team (IATT) joint mission for PMTCT and pediatric AIDS was conducted in 2008 in collaboration with GoC, IATT partners in China, and USG, to review the implementation status of 1) PMTCT services and make recommendations for improving their coverage and effectiveness in line with international standards, and 2) care, support, and treatment programs for HIV-infected children (see Pediatric HIV Care and Treatment narrative). As an immediate outcome of the IATT mission, GoC has committed to rapidly expand the scale-up of comprehensive PMTCT services from the current annual coverage of 1.96 million pregnant women in 271 counties to over 3.2 million women in 533 counties (nearly 20% coverage nationally) by September 2010. GoC at all levels continues to increase investments in the prevention and treatment of HIV/AIDS, with a particular focus on women and children. Financial input from the central and provincial governments increased from 100 million RMB in 2001 to 1.6 billion RMB (US $235 million) in 2009. Local governments (city and county) also contribute a substantial amount of HIV/AIDS funding, especially in richer areas of the country, but the total amount of local funding cannot easily be ascertained. National taxes from provinces to the central government have been earmarked for HIV/AIDS activities over the next five years. GoC recently prioritized PMTCT service coverage for people living in higher-HIV prevalence provinces. This is reflected in the 2010-2015 national budget plans. USG, together with UNICEF and the Joint United Nations Programme on HIV/AIDS (UNAIDS), played an important advocacy role in the formulation of these national plans. HIV prevalence among pregnant women in the 271 counties covered by PMTCT services by 2008 was 1.2 per 1,000 pregnant women tested. Of 17,309,000 deliveries in 2008, 8,655 (0.05%) are estimated to be HIV-positive. With no intervention, an estimated 2,856 children (33% transmission rate) will become HIV-infected each year. By August 2009, 333 counties in 28 provinces were implementing PMTCT services using centrally allocated funds. China has nearly 2,900 counties in 31 provinces, and many of these have a very low HIV prevalence. Current coverage of HIV testing among pregnant women using central funding is approximately 12% nationwide. Medical facilities providing obstetrical services in a number of cities that do not receive financial support from the central government also carried out HIV antibody screening in 2008. USG has been assisting GoC develop a system for collating PMTCT data nationally. The GoC Plan of Action for Reducing and Preventing the Spread of HIV/AIDS (2006-2010), aims by 2010 to reduce MTCT by 50%. Concrete and very ambitious targets were proposed: over 90% of counties covered by PMTCT services and over 90% of the pregnant women infected with HIV with access to PMTCT by 2010. While China is on track for a rapid scale-up to at least 3.2 million women accessing PMTCT services by September 2010, it is clear that the ambitious targets set in the 2006-2010 Plan of Action will not be reached. USG, in collaboration with UNICEF, is assisting the GoC carry out a cost-effectiveness analysis of different approaches to scaling-up HIV testing in ANC settings in low prevalence areas of the country. Many providers presently do not feel it is justified to do routine HIV testing in settings where ANC prevalence is less than the national average of 0.05%. The Action Plan also states that, _Artificial feeding should cover over 85% of identified perinatally HIV-exposed infants._ This national objective has been met. Approximately 12 to 15% of HIV-exposed infants do receive breast milk, usually because the diagnosis was made late or the mothers, often from rural minority ethnic groups, have a strong preference for breastfeeding despite the risk. National guidelines for PMTCT implementation have been developed and revised with input from USG. However, there are still some differences between NCWCH guidelines and the antiretroviral therapy (ART) guidelines for HIV-positive pregnant women developed by NCAIDS. In FY09, USG provided technical assistance to harmonize these two guidelines.

Other national-level policy barriers are also being addressed. Periodic cascade trainings have been carried out at national, provincial, city, and county levels. A series of teaching materials and books have been compiled by national experts and NCWCH. A cumulative number of more than 2,000 health care providers have been trained in national training sessions. China has developed and implemented the Monitoring and Evaluation (M&E) Plan for PMTCT. Each province and region applies the Plan, and a tiered M&E system has been gradually formed at provincial, city, and county levels to support the implementation and contribute to improving PMTCT service quality. In 2009, this system is functioning well in the 333 counties currently receiving central financing for PMTCT. Accomplishments since last COP In 2008, the USG began providing direct technical assistance to a large-scale PMTCT pilot program in mostly rural Guangxi province. Guangxi ranks second in total number of HIV/AIDS cases in China. Approximately 17,200 HIV cases in women have been reported there through 2008. With seed funding from USG, a routine opt-out approach for HIV testing among pregnant women was adopted in 7 rural counties and 3 cities, covering 112 ANC clinics and hospitals. As presented at the Windhoek PEPFAR Implementers Meeting in June 2009 (abstract 445 – oral), 129,285 (96%) pregnant women were provided HIV counseling and 121,218 (94%) were tested for HIV. Among the women tested, HIV prevalence was 2.2 per 1,000, and 269 HIV-infected women were identified. All were notified of their test result and 251 (93.3%) received ARV prophylaxis for PMTCT. All of the 216 viable infants received ARV prophylaxis and replacement feeding. Among them, nine tested HIV positive (4.2% transmission). Among dependents and sexual partners of the HIV positive women, 215 received HIV testing. By fostering integration between village, township, and county level health care systems, comprehensive PMTCT and treatment and care services were provided to HIV-infected women and their families. Goals and Strategies Host country ownership of the PMTCT program is clearly established in China. USG will use limited FY10 funds (~US $102,000) to assist at the central level with: a) harmonization of PMTCT guidelines; b) further development of the national PMTCT data management and reporting system; c) removal of key policy barriers; and d) supervisory visits by senior staff to improve implementation in the provinces. In addition, in Guangxi province, USG will continue to support the model pilot program (see above) for the delivery of PMTCT services in rural high prevalence areas, making optimal use of the three-tiered county/township/rural village health care system. This technical assistance program will be expanded in FY10 into 25 more counties in Guangxi through close collaboration with all levels of local government. In addition, the USG will support a small model pilot program in Yangjiang city in Guangdong, using provincial USG seed funding. In these sites, USG will emphasize linkages between the NCWCH system and NCAIDS to make sure that HIV-infected women are followed-up and given appropriate care and treatment after delivery. Testing of sexual partners and family members will also be emphasized. USG_s primary focus is on technical assistance and development of replicable models. Funding for activities on the ground will be provided by GoC. USG will provide assistance to NCWCH in data capture, management, and analysis for PMTCT to help ensure that clear criteria are utilized to guide PMTCT scale-up. The PMTCT reporting system will be integrated with the existing national web-based disease surveillance system. In FY10, USG will provide TA to the GoC and its partners to evaluate the feasibility and applicability of repeat HIV testing (in late pregnancy and/or at delivery) targeting high-risk populations of women and their partners, accessing PMTCT services, and accessing preventive interventions. With FY10 funding, the USG will provide technical support to China in PMTCT policy development. China is currently conducting roll-outs of more efficacious PMTCT regimens (beyond dual peripartum ARV prophylaxis) in five provinces and will be examining the findings to determine if and in what contexts they are appropriate for China. With USG support, best practices from other countries in the region (e.g., Thailand) will be reviewed for applicability in China. In addition, USG will actively champion the application of the new WHO PMTCT guidelines (expected in November 2009). Supervisory visits by senior staff will be both to observe routine program implementation and to see the progress of pilot programs. In FY10, USG will assist in piloting routine syphilis and HIV rapid screening in ANC clinics in Guangdong and Guangxi provinces (concurrently wit h an evaluation of the best management structures to ensure timely delivery of test results). For instance, in Shenzhen City (in Guangdong province near the border with Hong Kong) a routine PITC pilot has identified 27 HIV-positive pregnant women and >900 pregnant women who tested positive for syphilis among >30,000 women screened.

Thus, it is critically important to include routine syphilis testing in high prevalence ANC settings in China (nationally, syphilis screening has only about 10% coverage). USG will also work with NCWCH and NCAIDS to evaluate optimal approaches to retesting vulnerable HIV-negative women identified during premarital and PMTCT ANC services. Improved efficiency of current testing algorithms and improved access to WHO prequalified tests in CDC, ANC, and township hospitals are important objectives. USG will help define an improved package of services to be provided by NCWCH staff, linking to ART services for HIV-positive mothers and exposed infants at all levels, including cotrimoxazole prophylaxis for infants (current coverage is low; see Pediatric Care and Treatment section). USG will also provide technical assistance (see Laboratory Infrastructure narrative) to implement early infant virologic diagnosis by dried blood spot (DBS) at 6-8 weeks of age in 7 provinces through the networking of specialized laboratories with health facilities implementing PMTCT. USG technical support in Guizhou province in FY10 will focus on strengthening linkages between methadone maintenance treatment (MMT) and PMTCT and ART services in an innovative pilot program. Nationally, 7.5% of MMT clients are HIV positive and 25% are female. All MMT clients in Guizhou receive HIV testing and counseling on enrollment and are re-tested every 6 months. HIV testing and counseling are also provided to spouses of HIV positive MMT clients. Knowing HIV status encourages primary prevention of new infections for HIV discordant couples. HIV infected women can prevent mother-to-child transmission by preventing pregnancy, and women who choose to become pregnant can take PMTCT precautions. Finally, preventing new HIV infections among young women (PMTCT Prong 1) is critical, not only for their own health, but also to reduce the probability of transmitting HIV infection to their infants. A wide range of prevention interventions are being implemented in China, and over 9,710,000 women have been trained as volunteers with HIV information and education. In some areas, such as Xinjiang and Yunnan, provider-initiated testing and counseling (PITC) are embedded in premarital health screenings where routine physical check-ups and tests for HIV and other sexually transmitted infections (STI) are provided. USG will use FY10 funds to provide support for further expansion of these activities. Currently no USG staff are dedicated entirely to PMTCT.

Technical Area: Sexual Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVOP	993,000	
Total Technical Area Planned Funding:	**993,000**	**0**

Summary:

Other Sexual Prevention Context and Background The HIV/AIDS epidemic in China is concentrated in injecting drug users (IDU), female sex workers (FSW), men who have sex with men (MSM), and other people with multiple, concurrent sexual partners, such as clients of FSW. Although overall national HIV prevalence remains low (0.04_0.07%), cases of HIV in China increased by an average of 3,000 monthly between January 2006 and June 2007. Sexual transmission is now the primary mode for the spread of HIV. Among HIV/AIDS cases occurring in 2007, it was estimated that 44.7% were infected through heterosexual transmission, 42.0% via IDU, and 12.2% through MSM transmission. Given the recent data from the 61 city MSM HIV survey, the attribution to MSM is likely an underestimation. Prevalence among FSW nationwide is estimated to have risen from 1.1% in 2004 to 2.1% in 2005, although surveys of _hot spots_ found FSW HIV prevalence rates between 5-10%. Prevalence in FSW who also inject drugs is up to 30%, with the highest rates in Guangxi, Xinjiang, and Yunnan. HIV prevalence in FSW in Yunnan, with a population of approximately 50 million people, increased from 0.05% in the mid 1990s to 1.68% in 2006. Risk behaviors include low levels of consistent condom use and limited health seeking behavior, despite confidential anonymous services through government STI clinics. According to behavioral surveillance data, 60% of sex workers reported not using condoms at every sexual encounter. Although 85% of FSW report using condoms consistently with commercial partners, only 44% report using condoms consistently

