China

Operational Plan Report

FY 2012

Operating Unit Overview

OU Executive Summary

I. Country Context

Epidemiology of the HIV epidemic

China's 1.34 billion people, including 56 ethnic minority groups, are spread across 31 provinces, including 5 semi-autonomous regions. In cooperation with the Ministry of Health (MOH) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), we estimate that there are approximately 800,000 people living with HIV/AIDS (PLHA) in mid-2011, with at least 190,000 in immediate need of antiretroviral treatment (ART). Case reporting data reflect >380,000 HIV/AIDS cases have been reported in the national confidential HIV database by August 30, 2011. Incidence may have stabilized per the latest United Nations General Assembly Special Session report estimates, with approximately 50,000 new HIV infections estimated in 2007 and 2009. Preliminary findings from the 2011 HIV incidence estimation indicate a likely increase in HIV incidence these past two years, particularly for heterosexual and homosexual HIV transmission, while HIV incidence among people who inject drugs (PWID) has decreased. Sentinel surveillance data over the past decade show that HIV prevalence has remained stable among pregnant women, university students, truck drivers, and sexually transmitted infection (STI) clients in most regions. However, in approximately 50-60 counties located in 5 provinces (out of 2868 counties overall in China), the HIV/AIDS epidemic is now a more generalized epidemic (at or above 1%, according to UNAIDS) with prevalence in the general population (using door-to-door HIV testing) reaching as high as 5-7% in certain mountainous, primarily ethnic minority counties.

Initially, PWID along heroin trafficking routes in Yunnan, Sichuan, and Xinjiang as well as former plasma donors (FPD) in rural communities in provinces of East-Central China accounted for most HIV infections in China. Per 2009 estimates, however, transmission among men who have sex with men (MSM) accounted for approximately one-third of new infections in China, while heterosexual transmission accounted for 42% of incidence. Cumulatively from 1985 till 2009, 59% of the estimated total number of PLHA in China acquired the infection sexually, with 44% heterosexual and 15% homosexual transmission. Until 2005, most studies indicated relatively low HIV prevalence among MSM (<1-2%). However, prevalence has increased about one percent each year in Beijing and several other cities in recent years. In addition, a recent 61-city survey involving 54,000 MSM indicated HIV prevalence of 5% overall and prevalence exceeded 13% in several cities in Guizhou, Chongqing, Sichuan, and Yunnan provinces (Southwest China). The proportion of PLHA who are women has also doubled in the past decade to 31%.

Eight provinces (Anhui, Guangdong, Guangxi, Guizhou, Henan, Sichuan, Xinjiang, and Yunnan), with FPD constituting most cases in Henan and Anhui, account for approximately 85% of all HIV infections in China. HIV transmission related to blood or blood product transfusion primarily occurred before 1998. Our detailed analysis, together with the Surveillance Division of the National Center for AIDS/STD Control and Prevention (NCAIDS) within the Chinese Center for Disease Control and Prevention (China CDC), of cumulative HIV/AIDS cases until December 31, 2009, indicates that 37.4% of reported cases were among ethnic minorities (non-Han ethnicity; note that >92% of the Chinese population is Han). Ranked by the total cumulative HIV/AIDS cases (1985-2009), the Uighur (Muslim), Yi, Zhuang, Hui (Muslim), Dai, and Yao ethnic minority communities are especially severely affected by the HIV epidemic. While overall national prevalence in China remains low at 0.1%, prevalence is much higher in geographic hotspots, and national prevalence among most-at-risk-populations (MARPs) ranges from 1-2% for female sex workers (FSW), to 5% for urban MSM, to 7% for PWID, to 25-30% for FSW who also inject drugs. The Southwestern and Xinjiang region have the largest HIV epidemic and sexual transmission has emerged as the major transmission route in China.

Status of the national response

In 2008, official state media reported that for the first time, HIV/AIDS became China's leading cause of death among infectious diseases. Over the past seven years, the Government of China (GOC) has responded by dedicating and increasing the amount of resources to their national response. As described in more detail below, the Chinese government has developed a strong policy framework for its HIV response, founded on a core principle of "Four Frees and One Care" for all eligible patients. China's rapidly evolving HIV/AIDS epidemic calls for a dramatic expansion of prevention, care and treatment services, which has been facilitated by USG and other external donors and foundations.

Currently, more than 80% of the funding for HIV/AIDS in China comes from government sources. The GOC contributed approximately 2 billion RMB centrally ($315 million) to the AIDS response in 2011; half of this funding goes towards the National Free ART Program. In addition, provincial and county governments contributed an estimated $200-250 million towards the local response. However, this is mostly from the wealthier jurisdictions; the poorer Western part of the country has had very limited local resources dedicated to HIV.

The process of integrating foreign assistance into one national HIV/AIDS program in China has been a prime example of the "Three Ones" principle advocated by UNAIDS and has served as a useful model for other countries (Wu Z et al. Bull WHO 2011;89:227-33). This process of integration started slowly in China and initially consisted of unified data collection. The integration is now complete and encompasses

project planning, budgeting, implementation, monitoring and evaluation.

Other donors and contextual factors

The largest source of resources outside the Chinese government is the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). This year has been a challenging year for the GFATM program in China; USG engagement with and support of GFATM is discussed in detail in the section on Global Fund and Multilateral Engagement. In November 2011, GFATM decided that Upper Middle Income G20 nations with less than an extreme disease burden would no longer be eligible for grant renewals or new grants. As a result, GFATM grants to China will end in 2012, although transitional funding may be available for 2013. To a large extent, other bilateral and private organizations are in a transition phase or have already transitioned out of HIV/AIDS work in China. The UK Department for International Development (DfID), the Japan International Cooperation Agency (JICA), and the Clinton Foundation have recently ended their support. The Australian Agency for International Development (AusAID) will end its support for needle exchange programs in three provinces in June of 2012 and is in the process of handing the program over to the local government. The Bill and Melinda Gates Foundation supports work in 14 cities and 1 province, focusing primarily on MSM, and these activities will continue through 2013. MSD-Merck will continue its work in Sichuan Province through 2012. Médecins Sans Frontières (MSF) has ended its support for several large ART clinics and training sites. AIDS Healthcare Foundation, which has been a relatively small player in China to date, has continuing work in 3 provinces through 2014. The USG PEPFAR China team has worked closely with these partners in the past, and will increase its interaction through the transition to ensure that important activities are transitioned effectively to local, provincial or national organizations. This has been an important role for the USG PEPFAR China team in the past, for example, stepping in to provide transitional support for laboratory quality assurance (QA) and quality control (QC) activities previously supported by the Clinton Foundation.

USG fit into the national response

Although GOC and GFATM have dedicated relatively significant financial resources to HIV/AIDS, they are still not adequate. The quality of HIV interventions is often lacking, and the technical capacity of health professionals is low, especially at peripheral sites where most HIV infections in China occur.

Within this context, USG has established a focus on technical assistance that addresses these specific gaps and has established a vision that within five years, GOC will have the technical capacity to manage, coordinate and provide policy oversight of an effective, high-quality national HIV/AIDS program. To achieve that vision, USG has fully integrated its efforts into the national response, providing strategic support that strengthens the technical capacity of GOC. Main areas of technical assistance include

training, leadership and organizational development, laboratory strengthening, data analysis and utilization, and policy development. In addition, USG has invested strategically in the development of innovative models to strengthen the capacity of civil society and the health system to respond to the unique aspects of the evolving epidemic in China, particularly among most-at-risk populations including men who have sex with men and members of China's ethnic minorities.

To achieve this high level of integration, USG in collaboration with GOC has developed a rigorous planning process that allows USG resources to be allocated to high-priority needs based on the unique capabilities of the interagency PEPFAR team. These activities are carried out in support of a vision statement that was jointly developed with GOC to guide the work of USG in China. The vision is that USG will assist the Government of China to reduce HIV transmission and mitigate the impact of AIDS to achieve the ambitious goal of less than 1.0 million HIV cases by 2015.

II. PEPFAR Focus for FY2012

In August 2011, the USG PEPFAR China team had a strategic discussion with OGAC on USAID's transition out of China. USAID will terminate bilateral HIV/AIDS activities and transition out of China completely by FY2013.

USG's key priorities for China in FY2012 will be provided under the rubric of a technical assistance (TA) model. Activities undertaken under the TA model will be implemented at the national level in partnership with China CDC; at the provincial level with provincial CDCs and civil society organizations; and at the multilateral level through support for GFATM. In addition, certain activities will be prioritized to address the needs of specific underserved populations, including MSM and ethnic minorities.

Technical assistance in the area of systems development will be provided to the national government to support evidence-based policies and guidelines and will include:

- Standardization of algorithms for HIV rapid testing (RT).
- Introduction of a point-of-care (POC) viral load (VL) determination method, which will drastically reduce the time needed for treatment monitoring. China is one of the few countries in Asia that provides free VL testing. However, the cost per VL test has been very high as tests have to be done in a few laboratories that are not easily accessible to patients.
- Provision of simple, high quality POC CD4 testing which will enable patients to access ART at an earlier stage of disease progression. USG will assist in instituting a new quality control procedure for CD4 testing that can be readily implemented in laboratories at low level facilities nationwide.
- Assistance with the evaluation and use of a new avidity assay to measure HIV incidence developed by the U.S. CDC Division of Global HIV/AIDS (DGHA) Atlanta laboratory and now being

commercialized by a Chinese company.

- Streamlining national HIV-1 antiretroviral (ARV) drug resistance (DR) monitoring and quality control to ensure a routine process across the country.

One of the key priorities for USG is to assist GOC in strengthening the integration between the national and provincial HIV responses. In order to achieve this, TA will be provided to the national government for:

- Supporting a management training program for leadership and organizational development.
- Strengthening the quality of rural HIV prevention, care and treatment through the Luzhai Rural AIDS Clinical Training Center in Guangxi and TA for the development of a new site in Liangshan Prefecture, Sichuan. Both rural Guangxi and Sichuan have substantial ethnic minority populations. Liangshan Prefecture has the highest HIV prevalence in China.
- Developing a strong information base related to HIV surveillance, data collection and utilization, and support for publication and dissemination of treatment-related outcomes.
- Supporting PMTCT scale-up through database development.

At the provincial level, USG will prioritize TA support to five highly impacted provinces with substantial minority populations – Yunnan, Guangxi, Guizhou, Guangdong, and Xinjiang. TA efforts will be tailored to the needs of the individual provinces, but will include rollout of routine provider initiated testing and counseling (PITC), strengthening surveillance systems, laboratory QA/QC, and epidemiological analysis. In addition, USG will, to a much lesser extent, support TA opportunities to leverage innovation and operations research in ten additional provinces.

USG will also prioritize the close out of USG support and transition of community-based models for MARP prevention, care and treatment for PWID and MSM in four hotspots in Yunnan and Guangxi to local (city, prefectural, or provincial) support. In 2011, the Yunnan Provincial Government awarded the USAID China HIV/AIDS program “Outstanding Group” for the exceptional achievements of these HIV comprehensive service delivery models for MARPs over the last three years in Yunnan. USAID was the only international agency to receive this honor. As these models are based on partnerships between stakeholders, civil society organizations, and local government, there will be a focus on maintaining civil society support by local government in their continuation. The transition will concentrate on documentation and promotion of the models for replication as well as training opportunities, which will be made easier as the model has facilitated improved relationships, communications, HIV service delivery for MARPs, and coordination with local governments.

Finally, in light of the GFATM issues which have transpired in the past year and as a board member on the Country Coordinating Mechanism (CCM), USG will prioritize time limited support to the GFATM for one year to assist with one of the two requirements: the resumption of funding civil society engagement.

USG will provide support and technical assistance to the selected GFATM civil society sub-recipient to oversee the reallocation of the civil society appropriations.

Though China is not a GHI-Plus country, USG work in China exemplifies GHI's seven core principles. For instance, in the area of improving metrics, USG will continue to support improvements to the national surveillance system by increasing the number of HIV sentinel surveillance sites, building the capacity of local staff, and improving data quality and use in all 15 USG-supported provinces. Promoting research and innovation is an integral part of the technical assistance model USG implements in China. USG funding allows for flexibility to develop innovative approaches that, if proven effective, can be scaled up to provincial, national, or even global levels. In another example, support for PMTCT addresses the implementation of a woman- and girl-centered approach by developing models for the elimination of maternal to child transmission of both HIV and hepatitis B virus (HBV) in co-infected women. On a global level, China's relationship with USG takes on a different perspective in terms of the principle related to global health partnerships and private sector engagement. This is evidenced in China's interest in providing TA to other countries within the region and in sub-Saharan Africa. Recent examples include provision of harm reduction TA in Ukraine and Kazakhstan (methadone maintenance treatment trainings and site visits), HIV drug resistance surveillance TA to Cambodia and Laos, and cross-border initiatives with Vietnam and Burma. While not presently focused on HIV, there are on-going discussions on USG-China bilateral cooperation in Africa. Not only will continued USG support create greater country-level capacity by GOC to manage and operate programs, but a relationship built on trust which contributes technical expertise in China for enhanced clinical, epidemiologic and laboratory capacity can facilitate China's productive engagement within the global health community. This will enable further opportunities for win-win dialogues in the context of an increasingly complex political and economic relationship.

III. Country Ownership

As described above, the PEPFAR program is fully integrated with the national program and operates under a shared vision that was jointly developed by USG and GOC. As a result of this integration, the process of promoting country ownership is quite well-developed. The PEPFAR program in China has been operating under a technical assistance model which is predicated on transition of activities to local, provincial, and national authorities over a defined time period. This has already happened successfully with a number of USG-supported initiatives, including comprehensive prevention, care, and treatment models for commercial sex workers, the Rural AIDS Clinical Training Center focused on second line treatment in Anhui, and virtually all of the sentinel surveillance sites.

It is also important to note that significant host country government resources are being deployed in

response to HIV/AIDS. A large share of these resources is from sub-national governments. Therefore, it is also essential to develop the capacity of these jurisdictions to respond as well. The PEPFAR program works closely with 15 provinces (including seven out of the eight provinces that have contributed 85% of the HIV infections in China) and in four heavily-impacted localities to achieve this goal.

The PEPFAR program in China has supported the development of a national network of HIV surveillance sites (540 out of 1,888 have been transitioned to the host country with the remaining 38 to be transitioned in FY2012) that provide high-quality evidence for basing decisions regarding policy development, program implementation, and resource allocation for the national program. In addition, these data are now summarized in a National HIV Surveillance Report which is available in both English and Chinese. In FY2012, USG will be supporting the development of similar reports at the provincial level as well as providing ongoing technical assistance in the analysis and utilization of this data to support decision making by both government officials and civil society organizations.

In addition to a joint vision for its bilateral cooperation with USG, GOC has advanced both a policy framework for response to HIV/AIDS and a set of ambitious goals that demonstrate a high degree of political ownership and stewardship. GOC's policy framework encompasses the availability of free ARV treatment for all those eligible, a comprehensive strategy for prevention of maternal-to-child transmission that includes HIV, hepatitis and syphilis, the world's most expansive program of risk reduction for PWID that includes both methadone maintenance and needle exchange, and new initiatives for treatment of discordant couples, community-based drug treatment, and MSM couples counseling. This policy framework supports a set of goals that include reducing the number of new HIV infections by 25% by 2015.

VI. Central Initiatives

The only centrally funded project is the Methadone Maintenance Treatment Public Health Evaluation (MMT PHE). Substantial evidence suggests that receiving higher doses of methadone and remaining longer in treatment are effective in preventing HIV infection among people who inject drugs. However, MMT clinics in China often do not provide recommended doses of methadone. Moderate methadone dosing may predispose patients to drop out of MMT programs resulting in a higher likelihood of continued injecting drug use and other high risk behaviors for contracting HIV.

This study consists of two parts. Part one is a qualitative study to determine reasons behind current dosing practices as well as reasons drug users stay in and drop out of MMT services. The second part is a cluster-randomized controlled trial, with the unit of randomization the MMT clinic, to evaluate the effectiveness of a tailored education program for MMT service providers on prescribed methadone dose

for newly enrolled MMT clients based in part on the results of the qualitative study. The effects of methadone dose, with and without the inclusion of additional psychosocial services, will be measured through MMT retention, illicit opioid use, HIV, hepatitis C virus (HCV) and STI incidence, self-reported high-risk behaviors, quality of life measures, transition from non-injecting to injecting drug use, and all-cause mortality among opiate dependent persons attending MMT clinics.