with regular partners, thereby increasing the risk of passing the virus to regular partners. While FSW condom usage appears to be increasing, high-risk sex remains an issue, particularly among low-end sex workers. In studies conducted by Renmin University of China, 1 in 10 sexually active Chinese men have engaged in sex with a FSW at least once. According to recent case report data, there has been a notable increase of HIV/AIDS infections among men over 60 years of age. Most of these men are self-reporting their mode of infection as unprotected sex with low-fee FSWs. However, the recent data from the 61 city MSM HIV survey indicates a portion of this transmission is very likely associated with MSM behavior. Research is needed to formulate behavior change messages targeting men who have multiple, concurrent sex partners, including FSW and MSM. There is growing evidence and concern that China_s MSM epidemic is much larger and developing much faster than previously acknowledged. Cases among MSM increased eight-fold from 0.4% in 2005 to 3.3% in 2007. Until recently, there has been limited surveillance data on MSM. In early 2008, with support from the USG, NCAIDS conducted the first national 61 city MSM HIV survey. The results from the first round show an overall HIV prevalence among MSM of 4.9% and syphilis prevalence of 11.9%. HIV prevalence among MSM varies largely with regions. In the southwest, (Guiyang, Chongqing, Kunming and Chengdu) HIV prevalence was more than 10% among MSM; in the regions around Shanghai, the prevalence was 7%. The southeast, coastal areas and northeast had prevalences from 4-5%. HIV prevalence in Kunming, the only city in Yunnan province in the first phase of the 61 city survey, was 14%. In a behavioral survey of MSM, 70% reported having had sex with more than one partner in the past six months, 50% used condoms when they engaged in sex work, and only 30% reported using condoms for anal sex. In 2007, the State Council AIDS Working Group and UN Theme Group on AIDS in China reported that the proportion of women infected by HIV had doubled over the past decade. As 90% of these women are of child-bearing age (15_44), this could translate into increased potential for perinatal transmission. These data suggest that the HIV epidemic is maturing, and more effective preventive measures targeting MARPs are needed in order to address sex ual transmission from male MARPs to their female partners, as well as prevention targeting those who test HIV positive. Among heterosexual HIV transmission, a considerable proportion (20-30%) is occurring among discordant couples, indicating that greater attention to prevention with positives (PwP) activities is required. GoC targets FSW and MSM (as well as IDU and their partners) for focused prevention efforts within its national response to HIV/AIDS. Male-to-male sexual activity is not illegal in China, and GoC promotes inclusive, non-discriminatory approaches and services for MSM. FSW, on the other hand, are at risk for arrest and detention in rehabilitation centers under public security policies. However, GoC also promotes the 100% condom use program (CUP) for FSW. To prevent HIV transmission through commercial sex, GoC has set up _high-risk intervention teams_ throughout the country to insure implementation of the 100% CUP. Shortcomings of the 100% CUP include poor implementation due to low capacity of staff, low coverage, and reliance on the stand-alone intervention of condom distribution without concurrent efforts placed on voluntary counseling and testing (VCT), behavior change, and STI service provision. HIV programs targeting FSW are reasonably well-covered by GFATM, local CDCs, and USG partners. However, there is a lack of emphasis on lower-income and harder to reach FSW and their clients. For example, it is more difficult for outreach teams to engage with street-based FSW who normally charge low fees for sex. Condom availability in China is high, with over 1,000 brands available, many of which are low-cost. However, many are of low quality and not easily accessible for populations at highest risk of HIV transmission. The USG-funded social marketing program in Guangxi and Yunnan promotes existing high-quality, low-cost brands that are available in China to help increase access and use by MARPs. Although GoC has established HIV prevention interventions with most-at-risk populations (MARPs), many of these efforts are of low or inconsistent quality due to the different levels of resources and skills among implementers. There is a strong need for models of HIV prevention that are evidence-based, highly targeted, and non-discriminatory. Accomplishments since last COP USG supports sexual prevention activities in 15 high HIV-burden provinces, with higher levels of resources in Yunnan and Guangxi for development of replicable local implementation models. The more intense efforts in these two provinces is structured around the Comprehensive Prevention Package (CPP) which focuses on establishing high quality, targeted interventions that are linked with care and treatment services. The prevention elements of the CPP are provided by local governments and NGOs, CBOs and government-

owned NGOs (GONGOs) for FSW and their clients. Additional elements are targeted toward MSM who have multiple concurrent sexual partners and sexual prevention interventions for IDU. In FY09, The USG carried out a comprehensive review of the CPP models and modified programming according to the recommendations of the review. In FY08 and FY09, USG supported the STI Clinic-Based Peer-Driven Behavioral Intervention Model, in which community-based organizations (CBOs) and local CDCs in Beijing, Heilongjiang, Guizhou, Shandong and Sichuan provinces conducted testing and counseling, behavioral change interventions, MSM-friendly STI clinics, and linked MSM PLHA to CBOs and ART providers for positive prevention services. As discussed in more detail in the SI technical area narrative, in both FY08 and FY09 the USG provided support for the 61 city MSM survey, with data analysis completed in FY09. Information from this survey will help to inform targeting and content of MSM interventions. Goals and Strategies Given the epidemiology of the HIV epidemic in China, the bulk of USG_s FY10 funding for prevention of sexual transmission will continue to be directed towards FSW, t heir clients and partners and MSM, with a focus on creating replicable demonstration projects. Because of the relatively low HIV prevalence rate in the general population and among youth, coupled with the need to scale-up coverage and large unmet prevention needs for MARPs, USG will not invest its limited resources on AB prevention activities for youth and the general population. In FY10 the FSW CPP will be intensely monitored, with the goal of phasing-out USG implementation support for the FSW model during FY10 and the MSM model in FY11 in all but one site per MARP group in each province. These remaining sites will serve as model sites of excellence and platforms for technical assistance and training. Using FY10 funds, USG will continue to provide technical support to GoC to improve the quality of 100% CUP by revising the national guidelines, strengthening the capacity of implementing staff, and linking CUP with STI treatment, HIV testing, counseling, care and treatment. USG will also support field testing of interventions for street-based FSW, who are more difficult to reach. To complement the CUP, the USG will continue to support condom social marketing. USG will assist local partners leverage condoms from GoC sources, including local government-supported HIV programs, and target these supplies to the hardest to reach FSW (e.g., street- based FSW) and MSM. In FY10, USG will continue to support the national 61 city MSM HIV survey. In addition to the popular opinion leaders (POL) behavior change model for MSM which focuses on change of group norms, USG will also support individual-level intervention models at pilot sites. USG will promote linkages between interventions and other services such as counseling and testing, support, and care and treatment of both STIs and HIV/AIDS for MSM. In recognition that the internet is becoming an increasingly popular medium for exchange of information as well as meeting sexual contacts for MSM, in FY10 USG partners will assist local MSM organizations to create linkages with the Yunnan MSM network. Barriers to VCT will be addressed by creating a demand for MSM-friendly VCT services with an emphasis on improving the way government providers deliver VCT services to MSM. A toolkit for MSM condom promotion will be developed, and training sessions will be offered to local and international organizations working with MSM. USG will support local MSM groups to explore the option of registering under Yunnan_s newly instituted NGO registration policy. USG programs will continue to leverage funding from GFATM, Australian Agency for International Development (AusAID), Bill & Melinda Gates Foundation and other donors. In FY10, USG will provide technical assistance to GFATM and other projects in Guangxi and Yunnan, as well as in other provinces. USG prevention staff include a portion of a Senior Project Officer_s time as well as an HIV/AIDS Advocate.

Technical Area: Strategic Information

Budget Code	Budget Code Planned Amount	On Hold Amount
HVSI	741,655	
Total Technical Area Planned Funding:	**741,655**	**0**

Summary:

Context and Background Given China_s concentrated HIV/AIDS epidemic, targeted surveillance and behavioral surveys are conducted by NCAIDS and provincial CDCs among specific MARP and vulnerable groups in each province. NCAIDS Division of Epidemiology is primarily responsible for HIV/AIDS surveillance activities. The Division of Integration and Evaluation provides quality assurance. The Monitoring and Evaluation (M&E) Unit recently moved from under NCAIDS, and is now directly under the State Council on AIDS Working Committee Office (SCAWCO). The M&E Unit has a staff of six, and is responsible for overarching M&E activities for NCAIDS. This Unit recently revised the National HIV/ AIDS M&E Framework and is conducting an evaluation of the National Free ART program. There are over 600 national and 500 provincial HIV/AIDS sentinel surveillance sites throughout China_s 31 provinces. NCAIDS plans to increase the national sites to 1,020 in 2010 by assuming responsibility over many of the provincial sites. Sentinel surveillance is conducted for FSW, IDU, MSM, pregnant women, STI patients, TB patients, and other groups. Data from these sites are being used to calculate the 2009 national HIV estimations for each risk group. An additional 159 surveillance sites collect more extensive behavioral data among risk groups, and 105 sites collect HIV data specifically through STI clinics. Considering that China_s 31 provinces have 2 to 100 million residents each, there are relatively few staff to support essential HIV/AIDS SI activities, especially at the local level. The USG strategy is to assist national-, provincial-, and county-level staff to acquire skills they need to accomplish their tasks through TA and specialized trainings. The China Information System for Diseases Control and Prevention (CISDCP), a Web-based reporting system covering all reportable diseases, went on-line in 2003 during SARS. This system collects surveillance data from over 10,000 clinics and city, county and provincial CDCs. Users can view the data they input and generate simple reports. The HIV/AIDS reporting system is one of multiple modules. Accomplishments since last COP In addition to assisting with national M&E efforts, USG has developed a number of SI activities that serve as models at the provincial level. These include improving the quality and use of the CISDCP system, advocating for policy change by using data generated from the Integrated Analysis and Advocacy (A2) project, and supporting the development of standardized program monitoring and tools for measuring coverage for and behavioral change of MARPs as part of the Comprehensive Prevention Package (CPP) of Services project. USG helped improve data collection forms and questionnaires for the CISDCP and supported China CDC to strengthen training activities at the national level. USG worked with the Guangxi and Yunnan Provincial HIV/AIDS Prevention and Control Working Committee Office (PAWCO) to strengthen CISDCP and HIV/AIDS reporting systems for the timely production of M&E reports and management of HIV/AIDS services. Focused TA efforts resulted in developing enhanced analysis functions and feedback reports to strengthen the use of information from CISDCP. A training module is being modified to allow analysis by address and create feedback reports. With the assistance of China-US collaborative CIPRA program, NIH and USG, a computerized laboratory specimen management system was launched in 2009. The system was designed to manage NARL_s specimen inventory using bar codes. The system stores data on specimen source, sample type, test result, residual volume, and location. A workshop on electronic medical records (EMR) was convened at MoH, and an expert from USG Zambia discussed the structure and implementation of their EMR system using smart cards and touch screen technology. USG supported a pilot smart card MMT management system in Guizhou province to improve MMT data management and referral of clients from one MMT clinic to another. GoC is interested in developing a similar system for HIV/AIDS patients, and NCAIDS Division of Care and Treatment has applied for national-level funding to support future development. USG supported strengthening the provincial M&E frameworks in Guangxi and Yunnan, and completed data quality assessments (DQA) for projects in eight _hot spots_ for MARPs. As a result of the DQA process, USG partners will adopt and integrate this methodology into the QA/QI process. USG also completed development of the A2-Lite version to increase access to and utilization of this tool, and organized an orientation on A2-Lite for Yunnan_s new HIV policy makers, government officials, and key stakeholders to gain support for the process. Training on HMIS, M&E, and surveillance was provided to the 7th and 8th classes of Provincial Program Management trainees who graduated in FY09. These trainees from local and provincial CDCs across China spent six months learning all aspects of HIV/AIDS programs, and shadowing staff in NCAIDS Divisions of Epidemiology and Integration and Evaluation. USG provided TA to national and provincial HIV/AIDS Divisions of Epidemiology to help with

the 2009 estimation and projection of HIV incidence and prevalence among MARP groups. Assistance was provided on the EPP method in terms of using the software, appropriate ways to disaggregate data, choosing the best fitting curve, and how to use the available data to find the most accurate model possible. USG also assisted with MARP size estimation using the multipliers method. Additional questions were added to questionnaires for FSW, IDU, and MSM and used in several major cities. Data from the A2 and A2-Lite projects also contributed to this year_s estimations and projections of HIV among MARPs. USG conducted an Asian Epidemic Model (AEM) training for the A2 team members from Guangxi and Yunnan CDCs and MoH. After the training, GoC formally adopted the AEM methodology, and is using it at the national level to forecast HIV epidemic trends and prioritize resources for HIV programming. The MoH also trained participants from other provinces on AEM, which is currently being used in seven provinces for HIV projections and programming. In Guangxi and Yunnan, the AEM links to the GOALS model, which was used to project HIV epidemic trends at the provincial level and advocate for more resources for HIV programs. The 61-city survey among MSM was completed, including data analysis. USG assisted with all aspects of the study, including its design, implementation, and analysis. Results have been written up and submitted to an international journal for publication. A presentation of the results from one city, Shenzhen, was made at the 2009 PEPFAR Implementers_ Meeting in Namibia. USG also developed and piloted Integrated Biological and Behavioral Surveillance (IBBS) activities using RDS among MSM in four cities. These surveillance activities were completed and the data is being analyzed. In FY09, USG, along with the Gates Foundation, supported the scale-up of contact tracing among people newly identified with HIV/AIDS. On average, one new HIV case has been found by testing the contacts of people newly found to be HIV positive, resulting in a total of 500 new cases using this method. In four pilot sites, samples from HIV-negative high-risk individuals will be tested by the NARL using pooled RNA to detect newly converted cases. Several trainings were performed for national and provincial SI staff including RDS analysis and results display, BED data analysis and GIS. Goals and Strategies USG SI activities follow a TA-based model complementing GoC_s Five-Year Action Plan for HIV/AIDS. Activities focus on piloting innovative methods that are scaled-up by the government and ensuring local capacity to collect, analyze, and use HIV/AIDS data. USG will continue to provide TA to support the development, implementation, and documentation of innovative SI methods and models in the USG-supported provinces, and will collaborate on advancement of the _Three Ones_ in China. In 2010, GoC will develop a new Five-Year Action Plan for HIV/AIDS (2011-2016); all 31 provinces will develop individual five-year plans. Plans will follow Global Fund guidance as existing Global Fund Rounds are consolidated into the RCC. In addition to new action plans, a national initiative on Health Care System Reform will be carried out from 2009-2011 with a total budget exceeding US $140 billion. This initiative will expand insurance coverage, ensure essential medicines, improve infrastructure, standardize medical records, and expand prevention activities including HIV prevention. In FY10 and FY11, USG will work closely with NCAIDS and the GFATM RCC to promote access to and use of information collected in the CISDCP system. USG will provide TA on improving the analysis functions for routine data, including upgrading software to allow NCAIDS to conduct effective analyses and report on national indicators at both the national and sub-national levels. The national PMTCT data management and reporting system, which is under NCWCH, will be integrated with CISDCP. USG will provide assistance to NCWCH in data capture, management, and analysis of PMTCT information. A training curriculum on improving CISDCP performance, data quality, and information through enhanced analysis functions has been developed based on experiences from Guangxi and Yunnan. This model will be completed and packaged for expansion by the end FY10, and policy makers will be encouraged to scale-up the use of these enhanced functions to more provinces. USG will assist the SCAWCO M&E Unit and NCAIDS at the national level to evaluate the national HIV/AIDS program and develop the next five-year plan. USG will also help the seven higher prevalence provinces complete their M&E system assessments, and use the assessment results to develop 5-year HIV/AIDS strategic plans. In FY10 and FY11, USG will develop a standardized program monitoring tool for MARP groups in China using prevention models targeting MARPs developed in Guangxi and Yunnan. This tool will consist of a standardized operational definition on how to measure prevention coverage, and a set of monitoring tools, QA/QI checklists, and DQA tools, procedures, and analysis for program planning and improvement. USG will continue to provide TA to expand the A2 project and A2-Lite module,

particularly among provinces currently developing their five-year strategic plans, and advocate for using A2 and A2-Lite data for better estimations and projections of HIV among MARPs. To help improve the quality of HIV care and treatment services, USG will provide TA to NCAIDS to integrate an HIV/HBV M&E plan in the National Free ART program. USG will assist with an evaluation of PITC offered in ANC, STI, and TB clinics. Beginning in FY10, USG will support an outcome evaluation of the CPP for IDU project at a total of four sites in Guangxi and Yunnan. A quasi-experimental design will be employed with two rounds of data collection. Analysis and reporting will be completed by FY11, and the results will be used to advocate for scaling-up the program. Previously, USG supported sentinel surveillance sites in 15 provinces. Starting in FY10, USG will hand over routine surveillance for approximately half of the sites to GoC which has the ability, expertise, and funds to carry out this activity. USG will focus on piloting innovative surveillance methods, demonstrating feasibility, and encouraging national scale-up. As part of TA provided to NCAIDS, USG will continue to encourage the efficient use of Global Fund monies and use of high quality surveillance activities including hospital-based reporting into its surveillance system. 100 sites have already been identified. USG will continue to support the implementation of a low cost coverage and behavioral monitoring tool for FSW and MSM, which was adopted from PSI_s Tracking Surveys (TraC) methodology and MEASURE Evaluation_s Coverage Plus study. In FY10, the first round of data collection will take place among FSW at four sites and MSM at three sites in Guangxi and Yunnan. Findings will be used to guide and tailor intervention design. The tool will be used to identify higher risk FSW, highlight determinants of behavioral change, and monitor impact of interventions. In FY11, USG will undertake the second round of data collection among FSW in three of the four sites and among MSM at the same sites. To reach more people at risk of contracting HIV/AIDS, USG will assist with surveillance efforts to estimate HIV prevalence among migrant workers within China and women from higher prevalence countries coming to China as brides. More than 750,000 Chinese workers travel to sub-Saharan Africa to work in mines or on construction projects. USG will support several provincial-level evaluations routinely testing workers moving to and from Africa. The ILO is interested in tailoring educational materials for this group, and USG is enabling collaboration between the groups and providing TA on study design and analysis. Between January-March 2010, a large IDU HIV incidence survey will be conducted across China. Dry blood spots will be collected from each province, and BED will be performed by NARL. USG provided some assistance in the design of this evaluation. Using the 61-city MSM survey samples, USG will provide TA with several follow-up surveys including a third round of data collection. HIV-positive samples will be tested for incident HIV infection through BED and other testing methods. An impact evaluation of the CPP model for IDU in Guangxi and Yunnan will be conducted in FY10 and FY11 to assess the impact of the CPP model on risk behaviors. In close collaboration with NCAIDS, USG will organize a series of discussions at the national and provincial levels to synthesize existing empirical data from recent studies carried out among FSW and MSM and turn this knowledge into action. The first discussion workshop is planned for February 2010. USG SI activities complement other support by donors including the Clinton Foundation, DFID, Gates Foundation, Global Fund, UNAIDS, UNICEF, World Bank and WHO. USG will collaborate with UNAIDS to improve M&E of GF RCC programs in 31 provinces. UNAIDS will assist with budgeted program planning, target setting, workplan development and coordination. The USG SI Team is composed of three staff members: 1) a Medical Epidemiologist who works closely with the CDC/GAP China project officers and serves as the SI Liaison; 2) a SI Specialist who works with the USAID RDM HIV/AIDS team and serves as the SI point person for USAID activities in Guangxi and Yunnan; and 3) an ASPH Fellow who concentrates on M&E and surveillance. The Medical Epidemiologist and the SI Specialist positions are currently vacant. It is a priority to fill both positions.

Technical Area: TB/HIV

Budget Code	Budget Code Planned Amount	On Hold Amount
HVTB	25,600	

Total Technical Area Planned Funding:	**25,600**	**0**

Summary:

Context and Background China ranks 2nd in the world after India in terms of total number of people with TB, 2.6 million cases. In 2007, there were 1.3 million incident cases and 201,000 deaths due to TB. 80% of cases are in rural areas where the public health system is not optimally functioning. Multi-drug resistant TB (MDR-TB) is estimated to affect 65,000 people each year (5% of incident cases). The State Council created the National TB Control Program and implemented a National TB Prevention and Treatment Working Plan (2001-2010). Funding for TB control from the GoC has increased to US $163 million in 2009. The GFATM also provides significant support, US $41 million in 2009. With an estimated 25,000 new TB/HIV co-infections each year, 2% of incident TB is among people with HIV. The prevalence of TB/HIV co-infection is geographically heterogeneous, and low rates of cross-screening result in under diagnosis of both diseases, especially among migrant workers, which consists of 200 million people. Data from a TB/HIV co-infection pilot program in Guangxi from 2006-2008 showed the prevalence of active TB was 17.4% among HIV positive people in that area, and MDR-TB affected 3.3% of the HIV-positive patients. Nationally, the prevalence of isoniazide (INH) drug resistance is 23.6%. As a result, policy makers have been reluctant to implement intermittent preventive therapy (IPT) using INH for TB prophylaxis among HIV- positive patients in China. At the national level, the separation of TB and HIV/AIDS prevention and control among two health systems poses a major barrier to improving TB service coverage for HIV/AIDS patients. GoC needs assistance to improve collaboration between these two systems. Accomplishments since last COP USG assisted GoC develop national guidelines for TB/HIV co-infection. USG is working closely with the National AIDS Treatment Taskforce to improve linkages between the TB and HIV systems and enhance the current national diagnosis and treatment guidelines for TB in PLHA. USG supported the field testing and scale-up of TB/HIV co-infection programs in 134 GFATM Round 5 counties. These programs focus on HIV testing and counseling for clients in TB clinics through opt-out strategies. Referral mechanisms for HIV-positive TB patients to HIV/AIDS prevention, care and treatment programs (including ART and cotrimoxazole prophylaxis), TB screening of PLHA, and referral of HIV-positive patients diagnosed with TB to clinics for treatment through DOTs are also provided. In 2010, GFATM RCC and the Gates Foundation will expand this program to all 280 RCC-supported cities and 1120 counties. The programs will focus on early case finding and management, TB/HIV co-infection, cotrimoxazole prophylaxis and management of MDR-TB. Following China CDC_s request, in FY09, a senior TB clinical scientist was appointed under the umbrella of the USG Emerging and Re-emerging Infectious Disease Program in China, providing daily technical assistance and support to the National TB Center as well as NCAIDS on TB/HIV-related issues. Goals and Strategies In FY10, USG will continue to work with GoC to promote PITC programs at TB clinics located in seven high HIV endemic provinces (Anhui, Guangdong, Guangxi, Guizhou, Henan, Xinjiang, and Yunnan). In response to the IDU-driven epidemic in the southwest and northwest of China, USG will work on an operations manual with GoC that includes the development and field testing of optimal HIV care and treatment models for TB/HIV co-infected IDU. The model will be piloted first in Hunan province. USG will support five counties in Henan province conduct a TB/HIV co-infection program providing PITC in TB clinics, screening for TB in ART clinics and providing treatment and care to both TB patients and PLHA according to national guidelines. As part of the Lixin Rural AIDS Clinical Training Center and proposed Luzhai Rural AIDS Clinical Training Center, practicing physici ans from rural areas will be provided residency programs to learn how to treat HIV/AIDS patients following international standards. Training includes TB and other OI screening, diagnosis, prevention and treatment among HIV positive patients. In FY10, the curriculum for the 13 national HIV/AIDS clinical training centers will be revised to include best practices for HIV/TB co-infection practices. The USG is one of the two donor representatives sitting as voting members on the Country Coordinating Mechanism (CCM) of the GFATM. The USG is uniquely positioned to provide technical assistance to the GoC to ensure quality implementation of GFATM grants and ensure the HIV and TB grants are well-coordinated in their implementation. However, limited USG

resources in China preclude the USG from engaging sufficiently with the GFATM grants on a scale commensurate with their magnitude. No USG staff work exclusively on TB/HIV.

Technical Area Summary Indicators and Targets

REDACTED

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
7411	Family Health International	NGO	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	1,500,000
7414	Research Triangle Institute, South Africa	Private Contractor	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	716,150
10178	Chinese Center for Disease Prevention and Control	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP, GHCS (State)	2,345,000
10196	Management Sciences for Health	NGO	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	100,000
10197	Pact, Inc.	NGO	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	1,320,000
10199	Population Services International	NGO	U.S. Agency for International Development		
10481	International Training and Education Center on HIV	University	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHCS (State)	50,000
12257	TBD	TBD	U.S. Agency for	Redacted	Redacted

			International Development		
12258	United Nations Joint Programme on HIV/AIDS	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	20,000

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 7411	**Mechanism Name: TASC3**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Family Health International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,500,000	
Funding Source	**Funding Amount**
GHCS (State)	497,000
GHCS (USAID)	1,003,000

Sub Partner Name(s)

Gejiu Jinhudong Community Committee	Kunming Center for Disease Control and Prevention	Kunming Institute for Health Education
Kunming Red Cross	Luzhai Center for Disease Control and Prevention	Nanning Center for Disease Control and Prevention

Overview Narrative

FHI has been implementing HIV/AIDS programming in southern China since 2003 with the support of USAID. The primary of focus of USAID-supported programming has been to establish a Comprehensive Prevention Package (CPP) model focusing limited resources on the provision of comprehensive prevention services (behavioral change, VCT, STI, condom promotion and linkages to care and services) plus supportive interventions for those most at risk of being infected or transmitting HIV, in order to avert as many new infections as possible. This approach has been employed in eight "hot spots" in Yunnan and Guangxi provinces selected for their high HIV prevalence among specific MARPs: female sex workers (FSW), injecting drug users (IDU), and men who have sex with men (MSM). The hotspots include Kunming, Gejiu, Mengzi and Kaiyuan in Yunnan Province; and Nanning, Pingxiang, Ningming and Luzhai in Guangxi Province.

The goals of the project are to reduce the incidence and prevalence of HIV/AIDS and mitigate its impact on PLHA and their families. To achieve these goals, FHI focuses on five major programming components: comprehensive prevention interventions for MARPs; strategic information; increased access to care, support and treatment for PLHA and their families; strengthening the enabling environment; and enhancing the effectiveness of USG-supported programs by leveraging other donor resources.

Under the task order, FHI:
1. Provides HIV technical assistance (TA) to community and local partners receiving USAID support through other implementing agencies and stakeholders;
2. Provides sub-grants and TA to government and other partners; and
3. Provides TA for scaling up of the CPP model by the GoC, GFATM, and other donors.

As part of an overall strategy to shift away from direct implementation support to provision of TA for model replication and scale up, with FY10 funding, FHI will continue to strengthen prevention intervention models in potential centers of excellence, including an FSW project in Kunming, an IDU project in Gejiu, and MSM projects in Kunming and Nanning. In addition, FHI will continue to develop and strengthen Continuum of Prevention to Care and Treatment (CoPCT) programs for IDU and FSW in Luzhai to strengthen linkages between outreach and drop-in centers to uptake of VCT, STI, care and treatment services. These centers will function as model sites for replication by other government- and GFATM-supported projects. In FY10 FHI will develop and distribute model documentation and lessons learned for program replication and provide funding support for study tours or participation in internship courses provided through the model sites.

While strengthening projects at these hot spots to serve as model intervention sites, FHI will continue to build the institutional capacity of local health systems through the provision of ongoing TA and training as well as the development and distribution of standard operating procedures and training manuals for MARP interventions, counseling and testing, STI management, and clinical and home-based care and treatment services. FHI will also continue to improve referral linkages between disparate providers within the existing health system, and will support comprehensive HIV quality assurance and quality improvement (QA/QI) systems in Yunnan and Guangxi, which will help ensure the institutionalization of not only specific health systems improvements but also of the systems strengthening process in these provinces.

FHI will also continue to leverage funding from the GoC and other donors, including support for project offices and selected staff and cost-sharing for TA and training for GoC and GFATM project staff. Services will continue to be coordinated with existing providers, such as testing and treatment, needle and syringe

exchange, and methadone treatment services provided by the GoC, in order to encourage cost-effectiveness and sustainability.