Primary objectives of the study are to determine reasons behind current dosing practices and reasons clients stay in and drop out of MMT services, to evaluate the effectiveness of a tailored education program for MMT service providers on prescribed methadone dose, and to evaluate the effect of methadone dose with and without additional psychosocial services on MMT retention and illicit opioid use.

Secondary objectives include:

- Impact of interventions on high-risk needle use and sexual practices
- Quality of life measured by WHO QOL-BREF with additional questions on criminal activities, employment, and relationships with family and friends
- Incident HIV infection
- Incident HCV infection
- Incident syphilis infection
- Herpes simplex virus-2 (HSV-2) prevalence
- Transition to injecting drug use for previously non-injecting users
- All-cause mortality

Does the Mission receive funding for a Global Fund Liaison POSITION?

No, the PEPFAR program in China does not have a Global Fund Liaison, but USG does collaborate with the GFATM program in China. For more detailed information please review the Global Fund and Multilateral Engagement section.

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	730,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			

Adults 15-49 HIV Prevalence Rate	00	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Children 0-14 living with HIV						
Deaths due to HIV/AIDS	26,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Estimated new HIV infections among adults						
Estimated new HIV infections among adults and children						
Estimated number of pregnant women in the last 12 months	18,294,000	2009	State of the World's Children 2011, UNICEF.			
Estimated number of pregnant women living with HIV needing ART for PMTCT						
Number of people living with HIV/AIDS	740,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Orphans 0-17 due to HIV/AIDS						
The estimated number of adults and children with	270,000	2010	Global HIV/AIDS response: epidemic update			

advanced HIV infection (in need of ART)			and health sector progress towards universal access: progress report 2011			
Women 15+ living with HIV	230,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

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

In what way does the USG participate in the CCM?

Voting Member

What has been the frequency of contact between the Global Fund Secretariat (Fund Portfolio Manager or other Geneva-based staff) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.

7+ times

What has been the frequency of contact between the Local Fund Agent (LFA) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.

1-3 times

Has the USG or is the USG planning to provide support for Round 11 proposal development? Support could include staff time, a financial contribution, or technical assistance through USG-funded project.

CCM is not planning to submit proposals

Are any existing HIV grants approaching the end of their Phase 1, Phase 2, or RCC agreement in the coming 12 months?
Yes

If Yes, please indicate which round and how the end of this grant may impact USG programming. Also describe any actions the USG, with country counterparts, is taking to enable continuation of any successful programming financed through these grants.
All funding to China from Global Fund is now projected to end in March 2013. At its global board meeting in November 2011, it was decided that all upper middle income G20 countries with less than an extreme disease burden would no longer be eligible for grant renewals or new grants. USG will provide technical assistance to the Government of China to ensure transition of successful programming to both governmental and civil society organizations throughout China.

In your country, what are the 2-3 primary challenges facing the Global Fund grant implementation and performance (for example, poor grant performance, procurement system issues, CCM governance/oversight issues, etc)? Are you planning to address those challenges through any activities listed in this COP?
Redacted

Did you receive funds for the Country Collaboration Initiative this year?
No

Is there currently any joint planning with the Global Fund?
Yes

If Yes, please describe how the joint planning takes place (formal/informal settings; the forums where it takes place (CCM?); timing of when it takes place (during proposal development, grant negotiation, COP development, etc.); and participants/stakeholders). Also describe if this joint planning works well and its effects (has it resulted in changes in PEPFAR programming, better anticipation of stock-outs and/or TA needs, better communication with PR, etc.)
Redacted

Has the USG stepped in to prevent either treatment or service disruptions in Global Fund financed programs in the last year either during or at the end of a grant? Such assistance can take the form of providing pharmaceuticals, ensuring staff salaries are paid, using USG partners to ensure continuity of treatment, , or any other activity to prevent treatment or service disruption.

Public-Private Partnership(s)

(No data provided.)

Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
N/A	61-city survey	Behavioral Surveillance among MARPS	Men who have Sex with Men	Publishing	N/A
N/A	Adult CD4 normal reference value survey in Lhasa, Tibet	Other	General Population	Implementation	N/A
N/A	Behavioral survey among ATS users	Behavioral Surveillance among MARPS	Drug Users	Implementation	N/A
N/A	Behavioral survey among PLHA in Luzhai	AIDS/HIV Case Surveillance	Other	Other	N/A
N/A	Cohort study of HIV transmission among serodiscordant couples	Behavioral Surveillance among MARPS	Other	Other	N/A
N/A	Cohort study of MSM	Behavioral Surveillance among MARPS	Men who have Sex with Men	Data Review	N/A
N/A	HIV comprehensive sentinel surveillance	Sentinel Surveillance (e.g. ANC Surveys)	Female Commercial Sex Workers, Injecting Drug Users, Mobile Populations,	Other	N/A

			Men who have Sex with Men, Pregnant Women, Youth, Other		
N/A	HIV drug resistance	HIV Drug Resistance	Other	Implementation	N/A
N/A	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	N/A
N/A	HIV-1 molecular epidemiology among MSM	AIDS/HIV Case Surveillance	Men who have Sex with Men	Data Review	N/A
N/A	Laboratory quality control	Laboratory Support	Other	Implementation	N/A
N/A	Low-fee sex worker risk behavior survey	Behavioral Surveillance among MARPS	Female Commercial Sex Workers	Implementation	N/A
N/A	Methadone Maintenance Treatment (MMT) Outcome Study	Evaluation	Drug Users	Implementation	N/A
N/A	MSM HIV epidemic and risk behavior qualitative investigation	Qualitative Research	Men who have Sex with Men	Data Review	N/A
N/A	MSM pyschiatric examination	Behavioral	Men who	Data Review	N/A

		Surveillance among MARPS	have Sex with Men		
N/A	Needle and syringe program (NSP) evaluation	Evaluation	Injecting Drug Users	Other	N/A
N/A	New incidence assay development	Recent HIV Infections	Other	Implementation	N/A
N/A	Point-of-care technologies for CD4, VL, and EID	Laboratory Support	Other	Implementation	N/A
N/A	Population size estimation of MARPs	Population size estimates	Drug Users, Female Commercial Sex Workers, Men who have Sex with Men	Publishing	N/A
N/A	Round 2 Routine Behavior Change Tracking Survey among MSM	Behavioral Surveillance among MARPS	Men who have Sex with Men	Planning	N/A
N/A	Routine behavioral tracking (RBT) survey with FSW	Behavioral Surveillance among MARPS	Female Commercial Sex Workers	Other	N/A
N/A	Routine behavioral tracking (RBT) survey with MSM	Behavioral Surveillance among MARPS	Men who have Sex with Men	Other	N/A
N/A	Survey among wives from high HIV prevalence areas	Population-based Behavioral Surveys	Other	Other	N/A

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHP-State	GAP	GHP-State	GHP-USAID	
HHS/CDC		3,000,000	1,250,000		**4,250,000**
HHS/HRSA			50,000		**50,000**
USAID			1,700,000		**1,700,000**
Total	**0**	**3,000,000**	**3,000,000**	**0**	**6,000,000**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency				Total
	HHS/CDC	HHS/HRSA	USAID	AllOther	
HBHC	357,385	5,000			**362,385**
HLAB	312,566				**312,566**
HTXS	276,588	5,000			**281,588**
HVCT	368,316		50,628		**418,944**
HVMS	1,249,197		26,792		**1,275,989**
HVOP	183,498		920,373		**1,103,871**
HVSI	437,660		166,241		**603,901**
HVTB	61,718				**61,718**
IDUP	270,605		535,966		**806,571**
MTCT	149,924				**149,924**
OHSS	432,546	35,000			**467,546**
PDCS	82,897	2,500			**85,397**
PDTX	67,100	2,500			**69,600**
	4,250,000	**50,000**	**1,700,000**	**0**	**6,000,000**

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

(No data provided.)

Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	362,385	0
HVTB	61,718	0
PDCS	85,397	0
Total Technical Area Planned Funding:	**509,500**	**0**

Summary:
Overall Programmatic Strategy

In China, USG focuses on early case finding and case management as part of a Positive Health Dignity and Prevention strategy. This includes supporting referral mechanisms that link HIV testing and counseling (HTC) to care and treatment services. In China, CD4 testing is the main criterion for clinical care. According to this criterion, at least 60% of HIV-positive persons receive clinical care. In 2010, the Chinese Center for Disease Control and Prevention (China CDC) implemented minimum criteria for CD4 and viral load (VL) testing for people living with HIV/AIDS (PLHA). By the end of the year, CD4 and VL testing rates were 60% and 73%, respectively. The Government of China (GOC) provides free CD4 testing for PLHA once a year to assess eligibility for antiretroviral treatment (ART) and twice a year for treatment monitoring. Local China CDCs provide risk reduction counseling and condom promotion and distribution when PLHA present for CD4 and VL testing. In 2010, the Ministry of Finance approved reimbursement to PLHA for the cost of transportation and meals to access facility-based CD4 testing in order to improve retention of pre-ART patients in care. USG builds the capacity of the China CDC system to provide follow-up services, including CD4 and VL testing, partner testing and discordant couple support, and referrals for tuberculosis (TB), sexually transmitted infections (STI), and prevention of mother to child transmission (PMTCT). USG also builds the capacity of community-based organizations (CBOs) to provide care and support for PLHA and to link to clinical services provided by GOC.

Major accomplishments in FY10 to FY11

USG provided substantial support for peer educators to increase methadone maintenance treatment (MMT) enrollment, improve ART adherence, and provide psychosocial support to HIV-positive people who inject drugs (PWID) in Yunnan and Guangxi provinces. USG also supported the local Yunnan and Guangxi CDCs to provide care and support services, including clinical monitoring, adherence support, and opportunistic infection (OI), STI, and TB prevention and treatment, for HIV-positive men who have sex with men (MSM) and female sex workers (FSW) by strengthening linkages between prevention and care.

In FY10, USG provided technical assistance to the National Center for AIDS/STD Control and Prevention (NCAIDS) within China CDC to standardize the curriculum for 14 national HIV/AIDS clinician training centers. In FY11, USG supported Training of Trainers (TOT) from all centers on the new curriculum.

USG also provided technical assistance to the National Center for Tuberculosis Control and Prevention (NCTB) to develop a manual for health care providers on TB/HIV co-infection management and a monitoring and evaluation (M&E) plan for an isoniazide (INH) preventive therapy (IPT) pilot. USG supported GOC to strengthen directly observed treatment (DOT) through community and home-based care.

USG supported GOC and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) to scale up the Essential Care Package (ECP) model in 84 counties. ECP includes condom promotion and distribution, clinical monitoring, OI management, adherence support, and home-based care.

In FY10, USG collaborated with local partners to develop the Continuum of Prevention, Care and Treatment (CoPCT) model in Luzhai County, Guangxi Province to strengthen linkages between clinical services provided by government agencies and care and support provided by communities. The local Luzhai government is committed to supporting this model and the local Bureau of Health (BOH) will take the lead in coordinating implementation in FY13.

USG also supported the establishment of a Legal Aid Center for PLHA in Kunming, Yunnan that provides information, advice, outreach, and capacity building for the legal profession on HIV/AIDS issues. In FY10, the center delivered legal advice to a total of 111 clients and reached over 8,000 people with outreach messages.

Alignment with government strategy and priorities

The USG PEPFAR program is fully integrated with China's national HIV/AIDS program. In 2003, GOC issued the Four Frees and One Care policy. This policy provides free voluntary counseling and testing (VCT), free ART for eligible PLHA, free PMTCT services for HIV-positive pregnant women, and free education for children orphaned by AIDS. In 2010, the State Council issued the Circular on Further Strengthening AIDS Notifications, which contains GOC priorities for strengthening care and support for PLHA, including palliative care, poverty alleviation, and anti-discrimination activities.

Key priorities & major goals in FY12 to FY13

USG has shifted from direct provision of services to technical assistance (TA) for model replication and scale-up. To accomplish this transition, in FY12 to FY13, USG will focus on the following priorities and goals:

- Increase coverage and efficiency of care and support services to most at risk populations (MARPs)
- Provide TA to GOC and GFATM to scale up community and home-based care
- Support a local non-governmental organization (NGO) to provide care and support to PLHA
- Build the capacity of county-level clinicians to provide HIV care and support services through three Rural AIDS Clinical Training Centers
- Provide TA to NCAIDS to evaluate 14 national HIV/AIDS clinician training centers
- Assist NCTB to develop national guidelines for IPT
- Transition CoPCT to local ownership by FY13

Contributions from or collaboration with other development partners

GFATM is the second largest contributor of financial resources to the national HIV response, after GOC. In November 2011, GFATM decided that Upper Middle Income G20 nations with less than an extreme disease burden would no longer be eligible for grant renewals or new grants. As a result, GFATM grants

to China will end in 2012, although transitional funding may be available for 2013. In FY12, USG will continue to collaborate with GFATM and other development partners to transition successful models to GOC in preparation for the end of GFATM support.

Efforts to achieve efficiencies

USG efforts to achieve efficiencies in China focus on the integration of HIV prevention, care, and treatment services into a coordinated national HIV/AIDS program. In order to achieve this integration, USG strengthens linkages between vertical health systems, including: the maternal and child health (MCH) system responsible for PMTCT; the CDC system responsible for risk reduction, HTC, and CD4 testing; and the hospital system responsible antiretroviral (ARV) and OI treatment. USG also fosters integration between the village, township, and county levels of the three-tiered health system to deliver these services in rural areas.

Efforts to build evidence-base

USG investments have developed community and home-based care models including CoPCT and ECP. These models have been adopted by GOC and GFATM for expansion in the China Comprehensive AIDS Response (China CARES) program. Additionally, USAID commissioned an external study of outcomes of the Comprehensive Package of Services (CPS) Model for PWID in both Yunnan and Guangxi provinces to examine differences in behavior—specifically, levels and types of risk behavior and other outcomes—between PWID in four sites where USAID-funded projects are operating (survey: N = 421 in project sites) and two matched sites where no such projects exist (N = 200 in control sites). In addition, qualitative data were collected from 40 respondents in project sites and 20 in control sites. The results showed that overall the USAID-funded projects have made major differences in PWID lives in terms of education (on HIV; harm reduction; wound management; and options for treatment of drug use, STIs, and HIV) and in terms of the breadth and quality of services provided to PWID in the project sites, both by the projects and by agencies to which PWID are referred. These are substantial achievements and echo other assessments' findings that these services should be scaled up across China. PWID in China are difficult to find and reach because of the policies and laws governing the behavior of all who come into contact with drug users. Within this difficult environment, the USAID-funded projects have managed to achieve a real engagement with drug users on a number of levels related to knowledge and service utilization. This study was also able to provide some evidence that the elements of the CPS, provided together, appear to lead to increased knowledge and access to services.

USG has helped NCAIDS to develop national indicators for care services, including CD4 testing to measure follow-up. USG has also successfully advocated for GOC to provide financial support for these activities.

Adult Care & Support

USG PEPFAR-supported programs in China promote a minimum package of care and support services for PLHA, including clinical care services, such as CD4 and VL testing, adherence support, and cotrimoxazole (CTX) prophylaxis, and HIV prevention services, such as risk reduction counseling, condom promotion and distribution, partner testing, and STI management.

Through the Henan Community Care Program, USG supports clinicians in five counties to provide follow-up services, such as partner testing, CD4 and VL testing, and CTX prophylaxis. USG also supports residential training programs for county-level clinicians in Luzhai, Guangxi and Lixin, Anhui. As part of their training, clinicians conduct home visits to PLHA in the surrounding counties and provide care and support services, such as OI management, clinical monitoring, adherence support, . At Luzhai, USG supports referral mechanisms between MMT, PMTCT, and care and treatment services. In FY12 to FY13,

USG will continue to provide technical assistance to NCAIDS to develop MMT as a platform for care, including ART adherence and psychosocial support. This model will increase integration between prevention, care, and treatment services.

USG also supports centers of excellence for the Continuum of Prevention, Care and Treatment (CoPCT) model, which strengthens linkages between prevention, care, and treatment services and between community and government service providers. In FY12, USG will transition these centers to local ownership and provide TA to GOC and GFATM to replicate this model in small towns and rural areas.