In prior years, FHI developed a performance monitoring system to track program outputs and achievements for implementing agencies, shared standardized operational definitions of monitoring indicators and measurement tools, and provided training in their use to implementing agencies and other USAID cooperating agencies. FHI also helped develop monitoring systems for selected GFATM and China Cares project sites in Yunnan. With FY10 funding, FHI will continue to provide technical support to enhance monitoring systems and will collaborate with other partners to conduct outcome monitoring and/or outcome evaluations, as appropriate, for prevention programs targeting MARPs in FHI-supported sites in Yunnan and Guangxi.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Impact/End-of-Program Evaluation

Increasing women's access to income and productive resources

Budget Code Information

Mechanism ID:	**7411**		
Mechanism Name:	**TASC3**		
Prime Partner Name:	**Family Health International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HTXS	200,000	
Narrative:			
GHCS (USAID) = $134,000 GHCS (State) = $66,000 The GoC has proposed Luzhai in Guangxi province as a "Center of Excellence" for ART care and			

treatment. In FY 2010, FHI will conduct an assessment in Luzhai, in collaboration with GoC to identify gaps in clinical care and to target technical assistance in order to strengthen the linkages between prevention, care, treatment and support for PLHA (principally IDUs) as part of a Continuum of Prevention to Care and Treatment model. Depending on the outcome of the assessment, TA may consist of support for protocol and standard operating procedure development, and training of staff in order to enhance delivery of ART and other clinical services. FHI will also work with supporting the site in utilizing the Patient Management Information System to track clinical outcomes, including mortality, evaluate ART adherence and improve quality of service delivery. FHI will provide funding support to fill implementation gaps and will strengthen coordination and linkages, including referral to programming for ART adherence support activities being implemented by International HIV/AIDS Alliance (Alliance) in partnership with AIDS Care China.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	214,000	

Narrative:

GHCS (USAID) = $143,000
GHCS (State) = $71,000

HIV counseling and testing is not only a vital entry point to provision of care and treatment for PLHA, but also an important component of a comprehensive prevention program. Surveys have indicated that up to 90% of PLHA are unaware of their serostatus despite GoC expansion of free voluntary counseling and testing (VCT) service centers. Reasons for poor uptake of HIV testing include a lack of awareness of the benefits of testing, concerns about privacy and fears of discrimination by health care staff. In addition, some government policies – including a local regulation requiring identification for confirmatory testing – have limited access to counseling and testing, especially among MARPs.

Under FY10 COP, promotion of accessible, high-quality, non-stigmatizing VCT will be continued as a key component of all FHI-supported prevention projects for FSW, MSM and IDUs in Kunming, Nanning, Gejiu and Luzhai. Provision of HIV counseling and rapid testing at these drop-in centers will ensure accessible services for MARPs. Through VCT promotion during outreach activities, staff will refer to wellness/drop-in center-based pre- and post-test counseling and blood-based rapid testing using a nationally recognized test kit. As MARPs show less concern about stigma and discrimination when services are provided through non-government, non-clinic service centers, rapid testing can provide timely results and post-test counseling.

In line with the national testing algorithm, positive results on rapid testing will be referred to CDC for

ELISA screening and confirmatory testing. Individuals confirmed positive are referred directly into the GoC care and treatment system, as well as to home-based care, psychosocial support and other PLHA-specific services supported by FHI and other USAID CAs.

FHI will continue providing comprehensive VCT training to testing counselors to build their capacity to work with marginalized, stigmatized populations. FHI will continue to provide QA/QI using checklists and client satisfaction surveys. Additionally, FHI will continue to build capacity and provide technical assistance for other VCT providers upon request and share VCT QA/QI tools to strengthen VCT quality and systems in Yunnan and Guangxi.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	61,000	

Narrative:

GHCS (USAID) = $41,000
GHCS (State) = $20,000

FHI will develop standardized prevention monitoring tools for MARPs, and provide M&E TA for local implementing agencies (IAs), the RCC Global Fund, and GoC.

As a part of the CPP Model for MARPs in Guangxi and Yunnan provinces, USAID will support the development of standardized prevention monitoring tools for future replication by the GFATM RCC or other donors. Beginning in FY 2010 and continuing into FY 2011, FHI will coordinate this activity across partners to address the following objectives:

Reach consensus among implementing partners on key prevention indicators for prevention programs for FSW, IDU, and MSM relevant to the China context and include standardized operational definitions.
Document best practices on program monitoring forms including examples that can be easily adopted by local partners.
Develop data quality assessment (DQA) procedures including checklists that local organizations can apply as part of their project management.
Develop a basic data use section on how to use monitoring data for improving program performance.

USAID partners will share their prevention monitoring tools, indicators, and operational definitions. FHI will coordinate and organize a series of consultants and meetings to identify lists of key indicators and standardized operational definitions, examples of data collection forms, and promising practices on data collection, data quality analysis (DQA) procedures, and data use. FHI will train local IAs and other USAID

cooperating agencies (CAs) on implementing the tools. FHI and its partners will jointly conduct a DQA on a bi-annual basis to ensure the quality of project data and program implementation.

To better target intervention activities and provide reliable estimates on target population size, all IAs conducting outreach to MARPs will update their mapping of MARP sites and service platforms. In FY 2011, FHI will collaborate with other USAID partners to develop coverage and behavioral outcome monitoring tools for MARPs and an outcome evaluation of the IDU CPP model. FHI will provide TA and training on developing monitoring systems for selected Global Fund and GoC project sites in China, and provide TA in surveillance to local Chinese CDCs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	91,000	

Narrative:

GHCS (USAID) = $61,000
GHCS (State) = $30,000

FHI will continue on-going efforts to strengthen the capacity of implementing agencies in the areas of data use and dissemination, advocacy and program/financial management. FHI will also continue to provide institutional capacity building to strengthen the management systems for the 19 demonstration counties in Yunnan as well as to selected GFATM sites as requested.

As in the past, FHI will continue to support stigma reduction activities through events such as World AIDS Day and through community-based stigma reduction activities conducted by HIV-positive and HIV-negative MARPs. Stigma reduction will also be addressed through regular meetings between service providers and members of target communities, and through sensitization trainings for healthcare providers conducted by FHI country and regional technical staff.

Finally, FHI will continue working to strengthen overall health systems by leveraging prevention, care, treatment and support services provided through USAID CAs, other nongovernmental organizations, the GoC, GFATM, local civil society and the private sector in order to provide MARPs and PLHA with a truly comprehensive set of services as envisioned in USAID's CPP model. A major role for FHI in this process will be continuing to help strengthen coordination and build effective referral networks between disparate providers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	674,000	

Narrative:

GHCS (USAID) = $450,000
GHCS (State) = $224,000

In recent years, sexual transmission of HIV has outpaced injecting drug use as the primary route for new HIV infections. The FHI model for sexual prevention uses trained and salaried peer educators to target MARPs (FSW and MSM) with messages promoting correct and consistent condom use and mutually faithful, non-concurrent sexual relationships. This is combined with support for wellness/drop-in centers where MARPs can access high-quality, user friendly services to manage and treat sexually transmitted infections (STI) and provide HIV counseling and rapid testing as applicable. Condom use is promoted during outreach activities and supported by local Family Planning (FP) clinics and condom social marketing is provided by PSI.

Under COP FY10, FHI will continue to strengthen HIV prevention interventions for MARPs in three hot spots in Yunnan and Guangxi:

FSW projects in Kunming and Luzhai will target women at greatest risk due to lower transactional fees and higher numbers of clients and will link FSW to wellness/drop-in centers and local FP clinics.
Most traditional MSM venues are covered by existing interventions in Kunming and Nanning. FHI will increase health education through Internet-based outreach and SMS text messaging to reach those who do not frequent public venues.

The hot spots described above will also serve as learning centers for model scale-up by government and GFATM-supported projects, with on-going technical assistance by FHI to strengthen strategic behavior communications, MARP-friendly STI diagnosis and treatment, counseling and testing services, M&E, and linkages to clinical care and support including supportive interventions.
FHI technical staff and partners will ensure service quality through regular monitoring and use of QA/QI checklists and regular client satisfaction surveys. FHI has also designed a performance monitoring system to routinely track outputs and achievements.

Finally, the projects will leverage existing platforms to offer more comprehensive and sustainable services by linking to providers including GoC-funded STI and VCT clinics, PLHA care and treatment organizations, and income generation services and training provided by USAID partners and other organizations.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	260,000	

Narrative:

GHCS (USAID) = $174,000
GHCS (State) = $86,000

The HIV epidemic in China initially emerged among IDU in the southwest border region and continues to account for the largest number of infected individuals. Prevalence among IDUs in Yunnan has ranged from 40% to 80%. Up to 22% of male IDU and 21% of female IDU have reported engaging in commercial sex. Only a minority report having used condoms at last commercial sex. The situation is complicated by incarceration in "rehabilitation centers" where needle-sharing is believed to be common; upon release many former IDU return to communities where pressure and distrust contribute to high rates of relapse. USG supports the development of a comprehensive package of prevention, care and treatment services for IDU.

FHI will strengthen this package of services by delivering HIV prevention interventions for IDU in Gejiu City. Trained and salaried outreach workers and/or peer educators will reach IDU in their communities and will disseminate messages encouraging IDU to stop injecting drugs or to minimize sharing needles and other injecting equipment. FHI will continue to support a drop-in center where IDU can access HIV counseling and rapid testing, be treated for abscesses and opportunistic infections, and receive community and family support to quit and/or stay off drugs. The project will provide home-based care and support to PLHA/IDU.

FHI will leverage other service providers through linkages with existing services including MMT and NSP that are supported by the GFATM and the GoC. FHI will refer clients for care and treatment (provided by the GoC) and STI services as needed.

FHI will continue to strengthen Gejiu as a "center of excellence" for community-based IDU interventions. This project will serve as a model site to promote scale-up by other GoC and GFATM-supported projects. FHI technical staff and local partners will ensure quality through regular monitoring using QA/QI checklists, regular client satisfaction surveys, and a routine performance monitoring system. FHI will document the outcomes of this project. FHI will continue providing TA and support to the IDU project in Luzhai to increase staff capacity and effective linkages between services.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 7414	Mechanism Name: Health Policy Initiative
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Research Triangle Institute, South Africa	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 716,150	
Funding Source	**Funding Amount**
GHCS (State)	235,000
GHCS (USAID)	481,150

Sub Partner Name(s)

AIDS Project management Group	Macfarlane Burnet Institute for Medical Research and Public Health	

Overview Narrative

HPI aims to improve the enabling environment for HIV prevention, care and treatment in the Asia Pacific region by ensuring:

- national and local HIV policies, plans and programs, based on international best practice, are adopted and implemented;
- effective public sector and civil society champions and networks are developed, strengthened, and supported to assume leadership in the policy process; and
- timely and accurate data are used for evidence-based decision making.

In order to facilitate greater service utilization and to improve quality, HPI strengthens the enabling environment as it relates to supporting MARPs and PLHA. Activities are carried out in support of the USG's comprehensive and coordinated approach to China and in collaboration with the other USAID-funded cooperating agencies, with a focus on strengthening the supportive interventions within the context of the Comprehensive Package of Services (CPS) and Comprehensive Prevention Package (CPP). CPP and CPS ensure that MARPs can access a minimum set of HIV interventions: behavior change communication, counseling and testing, condom promotion and distribution, STI treatment, and linkages to care and treatment. HPI provides assistance in the documentation and packaging of the CPS

and CPP models so that these approaches can be cost-effectively scaled up beyond the USAID-funded program. Specifically, HPI directly contributes to 5 of the 6 supportive intervention components: policy, strategic information, capacity building, community mobilization, and stigma and discrimination (but not income generation).

The project works at the macro/structural level, rather than within specific hotspots. It works with both government and emerging civil society sector, and in so doing, promotes partnership between these stakeholders in support of a more enabling environment. Non-discrimination, gender equality and participatory approaches underpin the work.

HPI works at the national level and in Yunnan province, with some outreach activities to Guangxi province.

A review of the supportive interventions under the CPP is planned for December 2009. As a result, HPI planned activities for FY10 may be adjusted to respond to the findings of the review.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7414**		
Mechanism Name:	**Health Policy Initiative**		
Prime Partner Name:	**Research Triangle Institute, South Africa**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	103,355	
Narrative:			
GHCS (USAID) = $68,355 GHCS (State) = $35,000			

An impact evaluation of the CPP Model for IDU in Guangxi and Yunnan provinces will be conducted in FY 2010 and FY 2011. The IDU model includes behavior change communication, needle and syringe exchange, substitution therapy, HIV counseling and testing, linkages to clinic-, community-, and home-based care and treatment and income generation, and community-based PLHA group support services for HIV-positive IDU and their families. HPI/GMR-C will lead the coordination and documentation of the development and implementation phases of the IDU model and the development of standard operating procedures in collaboration with the other USAID CAs. Specific activities will include:

• Facilitate and coordinate the development and implementation of common tools, checklists, and approaches to quality assurance of service provision across the CAs.