USG also provides TA to GOC and GFATM to scale up implementation of the Essential Care Package (ECP) for PLHA. ECP includes condom promotion and distribution, clinical monitoring, CTX prophylaxis, adherence support, and home-based care.

Obstacles to the implementation of a minimum package of care and support services include a lack of communication and coordination between vertical health systems and a lack of community-based programs. USG supports referral mechanisms between the MCH, CDC, and hospital systems to foster integration between HIV prevention, care, and treatment services. USG also supports referral mechanisms between the village, county, and township levels of the three-tiered health system to improve service delivery in rural areas.

There remains a lack of community and PLHA involvement in the provision of care and support services in China. The CoPCT model combines improved facility-based care and treatment services provided by GOC with community-based programs for PWID, MSM, FSW, and PLHA. The integrated services package includes HTC, support groups, and livelihood training for MARPs and PLHA. USG facilitates collaboration between local government and CBOs at demonstration sites in Yunnan and Guangxi in support of this model.

In FY12, USG will award a new cooperative agreement to engage local NGOs in the national response to HIV/AIDS by building their capacity to deliver high quality HIV care and treatment services to vulnerable populations in Southwestern and Western China. Beginning with at least three provinces in FY13, the to-be-determined (TBD) local partner will supplement government care and treatment services with adherence counseling, support groups, and other activities. Preference will be given to local indigenous NGOs that are not affiliated with an international NGO or Chinese government agency.

USG also promotes support groups for PLHA through the Henan Community Cares Program to improve ART adherence. Support groups for HIV-positive PWID also increase enrollment and retention in MMT. In FY12 to FY13, USG will provide TA to GOC and GFATM to scale up community and home-based care through ECP.

USG established Rural AIDS Clinical Training Centers in Lixin, Anhui and Luzhai, Guangxi in 2004 and 2010, respectively, to build the capacity of county-level clinicians to deliver quality HIV care and treatment services. In FY12, USG will provide technical assistance to the China-MSD HIV/AIDS Partnership (C-MAP) to open a third Rural AIDS Clinical Training Center in the predominantly non-Han ethnicity, non-Mandarin speaking Liangshan Prefecture in Sichuan Province. This prefecture has the highest HIV prevalence in China. Butuo County in Liangshan Prefecture has 8% HIV prevalence in the general population. USG also provides TA to NCAIDS to improve the curriculum at 12 additional national HIV/AIDS clinician training centers in urban areas.

Pediatric Care and Support

The USG PEPFAR program in China does not support direct provision of pediatric HIV care, since GOC has a successful pediatric care and treatment program.

In FY12 to FY13, USG will continue to build the capacity of county-level clinicians to provide quality pediatric care and treatment services through the Rural AIDS Clinical Training Centers. USG will work closely with the provincial CDC in Henan and Guangxi to investigate possible transmission routes for HIV-positive children born to HIV-negative mothers and to improve pediatric HIV data quality, analysis, and utilization. USG will also provide technical assistance to NCAIDS to improve early infant diagnosis (EID) for HIV-exposed infants and to strengthen linkages between PMTCT and pediatric ART.

TB/HIV

China has the second highest number of TB cases in the world and the highest prevalence of multi-drug resistant TB. Although TB is the most common OI and a major cause of death among PLHA worldwide, only about 1% of TB cases in China are PLHA.

In FY10 and FY11, USG provided technical assistance to NCTB to develop a manual for health care providers on TB diagnosis and treatment in PLHA. In collaboration with the World Health Organization (WHO), USG also provided technical assistance to NCTB for a pilot study on IPT. USG implemented TB/HIV services through the Henan Community Care Program, including TB screening for PLHA, HTC for TB patients, and TB and ARV treatment for TB/HIV co-infected patients. In FY11, USG supported TB screening for 2,149 out of 2,237 PLHA (96%), HTC for 2,699 out of 2,739 TB patients (99%), and diagnosis and treatment for 76 TB/HIV co-infected patients in five counties in Henan. USG also supported GOC to strengthen DOT through community and home-based care in the Essential Care Package.

In FY12, USG will continue to provide technical assistance to NCTB on data validation, analysis, and utilization to monitor and evaluate the IPT pilot. USG will also provide technical assistance to NCTB to draft a manual on IPT. USG will continue to support TB/HIV services through the Henan Community Care Program. In addition, USG will provide technical assistance to NCTB to scale-up TB/HIV services. USG will work closely with local CDCs to improve TB screening among PLHA, HTC among TB patients, and treatment for TB/HIV co-infected patients based on national guidelines. Early initiation of ART for PLHA with TB has been integrated into the third edition of the Technical Handbook on TB and HIV Control and Prevention, which will be released in early 2012.

In FY12, USG will collaborate with NCTB to integrate TB/HIV M&E plans into local assessments of TB and HIV/AIDS programs in two counties. This will be done through building capacity at both the clinic and laboratory level for TB/HIV diagnosis, improving the quality of data collection, strengthening the reporting system, and facilitating collaboration between TB and HIV/AIDS programs.

Gender

The proportion of PLHA who are women has doubled over the past decade to 30.5% in 2009. Although many of these cases are FSW or female PWID, approximately one-third of heterosexual transmission occurs between discordant couples. In FY12 to FY13, USG will support NCAIDS to pilot gender-specific programming for female PWID and female sexual partners of male PWID that links MMT, PMTCT, and other HIV prevention services with care and treatment.

Most at Risk Populations (MARPs)

Among the estimated 740,000 PLHA in China, 32.2% were infected through injecting drug use, 14.7% were infected through MSM behavior, and 44.3% were infected through heterosexual transmission. Due to stigma and discrimination issues, the quality of care for MARPs is often suboptimal, especially for PWID, MSM and FSW.

The USG PEPFAR program in China addresses the care needs of MARPs through the Continuum of Prevention, Care and Treatment (CoPCT) model (described above). Through the CoPCT, USG programs have built effective linkages between clinical and community services, ensuring a minimum package of care-related services for MARPs.

Community-facilitated care and support services are essential components of the CoPCT. Through this model, USG has also supported three effective and reliable models of livelihood development interventions for MAPRS, including former PWID and MMT clients in Yunnan and Guangxi. These livelihood activities help improve economic security and quality of life for MARPs and PLHA and enhance positive public health outcomes for HIV prevention and care programs. To enhance sustainability, these programs also serve as models for future scale-up and replication.

To ensure accessible and friendly HIV support services, MMT clinic workers and PWID groups have been trained in psychosocial support. PEPFAR investments have also helped PLHA family members and community members to gain skills related to community and home-based care and support. USG also addresses legal barriers through the establishment of a Legal Aid Center based on the work of a lawyer from Yunnan University and his peers. The work of the Legal Aid Center has focused on providing information, advice, and outreach services and building capacity for the legal profession on HIV/AIDS issues. All of these activities are meant to create an enabling environment for MARPs to access services.

USG also continues to support anti-stigma and anti-discrimination activities in Yunnan and Guangxi through coordinated activities in the work plans among USG partners. Unfortunately, stigma and discrimination remain as barriers for PLHA to receive quality care and support services at the community level. For example, the USG activities mentioned above try to tackle issues surrounding the Dynamic Control System (DCS), which remains a barrier for former PWID to access HIV-related services. The DCS, a system established by Narcotics Control Bureau of the Ministry of Public Secruity, aims to monitor drug users and reduce crime related to drug use. It collects and tracks the identification of drug users (former and current) and saves this information in a database that is accessible to all public security bureaus across China. When drug users (current or former) are requested to show identification for any services (like hotel check-in, membership registration, and medical treatment), the system will alert local police to their presence. This can lead to discriminatory practices, such as involuntary drug testing and can act as a barrier for HIV testing. USG will continue technical assistance, anti-stigma and discrimination, and advocacy work in Yunnan and Guangxi with local governments, community-based organizations, and PWID advocacy groups as well as the Legal Aid Center regarding the continued use of the DCS.

Human Resources for Health (HRH)

At the Lixin and Luzhai Rural AIDS Clinical Training Centers, practicing clinicians from rural areas are provided with a hands-on 3-month residency program to learn how to provide quality care to HIV/AIDS patients following international standards and best practices. Training includes OI screening, diagnosis, prevention and treatment among HIV-positive patients. Training also focuses on HTC for patients in TB clinics through opt-out strategies, referrals for HIV-positive TB patients to HIV prevention, care and treatment services (including CTX prophylaxis and ART), TB screening for PLHA, and referrals of HIV-positive patients diagnosed with TB to clinics for treatment. The program also includes field visits to CBOs to learn about community and home-based care for PLHA. In FY12 and FY13, graduates from the Lixin and Luzhai Rural AIDS Clinical Trainings Centers will continue to add to the cadre of physicians and nurses providing HIV care and support services in rural areas. In FY12, USG will also provide technical assistance for the replication of this model in Liangshan, Sichuan.

Laboratory

Responsibilities for the establishment and quality management of the multi-tiered Chinese laboratory network were delineated in several national guidance documents. All HIV laboratories are ISO-17025 accredited. More than 100 AAA hospital laboratories providing HIV and other clinical tests (e.g. kidney and liver function tests) were ISO-17189 accredited in 2010.

Most national HIV-related laboratory technical guidelines were developed in close consultation with USG, WHO, and the Clinton Health Access Initiative. Quality assurance programs including proficiency testing, performance of domestic and international test kits, supervisory monitoring and staff training are also well-established and constantly improved overtime. Second to India, China has the highest TB burden in the world with high extent of multi-drug resistance. GOC has developed a national plan for TB/HIV dual infection control and received significant GFATM support. The National TB Reference Laboratory in China CDC has similar responsibilities to the National AIDS Reference Laboratory (NARL) in establishing national TB diagnostic testing standard, culture, quality management and coordination of TB laboratories at provincial and lower levels. Although PEPFAR does not directly support TB diagnostic operations in China, U.S. CDC works with China CDC on TB through the International Emerging Infections Program. In 2011, USG assisted NARL in formulating technical guidelines for hepatitis C virus (HCV) diagnostics, HCV proficiency quality management and genotyping.

In FY12, USG will facilitate the dissemination and training of provincial CDC laboratory staff to fully understand the appropriate use of new diagnostic guidelines.

Strategic Information (SI)

Key challenges in the past year

As GOC scales-up HIV testing, a rapid increase is expected in the number of HIV-positive people identified. Physicians provide most care services, including CD4 testing, CTX prophylaxis, and OI (including TB) diagnosis and treatment; however, physicians often lack the capacity and incentive to use data to monitor and evaluate these care services. This dearth of data analysis capacity is pervasive at all levels of care, but especially at provincial and county CDCs.

Another major challenge is the lack of linkages between the national HIV case reporting database and the national ART treatment database. Test results are uploaded to the HIV case reporting database but not to the ART treatment database. Likewise, some HIV-positive cases that are in the treatment database are missing in the case reporting database. It is important to physicians and health care workers that the HIV information system works efficiently to ensure a sustainable and effective case management process.

In addition, tracking referrals of clients across different service delivery sites has been a major challenge for ensuring effective care and support programs that are linked to prevention and HTC services.

Strategic responses in the future

USG will support GOC to strengthen the capacity of provincial and county CDC staff to analyze data by providing TA. In five focal provinces, USG will enhance data quality and the linkage between CDC and hospital systems by promoting good models, such as First Diagnosis Responsibility, for better HIV case finding, referral, and management. USG will collaborate with the Guangxi Provincial and Luzhai County AIDS Offices to conduct an evaluation of the Continuum of Prevention, Care and Treatment (CoPCT) model in Luzhai. Results and lessons learned will be shared with GOC to promote replication of the model in China.

USG will support the implementation of a management information system (MIS) across all USG-funded sites in Yunnan and Guangxi to enhance the referral and case management systems. MIS will also help

establish and document effective linkages to MARP-friendly services and providers.

Capacity Building

Capacity building plays an important role in USG collaboration with GOC and contributes to country ownership and sustainability. The priority capacity building objectives for care are to develop competencies among county-level clinicians and engage local, indigenous NGOs to deliver HIV care and support services. USG will also support NCTB to lead, manage, and monitor TB/HIV services by providing technical assistance on guidelines, manuals, and M&E.

USG will continue to partner with China CDC to address individual, organizational, and systems components of capacity building at all levels of government. In particular, USG will partner with NCAIDS and local government to support the Rural Clinical AIDS Training Centers in Lixin, Anhui and Luzhai, Guangxi. USG will also provide technical assistance to C-MAP to open a third Rural AIDS Clinical Training Center in Liangshan, Sichuan.

Please refer to the draft capacity building plan under supporting documents for activities, outputs, outcomes, and their measures by component.

Technical Area: Governance and Systems

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	312,566	0
HVSI	603,901	0
OHSS	467,546	0
Total Technical Area Planned Funding:	**1,384,013**	**0**

Summary:
Introduction

The PEPFAR program in China is well-integrated with the national HIV/AIDS program. The Government of China (GOC) provides the majority of funding for its HIV response, including all funding for first line treatment. The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) has also provided a significant share of funding, especially for second line treatment. The freezing of GFATM funding resulted in many challenges this year.

Within the context of a relatively well-resourced health system, significant challenges remain. Most people living with HIV/AIDS (PLHA) in China are from rural areas where access to health care remains an issue. Most at risk populations (MARPs) are further marginalized as a result of stigma and discrimination, making access to HIV prevention, care, and treatment an even greater challenge.

China's health infrastructure has been a major focus for investment over the past several years. While China currently produces an adequate number of health care providers, their capacity remains low. Health care facilities, including laboratories, are well-equipped but often lack skilled personnel and appropriate procedures. Most health care providers receive no training on HIV prevention, care, or treatment as part of their professional education. The Chinese health system is also strongly vertical, and coordination both within the public health system (MCH, HIV/AIDS, TB) and between the public health

system and the clinical system is weak. China is currently undertaking a major reform of its three-tier (village, township, county) health system to increase quality and utilization of services at the lowest levels. The PEPFAR program in China has implemented a number of activities that address these health systems challenges, including two Rural HIV/AIDS Clinical Training Centers, the Provincial Program Management Training Program, and a number of initiatives that focus on strengthening linkages within and between systems. PEPFAR has also supported a variety of laboratory initiatives that have placed China at the forefront of a number of new technological approaches in HIV diagnostics. As the primary funder and implementer of HIV/AIDS services in China, GOC has established a comprehensive national HIV/AIDS program that integrates the PEPFAR program, the few remaining bilateral programs, and GFATM. The USG vision is that over time, GOC technical capacity will be strengthened to a level commensurate with these significant financial commitments. To achieve that vision, over the next five years, USG plans to provide strategically-targeted technical assistance and capacity building to GOC and its civil society partners.

Global Health Initiative (GHI)

China is not a focus country for the Global Health Initiative (GHI), but PEPFAR's activities in China are consistent with the seven GHI principles described below:

Focus on women, girls, and gender equality
Based on the epidemiology of the HIV epidemic in China, women and girls have not been a primary focus of the PEPFAR program. However, PEPFAR has made significant contributions in responding to the challenge of HIV for Chinese women by demonstrating the effectiveness of a comprehensive approach to prevention of mother to child transmission (PMTCT) that includes HIV, hepatitis B, and syphilis, which is now being scaled up nationally. PEPFAR programs also engage women who are members of MARPs such as people who inject drugs (PWID), sexual partners of PWID, and female sex workers (FSW). USG also builds the capacity of GOC and civil society partners to use data effectively to allocate resources to those with the greatest need regardless of gender.

Encourage country ownership and invest in country-led plans
The PEPFAR program in China has made significant strides in transitioning to a technical assistance (TA) model that focuses on building the capacity of GOC and civil society partners. This model strengthens GOC ability to provide oversight and manage its national HIV response sustainably. With GOC providing close to 80% of total HIV/AIDS funding in China, USG has a unique opportunity to both influence and support a strategic and integrated approach that is grounded in high quality data via this TA model.

Strengthen and leverage other efforts
Few bilateral organizations continue to support HIV/AIDS programs in China, and those that remain increasingly look to the USG PEPFAR team to support their transition to host country ownership. Although GFATM decided in November 2011 that Upper Middle Income G20 nations with less than an extreme disease burden would no longer be eligible for grant renewals or new grants after 2012, GFATM remains a key player and the USG PEPFAR team is an active participant in the GFATM Country Coordinating Mechanism (CCM) and AIDS Working Group. U.S. CDC is currently co-located with both the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), which allows for routine coordination of activities that will intensify in FY12 to provide additional, needed support for civil society engagement in the HIV response. Furthermore, it will be important to engage the private sector and foundations in discussions regarding the transition of models developed by USAID to sustainable, locally-owned mechanisms over time.

Build sustainability through health systems strengthening
GOC is currently implementing a substantial program of health reforms designed to increase health system efficiency, improve quality, and increase access to services. PEPFAR activities complement this

series of health reforms by focusing on key health systems needs, including laboratory systems development and specialized training for primary care providers and public health professionals. In FY12, special emphasis will also be placed on provider-initiated testing and counseling (PITC).

Promote learning and accountability through monitoring and evaluation
The USG PEPFAR team has been instrumental in supporting the development of a number of data systems that serve as metrics for measuring the performance of the Chinese HIV response. In the area of improving metrics, USG will continue to support improvement of the national surveillance system by increasing the number of HIV sentinel surveillance sites, building the capacity of local staff, and improving data quality and use in all 15 USG-supported provinces.

Increase impact through strategic coordination and integration
U.S. CDC and USAID effectively use their comparative technical advantages for maximum impact. U.S. CDC's relationship with the Chinese Centers for Disease Control and Prevention (China CDC) at national and provincial levels focuses on systems development, policy guidelines and technical approaches, while USAID's relationships with provincial and local CDCs, local NGOs, and other implementing partners focus on developing implementation models for MARPs. Beyond PEPFAR, the National Institutes of Health's research mandate in China helps develop capacity and infrastructure for HIV research relevant to China. The Embassy's Environment, Science, Technology and Health Section and the HHS Health Attaché provide guidance and technical advice and actively support the PEPFAR program in China. Perhaps more significantly, with support from the USG PEPFAR team, GOC is increasingly engaging in global health partnerships designed to bring the unique expertise and experience of Chinese public health professionals to bear on important regional and global challenges in HIV response. This includes partnerships around laboratory, risk reduction, and other key areas.

Accelerate results through research and innovation
This final GHI principal is truly the cornerstone of the PEPFAR program in China. With relatively modest resources, USG supports innovative activities with high potential for payoff in terms of improved health outcomes. These models have a strong track record for scale-up at the national and provincial level using host country resources. Furthermore, PEPFAR provides a platform for addressing other high priority issues that link strongly to the goals of GHI. One example in China is the collaboration with U.S. CDC's Division of Reproductive Health to evaluate the safety and effectiveness of tenofovir in pregnancy for PMTCT of both HIV and hepatitis B virus (HBV). HIV/HBV co-infection rates are quite high in China. This work also has the potential to benefit women and children in other parts of the world.

Leadership, Governance, and Capacity Building

The PEPFAR program in China is fully integrated with the national HIV/AIDS program. Specific areas of focus and activity are developed in consultation with GOC to address critical gaps in the current response. U.S. CDC works with the National Center for AIDS/STD Control and Prevention (NCAIDS) at China CDC as its primary partner and specifically focuses on the development of models and strategic information systems that will support policy innovation in the national response. A key activity over the past year has been support for the development of the first National HIV/AIDS Surveillance Report, which will be made widely available in both English and Chinese and serves both to document the current situation in China and as a benchmark against which future progress can be measured.

Given China's large size as well as its geographic and economic complexity, it has been part of the strategic approach for PEPFAR to include robust collaborations at the provincial level as well. As part of its efforts with 15 of China's 31 provinces, U.S. CDC will also support the development of provincial surveillance reports. U.S. CDC has been developing the Chinese public health laboratory infrastructure and its epidemiologic capacity to conduct rigorous and high-quality HIV incidence surveillance as part of an effort to support China's ambitious goal to reduce the number of new HIV infections by 25% by 2015.

In addition to developing the data systems which support improved decision making, a major focus of PEPFAR technical assistance to GOC relates to policy development. PEPFAR has contributed significantly to national guidelines on free antiretroviral treatment (ART), second line ART, cotrimoxazole (CTX) prophylaxis, TB/HIV co-infection, CD4 testing, and PITC. Furthermore, through the Provincial Program Management Training Program, PEPFAR promotes the development of improved management, operations, and fiduciary skills. It is notable that 80% of this program's graduates remain working in HIV and 13% have now assumed leadership roles at the Division Deputy Director level or above. It is critical to support program management capabilities, both operational and fiduciary, at the sub-national level because this is where capacity is weakest. In general, the national authorities are well-versed in monitoring and evaluation, quality improvement, internal controls and audit functions. However, with the majority of program implementation occurring at the provincial or even the county level, the possibility of poor management controls is quite significant, as was demonstrated by the GFATM risk analysis.

USAID programs support provincial government in Yunnan and Guangxi through joint planning and technical assistance to routinely review program data, epidemiologic data, and other strategic information for decision making and priority setting. To support this effort, simplified Analysis and Advocacy (A2) Tools were launched in 2010, and have since been rolled out to ten provinces to assist in using data analysis for HIV program and resource allocation projections. Through continuous dialogue, coordination, and collaboration, USAID coordinates the transition of technical HIV prevention, care, and support models – CPP and CoPCT (described below in the service delivery section) – to local government and stakeholders. This builds on considerable civil society efforts to leverage existing government services and integrate programming for PWID, men who have sex with men (MSM), and FSW. USAID also leverages the growing private sector to extend care and support services to MARPs and offer greater options for access to services through a Clinical Health Network (CHN).

Broadly speaking, GOC has advanced both a policy framework for its response to HIV/AIDS and a set of ambitious goals that demonstrate a high degree of political ownership and stewardship. GOC's policy framework encompasses the availability of free ART for eligible PLHA, a comprehensive strategy for PMTCT that includes HIV, HBV and syphilis, the world's most expansive program of risk reduction for PWID that includes both methadone maintenance treatment (MMT) and needle exchange, and new initiatives for treatment as prevention among discordant couples, community-based drug treatment, and MSM couples counseling.

A significant challenge remains in terms of the engagement of civil society and the private sector. China's political, social and legal framework is not very conducive to the development of a robust civil society, precipitating some of the challenges with GFATM this year. However, GOC has committed to achieving the agreed upon targets for civil society engagement in China's HIV response and will be selecting a civil society sub-recipient in 2011. Furthermore, the plan is for the sub-recipient to transition to principal recipient status in 2012. The Ministry of Health (MOH) has indicated its willingness to fund NGOs after the withdrawal of GFATM, pending approval from the Ministry of Finance. The USG PEPFAR team will support these ongoing efforts to engage with civil society, both through transition of models that have been developed by USAID that are grounded in the engagement of civil society and through increased technical assistance to the GFATM sub-recipient and other civil society organizations. In FY12, U.S. CDC will award a new cooperative agreement to engage local NGOs in the national response to HIV/AIDS by building their capacity to deliver high quality HIV care and treatment services to vulnerable populations in Southwestern and Western China. Beginning with at least three provinces in FY13, the to-be-determined (TBD) local partner will supplement government care and treatment services with adherence counseling, support groups, and other activities. Preference will be given to local indigenous NGOs that are not affiliated with an international NGO or Chinese government agency.

Strategic Information (SI)

Key successes of the past year

The USG PEPFAR team implemented a number of strategic information (SI) activities to strengthen country systems for monitoring HIV prevalence trends, HIV incidence among MARPs, and drug resistance to ART and for assessing behavioral change outcomes resulting from USG interventions. In addition to introducing cutting edge techniques to the existing HIV surveillance system, USG improved the quality of the current system and strengthened data analysis and utilization at national and sub-national levels.

USG, jointly with WHO and UNAIDS, conducted an external evaluation of the national HIV sentinel surveillance system after its dramatic expansion from 600 sites in 2009 to 1888 sites in 2010. The final report is currently under development. Proposed recommendations for tackling key challenges will result in a better quality and more sustainable surveillance system. USG also helped NCAIDS develop a work plan for evaluating the impact of the national HIV response over the past five years.

USG supported a national pilot study to estimate the population size of MARPs using the network scale-up method (NSUM). This new method generates estimates of all populations of interest through one population survey among the general public. A comparison of the results between NSUM and conventional methods will assist GOC to determine optimal methods for size estimation to generate more reliable results for HIV epidemic estimation and projection.

USG technical support was instrumental in the development of the 2010 National HIV/AIDS Surveillance Report from NCAIDS. New statistical methods were introduced to GOC. This was the first year the report was comprehensive and produced in both English and Chinese. It will help the international community to better understand HIV epidemic changes in China.

To take full advantage of the national platform for HIV incidence testing, USG supported training on data analysis using the BED-CEIA method. By working closely with U.S. CDC experts in Atlanta, a NCAIDS trainee received hands-on experience in advanced statistical methods. Challenges in data analysis and interpretation of the BED method in China were identified. An update of the national HIV incidence testing guidance is expected in 2012.

USG supported 8 innovative operational research studies in 10 provinces with relatively low and stabilized HIV epidemics. The provinces were responsible for study design, implementation, and data analysis with TA from USG. For the five focal provinces with high HIV epidemics, USG continued financial support and TA. In Guangxi province, which has the highest cumulative number of reported HIV infections, USG supported data analysis and utilization at the provincial level and in one selected county, Luzhai. Monitoring and evaluation (M&E) guidelines that included harmonized indicators for MARPs were completed and reinforced for use among all implementing partners.

Under the Comprehensive Prevention Package (CPP) implemented in Yunnan and Guangxi, USG increased its effort to make available and share research and program documentation to promote the use of data and advocate for program scale-up and replication of the CPP model at the national level. For example, USG finalized the outcome evaluation of the PWID Track Two survey, which compared levels and types of risk behavior among PWID at USG-supported sites where CPP is available and at control sites where no or limited services are available. In collaboration with GOC, a national forum was organized to disseminate results and share lessons learned. Two study papers were accepted for presentation at the 22nd annual meeting of the International Harm Reduction Association in Beirut, Lebanon in April 2011. USG also conducted in-depth data analysis and completed reports for the FSW and MSM Routine Behavioral Tracking (RBT) surveys, which measure levels, trends, and determinants of behaviors to monitor, evaluate, and improve the HIV comprehensive interventions. This also resulted in the submission and presentation of three RBT study abstracts at the International Congress on AIDS in

Asia in Pusan, South Korea in August 2011. Data collection and analysis have been completed for the Longitudinal Enhanced Evaluation (LEE) study of ART patients in Guangxi, which will be used to improve care and support programs.

Key challenges of the past year

China has well-established systems for HIV/AIDS case reporting and HIV sentinel surveillance. One of the challenges is how to ensure a stable surveillance system with good data quality. For example, the national HIV sentinel surveillance dramatically expanded from 600 sites in 2009 to 1888 sites in 2010. Eight populations are targeted (ANC patients, FSW, PWID, long distance drivers, male mobile populations, MSM, male STI clinic attendees, and college students) covering all 31 provinces. Issues identified during the external evaluation include: 1) lack of support from implementing sectors such as hospitals, education departments/universities, and public security bureaus, which influences recruitment of survey participants within each survey round; 2) inconsistent adherence to national instructions on sampling methods and results feedback, which affects the representativeness of target populations; and 3) lack of capacity for data analysis and utilization at prefecture and county levels. Another challenge is the use of data from a variety of sources. China has a comprehensive information system with systematic data collection on HIV sentinel surveillance, case reporting, ART, voluntary counseling and testing (VCT), MMT and risk reduction. Given the vast amount of information collected, how to effectively use and triangulate the results for program planning remains challenging.

Strategic priorities for the future

In FY12, USG SI activities will follow a TA model to build local capacity to collect, analyze, and use HIV/AIDS data. USG will provide TA to support the development, implementation, and documentation of innovative SI methods and models at the central level and in USG-supported provinces.

USG will support GOC efforts to improve the quality and sustainability of the national HIV surveillance system and strengthen the capacity of data analysis and use at national and sub-national levels. USG will support NCAIDS in population size estimation of MARPs, HIV incidence estimation using multiple methods particularly BED-CEIA testing, and data triangulation using national HIV and sexually transmitted infections (STI) sentinel surveillance data. Similar assistance to sub-national levels will be provided. USG will collaborate with GOC to prioritize the collection of strategic information, documentation and dissemination of results and lessons learned from programmatic research and evaluations.

Additionally, USG will conduct the following strategic information activities at the provincial level in collaboration with local stakeholders: PWID RBT covering Kunming, Nanning, Luzhai and Gejiu; MSM qualitative study in Kunming and Nanning to explore the intervention/services gaps with regards to prevention, care, and availability of health products for MSM; MSM follow-up RBT in Kunming, Nanning and selected hotspots in Honghe Prefecture; and Continuum of Prevention to Care and Treatment (CoPCT) model process evaluation in Luzhai County. USG will continue to build the capacity of local organizations and government to use SI tools and results to improve health systems and to inform program interventions, while simultaneously implementing quantitative studies to inform, monitor and improve project implementation. A special focus will be placed on operational research, which documents new ways of implementing the CPP and CoPCT models.

USG will assist NCAIDS to develop the national HIV/AIDS M&E framework for the next five years (2011-2015). In addition, USG will support NCAIDS to conduct cost-effectiveness analyses of national HIV programs. USG will also emphasize the need to harmonize indicators and streamline reporting for MARPs in line with national guidelines.

Service Delivery

In 2003, GOC issued the Four Frees and One Care policy, which includes free VCT, ART, and PMTCT. Since then, USG has shifted from direct provision of services to TA for model replication and scale-up. To accomplish this transition, USG has developed the Continuum of Prevention, Care and Treatment (CoPCT) model for PWID, MSM, FSW and PLHA at demonstration sites in Yunnan and Guangxi. At these sites, an integrated services package combines strengthened GOC institutional care and treatment, community and home-based care, and PLHA support groups. These services are delivered by local government departments and civil society organizations (CSOs). USG will continue to support several of these interventions, including peer ART adherence support for PLHA in drop-in centers located within health care facilities and livelihood development support for PLHA and their households. As part of model roll-out, USG provides documentation and lessons learned for program replication, study tours, and internship courses at model sites. USG successfully leveraged funding from GOC and other donors to support project offices and staff.

USG also developed the Comprehensive Prevention Package (CPP) model, which focuses limited resources to ensure the provision of a comprehensive package of prevention services to those most at risk of being infected or transmitting HIV to others so as to avert the maximum number of new infections. The CPP approach has been used with PWID, MSM, FSW, and PLHA in high HIV prevalence hotspots in Yunnan and Guangxi. CPP includes behavior change communication (BCC) aimed at providing information that leads to a choice of healthy behaviors, VCT, STI screening and treatment, and capacity building of grassroots groups as well as linkages to care and treatment services such as ART, opportunistic infections (OI) treatment, home-based care, and psychosocial support. USG has supported these interventions by networking and establishing referral networks to existing GOC services. USG also recognizes the importance of supportive interventions to create an enabling environment and thus has supported activities in the six supportive intervention components of capacity building, community mobilization, income generation, policy, stigma and discrimination reduction, and strategic information.

The CoPCT and CPP models described above are fully aligned with PEPFAR's Continuum of Response (CoR) core principles. This pragmatic approach to HIV prevention and mitigation in Yunnan and Guangxi is designed to surround target MARPs with the full range of prevention, care, and treatment services and better enable them to access these services without fear of stigma and discrimination. USG has worked within the context of a TA model to promote CoPCT and CPP. This approach will continue in FY12 with eventual transition to local ownership at the end of FY13.

To further support local ownership of service delivery, USG continues to support GOC and GFATM scale-up of the Essential Care Package (ECP) model, a comprehensive approach for providing care and support services to PLHA that includes condom promotion and distribution, clinical monitoring, OI prophylaxis, ART adherence, and home-based care. ECP is delivered through the three-tier health system and involves community and family members.

Human Resources for Health (HRH)

As discussed with OGAC in August 2011, pre-service training of new health care providers is not part of the PEPFAR program in China, since China does not have a general shortage of health care providers. The PEPFAR program in China is a high level technical assistance program focusing on in-service training to improve the performance of the health care workforce, particularly in rural areas.

In December 2010, the State Council issued the Circular on Further Strengthening AIDS Notifications, which requires the expansion of HIV/AIDS services, including PMTCT, HIV testing and counseling (HTC), ART, and palliative care. Given that more than 70% of PLHA reside in rural areas, the major challenge for effective implementation of these policies is the low capacity of health care workers at the local level.