• Conduct the IDU CPP impact evaluation study in 4 of the 7 "hot spots" (Gejiu, Kunming, Nanning, and Ningming) to address the following key research questions:

o What is the impact on risk behaviors resulting from the implementation of the comprehensive prevention package of services targeting IDU?

- Does a minimum package of prevention services lead to a greater reduction of risk behaviors?
- Do supportive interventions advance the impact of the minimum package of prevention services?
- Does CPP lead to greater access of IDU PLHA to care and treatment?

A quasi-experimental design will be used with two rounds of data collection for the control and intervention sites. A triangulation analysis with the MMT cohort study in 54 clinics in Guangxi will be proposed.

• Package, document, and disseminate the USAID CPP model for a wider audience and support the adoption of successful models. Dissemination of the model may include assisting GoC to issue official policy briefs, fact sheets, success stories, high-level forums with stakeholders, one-on-one meetings, and conference presentations.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	612,795	

Narrative:

GHCS (USAID) = $412,795
GHCS (State) = $200,000

HPI will target issues identified in the 2009 Minimum Package of Services and Supportive Interventions

reviews, in line with the Comprehensive Service Package and Comprehensive Prevention Package approach, as follows:

A. Ensuring national and local policies and plans are adopted--HPI provides TA in policy development, implementation and monitoring, supports government and civil society to improve policies and legal frameworks. Policy environment has improved, but vague policies and local implementation remain challenges. Ongoing FY11 activities include:
- VCT (Yunnan, Guangxi): Promote NGO role in administering rapid tests; facilitate policy dialogue and implementation to strengthen PITC.
- MMT (Yunnan): Strengthen policy linkages between PSB and Public Health Bureaus; address barriers to MMT access and uptake and IDU rights through HIV legal center.
- NGO regulatory environment (Yunnan): Build on relationships with the Civil Affairs Bureau, emerging civil society and other stakeholders to track civil society development; document NGO registration experiences; advocate for policy improvements with GFATM; forge relationships with government supervisory units and build their capacity to work with MARP- and PLHA-driven NGOs; provide TA from legal center to NGOs wishing to register.
- Stigma and discrimination (Yunnan, Guangxi): Promote legal rights of MARPs/PLHA by supporting government to improve policies and service quality by removing legal and procedural barriers to access; work with PHB to reduce stigma and discrimination by health workers.

B. Strengthening civil society champions and advocates, enabling environment, legal rights, and mitigating stigma and discrimination:
- Advocates (Yunnan, Guangxi): Support PRISM database to assist CA capacity building; expand Resource Needs Estimation Tool (RNET) to MSM treatment and care; develop advocacy plans by PRISM and RNET users and execution via small grants.
- Legal rights and policy champions (Yunnan): TA to the legal clinic to track advocacy issues; TA to develop materials to inform MARPs and PLHA of their rights and strengthen referrals between services and legal center; document legal center model and sustainability.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10178	**Mechanism Name: China CDC COAG**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and	Procurement Type: Cooperative Agreement

Prevention	
Prime Partner Name: Chinese Center for Disease Prevention and Control	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,345,000	
Funding Source	**Funding Amount**
GAP	915,000
GHCS (State)	1,430,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of this cooperative agreement award to China CDC is to facilitate China's prevention, treatment and care programs for HIV/AIDS by improving the effectiveness of national and provincial programs. This award spans all technical areas in which CDC GAP-China works: PMTCT, sexual prevention, drug use, counseling and testing, adult and pediatric care and treatment, TB, lab, SI and health systems strengthening.

China CDC's programs cover the entire country and population. Most of the HIV/AIDS programs focus on targeting specific MARPs including IDU, MSM, FSW and other vulnerable populations.

China CDC is the leadership body for HIV/AIDS programs in China. They propose national policies, develop the national action plan, influence provincial and local level activities and reporting mechanisms, carry out GFATM programs and facilitate donor coordination. China CDC supports national, regional and district level systems that deal with financing HIV/AIDS programs.

Since China CDC works in all areas of HIV/AIDS programming several cross-cutting and key issues are addressed, including HRH, TB, gender and mobile populations.

HRH

China CDC runs 13 HIV/AIDS clinical training centers to ensure physicians from across China are familiar with HIV/AIDS care and treatment issues. China CDC contributes to the Lixin and proposed Luzhai Rural HIV/AIDS Clinical Training Centers for physicians and the PPMTP training program for HIV/AIDS program managers.

Gender
Many of the China CDC HIV/AIDS programs touch on gender issues including PMTCT, testing and counseling and care and treatment for FSW, female IDU and wives of MSM. These programs deal both with providing services to women and providing gender equity for all HIV-infection persons.

Mobile Populations
Mobile populations are one of the other vulnerable populations targeted in China. Many people move from the countryside to urban areas for work. In addition to internal mobile populations, there are also immigrants who enter China from areas of higher HIV/AIDS prevalence. These people include women who enter China to become brides and mobile populations at the border areas. Recently many Chinese workers have been traveling to sub-Saharan Africa to work. These men may be sailors or workers who live and work in Africa. Many of them return to China when their work is over. These mobile populations are targeted by testing and counseling efforts. Since many may move again after they have been diagnosed, additional efforts are made to continue their treatment.

One of USGs main strategies is to help China CDC become more cost efficient. This is done through increased coordination and de-duplication of efforts with GFATM, other international partners, and other China CDC divisions, including the NCWCH and TB divisions.

China CDC is in the process of evaluating their HIV/AIDS program and developing a new M&E framework to go along with the next 5-year National Plan for HIV/AIDS implementation. The current efforts will include evaluating both outputs and impacts to see if the HIV/AIDS program has been effective in its efforts.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,770,000

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Mobile Population
TB

Budget Code Information

Mechanism ID:	**10178**
Mechanism Name:	**China CDC COAG**
Prime Partner Name:	**Chinese Center for Disease Prevention and Control**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	249,100	

Narrative:

Base (GAP account): $93,300
GHCS (State): $155,800

The population covered by China CDC's efforts is the entire population of China. Since China has a targeted HIV epidemic, MARP groups including MSM, IDU and FSW are targeted more aggressively than others. China CDC provides care and support services to HIV/AIDS patients through the Four Frees and One Care program which covers rural and poor populations in China. Most service delivery sites are facility-based, although there is a movement to become more community- and home-based.

Activities supported in adult care and support in COP FY10 by GAP funds will include:

• Providing TA to China CARES and RCC to better implement comprehensive care and support services to PLHA, including serodiscordant couples.
• Assist in the enrollment of PLHA into MMT clinics and the provision of peer psychological support and follow-up services to these IDU
• Assist in the use of IDU peers to improve ART adherence among PLHA
• Assist RCC to scale up MMT clinics as a platform for care and support to HIV- positive IDU as well as promote the integration of care and support with ART services in seven IDU driven HIV epidemic provinces. Activities will include establishing PLHA self-help groups for improving enrollment rates, follow-up rates and adherence, setting up DOT in MMT clinics, conducting quarterly CD4 testing, providing cotrimoxazole for OI prevention, and setting up referral services to ANC, ARV, and TB clinics.
• Work toward strengthening links between VCT, prevention, care, and treatment to increase follow-up and referral rates and develop comprehensive care packages

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	185,800	

Narrative:

Base (GAP account): $87,000
GHCS (State): $98,800

The population covered by China CDC's efforts is the entire population of China. Since China has a targeted HIV epidemic, MARP groups including MSM, IDU and FSW are targeted more aggressively than others. China CDC provides treatment to HIV/AIDS patients through the Four Frees and One Care program which covers rural and poor populations in China. However, information about all patients on AIDS treatment, including test results and clinical outcomes, are tracked using the national web-based disease database. Clinical outcomes are evaluated using CD4 count and viral load levels, which are maintained the database. GoC has begun using WHO Early Warning Indicators for drug resistance and have pilot studies directly assessing drug resistance in specific areas. The GoC recently published a paper in the Annals of Internal Medicine titled Five-Year Outcomes of the China National Free Antiretroviral Treatment Program, quantifying clinical treatment outcomes from the past five years. China CDC estimates 85,000 people currently in need of ART and expects to provide ART to 80,000 people by 2010. Cotrimoxazole prophylaxis is not recorded in the web-based database system, so less information is known on coverage of its use. TB screening is carried out by the Division of TB and is not yet fully integrated with the HIV program.

Training activities for physicians are provided through 13 HIV/AIDS national clinical training centers, the Lixin Rural HIV/AIDS Clinical Training Center and proposed Luzhai Rural HIV/AIDS Clinical Training Center. These centers will provide residency programs to practicing physicians. In-service training is provided to laboratory staff to conduct CD4 count, viral load, and drug resistance testing.

Activities supported in adult treatment through FY10 GAP funds will include:
• Providing TA to China CARES and RCC to better implement the National Free ART program which provides 1st and 2nd line ART, OI management and prophylaxis, CD4 and viral load testing, clinical monitoring and follow-up
• Assisting the RCC scale-up a community- and home-based treatment model in 76 counties. This will include strengthening the three-tier village, township and county health network system to provide quality ART services to patients.
• Providing TA to NCAIDS to scale up the 2nd line ARV program to additional provinces and will assist 15 provinces improve CD4 and VL testing rates based on the national guidelines.
• Provide TA on integrating the new M&E plan into the National Free ART Program.
• Assist in the pilot of HIV/HBV and HCV co-infection programs in Guangdong and Guangxi provinces.
• In cooperation with Guangxi Health Bureau, open the 2nd Rural AIDS Clinic Training Center in Luzhai, Guangxi. The placement will help the scale-up ART services to rural and suburban IDU populations and will strengthen referral services between MMT clinics, PMTCT and ART programs, particularly in that

high-prevalence area

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	377,700	

Narrative:

Base (GAP account): $141,400
GHCS (State): $236,300

CDC China will be supported for testing and counseling activities both at the national and provincial CDC level. Testing and counseling activities will focus on MARPs and discordant couples.

GAP-supported testing and counseling activities will include several projects. Assisting with the development ofa VCT data quality evaluation protocol. Assisting with the implementation of a VCT data quality evaluation. Improving VCT utilization and quality. Assisting in the development of the Chinese PITC technical guidance and guidelines for PITC implementation. Facilitating PITC advocacy and policy support at the central level. Technical support for pilot tests of saliva rapid test acceptance.

Testing and counseling activities at the provincial level will include: Assisting with scale-up, summary and promotion of PITC models. Supporting testing and counseling activities among MARPs. Assisting with pilots of multiple testing and counseling models such as couples testing and counseling and community-based testing and counseling. Assisting with improvement of VCT services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	73,800	

Narrative:

Base (GAP account): $27,600
GHCS (State): $46,200

The population targeted by China CDC is the population of China. Testing, care, support and treatment for HIV positive children is provided by the GoC through the Four Frees and One Care policy and the National Free HIV/AIDS Pediatric Treatment Program.

GAP funds support China CDC's pediatric care and support by providing technical assistance and training. Activities to be conducted with FY10 funds include:

• Assisting Global Fund strengthen the three-tiered health system to involve families in pediatric care and

support, including OI screening and management
• Train physicians in screening and treatment of pediatric OIs, including TB, and revise the national HIV/AIDS training curriculum to include best practices
• Increasing links between NCWCH and NCAIDS to ensure that children placed on ART receive proper care services
• Encourage the use of cotrimoxazole when indicated for children and champion for collection of this information in the web-based reporting system
• Collaborate with UNICEF, WHO and Clinton Foundation to assist NCWCH and NARL in establishing a sound China-specific EID testing algorithm, guidelines and laboratory capacity
• Clarify and publicizing new EID guidance. Provide technical assistance on pilot projects for EID.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	70,300	

Narrative:

Base (GAP account): $32,300
GHCS (State): $38,000

The population targeted by China CDC is the population of China. Testing, care, support and treatment for HIV positive children is provided by the GoC through the Four Frees and One Care policy and the National Free HIV/AIDS Pediatric Treatment Program. China CDC supplies free drugs to pediatric AIDS patients.

GAP funds support China CDC's pediatric treatment program by providing technical assistance and training. Activities to be conducted with FY10 funding include:

• Assisting Global Fund strengthen the three-tiered health system to involve families in pediatric treatment and improve adherence
• Train physicians in pediatric screening and treatment, including 2nd line treatment, and revise the national HIV/AIDS training curriculum to include best practices
• Increasing links between NCWCH and NCAIDS to ensure that children placed on ART receive proper clinical monitoring

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	357,300	

Narrative:

Base (GAP account): $147,300

GHCS (State): $210,000

CDC GAP China funds will provide technical assistance for SI activities in HMIS, M&E and surveillance. GAP-supported SI activities through China CDC will include:

• Assisting with development of China's Five-Year Action Plan for HIV/AIDS (2011-2016), particularly for M&E.
• Facilitating national M&E of provincial HIV/AIDS control activities.
• Providing assistance with size estimations and projections of HIV among MARPs.
• Supporting training in the Asian Epidemic Model (AEM).
• Assisting with trainings on the national surveillance system.
• Providing technical assistance for contact tracing among newly-reported HIV cases in 3 provinces.
• Assisting with development of provincial Five-Year Action Plans for HIV/AIDS, particularly for M&E.
• Facilitating program-level M&E of provincial AIDS control activities.
• Supporting provincial training in data analysis and use.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	155,700	

Narrative:

Base (GAP account): $58,300
GHCS (State): $97,400

China CDC in collaboration with USG will address the need for a health workforce capable of managing and implementing HIV/AIDS programs at the provincial and local levels of government as well as capable of providing HIV/AIDS specific medical services in rural areas of China. Additionally, China CDC will address strengthening laboratory quality, surveillance methods, PITC, roll-out of 2nd line ART, and challenges of controlling HIV/AIDS in a vertical system.