In order to build the capacity of county-level clinicians to deliver quality HIV care and treatment services, USG established two Rural AIDS Clinical Training Centers in Lixin, Anhui and Luzhai, Guangxi in 2004 and 2010, respectiviely. These centers provide a 3-month residential training program in a setting similar to rural physicians' regular working environment. They also provide a model for linking village, township, and county levels of the three-tier health system to deliver HIV/AIDS services, which graduates can replicate once they return home. In FY11, the Lixin Rural AIDS Clinical Training Center was transitioned to the Anhui Bureau of Health (BOH). In FY12, USG will continue to provide TA to the Lixin Rural AIDS Clinical Training Center on second line ART and provide direct support for greater outreach to the surrounding counties. In FY12 to FY13, USG will continue to support the full operation of the Luzhai Rural AIDS Clinical Training Center. In addition, USG will provide technical assistance to the China-MSD HIV/AIDS Partnership (C-MAP) for the establishment of a third Rural AIDS Clinical Training Center in the predominantly non-Han ethnicity, non-Mandarin speaking Liangshan Prefecture in Sichuan Province. This prefecture has the highest HIV prevalence in China. Butuo County in Liangshan Prefecture has 8% HIV prevalence in the general population. USG will also continue to partner with I-TECH to evaluate all 14 national HIV/AIDS clinical training centers.

USG will continue to support the Provincial Program Management Training Program (PPMTP) to build provincial-level HIV/AIDS program managers' capacity in program planning, implementation, supervision, and evaluation. PPMTP provides 6-months of on-the-job training for provincial HIV/AIDS personnel. As of June 2011, 11 cohorts totaling 86 trainees from 30 provinces have graduated. Most trainees directly participate in local HIV/AIDS prevention and control programs and play key roles in China Comprehensive AIDS Response (China CARES), GFATM, and other major programs. In FY12 to FY13, USG will collaborate with I-TECH to add leadership and management training, qualitative research training, and case study methods to the PPMTP curriculum.

Laboratory Strengthening

China has a well-established multi-tier HIV laboratory network that spans the CDC, hospital, and maternal and child health (MCH) systems. Responsibilities for the establishment and management of the laboratory network were delineated in several national guidance documents. Laboratory technical guidelines for HIV testing were developed in close consultations with USG, WHO, and the Clinton Health Access Initiative. All HIV laboratories have been ISO-17025 accredited.

The top two tiers of the network consist of the National AIDS Reference Laboratory (NARL) at NCAIDS and 35 provincial confirmatory laboratories. In 2010, GOC opened an additional 283 confirmatory laboratories in prefectural CDCs and large hospitals and more than 8,870 screening laboratories in county CDCs, blood stations, and MCH facilities. About 32% of laboratories are in CDCs and 57% are in hospitals. Serologic testing services have been extended to 97% of prefecture level health systems. In 2010, 360 CD4, 95 viral load, 30 incidence and 20 drug resistance laboratories produced 62 million antibody, 287,000 CD4, 80,000 viral load (VL) and 4,000 drug resistance (DR) tests. There are more than 2,000 detection sites with minimal laboratory equipment using rapid testing (RT) algorithms. Expansion of RT using non-laboratory personnel is expected to greatly increase in 2012, as a result of a GOC mandate to complete new technical guidelines for RT by late 2011. Maintenance of data quality and timeliness of reporting are of critical importance. Quality assurance programs including proficiency testing, performance of domestic and international test kits, supervisory monitoring and staff training are well-established and constantly improved overtime. In FY12, USG will work closely with NARL to devise a national five-year laboratory strategic plan.

Health Efficiency & Financing

China is currently undertaking a substantial reform of its health care system with the goal of increasing efficiency and achieving more equitable access to health care for all Chinese people. USG, including but

not limited to the PEPFAR team, is actively involved in supporting these health reform efforts. HIV/AIDS-related activities are described below.

The health economist in U.S. CDC's Beijing office is working with GOC to conduct a cost-effectiveness analysis of OI prevention on all-cause mortality in one province. In FY11, U.S. CDC supported health economics and cost-effectiveness analysis training for public health professionals in China, including a team of researchers from NCAIDS. In FY12, U.S. CDC will continue to support this team in completing their analyses on the cost-effectiveness of PITC with mentoring from both the health economist in Beijing and technical experts in Atlanta.

In terms of financing, PEPFAR funds are highly leveraged. In FY12, a new initiative for matching funds will be implemented. Provinces receiving funds through the U.S. CDC cooperative agreement with NCAIDS will match each dollar at a rate of 1:1.

Gender

Women and girls make up 31% of PLHA in China. PEPFAR has supported a number of initiatives related to women and girls. Since FY07, USG has supported an enhanced PMTCT pilot program in Guangxi. Based in part on the success of this model, GOC has decided to expand the national PMTCT program. USG will continue to provide TA to the National Center for Women and Children's Health (NCWCH) during this rapid expansion. USG has also successfully transitioned comprehensive prevention and care models for FSW and strengthened linkages between national programs that serve women, including MMT, MCH and ART. Based on recent research findings supporting treatment as prevention, MOH has announced a plan to make treatment available for all discordant couples, which is likely to have a significant benefit to women.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	1,275,989	
Total Technical Area Planned Funding:	**1,275,989**	**0**

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVCT	418,944	0
HVOP	1,103,871	0
IDUP	806,571	0
MTCT	149,924	0
Total Technical Area Planned Funding:	**2,479,310**	**0**

Summary:
Overview

Key populations & risk factors
The HIV/AIDS epidemic in China is concentrated among people who inject drugs (PWID), men who have sex with men (MSM), female sex workers (FSW), and other people with multiple, concurrent sexual partners, such as clients of FSW. Although national HIV prevalence remains low (0.04–0.07%), some localities have a more generalized epidemic with HIV prevalence over 1%. Sexual transmission is now the primary mode of transmission. Among the estimated 48,000 new infections in 2009, heterosexual transmission accounted for 42.2%, MSM behavior for 32.5%, and injecting drug use for 24.3%.

People Who Inject Drugs (PWID)
The contribution of injecting drug use (IDU) to overall HIV incidence decreased from 42.0% in 2007 to 24.3% in 2009. The national HIV prevalence among PWID is 9.3%, but much higher HIV prevalence has been reported among PWID at provincial levels, including 29.0% in Xinjiang, 25.0% in Guangxi, and 18.3% in Yunnan. By 2009, approximately 238,280 PWID were estimated to be infected with HIV, primarily in the provinces of Xinjiang, Yunnan, Guizhou, Guangxi, and Guangdong, each of which had more than 10,000 PWID infected with HIV. In the 2009 National HIV/AIDS Sentinel Surveillance, 71.5% of PWID reported using sterile injecting equipment at last injection. Condom use among PWID is low compared to MSM and FSW. Only 35.8% of PWID reported using a condom at last sexual intercourse.

In 2007, the National Center for AIDS/STD Control and Prevention (NCAIDS) within the Chinese Center for Disease Control and Prevention (China CDC), in collaboration with the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), estimated the population size of PWID to be 1.5 to 3.0 million. The prevalence of injecting drug use among people aged 15-64 years is 0.25% or an estimated 2,350,000 persons, according to the United Nations Office on Drugs and Crime. The China National Narcotics Control Commission reported that the registered number of drug users in 2009 was 1,335,920 of whom 978,226 (73.2%) were heroin users.

Men Who Have Sex Men (MSM)
There is growing evidence and concern that China's MSM epidemic is much larger and developing much faster than previously acknowledged. The contribution of MSM to overall HIV incidence increased from 12.2% in 2007 to 32.5% in 2009. Until recently, there has been limited surveillance data on MSM. In early 2008, with support from 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%. HIV prevalence among MSM varies largely by region. In the southwest (Kunming, Guiyang, Chongqing, and Chengdu) HIV prevalence was more than 10%; in Kunming, the prevalence was 14%. The southeast, northeast, and coastal areas had prevalence rates around 4-5%. In Shanghai, the prevalence was 7%. 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 contrast, in the 2009 National HIV/AIDS Sentinel Surveillance, 73.1% reported using a condom the last time they had anal sex with a male partner.

Population size estimates for MSM in China vary. In 2007, the NCAIDS estimate was 3.1 to 6.3 million MSM. However, this may be an underestimate, as many other sources report much higher figures, the most common being 5-10 million MSM, with some national estimates as high as 18-20 million. Government size estimates are generally based on the assumption that small proportions of the male population have sex with men, such as 0.5% to 2.0%. However, many studies have shown 2% to be the lower limit in many male populations, with the upper limit as high as 15% (MSM Country Snapshot, UNAIDS, 2010).

Female Sex Workers (FSW)
According to 2009 National HIV/AIDS Sentinel Surveillance results, the national HIV prevalence among female sex workers (FSW) is 0.6%, but surveys of FSW in hotspots have found 5-10% HIV prevalence. HIV prevalence among FSW who inject drugs is up to 30%, with the highest prevalence in Guangxi, Yunnan, and Xinjiang. According to behavioral surveillance data, 60% of sex workers reported not using condoms at every sexual encounter. Although 85% of FSW report using condoms at last commercial sexual intercourse, only 44% report using condoms consistently with regular partners, thereby increasing the risk of transmission to regular partners. While FSW condom use appears to be increasing, high-risk sex remains an issue, particularly among low-fee FSW.

In 2007, NCAIDS in collaboration with UNAIDS and WHO, estimated the population size of sex workers to be 1.8 to 3.8 million. Population size estimates were based on sentinel surveillance data, behavioral surveillance data, Public Security Bureau (PSB) registration data, and published literature.

In studies conducted by Renmin University, 1 in 10 sexually active Chinese men have engaged in sex with a FSW at least once in their lifetime. According to recent case report data, there has been a notable increase in HIV infections among men over the age of 50. The percent of reported cases in men aged 50-64 increased from 6.1% in 2007 to 10.6% in 2009. Likewise, the percent of reported cases in men aged 65 and over increased from 1.7% in 2007 to 4.3% in 2009. Most of these men reported their mode of infection as unprotected sex with low-fee FSW. However, recent data from the 61-city MSM HIV survey indicates that a portion of this transmission is likely due to MSM behavior. Research is needed to formulate behavior change messages targeting men who have multiple, concurrent sex partners, including FSW and MSM.

Influence of gender issues
The proportion of people living with HIV/AIDS (PLHA) who are women has doubled over the past decade to 30.5% in 2009. Although many of these cases are FSW or female PWID, approximately one-third of heterosexual transmission occurs between discordant couples, indicating that greater attention to prevention with positives (PwP) is required. These data also suggest that the HIV epidemic in China is maturing, and more effective prevention measures targeting most at risk populations (MARPs) are needed in order to address sexual transmission from male MARPs to their female partners.

Influence of social/cultural factors
Ethnic minorities are disproportionately affected by HIV/AIDS in China. Comprising less than 8% of the total population, they nonetheless contribute 37.4% of reported cases. Ranked by total cumulative HIV/AIDS cases from 1985 to 2009, the Uighur (Muslim), Yi, Zhuang, Hui (Muslim), Dai, and Yao ethnic minorities are especially severely affected by the HIV epidemic.

Most recent DHS, AIS, BSS, etc.
HIV surveillance in China is based upon multiple data sources to monitor the dynamics of the epidemic. The most important data source is the National HIV/AIDS Sentinel Surveillance System, a comprehensive annual survey with nationwide data of varying quality. The first national surveillance survey was conducted in 2002 and has since become an annual routine for provincial CDCs. The National HIV/AIDS Sentinel Surveillance System collects HIV prevalence data for PWID, MSM, FSW, and other population subgroups. The Government of China (GOC) has also established a Behavioral Surveillance System, which collects data on risk behaviors among MARPs. Since 2003, GOC has conducted biennial HIV/AIDS estimation exercises using the Workbook Method recommended by UNAIDS and WHO and has published estimation methods and results.

Sources of the next 1,000 infections
In September 2011, we expect the sources for the next 1,000 HIV infections to include: 42% due to heterosexual transmission; 33% due to MSM transmission; 24% due to injecting drug use; and 1% due to

mother-to-child transmission. The male-to-female ratio will be approximately 2:1. Six provinces (Guangdong, Guangxi, Guizhou, Sichuan, Yunnan, and Xinjiang) will account for 75% or more of the cases.

How is epidemiological data used to support decisions on prevention portfolio investments?
The USG PEPFAR team provides technical assistance (TA) to GOC in support of epidemiologic and surveillance efforts. USG is actively involved in the process of protocol development, staff training, and support for the development of provincial and national HIV estimates. Key priorities for prevention interventions among MARPs have been based on epidemiologic data, and the team will continue to base future priorities on trends in the epidemic.

Overarching accomplishments in FY10 to FY11
- USG promoted HIV rapid tests and provider initiated testing and counseling (PITC), which were included in the State Council Circular on Further Strengthening AIDS Notifications in December 2010. In August 2011, NCAIDS issued technical guidelines on HIV rapid tests.
- USG supported couples HIV counseling and testing (CHCT) for both heterosexual and MSM couples. NCAIDS incorporated CHCT into its national training curriculum for HIV counselors.
- USG reduced barriers to voluntary counseling and testing (VCT) by creating demand for MSM-friendly VCT services and building the capacity of government providers to deliver VCT services to MSM.
- USG supported innovative internet and mobile technologies, including the web-based, interactive Xiuboy promotional platform, to expand sexually transmitted infection (STI) and HIV testing and counseling (HTC) intervention coverage for MSM.
- USG leveraged existing contacts to contribute to the development of the newly mandated Provincial IDU Community Outreach Program in Yunnan.

Alignment with Government Strategy and Priorities
USG key priorities for prevention were developed to align with GOC strategy and priorities. On December 31, 2010, the State Council issued the Circular on Further Strengthening AIDS Notifications, which contains GOC priorities for the implementation of HIV/AIDS policies at all levels of government. HIV prevention priorities include expanding coverage of prevention of mother to child transmission (PMTCT), HTC, and comprehensive interventions for MARPs, including methadone maintenance treatment (MMT), needle and syringe programs (NSP), and community rehabilitation.

Key priorities & major goals in FY12
- USG will continue to support GOC to expand and improve the quality of interventions for PWID, including MMT and community rehabilitation.
- USG will provide TA to GOC and civil society partners to improve the quality of HIV/AIDS services targeting MSM.
- In FY12, USG will conduct a cross-sectional survey on risk perceptions and behaviors among low-fee FSW, which will inform behavioral interventions for this MARP.
- By FY13, USG will transition Comprehensive Prevention Package (CPP) sites to local ownership.

Contributions from or collaboration with other development partners
The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) is the second largest contributor of financial resources to the national HIV response, after GOC. In November 2011, GFATM decided that Upper Middle Income G20 nations with less than an extreme disease burden would no longer be eligible for grant renewals or new grants. As a result, GFATM grants to China will end in 2012, although transitional funding may be available for 2013. The Bill and Melinda Gates Foundation focus on MSM in

14 cities and 1 province. USG will continue to collaborate with GFATM and other development partners to replicate and scale-up successful models.

Policy advances or challenges
GOC has undertaken differing policy approaches in prevention efforts for MARPs. Unlike many other countries, male-to-male sexual activity is not illegal in China, and GOC promotes inclusive, non-discriminatory approaches and services for MSM. On the other hand, sex work is illegal, and FSW are at risk for arrest and detention under public security policies. However, GOC also promotes the 100% Condom Use Program (CUP) for FSW. GOC has not sufficiently addressed these contradictory policies regarding sex workers. The challenges presented by these contradictory policies are intensified when specific higher-level demands (i.e., special occasions such as foreign visits and large events) subordinate public health to public security.

Among PWID, while MMT and other interventions are being scaled-up, implementation is hampered by police crackdowns and regular incarceration in compulsory detention centers. Nonetheless, recent developments suggest that the need to prevent HIV/AIDS is moving China's policy environment towards a less retributive response to PWID. 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 law instructs local authorities not to forcibly take PWID to compulsory detention centers if urine tests show they have been using drugs. The law allows for PWID to remain within their communities provided they regularly report to a designated community contact person. However, many officials remain unclear about how this law should be implemented. USG sees this as an opportunity to counteract the compulsory detention center model and expand the rehabilitation approach to drug use. Another policy shift concerns eligibility for MMT. Previously, only PWID who had been arrested and registered by PSB were eligible for MMT, but the latest version of the GOC MMT implementing guidelines has dispensed with this requirement. Currently, all PWID are allowed to enroll directly into MMT without referral from PSB. To complement these policy changes, there is strong political concern about MMT adherence rates, leading to a greater willingness to explore new interventions to reduce drop-out rates. Together, these four factors – the need to act quickly to halt the HIV/AIDS epidemic among PWID, a new, more tolerant anti-drug law, a loosening of the entry requirements for MMT, and a strong concern about MMT outcomes – create an opportunity to further develop existing PWID services and implement new ones that push for improved access to drug treatment.

Efforts to build evidence-base
In FY10, USG conducted a two-phase external evaluation of its Comprehensive Prevention Package (CPP) for PWID in Yunnan and Guangxi. The first phase used qualitative methods to describe the achievements, strengths, and weaknesses of CPP and make recommendations. The second phase used qualitative and quantitative methods to evaluate CPP and compare PWID risk behavior and other outcomes between sites where CPP services were available and matched sites where they were not. The evaluation confirmed results from earlier assessments that CPP increased knowledge and access to services and improved the lives of PWID.

GOC consistently analyzes the national MMT database in order to make ongoing adjustments to increase the effectiveness of the national MMT program as both a drug treatment and HIV risk reduction intervention.

PMTCT

Although national HIV prevalence among pregnant women is low (0.05%), in some counties it is as high as 3-5%. Since FY07, USG has supported an enhanced PMTCT pilot program in high HIV prevalence

areas of Guangxi. By fostering integration between the village, township, and county levels of the three-tiered health system, this model successfully increased HIV testing to 97% of pregnant women, provided antiretroviral (ARV) prophylaxis to 87% of HIV-positive pregnant women, and reduced MTCT to 3.2% of HIV-exposed infants at USG-supported sites. In contrast, MTCT in counties supported by the national PMTCT program was 8.7% in 2009. When GOC expanded the national PMTCT program from 333 to 1,156 high HIV prevalence counties in 2010, it incorporated elements from the USG-supported model, including increased collaboration between the maternal and child health (MCH) system responsible for PMTCT, the CDC system responsible for CD4 testing, and the hospital system responsible for antiretroviral treatment (ART).

In 2011, GOC released national guidelines for PMTCT of HIV, hepatitis B virus (HBV), and syphilis, developed with technical assistance from USG. The guidelines recommend WHO Option B for pregnant women known HIV-positive prior to delivery. Pregnant women who only test HIV-positive at delivery receive single-dose nevirapine (NVP). GOC strategy is to integrate PMTCT for HIV, HBV, and syphilis into routine MCH services. PMTCT goals in the National Action Plan (2011-2015) include testing 80% of pregnant women for HIV, providing ARV prophylaxis to 90% of HIV-positive pregnant women, and reducing MTCT to 5% of HIV-exposed infants.

Priorities for FY12 to FY13 include improving data management and reporting to guide scale-up of the national PMTCT program and supporting the National Center for Women and Children's Health (NCWCH) within China CDC to conduct supervision at the provincial and local levels to ensure the quality of PMTCT implementation. USG will also support the Guangxi Bureau of Health (BOH) to expand comprehensive PMTCT services to all 109 counties in the province.

Challenges include limited data analysis and utilization, especially at the provincial and local levels, and poor integration of PMTCT and other HIV/AIDS services. USG strengthens linkages between the vertical health systems responsible for antenatal care (ANC), CD4 testing, and ART by supporting follow-up and referrals. Because many pregnant women do not access health services until they go into labor, USG also promotes integration of HTC in pre-marriage health screenings in order to increase HIV diagnosis and appropriate CD4 and viral load testing prior to delivery.

HTC

Less than half of the estimated 740,000 PLHA in China have been tested for HIV and know their status. USG provides technical assistance to NCAIDS, provincial CDCs, and local community-based organizations (CBOs) to increase HTC, particularly among MARPs, and to link to prevention, care, and treatment services. In FY12 to FY13, USG will continue to pursue multiple HTC approaches, including VCT, CHCT, and PITC. In particular, USG will assist NCAIDS to improve VCT data quality and utilization for program planning. Because studies show that CHCT facilitates communication, promotes behavior change, and reduces HIV transmission in discordant couples, USG will continue to support CHCT pilots in high prevalence provinces, including two pilots for MSM couples. USG will also support local MSM CBOs to provide VCT with on-site oral rapid HIV tests and to link MSM to other prevention, care, and treatment services. Having contributed to the recently released technical guidelines on HIV rapid tests, USG will continue to support implementation by providing technical assistance on quality assurance (QA) and quality control (QC). USG will also assist with the development and implementation of technical guidelines on PITC. In order to provide evidence for advocacy, USG will continue to support PITC pilots in both low and high HIV prevalence provinces.

Condoms

China is a major condom manufacturer with the capacity to produce high-quality condoms. GOC purchases condoms from domestic manufacturers and distributes them in mostly rural areas.

Condom availability in China is high, with over 1,000 brands available, many of them low-cost. According to 2009 National HIV/AIDS Sentinel Surveillance results, 85% of FSW used a condom with their most recent client, 73% of MSM used a condom the last time they had anal sex with a male partner, and 36% of PWID used a condom the last time they had sexual intercourse. Data was unavailable for condom use outside of these MARPs. As part of CPP transition, USG will no longer support social marketing of condoms and lubricants, instead relying on low-cost or free condoms.

Positive Health Dignity and Prevention (formerly PwP)

GOC provides free CD4 testing for PLHA twice a year to assess eligibility for ART. When PLHA present for CD4 testing, they also receive HIV prevention services, such as risk reduction counseling and condom promotion and distribution. USG promotes early case finding and case management to identify PLHA and link them to HIV prevention and other services before their health deteriorates. USG supports referral mechanisms to improve follow-up for CD4 testing, partner testing, PMTCT, and STI management. USG also provides technical assistance to NCAIDS and GFATM to scale-up the Essential Care Package (ECP), which includes condom promotion and distribution, adherence support, OI prophylaxis, and home-based care. For community programs, USG supports MMT clinics to establish PLHA support groups to increase MMT enrollment and retention and link to ART. In FY12, USG will provide technical assistance to NCAIDS to investigate treatment as prevention for discordant couples.

MARPs

Although GOC provides the minimum package of services to MARPs, the quality of these services is inconsistent. USG supports GOC to improve the quality of HIV prevention services by developing models that are evidence-based, highly targeted, and non-discriminatory. USG has implemented and evaluated Comprehensive Prevention Package (CPP) models for PWID, MSM, and FSW. By FY13, USG will transition CPP sites to local ownership. During the transition, USG will continue to advocate for replication of successful models by GOC, GFATM, and other development partners.

PWID
The CPP model for PWID includes peer education and outreach, risk reduction counseling, condom and lubricant promotion and distribution, VCT, referrals for STI management and linkages to HIV care and treatment services provided by local government and CBOs. Drop-in centers provide a base from which peer educators and outreach teams go into the community to engage PWID where they socialize or engage in risk behavior. Counseling is provided at drop-in-centers, but HIV testing is done at local CDC offices. Drop-in centers also link to NSP sites and MMT clinics operated by GOC.

MMT is the core intervention for PWID in China. Since 2004, GOC has expanded the national MMT program to 715 clinics in 28 provinces. Several studies in China have shown reduced crime and improved family relations among drug users in MMT. Overall mortality in the program is 6 per 100 person-years, but mortality is lower for MMT clients on ART. Increasing access to ART for HIV-infected MMT clients is a GOC priority, and USG provides technical assistance to strengthen linkages between MMT and ART. GOC launched NSP in 2010. Currently, there are 937 NSP sites in 26 provinces.

In FY12 to FY13, USG will continue to support GOC to improve the quality of MMT services. USG will provide technical assistance to increase MMT enrollment and retention through peer education and outreach. In particular, USG will support efforts to target female PWID and female partners of male PWID for condom promotion, HTC, and PMTCT. USG will also ensure that FSW who inject drugs receive appropriate messages and interventions for the dual risk of sex work and injecting drug use.

MSM

In FY12, USG will continue to support peer education and outreach for MSM. USG will also promote direct provision of VCT by MSM CBOs using rapid tests. USG will continue to support a comprehensive intervention pilot for MSM in bathhouses, which includes condom promotion and distribution, on-site VCT, and linkages to STI management and HIV care and treatment services. USG will also support selected provincial CDCs to conduct operational research on interventions targeting MSM.

FSW

GOC has established high-risk intervention teams to insure the implementation of the 100% Condom Use Policy (CUP), but the focus on condom distribution without linkages to other services, such as VCT and STI management reduces the effectiveness as a behavior change intervention as well as missing an opportunity to get HIV-positive FSW into treatment earlier. In the next two years, USG will continue to provide technical assistance to GOC to improve the quality of 100% CUP by revising national guidelines, training staff, and strengthening linkages to VCT, STI management, and HIV care and treatment services. USG will also support selected provincial CDCs to field test interventions for low-fee FSW and older clients who are often not reached by current venue-based 100% CUP teams.

General Population

Due to relatively low HIV prevalence among youth and the general population, USG will focus on MARPs and not invest its limited resources on abstinence and be faithful (AB) prevention activities for youth and the general population.

Human Resources for Health (HRH)

USG provides technical assistance to NCAIDS and provincial CDCs to train local CDC staff and peer educators on outreach, risk reduction counseling, and condom promotion. Local CDCs provide supervision for peer educators in the field. USG also promotes task shifting of HTC to CBOs using rapid tests. USG builds the capacity of local CBOs to sustain their role in providing prevention services by developing competencies in M&E and resource mobilization.

Gender

In FY12 to FY13, USG will support NCAIDS to pilot gender-specific programming for female PWID and female sexual partners of male PWID in combination with MMT and NSP. In order to determine the effectiveness of the interventions, data will be collected on the percentage of female PWID and female partners of male PWID who receive HIV prevention services such as condom promotion, HTC, and PMTCT, the percentage of discordant couples among PWID, as well as the prevalence of HIV among female PWID and female partners of male PWID.

Strategic Information (SI)

Key challenges
PMTCT is an important component of the national HIV response. In 2010, the National Action Plan for PMTCT of HIV, HBV, and Syphilis was formally released with NCWCH as the implementing agency. NCWCH is also responsible for PMTCT data collection, management, analysis, and use. Although a PMTCT information system has been developed, it needs further improvement as some essential variables are still missing, such as HBV and syphilis.

Another challenge is the disconnect between the PMTCT information system and the national HIV information system, which has greatly impacted the use of PMTCT data. Each year, NCAIDS allocates substantial human and financial resources to monitor HIV prevalence among pregnant women in ANC

clinics, while NCWCH requires routine HIV testing for pregnant women, which results in capturing HIV testing among pregnant women in two different and independent databases. The capacity for data collection, management, and use at NCWCH is weaker compared to NCAIDS, and the quality of NCWCH data needs to be improved. Collaboration between NCAIDS and NCWCH is difficult given the current administrative structures of the organizations.

For HTC, multiple forms are requested by GOC Central Office for use at the service delivery level, which makes data use more complex. There is a need harmonize data collection and recording systems at different levels in the system.

With regard to targeting prevention among MARPs, the biggest challenge is obtaining realistic population size estimates. Unfortunately, there is no single method that works for all target populations. USG has discussed this issue with GOC as well as epidemiologists, program staff, and community members, all of whom disagree on the estimation methods, the representativeness of sampling, and the estimates generated. Reaching a consensus on the population size of MARPs is extremely difficult. There is limited data on current levels of HIV risk behaviors. At the community level, there is limited capacity among CBO staff to analyze and use data for program improvement.

Strategic responses
In FY12, USG will help build capacity for PMTCT data collection, management, analysis, and utilization at both national and provincial levels. In Guangxi, USG will support collaboration between provincial CDC and MCH to generate a comprehensive provincial MCH database, which incorporates PMTCT data.

Another priority is generating population size estimates, particularly for PWID and MSM. The feasibility of integrating population size estimation activities with the national HIV sentinel surveillance system will be tested in selected sites. USG will provide technical advice and participate in these activities.

Strategic information (SI) activities planned at the sub-national level include undertaking social marketing research on condom use among MARPs and an MSM qualitative assessment in Kunming and Nanning to explore the need for MSM targeted condoms and lubricants and their effective distribution for HIV prevention. A PWID routine behavior change track survey will be conducted in Kunming, Luzhai, and Nanning to tailor intervention design, identify higher risk PWID, and highlight determinants of behavioral change, as well as monitor program outcomes. For MSM, a track survey will be conducted in Kunming, Nanning, and selected hotspots in Honghe Prefecture.

USG will build the capacity of local organizations to use SI tools and results to inform programming through training and dissemination of research methods and findings. Technical support on M&E and M&E training will be provided to select CBOs and health care providers in Yunnan.

Capacity Building

Due to rapidly increasing HIV incidence among MSM in recent years, USG will provide technical assistance to government and civil society partners to improve the quality of HIV/AIDS services targeting this MARP. In particular, USG will develop competencies among local CDCs and civil society organizations (CSOs) to reach MSM with HTC and other HIV/AIDS services, including peer education and outreach, condom promotion and distribution, and HIV care and treatment. USG will also build the capacity of local CDCs and CSOs to implement the CPP and Continuum of Prevention to Care and Treatment (CoPCT) models and to identify and secure new sources of funding. USG will build host government capacity to lead and manage their response by supporting provincial CDCs to pilot innovative interventions. Other priority capacity building objectives include supporting the government to scale-up PITC and PMTCT in high prevalence counties.

Given GOC leadership and success with MMT, USG will collaborate with GOC to provide technical assistance to other countries with IDU-driven epidemics, particularly in Central Asia. USG will provide opportunities to share China's MMT experience by convening workshops, receiving study tours, and arranging for USG and GOC staff to travel abroad as consultants.

USG will continue to partner with GOC and civil society to address individual, organizational, and systems components of capacity building at all levels. Please refer to the draft capacity building plan under supporting documents for activities, outputs, outcomes, and their measures by component.

Technical Area: Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXS	281,588	0
PDTX	69,600	0
Total Technical Area Planned Funding:	**351,188**	**0**

Summary:
Adult Treatment

Access & Integration

In 2003, the Government of China (GOC) issued the Four Frees and One Care policy, which included free antiretroviral treatment (ART) for eligible, socioeconomically disadvantaged people living with HIV/AIDS (PLHA). In order to implement this new policy, the National Center for AIDS/STD Control and Prevention (NCAIDS) within the Chinese Center for Disease Control and Prevention (China CDC) invited an expert panel to develop and issue the first edition of the National Free ART Program Manual in 2005. This manual provided technical guidelines for the implementation of widespread access to free ART for PLHA throughout China. In 2008, GOC issued a second, revised edition of the National Free ART Program Manual, with technical assistance from USG, and increased treatment eligibility from CD4 count <200 cells/µL to 350 cells/µL.

Since 2008, more than 20,000 new patients have been placed on ART each year (21,151 in 2009 and 26,667 in 2010, respectively). By the end of 2010, a cumulative 108,788 PLHA had received ART, including 106,613 adults and 2,175 children. At the same time, 86,122 PLHA were still on ART, including 84,273 adults and 1,849 children. Of these patients, 7,271 were on a second line regimen. GOC has set national ART targets of 150,000 patients by 2012.

Despite rapid expansion, the National Free ART Program still faces many challenges. An urgent need exists for earlier HIV diagnosis. The median CD4 count at ART initiation was 160 cells/µL in 2011. Although treatment coverage increased from almost 0 to 63.4% between 2002 and 2009, and overall mortality declined from 39 per 100 person-years to 14 per 100 person-years, the number of deaths due to HIV/AIDS is still high. Between 2008 and 2010, the number of reported deaths per year increased from 9,748 to 18,987. Among the 18,987 deaths reported in 2010, 81.4% of patients did not receive ART, indicating a persistent need to increase access.