China CDC will address system barriers in a multitude of ways including requesting support for technical assistance from CDC. The three training programs (Lixin Rural AIDS Clinical Training Center, Luzhai Rural AIDS Clinical Training Center, and Provincial Program Management Training Program) will continue to be co-managed by China CDC and USG and are designed to support in-service training of health care workers who will be able to conduct HIV/AIDS activities at a higher quality.

Laboratory quality will be a major area of emphasis in FY10 and FY11 for China CDC. This includes adoption of accreditation systems for laboratories in China, strengthening the capacity of existing

laboratories to operate at high standards of quality, and piloting of newer techniques and international best practices.

China CDC has and will continue to support intentional spill-overs of systems in China as related to HIV since strengthening across these systems will directly and indirectly impact HIV control. This includes continued work with the TB system to address TB/HIV co-infections, MCH to strengthen PMTCT, and MMT clinics and detoxification centers to address the high rates of HIV among IDU.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	131,100	

Narrative:

Base (GAP account): $49,100
GHCS (State): $82,000

In recent years, sexual transmission of HIV has outpaced injecting drug use as the primary route for new HIV infections. FSW (especially low-fee ones), men who have multiple concurrent partners, HIV discordant couples, and MSM are all contributing to the increase of sexual transmission of HIV. Compared to that of other groups, the epidemic among MSM in China is rapidly increasing.

Under COP FY10, China CDC will continue to strengthen HIV sexual prevention interventions in 15 provinces.

To prevent HIV transmission through commercial sex, GoC has set up "high-risk intervention teams" throughout the country to insure implementation of the 100% CUP. Shortcomings of the current 100% CUP, including poor implementation due to low staff capacity, low coverage, and reliance on the stand-alone intervention of condom distribution without concurrent efforts placed on VCT, behavior change, and STI service provision, will all be addressed.

China CDC will also conduct field test of interventions for street-based FSW and older clients. This subgroup of FSW and older male clients who visit them have higher prevalence of HIV and STIs, and they are usually not reached by current entertainment venue-based 100% CUP programs.

For MSM interventions, political opinion leader (POL) has become a standard intervention model focusing on change of group norms. In the FY10 COP, prevention counseling and other individual level intervention will be incorporated into the comprehension intervention package to enhance its effectiveness. CDC technical staff will ensure service quality through regular monitoring and regular

client satisfaction surveys. CDC has also designed a program database system to routinely track outputs and achievements.
With FY10 funds, USG will continue to provide technical support to GoC to improve the quality of sexual prevention interventions by revising the national guidelines, strengthening the capacity of implementing staff, and linking sexual prevention with STI treatment, HIV testing, counseling, care, and treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	273,200	

Narrative:

Base (GAP account): $102,300
GHCS (State): $170,900

Drug use is an important driver of the HIV/AIDS epidemic in China and the major transmission mode in China's southwestern provinces and Xinjiang in the northwest. The cumulative number of reported HIV cases in China as of October 2008 was 276,335, 32.8% of whom were infected via IDU. Of the 1.1 million registered drug users in China by the end of 2008, approximately 15% are women. The estimated number of actual drug users is 2-3 times higher than the registered number. It is estimated that 77.5% drug users use heroin and 55.7% inject.

MMT is the core intervention for IDUs in China. By May 2009, 625 MMT clinics have been set up in 23 provinces. GoC has a target of 1,000 MMT clinics to be operational by the end of 2009. As of May 2009, there were 204,165 clients enrolled in the national MMT program with 104,239 clients currently on treatment. As a complement to MMT, GoC has also launched a nation-wide needle and syringe program (NSP) to reduce HIV transmission risk among IDU. By the end of 2008, 897 NSP sites were set up in 26 of 31 provinces, covering 526 counties. The average monthly coverage of the program is 36,000 IDU.

Funds to China CDC in the FY10 COP will support improvements in MMT services including scale up of peer educators and outreach workers to increase MMT enrollment countrywide and improve retention. An assessment of the national MMT program will provide information for program improvements and generate data for decision making. Building strong linkages with care and support services will promote referrals between detoxification centers and MMT as well as with MMT and HIV/AIDS treatment and care programs. China CDC will support an evaluation of the NSP program to determine its efficacy. In addition, China CDC will develop a technical assistance program aimed at sharing China's MMT experiences with other countries that have an IDU-driven epidemic, such as Vietnam, Ukraine, Kazakhstan and other Central Asian countries. The program will consist of workshops, sending Chinese experts abroad as consultants, and receiving study tours from other countries.

Via provincial CDCs, China CDC will support provincial MMT clinics and associated community groups to train outreach workers and female IDU peer educators on condom promotion and behavior change targeting female IDU.

Via China CDC, USG and its partners will continue strong integration and collaboration with national and local government partners, GFATM, and the Australian government-funded highly active antiretroviral therapy (HAARP) project to promote success in reducing the HIV epidemic.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	66,200	

Narrative:

Base (GAP account): $24,800
GHCS (State): $41,400

CDC-GAP China funds will support the GoC in carrying out comprehensive PMTCT activities at the community, district and provincial levels and coordinate the program areas of testing, treatment, care, lab, and SI. These activities will help the GoC reach their national goal of reaching over 3.2 million women in 533 counties (nearly 20% coverage nationally) by September 2010.

Specific GAP-supported PMTCT activities with FY10 funding will include:

• Piloting routine syphilis and HIV rapid screening in ANC clinics in two provinces
• Evaluating the feasibility and applicability of repeat HIV testing in late pregnancy and/or at delivery targeting high-risk populations of women
• Supporting a model PMTCT pilot program in Guangxi and adding 25 counties
• Supporting a new PMTCT model pilot program in Yangjiang city, Guangdong
• Providing technical assistance implementing early infant virologic diagnosis in 7 provinces
• Assisting with additional development of the national web-based PMTCT data management and reporting system
• Strengthening linkages between MMT and PMTCT services
• Conducting supervisory visits by senior staff to improve implementation in the provinces
• Updating PMTCT regimen guidelines
• Assisting with the harmonization of PMTCT guidelines
• Supporting the application of the new WHO PMTCT guidelines (expected in November 2009).
• Clearing key policy barriers

• Expanding PITC in premarital health screenings

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	379,200	

Narrative:

Base (GAP account): $142,000
GHCS (State): $237,200

CDC GAP China funds will support China CDC laboratory activities for capacity building in the National AIDS Reference Laboratory (NARL) in NCAIDS and provincial CDC laboratories.

GAP-supported laboratory activities at NCAIDS will include:

• Strengthening the national laboratory test quality by assisting NARL's CAP accreditation process and extending domestic PT program network
• Assisting with the establishment of an early infant diagnosis laboratory network using testing algorithms, guidelines, and supplementary nucleic acid assay(s) for the timely return of high quality lab data. Linking infected infants to care to treatment following the upcoming Chinese PMTCT/EID expansion efforts
• Piloting new incidence assays developed by US CDC and evaluating their use as independent assays or in combination with BED to enhance the accuracy of incidence measurement
• Evaluating the potential and utility of novel point-of-care and specimen collection/transport technologies in partnership with international manufacturers to overcome low CD4 and viral load coverage obstacles
• Evaluating the utility of fourth generation assays for the identification of persons with acute HIV infection and the utility and effectiveness of using oral exudates-based assays for most-at-risk populations including IDU, MSM and FCW
• Assisting NARL and provincial CDCs with quality assurance of domestic rapid tests and their appropriate use at VCT sites

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	25,600	

Narrative:

Base (GAP account): $9,600
GHCS (State): $16,000

The TB division of China CDC creates host county national policies and strategic plans and is the main actor on TB issues in China. Training of health care providers on TB/HIV co-infection will be conducted at

the Lixin and proposed Luzhai Rural HIV/AIDS Clinical Training Centers. These centers will provide residency programs to practicing physicians. Training includes TB and other OI screening, prevention and treatment among HIV positive patients. National TB data is reported through the web-based China Information System for Diseases Control and Prevention database. TB data is reported separately from HIV data. The TB and HIV programs also have separate M&E programs. FY10 COP funding to CDC China will assist the national TB and HIV programs by promoting screening, treatment and care models for TB/HIV co-infected patients. GAP-supported TB/HIV activities will include: providing daily technical assistance and support to National TB Center and NCAIDS on TB/HIV related issues, including technical guideline, data collecting and reporting, and M&E; assisting with operation manual development on TB/HIV co-infected IDU, and piloting the manual at one IDU-driven site; promoting PITC in TB clinics in 7 high HIV prevalence provinces; promoting TB screening in ARV clinics, and HIV PITC in TB clinics in 5 counties in Henan; and supporting training of physicians to treat HIV and TB co-infections at the Lixin and Luzhai training centers.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10196	**Mechanism Name: Strengthening Pharmaceutical Systems**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 100,000	
Funding Source	**Funding Amount**
GHCS (State)	20,000
GHCS (USAID)	80,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Management Sciences for Health's (MSH) Strengthening Pharmaceutical Systems (SPS) Program provides technical assistance to support the strengthening of pharmaceutical management operations for the HIV/AIDS program in China to improve the availability of and access to treatment.

In December 2008, MSH/SPS reviewed pharmaceutical management operations at ART treatment and distribution sites in Guangxi Province and worked with stakeholders, including WHOand NCAIDS at the national level, and Bureau of Health (BOH) and Chinese CDC managers at the provincial level, to develop an action plan for strengthening the pharmaceutical management system for ARVs in Guangxi.

Following this review, SPS met with stakeholders from Guangxi, NCAIDS and WHO in Nanning and Beijing to present key findings and identify activities that SPS could potentially support. The activities reviewed and agreed upon in principle included developing draft standard operating procedure (SOP) manuals for managing ARV medicines based on existing systems and revising formats to standardize and strengthen operations. Subsequently SPS drafted a set of three SOP manuals and related tools for managing the supply and use of ARVs and medicines used to prevent or treat opportunistic infections for each operational level of the pharmaceutical management system—namely, the provincial store, city and county CDC offices, and service delivery sites. These drafts were then reviewed with national stakeholders during a validation workshop in Guangxi and final versions were prepared.

In FY09, SPS, in collaboration with WHO/China and Guangxi authorities, continued to conduct training of trainers for implementation of the validated SOPs. SPS will continue to provide support to Guangxi as the SOPs are rolled out to treatment facilities throughout the province.

With FY10 funds, SPS will continue to provide technical assistance to address pharmaceutical management issues in Guangxi, with a focus on use of the electronic tools developed to facilitate pharmaceutical management in treatment sites. In addition, in FY10 SPS will work with NCAIDS to make the lessons learned in Guangxi on SOP development and implementation available at the national level. SPS plans to provide technical assistance to NCAIDS in developing national standard operating procedures and tools for pharmaceutical management that can then be adapted and rolled out to other provinces in China.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10196**
Mechanism Name:	**Strengthening Pharmaceutical Systems**
Prime Partner Name:	**Management Sciences for Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	100,000	

Narrative:

GHCS (USAID) = $80,000
GHCS (State) = $20,000

SPS proposes two main activities FY10 funding that will contribute to strengthening pharmaceutical management operations for HIV/AIDS in China:

1. Continued support to Guangxi for Standard Operating Procedure (SOP) and tool implementation in treatment facilities--This activity is continuing from the previous year, when SOP implementation in Guangxi began. SPS will continue to assist health authorities in Guangxi in SOP implementation and use of related tools. SPS will visit selected sites in Guangxi to assess progress on implementation and provide on-site technical support. SPS will suggest revisions to the SOPs and adapt tools as necessary. SPS will also provide distance-based support to Guangxi as required.

2. Development of national standard operating procedures and related tools with NCAIDS--SPS will work with NCAIDS to develop a set of national standard operating procedures, including the necessary forms and tools, which provinces can then adapt to their specific contexts. These national SOPs and tools will provide the overall framework for pharmaceutical management operations in China. In addition, as NCAIDS is in the process of developing a management information system for the ART program, SPS will provide assistance so that key pharmaceutical management data is included.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10197	**Mechanism Name: Community REACH Greater Mekong Region Associate Award**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Pact, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,320,000	
Funding Source	**Funding Amount**
GHCS (State)	417,000
GHCS (USAID)	903,000

Sub Partner Name(s)

AIDS Care China	Blue Sky	International HIV/AIDS Alliance
Other	TBD	

Overview Narrative

REACH covers a breadth of key technical and cross-cutting areas, and supports and mobilizes local partners in the HIV/AIDS response. Its goals are to "enhance the scale, quality and effectiveness of the HIV prevention, care, support and treatment interventions in the region through the efficient provision of grants along with organizational capacity building."

REACH covers Burma, Thailand, Laos, China and Regional. Objectives are: 1) Reduce HIV transmission among MSM; 2) Improve quality of life of MARPs and PLHA by increasing livelihood skills and income generating opportunities and enabling access to prevention, care and support; 3) Develop, and disseminate effective models and methodologies for prevention, care and support for PLHA/MARP livelihoods.

REACH provides a grants mechanism to improve CBOs' service delivery through tailored organizational capacity building (OCB) using participatory methods. OCB includes training and mentoring in business

planning and managing livelihoods projects for PLHA/MARP support groups and PLHA-run businesses. The result is civil-society strengthening, good governance and improved linkage of PLHA groups to local markets for sustainability, access to care and treatment, and public-private partnerships (PPPs). Other benefits include technical innovation; linking comprehensive prevention community care and support pilots for MARPs including supportive interventions; support for SI including PACT's approach to monitoring and evaluation, research and learning (MERL) at the CBO level; documentation of models; and scale up with GFATM.

REACH achieves efficient programming by combining grants with OCB for CBOs to become more sustainable; working with CBOs to use financial data to improve budgeting and resource allocation; leveraging models and scaling them with GFATM funds; and developing cost-effective approaches to TA from local providers.

REACH develops M&E plans and works with CBO partners to improve data quality and harmonized reporting frameworks. REACH develops MERL guidelines for prevention, care, support and livelihoods interventions, and TA on M&E for improvements in implementation, targeting and effectiveness. In FY10, Pact will introduce the MERL approach to build community buy-in for M&E and participatory approaches.

Pact's livelihoods strengthening (LS) models (i.e., economic strengthening) for PLHA/MARPs fortify other CPS interventions and are a critical supporting intervention for stigma reduction and community mobilization, governance and civil society development. Vocational skills training and counseling for recovering IDUs eases reintegration from drug rehabilitation treatment into the community, reducing the risk of relapse and reducing internal stigma. LS improves community mobilization and participation of MARPs.

REACH implements 6 partnerships in 4 hotspots: 3 hospital-based PLHA support groups; 1 support group of MMT clinic clients living with HIV; 1 IDU drop-in center; and 1 medium-sized social enterprise managed by and employing rehabilitated IDU. By FY11 Pact will develop operational guidelines, and focus on scaling up and refining these models through TA.

As a sub-partner, the International HIV/AIDS Alliance (Alliance) focuses on MARP community mobilization, in order to expand coverage, ensure appropriateness of interventions, and generate community ownership. This is critical for tackling the internal stigma and denial that exists within MARPs.

Alliance supports 4 models of community-organizing: 1) managed community team (to reduce dependency on government partners); 2) independent commercially-registered CBOs (AIDS Care China), 3) MARP network with government leadership; and 4) MARP network without government membership.

Key contributions to HSS include MARP group institutional capacity building; network development; strengthening MARP community involvement in prevention and care; peer-led MMT adherence; and care and support programming for MSM.

In Yunnan province, target groups are MSM Care and Treatment Support, PLHA Network Support and PLHA small grants, and MSM network support in Kunming; MSM Drop in Center and outreach in Kaiyuan, Gejiu and Mengzi; and IDU PLHA psychosocial support in Gejiu. In Guangxi province, target groups are IDU peer-led MMT and ART adherence support, MSM network support, MSM care and treatment adherence support, and PLHA CBO peer treatment adherence support in Nanning; and PLHA CBO peer treatment adherence support in Luzhai. Other hotpots in Guangxi include Ningming and Pingxiang.

Gender equity is addressed in relation to treatment access, prevention access for IDU, and care and support access. Male norms and behaviors are directly addressed by all interventions targeting MSM and prevention programming targeting IDU.

A key strategy for cost efficiency is to ensure the transfer of technical capacity from USAID interventions to the larger pool of local government- and donor-supported interventions. Mechanisms include toolkits which enable replication, learning exchanges, leveraging other donors' funds for scale up, and technical workshops.

Partners report quarterly against annual indicators. Partners receive TA to develop their own monitoring systems and conduct an annual review and re-planning process.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	294,000

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	10197		
Mechanism Name:	Community REACH Greater Mekong Region Associate Award		
Prime Partner Name:	Pact, Inc.		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	469,600	

Narrative:

GHCS (USAID) = $313,600
GHCS (State) = $156,000

With FY10 funding, Pact, through the Alliance, will continue to support care and support activities at 5 sites in Yunnan and Guangxi.

Activities will be conducted with HIV+ IDU in Gejiu; HIV+ MSM in Kunming and Nanning; PLWHA in Nanning and Luzhai; and HIV+ MMT Clinic attendees in Nanning. Activities include home & hospital visits, peer psycho-social support/counseling, PLWA support group, positive prevention activities, and family support groups. These will be located in government-run clinics or hospitals ensuring direct linkages with, and referrals between, clinical services and include a peer-ART treatment adherence support service component.

Support will be provided to local partners to develop and monitor the quality of programs, including client database development support, training on counseling and psycho-social support skills, supporting the development of basic peer-support service protocols, and PLWA group development support.

Pact will provide livelihood strengthening support for PLHIV and their family members through interventions with partner PLHA support groups. This will involve support in small business development through training and mentorship, a micro-loans scheme for individual PLHA and their families, capacity building for project planning, implementation and evaluation for the group leadership, and other related interventions as needed.

In FY11, Pact will disseminate its program experience and promote the use of tools and materials through an AIDS and livelihoods capacity building center which will have been set up in FY10. The center will be the hub for local capacity development and for a network to support scale up of the program and TA provision to GoC and GFATM.

Pact will scale up its interventions through direct support to current partners, especially in the hotspots

where the COPCT interventions are being developed. Pact will also develop variations of its model through initiating cooperation with new partners. Interventions will be linked with other services through a network of referrals. Pact will also work to reduce barriers and create linkages for PLHIV to access mainstream livelihoods services such as micro-loans and health insurance.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	116,800	

Narrative:

GHCS (USAID) = $86,800
GHCS (State) = $30,000

Under COP10, Pact, through the Alliance, will continue to support ART adherence interventions at 4 sites, adding a fifth site following a Participatory Community Assessment conducted among HIV+ MSM in Nanning in FY10. All adherence activities are integrated into the care and support programs funded by USG and GoC.

The activities will be conducted among the following populations in specific geographic locations: HIV+ IDU in Gejiu; HIV+ MSM in Kunming and Nanning; PLWHA in Nanning and Luzhai; and HIV+ MMT Clinic attendees in Nanning.

The service model consists of clinic and hospital-based peer-led ART adherence support. Model implementation varies according to the 3 service delivery point. At China CDC sites, newly diagnosed PLHA and existing patients returning to CDC (for additional drug supplies, management of side effects and/or adjustment of treatment regimen) are referred to the peer-run DiC for adherence support counseling. For PLHA coming to the hospital for in-patient care, adherence support will consist of counseling from peers. For MMT Clinic Based ART adherence support, HIV+ IDU attending the MMT clinic for daily doses of methadone doses receive adherence support counseling from peers.

In addition to centre-based services, USG funding supports an SMS messaging service providing treatment information and advice delivered by AIDS Care China PLHA CBO. Education on ART adherence is also integrated into group education and support activities for PLHA.

USG funding also supports the AIDS Care China CBO database which is used to monitor treatment adherence. It records the individual client's treatment regimen, the date of their next appointment (so that reminders can be issued) and reasons for discontinuing treatment (such as loss to follow up, and death.) The database enables AIDS Care China to identify which patients are experiencing adherence issues

and are in need of additional support.

A Chinese-language training manual to train peers in the delivery of adherence support services has been produced and will be disseminated widely. The manual gives a comprehensive overview of treatment issues from the perspective of people on treatment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	347,200	

Narrative:

GHCS (USAID) = $232,200
GHCS (State) = $115,000

Livelihoods activities are a critical support intervention for stigma reduction, community mobilization, and governance and civil society development, achieving cross-program impact that supports and leverages health and HIV/AIDS interventions with private sector and market contributions. The resulting improved local governance positively impacts local communities and the enabling environment.

PACT's livelihoods strengthening has psychosocial and health benefits in the community. As income is generated through small enterprise and vocational training, PLHA groups are strengthened. Individuals' status within the family is also positively affected. PACT is developing pro-bono field internships with companies (e.g., McKinsey) to mobilize private sector in microenterprise and business planning. PACT creates a platform of technical exchange with Chinese experts. As local models are validated and shared, local and provincial government is engaged in a way that strengthens CBOs over time.

Pact's work through Alliance focuses on community mobilization. This includes leadership and governance training and support, institutional capacity building for MARP groups, and TA to GFATM around community mobilization. The following activities will be implemented in under COP10:
• MARP group development support for MARP teams working on GFATM programs
• PLHA and MSM network development support (1 provincial PLHA network in Yunnan; 2 provincial MSM networks in Yunnan and Guangxi)
• Institutional capacity building support to the only autonomous MARP-led CBO within the USAID program (AIDS Care China)
• Small grants program to support PLHA group institutional capacity building.
• Toolkits to promote more effective community responses to HIV/AIDS.

Systemic barriers to strengthening MARP capacity in the health systems response to HIV/AIDS are: a)

absence of a supportive legal framework to promote autonomous MARP-led CBOs; b) most MARP teams are created and led by government entities, inhibiting community ownership; c) IDU and FSW are criminalized; and d) stigma (from health workers and even between different MARP communities) hinders intervention effectiveness and community involvement.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	37,900	

Narrative:

GHCS (USAID) = $37,900
GHCS (State) = $0

Pact, through Alliance, will support the Honghe Brothers MSM group targeting MSM in three hotspot cities in Honghe Prefecture. The prefecture includes 3 hotspot cities: Gejiu pop 380,000, Kaiyuan pop 260,000 and Mengzi pop 310,000 that are home to anestimated 5,000-8,000 MSM.

Alliance supports the MSM DiC in Kaiyuan and conducts outreach in the nearby cities of Gejiu and Mengzi. Funds are subgranted through the Kaiyuan Health Education Institute to MSM CBOs as most MARP groups working on HIV in China are not a registered. Service components include:
• Twice weekly outreach prevention
• Daily online Interventions: QQ (Chinese Messenger application) & Chatroom "outreach"
• Twice weekly IEC dissemination
• Twice weekly condom education and distribution
• Weekly pre-test and post-test counseling for DiC-based VCT services

Alliance provides the following support to CBO and local government partner to ensure quality of intervention:
• Assistance with the design of service protocols
• Skills training to ensure effective service delivery, eg. outreach skills
• Organizational development support
• Financial management training

Trainings and support are delivered through field visits and through large group trainings.
• For STI services the group refers clients to Gejiu CDC where staff have already been trained by FHI on the delivery of STI services including services for MSM
• For VCT the collaboration with Kaiyuan CDC will be developed to include DiC based rapid testing with pre and post-test counseling by peers and blood collecting and results by CDC staff

• The Honghe Brothers are member of the Yunnan MSM network enabling them to connect with more developed MSM programs in Kunming
• The group provides technical support to other government-led MSM groups in nearby cities

Alliance supports groups to participate in the national MSM network.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	348,500	

Narrative:

GHCS (USAID) = $232,500
GHCS (State) = $116,000

The GoC has committed to an ambitious MMT program that has seen the number of clinics nationally grow to 600 by the end of 2008, with a further 100 new clinics scheduled to open by the end of 2009. By December 2008, over 170,000 persons had registered in the program of whom over 93,000 were thought to be currently in treatment. In the same period Guangxi province opened 60 MMT clinics with 13,014 registered clients of whom 6,040 were still actively on treatment.

Pact, through the Alliance, will support a peer-led MMT adherence support program with an accompanying package of support services for HIV+ MMT clinic attendees implemented by the Guangxi Red Cross (GXRC) and run through 4 government-run MMT clinics in Guangxi Province. Interventions were selected and designed in response to the relatively high drop-out rates (40-50%) from MMT program and the need to build stronger linkages with care and support services.

Intervention components include peer-led MMT adherence support; HIV peer education; outreach to bring in new clients; family support activities; IEC dissemination; peer psycho-social counseling; and home visits. Support will be provided to the GXRC to ensure the quality of the intervention through; support for monitoring and supervision systems, TA for service model protocols, IEC materials and peer training program curriculum development; and training for peers, clinicians and staff.

Anecdotal evidence reports that having a job and receiving rehabilitation support can reduce the risk of relapse and therefore HIV transmission. PACT will support two employability and employment skills training models: an enterprise-based model and a MMT clinic-based model. These combine job opportunity and job training in a supportive environment, a peer rehabilitation support system, including relapse prevention, and mechanisms supporting family reintegration. Direct support will be provided to a small number of pilot sites. TA will be provided to interventions funded by the GoC, GFATM and other

donors to replicate the models. Pact will also develop linkages with IDU rehabilitation centers and community-based support initiatives to enable smooth flow of IDU coming out of government facilities to these services.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10199	**Mechanism Name: Social Marketing and Targeted Communications for HIV/AIDS Prevention Among Most-At-Risk Populations**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

Kaiyuan Center for Disease Control and Prevention	Luzhai Center for Disease Control and Prevention	Ningming Center for Disease Control and Prevention
Pingxiang Center for Disease Control and Prevention		

Overview Narrative

PSI will receive no FY10 funding. Activities will end on 9/29/10 and in its final year of implementation, PSI will use FY09 funds to build on its experience and successes gained through working with high-risk groups in China. BCC interventions for MARPs will continue to focus on normalizing and promoting correct and consistent condom use with all partners and decreasing the sharing of needles. Programs will include a Comprehensive Package of Services (CPS) for FSWs and IDUs, including peer education, drop-in centers, targeted interpersonal community outreach activities, community events, VCT and rapid

testing, support groups, STI management and health service referrals. Technical support will be given to MSM groups to increase access to prevention products and services, and to HIV prevention partners to increase demand for risk reduction products and services. PSI will also conduct capacity building to local grassroots and government organizations on MARPs prevention.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10481	**Mechanism Name: I-TECH COAG**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: International Training and Education Center on HIV	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 50,000	
Funding Source	**Funding Amount**
GHCS (State)	50,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

I-TECH, the International Training and Education Center on HIV from University of Washington, in close collaboration with University of California - San Francisco, supports the development of a skilled health work force and well-organized national health delivery systems in order to provide effective prevention, care, and treatment of infectious disease in the developing world. Their goals and objectives under this award are to revise and develop a comprehensive and useable training curriculum on HIV/AIDS care and treatment for China CDC to be used in the 13 training centers which teach HIV/AIDS care and treatment through 2-3 month residency programs. This mechanism affects the technical area for care and treatment.

This mechanism's products will be implemented at the 13 training centers, but will have national impact as each graduating physician trained in these methods returns to his/her province to practice. The populations targeted for the training are the physicians attending the training centers. Populations targeted in the training and by the physicians after graduation are China's MARPs including FSW, IDU, MSM and migrant workers.

Improvement of the HIV/AIDS care and treatment curriculum will contribute to health systems strengthening by ensuring a well-educated and well-prepared cadre of health professionals. Improving curriculum has a direct impact on human resources for health by providing quality in-service training, ensuring that the physicians trained are familiar with the most up-to-date thinking, methods and techniques to improve outcomes and experiences of PLHA within the health system, and providing a benchmark from which performance assessments and quality improvements can be conducted.

This mechanism strengthens several cross-cutting and key issues in addition to human resources for health including TB, gender, and mobile populations. Part of the HIV/AIDS care and treatment curriculum will include OI screening and treatment, including TB. Since TB is so prevalent in China, its screening and treatment, including MDR and XDR-TB, among PLHA is an important aspect of physician training. The covers MARPS including FSW and female IDU. The training will also deal with mobile populations: those who are mobile within China; people from outside of China who enter the country, such as brides from other countries and people living along the border regions; and Chinese workers who travel to Africa to work and then return to China.

A monitoring and evaluation activity has been incorporated into this implementing mechanism as part of the award includes developing an evaluation tool for the National AIDS Clinic Training Program. This tool will include evaluation of the changes included through the new training curriculum.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	50,000

Key Issues

Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Mobile Population
TB

Budget Code Information

Mechanism ID:	**10481**
Mechanism Name:	**I-TECH COAG**
Prime Partner Name:	**International Training and Education Center on HIV**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	37,500	

Narrative:

USG will cooperate with the I-TECH to revise the national training curriculum on HIV/AIDS care and treatment and to develop an evaluation tool for China's National AIDS Clinic Training Program.

There are 13 HIV/AIDS clinical training centers which teach 2-3 month residencies for physicians from across China. Training materials to be developed will meet international standards for HIV/AIDS care and treatment and be sensitive to the needs of China's MARP groups. Training will include a comprehensive care and treatment package including ART provision, cotrimoxazole prophylaxis and TB screening.

I –TECH will hire one Project Officer (FSN-10) to closely work with the Care and Treatment division (60% of time load) in NCAIDS division of China CDC to provide direct TA support on the revision of the national training curriculum on HIV/AIDS care and treatment, supply daily management and supervision of the national AIDS Clinic training program, and develop other quality training materials.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	PDTX	12,500	

Narrative:

USG will cooperate with the University of Washington's International Training and Education Center on HIV (I-TECH) to revise the national training curriculum on HIV/AIDS care and treatment and to develop an evaluation tool for China's National AIDS Clinic Training Program.

There are 13 HIV/AIDS clinical training centers which teach 2-3 month residencies for physicians from across China. Training materials to be developed will meet international standards for pediatric HIV/AIDS care and treatment and be sensitive to the needs in China. Training will include a comprehensive care and treatment package for infants and children including early diagnosis, pediatric ART formulations, regular clinic and CD4 monitoring, monitoring of growth and development, cotrimoxazole prophylaxis and treatment adherence support as well as TB and other OI screening and treatment.

I –TECH will hire one PO (FSN-10) to closely work with the Care and Treatment division (60% of time load) in NCAIDS division of China CDC to provide direct TA support on the revision of the national training curriculum on HIV/AIDS care and treatment, supply daily management and supervision of the national AIDS Clinic training program, and develop other quality training materials.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12257	**Mechanism Name: TBD**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

One of the two USAID implementing mechanisms with primary responsibility for prevention and HIV technical capacity building ends September 30, 2010. This TBD implementing mechanism will focus on HIV technical assistance for prevention and care, targeting MARPs (IDUs, FSWs, MSM) and MARP PLHA. Implementation of activities will be in partnership with provincial and/or other local government partners as well as NGOs and community-based organizations. This implementing mechanism will also engage in partnerships with national and/or provincial and/or other Chinese institutions with the goal of building in-country ability to provide HIV technical assistance for MARP prevention and care at the program implementation level, so that longer term sustainability of the HIV response in China is also built.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12257**		
Mechanism Name:	**TBD**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVCT	Redacted	Redacted
Narrative:			
Redacted This TBD implementing mechanism will focus on HIV technical assistance for prevention and care			

targeting MARPs (IDUs, FSWs, MSM) and MARP PLHA. Implementation of activities will be in partnership with provincial and/or other local government partners as well as NGOs and community-based organizations. This implementing mechanism will also engage in partnerships with national and/or provincial and/or other Chinese institutions with the goal of building in-country ability to provide HIV technical assistance for MARP prevention and care at the program implementation level, so that longer term sustainability of the HIV response in China is also built.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	Redacted	Redacted

Narrative:

REDACTED

Through a TBD partner, USAID will undertake the first and second rounds of coverage and behavioral monitoring for FSW and MSM in Guangxi and Yunnan provinces. Based on lessons learned implementing this methodology, USAID will support the development of a manual to serve as a handbook for program implementers to replicate the methodology and tool in the future.

A standard module for measuring coverage and the quality of coverage will be incorporated into the CPP Model for FSW and MSM in Guangxi and Yunnan provinces. The TBD partner will develop and undertake a low cost survey to measure key information for FSW and MSM including prevention coverage, intensity of interventions and exposure (dose responses), intermediate outcomes or determinants for behavioral change, and key behaviors. A Technical Working Group (TWG) will be established among USAID partners to modify the methodology for each target population, oversee the intervention design, and ensure results are disseminated and used properly. In FY 2010, coverage and behavioral monitoring methods and questionnaires will be developed by modifying PSI's Tracking Surveys methodology (TRaC). Measuring coverage and intensity of coverage will be adapted from MEASURE Evaluation's coverage plus study. Probability sampling will be employed with approximately 500 persons per target population per site. Data will be analyzed to identify behavioral determinants, risks, needs, and exposure to service levels, and to demonstrate any significant changes over time.

In FY 2010, the first round of data collection will take place at four FSW sites (Gejiu, Kunming, Luzhai, and Mengzi) and three MSM sites (Gejiu-Mengzi-Kaiyuan, Kunming, and Nanning). In FY 2011, the second round of data collection will take place at all first-round sites except for FSW in Gejiu. The study results will be used for program planning and improvement. For the FSW CPP model, the results will be used to identify two "learning sites for excellence" that can serve as learning centers for replication and expansion of the model. By the end of FY 2011, a manual will be developed to serve as a handbook for

program implementers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

REDACTED

This TBD implementing mechanism will focus on HIV technical assistance for prevention and care targeting MARPs (IDUs, FSWs, MSM) and MARP PLHA. Implementation of activities will be in partnership with provincial and/or other local government partners as well as NGOs and community-based organizations. This implementing mechanism will also engage in partnerships with national and/or provincial and/or other Chinese institutions with the goal of building in-country ability to provide HIV technical assistance for MARP prevention and care at the program implementation level, so that longer term sustainability of the HIV response in China is also built.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	Redacted	Redacted

Narrative:

REDACTED

This TBD implementing mechanism will address on HIV technical assistance for prevention and care targeting IDUs, FSWs, MSM and MARP PLHA. Implementation of activities will be in partnership with provincial and/or other local government partners as well as NGOs and community-based organizations. This implementing mechanism will also engage in partnerships with national and/or provincial and/or other Chinese institutions with the goal of building in-country ability to provide HIV technical assistance for MARP prevention and care at the program implementation level, so that longer term sustainability of the HIV response in China is also built.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12258	Mechanism Name: UNAIDS COAG
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and	Procurement Type: Cooperative Agreement

Prevention	
Prime Partner Name: United Nations Joint Programme on HIV/AIDS	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 20,000	
Funding Source	**Funding Amount**
GHCS (State)	20,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

UNAIDS has focused on providing technical assistance to Global Fund programs in China, most recently through support in the development of the RCC HIV proposal and detailed workplans. Two UNAIDS staff were dedicated full-time to proposal writing, and one staff has been dedicated full time to supporting the development of the workplans. USG also offered the assistance of one staff member to proposal writing as well as offered the time of various project officers to support the workplan development at both the provincial and national levels.

The UNAIDS staff member dedicated to supporting RCC workplan development covering the 31 provinces of China has focused especially on ensuring strong program and financial management including the promotion of management reviews. This support has been critical to supporting high quality and efficient roll-out of this new program in January 2010. USG's technical expertise in the areas of program implementation quality, international best practices, and community-based interventions could offer together with UNAIDS' expertise in program and financial management a complementary partnership to ensuring a strong GF-RCC program in China.

Since USG is the largest contributor to Global Fund, there is a vested interest in ensuring the success of the RCC grant. UNAIDS has already been making substantial efforts to ensure China's Global Fund grant success. A multilateral partnership between USG and UNAIDS can strengthen the capacity of both organizations to offer targeted support to GF RCC implementation. While USG's financial resources for GF technical assistance remain limited, collaboration with UNAIDS can leverage these resources to provide high quality assistance while avoiding duplication.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12258**
Mechanism Name:	**UNAIDS COAG**
Prime Partner Name:	**United Nations Joint Programme on HIV/AIDS**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	20,000	

Narrative:

Through this cooperative agreement, UNAIDS will provide assistance to the RCC in China to support with budgeted program planning, target setting, workplan development, program management and accountability, coordination, monitoring and evaluation, financial management, and other areas as needed. RCC programs will cover the 31 provinces in China where assistance is provided.

UNAIDS expertise in financial management, costing and budgeting, and monitoring and evaluation, in addition to their network of international experts, can bring much needed and complementary expertise to the GF-RCC program in China. Since they are already providing technical assistance to the Global Fund, this agreement will allow UNAIDS to provide additional, targeted support in areas that have been identified as gaps and where additional assistance is required, particularly in the area of grant monitoring. Collaboration with UNAIDS will leverage and maximize USG's limited resources to better ensure an efficient and effective Global Fund program in China.

This agreement is proposed for FY 2010 and may be continued into future fiscal years, though the scope is limited based upon small amount of USG resources available for Global Fund support.

Implementing Mechanism Indicator Information

(No data provided.)

USG Management and Operations

1.

Redacted

2.

Redacted

3.

Redacted

4.

Redacted

5.

Redacted

Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Computers/IT Services					28,767	28,767
ICASS					79,311	79,311
Institutional Contractors					44,000	44,000
Management Meetings/Professional Developement					46,357	46,357
Non-ICASS Administrative Costs					54,161	54,161
Staff Program Travel					194,783	194,783
USG Staff Salaries and Benefits					416,471	416,471

Total	**0**	**0**	**0**	**0**	**863,850**	**863,850**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHCS (USAID)		28,767
ICASS		GHCS (USAID)		79,311
Management Meetings/Professional Developement		GHCS (USAID)		46,357
Non-ICASS Administrative Costs		GHCS (USAID)		54,161

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Computers/IT Services			30,000			30,000
ICASS			140,000			140,000
Institutional Contractors			155,000			155,000
Management Meetings/Professional Developement			44,200			44,200
Non-ICASS Administrative Costs			409,500			409,500
Staff Program Travel			118,000			118,000

USG Staff Salaries and Benefits			1,188,300			1,188,300
Total	**0**	**0**	**2,085,000**	**0**	**0**	**2,085,000**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GAP		30,000
ICASS		GAP		140,000
Management Meetings/Professional Developement		GAP		44,200
Non-ICASS Administrative Costs		GAP		409,500