In response to these challenges, GOC undertook the third revision of the National Free ART Program Manual in 2011, with technical assistance from USG. The final version is expected to be released in early 2012. This manual is intended for HIV care and treatment providers at all levels of the Chinese health

care system, especially county-level ART doctors and nurses. The third edition of the National Free ART Program Manual will include: 1) treatment recommendations for PLHA with higher CD4 cell counts, 2) treatment as prevention for discordant couples, and 3) antiretroviral (ARV) drugs with fewer side effects to improve adherence and compliance. The new guidelines will also simplify laboratory monitoring protocols for patients on ART to focus on accessibility, patient follow-up, and treatment failure detection. During the revision process, NCAIDS worked closely with the National Center for Women and Children's Health (NCWCH) and the National Center for Tuberculosis Control and Prevention (NCTB) to ensure that the manual was consistent with other national guidelines.

Scale-up of the National Free ART Program has been funded almost entirely by GOC. The USG PEPFAR program in China does not support procurement and distribution of ARV drugs. Instead, USG provides technical assistance for model development and scale-up. USG fosters integration between HIV prevention, care, and treatment services by strengthening linkages between vertical health systems, including the CDC system responsible for risk reduction, HIV testing and counseling (HTC), and clinical monitoring and the hospital system responsible for ARV and opportunistic infection (OI) treatment. USG also facilitates collaboration between NCAIDS, NCWCH, and NCTB at the national level of the China CDC system and supports referral mechanisms at the village, township, and county levels of the three-tiered health system in order to foster integration between HIV/AIDS, maternal and child health (MCH), and tuberculosis (TB) services.

Through the Henan Community Care Program and two Rural AIDS Clinical Training Centers, USG supports clinicians in five counties in Henan, one county in Guangxi, and one county in Anhui to provide follow-up services, such as ART adherence support, clinical monitoring, and OI management. In FY10 and FY11, USG supported implementation of a TB/HIV co-infection program, including provider initiated testing and counseling (PITC) in TB clinics, TB screening in ART clinics, and ARV and TB treatment for patients with TB/HIV co-infection, using the Henan Community Care Program and Luzhai Rural AIDS Clinical Training Center as platforms. In FY12 to FY13, USG will continue to support integration of TB/HIV services in these counties. USG will also continue to facilitate collaboration between NCAIDS and NCTB to implement the TB/HIV co-infection manual, developed with technical assistance from USG in FY11. USG will support NCTB to monitor and evaluate a pilot on isoniazid (INH) preventive therapy (IPT) for TB/HIV co-infection patients to determine suitability for China.

USG will provide technical assistance to GOC and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) to utilize the three-tiered health system to scale up the national prevention of mother to child transmission (PMTCT) program and to strengthen linkages between MCH and ART services. This model promotes earlier HIV diagnosis through HTC at pre-marital health screenings and improves follow-up for HIV-positive pregnant women, including ARV prophylaxis for PMTCT or ART for eligible women. USG will also provide technical assistance to promote early infant diagnosis (EID) for HIV-exposed infants and strengthen linkages between PMTCT and pediatric ART.

Quality & Oversight

To improve the quality of HIV care and treatment, particularly in rural areas, USG established two Rural AIDS Clinical Training Centers for county-level clinicians at Lixin, Anhui and Luzhai, Guangxi in 2004 and 2010, respectively. Training includes CD4 and viral load (VL) testing, OI prophylaxis and treatment, ARV regimens and side effects management. During the 3-month training program, trainees gain hands-on experience by providing services such as clinical monitoring and adherence counseling to PLHA.

In FY12 to FY13, USG will continue to support GOC to ensure the quality of the National Free ART Program. USG will provide technical assistance to NCAIDS to develop a monitoring and evaluation (M&E) plan and quality assessment framework for the National Free ART Program. USG will continue to assist NCAIDS to improve the national ART database and to analyze and utilize data. In particular, USG will

assist NCAIDS to include hepatitis B virus (HBV) and hepatitis C virus (HCV) co-infection in the national ART database and analyze the impact of co-infection on treatment outcomes. USG will provide technical assistance to NCAIDS to scale up second line ARV regimens based on national guidelines. In collaboration with the World Health Organization (WHO), USG will assist NCAIDS with protocol development for a pilot study to evaluate the effectiveness of implementing WHO HIV drug resistance early warning indicators. USG will support NCAIDS to analyze and utilize the pilot data to scale up implementation of these indicators in other areas. USG will continue to support NCAIDS to develop a national HIV drug resistance network and to evaluate novel point-of-care (POC) technologies for CD4 and VL testing to facilitate timely access to treatment.

In FY12, USG will award a new cooperative agreement to a local NGO to increase early HIV detection and ART initiation, improve adherence and retention, and minimize loss to follow-up by supplementing government treatment services with adherence counseling, support groups, and other activities. The to-be-determined (TBD) local partner will provide services in at least three provinces the first year of the cooperative agreement, with the possibility of expansion to other provinces in Southwestern and Western China in later years. Preference will be given to local indigenous NGOs that are not affiliated with an international NGO or Chinese government agency.

Sustainability & Efficiency

USG will support the Joint United Nations Programme on HIV/AIDS (UNAIDS) to build capacity for tracking and assessing expenditures and analyzing cost-efficiency and cost-effectiveness at the national and provincial level. USG will also provide technical assistance to the Henan Provincial CDC to analyze the cost-effectiveness of cotrimoxazole (CTX) prophylaxis for PLHA to provide evidence for wider implementation.

GFATM funds some second line ARV drugs, but all first line ART is provided by GOC. The Clinton Foundation previously supported procurement and distribution of pediatric ARV drugs, but GOC assumed responsibility in December 2010.

In November 2011, GFATM decided that Upper Middle Income G20 nations with less than an extreme disease burden would no longer be eligible for grant renewals or new grants. As a result, GFATM grants to China will end in 2012, although transitional funding may be available for 2013. USG will work with GFATM and GOC to ensure the sustainability of programs after the withdrawal of GFATM support.

Pediatric Treatment

The USG PEPFAR program in China does not support direct provision of pediatric treatment. GOC covers pediatric HIV treatment services under the National Free ART Program.

In FY12 to FY13, USG will continue to build capacity for pediatric HIV treatment at the county level through two Rural AIDS Clinical Training Centers. USG will also work closely with Henan CDC and Guangxi CDC to improve pediatric HIV data collection, analysis, and utilization.

Laboratory

By the end of 2010, there were more than 2,800 ART sites serving over 80,000 PLHA. Treatment related laboratory services include: (1) annual CD4 testing for treatment eligibility determination, (2) semiannual CD4 and VL testing for treatment monitoring, and (3) annual drug resistance (DR) determination on ART-failed patients for ARV regimen decisions. There are 360 CD4, 95 VL and 20 DR laboratories in the nation, which conduct 287,000, 80,000, and 4,000 tests, respectively. Most of these laboratories are located in the CDC system (CD4, VL and DR), the MCH system (mostly refers specimens to CDC or

hospitals), and the hospital system (CD4, VL and OI). Coverage of CD4 and VL services has remained low and accuracy has sometimes been questionable. Cross-system barriers and insufficient guidance has led to suboptimal specimen flow from patients to laboratories.

In FY11, USG supported the following activities:
- Developed a protocol to evaluate a simple point-of-care CD4 technology to bring service closer to patients.
- Enhanced VL quality management by using a novel dried tube method for laboratories to self-monitor quality.
- Assisted with the development of the first national HIV-1 DR determination program to return timely results to ART clinicians. Resistance genotypes of nearly 4,000 ART-failed patients were determined in a period of 6 months. Numerous challenges including specimen quality management, data turn-around- time, and standardization of report format were identified.

In FY12 to FY13, USG will collaborate with GOC on the development of a five-year strategic laboratory plan in accordance with the new National HIV/AIDS Action Plan (2011-2015). USG will also provide technical assistance to the National AIDS Reference Laboratory (NARL) to attain College of American Pathologists accreditation. USG will implement Alere CD4 POC technology using finger-prick blood at three sites and will provide technical assistance to extend the technology to several geographically remote areas in Xinjiang, Tibet, Yunnan, and Guangxi. USG will also implement a novel CD4 internal quality assurance program in several provincial and sub-provincial CD4 laboratories for personnel to self-monitor laboratory performance on a daily basis. USG will further strengthen the national HIV DR monitoring program by devising an efficient overall specimen collection, DR sequencing, and reporting scheme to ensure ART clinicians obtain timely, quality-assured and ART-informative reports. USG will also support NCAIDS staff to receive DR management training in the U.S. in order to fully comprehend the overall management of the program.

Gender

Based on detailed analysis of the national ART database and linkage to the national epidemiology database, there is no evidence of reduced treatment coverage for women overall. There may be reduced coverage in certain subgroups such as female sex workers or women who inject drugs. USG has prioritized the linkage of HIV-positive women identified through methadone maintenance treatment (MMT) clinics with MCH and ART services in FY12 to FY13.

Most at Risk Populations (MARPs)

By the end of 2009, there were a total of 323,252 reported cases of HIV/AIDS in China, of which 145,484 were eligible for ART. Treatment coverage varies among different transmission groups. People who inject drugs (PWID) and those infected sexually are significantly less likely to receive treatment compared with those infected through plasma donation or blood transfusion. By the end of 2009, treatment coverage for people infected through blood donation or blood transfusion was around 80%, while the treatment coverage for people infected sexually and PWID were about 63% and 45%, respectively. Barriers to treatment include residency requirements for mobile populations.

GOC provides the minimum package of services for most at risk populations (MARPs), including peer education and outreach, risk reduction counseling, condom promotion and distribution, HIV testing and counseling, and HIV care and treatment, free of charge. Sexually transmitted infections (STI) treatment is also available, but it is not free. GOC supports MMT and needle and syringe programs (NSP) for PWID. PWID have higher CD4 counts at HIV diagnosis because of routine HTC at compulsory detention centers and MMT clinics. In FY10 and FY11, USG provided technical assistance to NCAIDS and provincial CDCs to train peer educators for PWID, men who have sex with men (MSM), and female sex workers (FSW).

USG also supported referral mechanisms and strengthened linkages between MMT, HTC, and ART. In FY12 to FY13, USG will continue to support GOC to promote HTC among PWID, MSM, and FSW and to strengthen linkages between HTC and ART. USG will also support GOC to expand treatment coverage and improve the quality of care and treatment services.

Human Resources for Health (HRH)

To support the expansion and decentralization of HIV treatment, USG established two Rural AIDS Clinical Training Centers in Lixin, Anhui and Luzhai, Guangxi. The aim of the training centers is to build the capacity of county-level clinicians to deliver quality HIV care and treatment services, including first and second line ARV regimens and OI management. The training centers are designed to provide trainees with a setting that is similar to the regular working environment of a rural physician. The curriculum provides trainees with the opportunity to gain hands-on experience treating PLHA at county and township hospitals and village clinics. Trainees are also able to take the curriculum's operational framework and replicate it as a model once they return home, linking HIV care and treatment services to the local three-tiered health system. For ongoing support, the trainees are provided with a mentor physician who is experienced in providing care and treatment to PLHA. In the past, some trainees were paired with high level physicians from county hospitals, the Clinton Foundation, and Médecins Sans Frontières (MSF).

In FY11, the Lixin Rural AIDS Clinical Training Center was adopted by the Anhui Bureau of Health (BOH) as one of the national HIV/AIDS clinical training centers. In FY12, USG will continue to provide technical assistance to the Lixin Rural AIDS Clinical Training Center on second line ART and direct support for outreach to the surrounding counties.

In FY12 to FY13, USG will continue to support the operation of the Luzhai Rural AIDS Clinical Training Center, with increasing support from Guangxi BOH and NCAIDS over time. USG will also provide technical assistance to the China-MSD HIV/AIDS Partnership (C-MAP) to open a third Rural AIDS Clinical Training Center in the predominantly non-Han ethnicity, non-Mandarin speaking Liangshan Prefecture in Sichuan Province. This prefecture has the highest HIV prevalence in China. Butuo County in Liangshan Prefecture has 8% HIV prevalence in the general population.

Strategic Information (SI)

Key challenges of the past year

In China, the information systems for HIV case reporting and treatment are independent with poor linkages. For example, some HIV-positive cases that are included in the treatment database are missing in the case reporting database, which makes data analysis and results interpretation difficult. CD4 cell count is critical for assessing HIV disease status and monitoring ART effects; however, free CD4 testing is only available at local CDCs. It is, therefore, important to have good laboratory information flow between local CDCs and hospitals, which may be a challenge in areas with limited resources. In addition, data analysis capacity is low at provincial and local CDCs. Physicians often lack the capacity and incentive to use treatment data to monitor the overall effects of ART.

Another challenge is drug resistance surveillance, since three divisions of NCAIDS are responsible for DR. Although DR surveillance is currently at an early phase in China with only those provinces with laboratory capacity for DR testing reporting to NCAIDS, data collection, management, and analysis could become an issue as DR surveillance develops. A national framework for monitoring and evaluating the DR surveillance system needs to be established.

Strategic priorities for the future

In FY12, USG will provide technical assistance on analyzing data from the National Free ART Program at national and subnational levels. USG will provide technical assistance as needed to provincial and local CDCs to strengthen their data analysis capacity. USG will also support GOC to strengthen the DR information system and the linkages between this system and the treatment database.

USG will support innovative approaches by promoting good models, such as First Diagnosis Responsibility, for better linkages between HIV case finding, management, and referral. USG will also use PMTCT and/or PITC programs as a platform for increased HIV case finding and referral.

Capacity Building

Capacity building plays an important role in USG collaboration with GOC and contributes to country ownership and sustainability. The priority capacity building objective in treatment is to develop competencies for ART service provision among physicians from rural, ethnic minority areas, which have the highest HIV prevalence. In FY12, USG will provide technical assistance to C-MAP to open a third Rural AIDS Clinical Training Center in the predominantly Yi minority area of Liangshan, Sichuan. In addition, USG will continue to partner with NCAIDS and provincial bureaus of health to strengthen the national HIV/AIDS training program by supporting the existing Rural AIDS Clinical Training Centers in Lixin, Anhui and Luzhai, Guangxi. USG will also collaborate with I-TECH to provide training and evaluate the performance of all 14 national HIV/AIDS clinician training centers. USG will work with WHO and GFATM to provide technical assistance to NCAIDS. In FY12, USG will support NCAIDS to implement second line ART by providing technical assistance on guidelines, manuals, and training.

Please refer to the draft capacity building plan under supporting documents for activities, outputs, outcomes, and their measures by component.

Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

Indicator Number	Label	2011	Justification
P1.1.D	P1.1.D Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	n/a	Redacted
	Number of pregnant women who were tested for HIV and know their results	43,700	
P1.2.D	P1.2.D Number and percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	90 %	Redacted
	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission	126	
	Number of HIV-positive pregnant women identified in	140	

	the reporting period (including known HIV-positive at entry)		
	Life-long ART (including Option B+)	0	
	Newly initiated on treatment during current pregnancy (subset of life-long ART)		
	Already on treatment at the beginning of the current pregnancy (subset of life-long ART)		
	Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	126	
	Maternal AZT (prophylaxis component of WHO Option A during pregnancy and deliverY)	0	
	Single-dose nevirapine (with or without tail)	0	
P7.1.D	P7.1.D Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of	n/a	Redacted

	'Prevention with PLHIV (PLHIV) interventions		
	Number of People Living with HIV/AIDS reached with a minimum package of 'Prevention of People Living with HIV (PLHIV) interventions	5,073	
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	21,109	
	By MARP Type: CSW	9,364	
	By MARP Type: IDU	1,689	
	By MARP Type: MSM	10,056	
	Other Vulnerable Populations	0	
P11.1.D	Number of individuals who received T&C	73,154	Redacted

	services for HIV and received their test results during the past 12 months		
	By Age/Sex: <15 Female		
	By Age/Sex: <15 Male		
	By Age: <15	112	
	By Age/Sex: 15+ Female		
	By Age: 15+	73,042	
	By Age/Sex: 15+ Male		
	By Sex: Female	56,647	
	By Sex: Male	16,507	
	By Test Result: Negative		
	By Test Result: Positive		
C1.1.D	Number of adults and children provided with a minimum of one care service	8,449	Redacted
	By Age/Sex: <18 Female		
	By Age/Sex: <18 Male		
	By Age: <18	140	
	By Age/Sex: 18+ Female		
	By Age: 18+	8,309	
	By Age/Sex: 18+ Male		
	By Sex: Female	3,487	
	By Sex: Male	4,962	
C2.1.D	Number of HIV-positive	2,999	Redacted

	individuals receiving a minimum of one clinical service		
	By Age/Sex: <15 Female		
	By Age/Sex: <15 Male		
	By Age: <15	4	
	By Age/Sex: 15+ Female		
	By Age: 15+	2,995	
	By Age/Sex: 15+ Male		
	By Sex: Female	1,436	
	By Sex: Male	1,563	
C2.2.D	C2.2.D Percent of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	21 %	
	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	640	Redacted
	Number of HIV-positive individuals receiving a minimum of one clinical service	2,999	
C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	74 %	Redacted
	Number of	2,220	

	HIV-positive patients who were screened for TB in HIV care or treatment setting		
	Number of HIV-positive individuals receiving a minimum of one clinical service	2,999	
C2.5.D	C2.5.D TB/HIV: Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	2 %	Redacted
	Number of HIV-positive patients in HIV care who started TB treatment	72	
	Number of HIV-positive individuals receiving a minimum of one clinical service	2,999	
C4.1.D	C4.1.D Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	80 %	Redacted
	Number of infants who received an HIV test within 12 months of birth during the reporting period	112	

	Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positive at entry)	140	
	By timing and type of test: either virologically between 2 and 12 months or serology between 9 and 12 months	0	
	By timing and type of test: virological testing in the first 2 months	0	
T1.1.D	By Age/Sex: <15 Female	0	Redacted
	By Age/Sex: <15 Male	0	
	By Age/Sex: 15+ Female	167	
	By Age/Sex: 15+ Male	236	
	By Age: <1	0	
	By: Pregnant Women	0	
	Number of adults and children with advanced HIV infection newly enrolled on ART	403	
T1.2.D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)	2,287	Redacted
	By Age/Sex: <15	25	

	Female		
	By Age/Sex: <15 Male	25	
	By Age/Sex: 15+ Female	1,012	
	By Age/Sex: 15+ Male	1,225	
	By Age: <1	0	
T1.3.D	T1.3.D Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	80 %	Redacted
	Number of adults and children who are still alive and on treatment at 12 months after initiating ART	380	
	Total number of adults and children who initiated ART in the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up.	476	
	By Age: <15	9	
	By Age: 15+	0	
H2.3.D	The number of health care workers who successfully completed an	2,181	Redacted

	in-service training program		
	By Type of Training: Male Circumcision	0	
	By Type of Training: Pediatric Treatment	0	

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
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	GHP-State, GAP	1,251,910
10481	International Training and Education Center on HIV	University	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHP-State	50,000
12258	United Nations Joint Programme on HIV/AIDS	Multi-lateral Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	100,000
13186	Population Services International	NGO	U.S. Agency for International Development	GHP-State	1,543,637
13980	AIDS Care China	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and	GAP	448,090

			Prevention		

Implementing Mechanism(s)

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 Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Chinese Center for Disease Prevention and Control	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,251,910	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GAP	101,910
GHP-State	1,150,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of this implementing mechanism is to build the capacity of the Chinese Center for Disease Control and Prevention (China CDC) to improve the coverage, efficiency, and quality of HIV/AIDS services in China. U.S. CDC will collaborate with China CDC at the national level to develop technical guidelines and manuals and to strengthen laboratory and surveillance systems. U.S. CDC will also support 15 provincial CDCs to explore innovative models and conduct operational research. This implementing mechanism has a strong history of producing successful models, which are scaled up using host country resources. Moreover, beginning in FY12, provinces supported by this implementing mechanism will match funds 1:1. Since China has a concentrated HIV epidemic, target populations include PWID, MSM, and FSW. U.S. CDC will provide technical assistance to improve data collection, analysis, and utilization for monitoring and evaluation at all levels.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Principal Recipient**
3. What activities does this partner undertake to support global fund implementation or governance? **(No data provided.)**

Cross-Cutting Budget Attribution(s)

Human Resources for Health	345,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

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	157,970	0

Narrative:

This implementing mechanism supports clinicians and health care workers in five counties in Henan to provide follow-up services, including adherence counseling, CD4 testing, and CTX prophylaxis, in county CDCs, county and township hospitals, and village clinics. The Henan Community Care program also includes support groups for PLHA. In addition, this implementing mechanism supports outreach and home visits for PLHA in Anhui and Guangxi by clinicians from the Lixin and Luzhai Rural AIDS Clinical Training Centers, who provide adherence counseling, clinical monitoring, and OI management. The Luzhai Rural AIDS Clinical Training Center also strengthens linkages between MMT, PMTCT, and care and treatment services.

HIV-positive pregnant women, their partners and infants also receive care services, such as clinical monitoring, partner testing, and EID, through the enhanced PMTCT program at 112 ANC clinics and hospitals in Guangxi. This program increases referrals between PMTCT, care, and treatment services and between village, township, and county levels of the three-tiered health system.

Through this implementing mechanism, U.S. CDC provides technical assistance to China CDC and 15 provincial CDCs. This implementing mechanism focuses on the development of models for scale-up by GOC. In FY12, U.S. CDC will assist GOC to scale up community and home-based care through the Essential Care Package model.

Joint site visits are conducted for program monitoring and evaluation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	47,391	0

Narrative:

Through this implementing mechanism, U.S CDC facilitates collaboration between the National Center for AIDS/STD Control and Prevention (NCAIDS) and the National Center for TB Control and Prevention (NCTB) within China CDC to ensure alignment of national policies and technical guidelines.This implementing mechanism supports TB/HIV services, including TB screening for PLHA, HTC for TB patients, and TB and ARV treatment for TB/HIV co-infected patients, in five counties in Henan and one county in Guangxi. In FY11, 96% of PLHA were screened for TB and 99% of TB patients were tested for

HIV at supported sites. Other accomplishments include the development of a manual for health care providers on TB/HIV co-infection management and an M&E plan for an IPT pilot.

Building on these accomplishments, in FY12, U.S. CDC will provide technical assistance to NCTB to monitor and evaluate the IPT pilot, to draft a manual on IPT, and to scale up TB/HIV services. NCTB will integrate TB/HIV M&E plans into local assessments of TB and HIV/AIDS programs in two counties. This will be done through building capacity at both the clinic and laboratory level for TB/HIV diagnosis, improving the quality of data collection, strengthening the reporting system, and facilitating collaboration between TB and HIV/AIDS programs.

This implementing mechanism also supports training for county-level clinicians on TB/HIV services through the Rural AIDS Clinical Training Centers in Lixin, Anhui and Luzhai, Guangxi.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	47,391	0

Narrative:

This implementing mechanism does not include direct provision of pediatric HIV care, since GOC covers pediatric care under the Four Frees and One Care policy. Instead, it focuses on technical assistance: to define an improved package of services, including cotrimoxazole prophylaxis for infants; to implement EID by dried blood spot at 6-8 weeks of age in 7 provinces through a network of specialized laboratories; and to investigate possible transmission routes for HIV-positive children with HIV-negative mothers. This implementing mechanism also supports in-service training for county-level clinicians to provide quality pediatric HIV care through the Rural AIDS Clinical Training Centers in Lixin, Anhui and Luzhai, Guangxi.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	143,752	0

Narrative:

China has a well-established multi-tier HIV laboratory network that spans CDC, hospital, and MCH systems. The top two tiers of the network consist of the National AIDS Reference Laboratory (NARL) at NCAIDS and 35 provincial confirmatory laboratories. In 2010, GOC opened an additional 283 confirmatory laboratories in prefectural CDCs and large hospitals and more than 8,870 screening laboratories in county CDCs, blood stations, and MCH facilities. About 32% of laboratories are in CDCs and 57% are in hospitals. Serologic testing services have been extended to 97% of prefecture level health systems. Laboratory technical guidelines for HIV testing were developed in close consultation with USG, WHO, and the Clinton Health Access Initiative. All HIV laboratories have been ISO-17025

accredited.

This implementing mechanism focuses on technical assistance. Activities for FY12 include: Develop a national five-year laboratory strategic plan
; Evaluate the utility of Alere point-of-care (POC) CD4 technology
; Formulate an evaluation protocol to test Alere POC viral load (VL) technology; Deveop a comprehensive HIV-1 drug resistance (DR) monitoring system to ensure timeliness, accuracy, and usefulness to clinicians by standardizing the report on DR results based on clinically useful DR mutations; Assist NARL to upgrade laboratory quality management to attain College of American Pathologists (CAP) accreditation; Continue to support the evaluation and commercialization of affinity-based incidence assay and convene a training workshop with domestic and international participants from neighboring countries; Facilitate regional exchange of laboratory knowledge.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	157,970	0

Narrative:

This implementing mechanism provides technical assistance to develop, implement, and document innovative SI methods and models to build capacity for data collection, analysis, and use at national and sub-national levels.

Activities for FY12 include:
Harmonize indicators and streamline reporting for MARPs in line with national guidelines
; Conduct cost-effectiveness analyses of national HIV/AIDS programs
; Improve the quality and sustainability of the national HIV surveillance system and strengthen the capacity of data analysis and use at national and sub-national levels by training provincial, city, and county CDC staff
; Apply recommendations from national HIV sentinel surveillance system evaluation
; Support development and dissemination of provincial surveillance reports
; Support national population size estimation of MARPs, HIV incidence estimation using multiple methods particularly BED-CEIA testing, and data triangulation using national HIV and STI sentinel surveillance data.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	150,070	0

Narrative:

This implementing mechanism addresses the lack of capacity at sub-national levels to manage operational and fiduciary functions through the Provincial Program Management Training Program. This program provides provincial HIV/AIDS program managers with one month of classroom instruction and five months of hands-on learning through rotations in NCAIDS divisions and in the field.

Although China currently produces an adequate number of health care providers, their training and capacity in HIV prevention, care, and treatment remain low, particularly at the county level and below. This implementing mechanism supports two Rural AIDS Clinical Training Centers for county-level clinicians to improve the quality of HIV/AIDS services.

This implementing mechanism also strengthens linkages between vertical health systems by facilitating collaboration between NCWCH, NCAIDS, and NCTB at the national level and supporting referral mechanisms between MCH, CDC, and hospitals at the local level.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	138,224	0

Narrative:

According to the 2009 National Sentinel Surveillance, HIV prevalence among MARPs is 9.3% for PWID, 5.0% for MSM, and 0.6% for FSW. HTC coverage is 37.3% for PWID, 44.9% for MSM, and 36.9% for FSW. HIV prevalence among pregnant women ages 15-24 is 0.2%.

Through this implementing mechanism, U.S. CDC provides technical assistance to NCAIDS, provincial CDCs, and CBOs to increase HTC coverage, particularly among MARPs, and to link HTC to prevention, care, and treatment services. In FY12, China CDC will continue to pursue multiple approaches, including VCT, CHCT, and PITC. This implementing mechanism will support MSM CBOs to provide on-site and mobile VCT using oral rapid tests. Having contributed to the recently released technical guidelines on HIV rapid tests, U.S. CDC will continue to support implementation by providing technical assistance on QA and QC. Implementing mechanism activities include CHCT pilots in high prevalence provinces, including two pilots for MSM couples. U.S. CDC will continue to assist with the development and implementation of technical guidelines on PITC. U.S. CDC will also provide technical assistance to scale up PITC pilots in both low and high HIV prevalence provinces. This implementing mechanism will continue to support PITC in pre-marriage health screenings and ANC clinics for PMTCT and in TB clinics for TB/HIV co-infection management. Because approximately one-third of heterosexual transmission occurs between discordant couples, these activities also promote partner testing through PMTCT and care services.

Targets and results by approach:
VCT
- FY12 target: 3,300 (1,500 MSM through Tianjin bathhouse pilot + 1,800 from Henan Community Care program); FY11 result: 3,666.
CHCT
- FY12 target: 600 partners tested through CHCT pilots in Sichuan and Xinjiang
; FY11 result: 0.
PITC
- FY12 target: 45,238 (43,700 pregnant women, 126 partners and 112 infants of HIV-positive pregnant women through PMTCT and 1,300 TB patients through Henan Community Care program)
; FY11 result: 69,518.

In addition, this implementing mechanism will continue to support 38 provincial-level sentinel surveillance sites, which will provide HTC for 17,000 individuals (PWID, STI patients, and college students). This implementing mechanism will also support HTC for 5,164 MARPs through operational research studies.

U.S. CDC provided technical assistance to NCAIDS to develop national indicators to monitor follow-up from HTC to care and treatment, including CD4 testing. U.S. CDC will continue to provide technical assistance to NCAIDS to improve VCT data quality and utilization. In particular, U.S. CDC will assist with protocol development for VCT data quality evaluation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	94,782	0

Narrative:

Target population: MSM;

Approximate Dollar Amount: $70,218;

Coverage: 4,100

; Activities:

Train local CDC staff and MSM peer educators on outreach

; Pilot intervention for MSM in bathhouse, including condom promotion and distribution, on-site VCT using oral rapid tests, and linkages to STI management and HIV care and treatment services (1,500 MSM)

; Support comprehensive HIV prevention intervention, including risk reduction counseling, condom promotion and distribution, and STI referrals, for MSM in 3 provinces (Guangzhou, Guizhou, and Xinjiang); promote quality assurance through supportive supervision and regular client satisfaction surveys (1,500 MSM)

; Support provincial CDCs to conduct operational research on interventions targeting MSM (1,100 MSM)

; Promote direct provision of VCT by MSM CBOs using rapid tests.

Target population: FSW;

Approximate Dollar Amount: $46,812

; Coverage: 1,764;

Activities:

Conduct cross-sectional survey on risk perceptions and behaviors among low-fee FSW to inform behavioral interventions; provide risk reduction counseling, condom promotion and distribution, HIV, syphilis, and herpes testing, and referrals for free syphilis treatment, discounted herpes treatment, and partner testing to participants (1,564 FSW)

; Support provincial CDC to conduct operational research in Inner Mongolia (200 FSW)

; Provide technical assistance to provincial CDCs to field test interventions for low-fee FSW and older clients who are often not reached by current venue-based 100% CUP

; Provide technical assistance to improve the quality of 100% CUP by revising national guidelines and strengthening linkages to VCT, STI management, and HIV care and treatment services; Train local CDC staff and FSW peer educators on outreach.

There is no agreed upon population size estimate for MSM in China. In 2007, the NCAIDS estimate was 3.1 to 6.3 million MSM. However, this may be an underestimate, as many other sources report much higher figures, the most common being 5-10 million MSM, and with some national estimates as high as 18-20 million.

In 2007, NCAIDS in collaboration with UNAIDS and WHO, estimated the population size of sex workers to be 1.8 to 3.8 million. Population size estimates were based on sentinel surveillance data, behavioral surveillance data, Public Security Bureau (PSB) registration data, and published literature.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	146,122	0

Narrative:

In 2007, NCAIDS estimated the population size of PWID to be 1.5 to 3.0 million. The prevalence of injecting drug use among people aged 15-64 years is 0.25% or an estimated 2,350,000 persons, according to the United Nations Office on Drugs and Crime. The China National Narcotics Control Commission reported that the registered number of drug users in 2009 was 1,335,920 of whom 978,226 (73.2%) were heroin users. By 2009, approximately 238,280 PWID were estimated to be infected with HIV, primarily in the provinces of Xinjiang, Yunnan, Guizhou, Guangxi, and Guangdong, each of which had more than 10,000 PWID infected with HIV.

MMT is the core intervention for PWID in China. Since 2004, GOC has expanded the national MMT program to 715 clinics in 28 provinces. In 2010, GOC launched NSP. There are now 937 NSP sites in 26 provinces.

In FY12, U.S. CDC will continue to provide technical assistance to increase the coverage and improve the quality of MMT services. This implementing mechanism will support NCAIDS and provincial CDCs to train MMT clinic staff and PWID peer educators on outreach to increase MMT enrollment and retention. Other activities include piloting gender-specific programming for female PWID and female sexual partners of male PWID, including condom promotion and distribution, HTC, and PMTCT, in combination with MMT and NSP. U.S. CDC will promote messages and interventions for FSW who inject drugs that address the dual risk of sex work and injecting drug use. U.S. CDC will also provide technical assistance to strengthen linkages between MMT and ART.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	77,405	0

Narrative:

This implementing mechanism supports an enhanced PMTCT pilot program at 112 ANC clinics and hospitals in high HIV prevalence areas of Guangxi. By promoting PITC and strengthening linkages between the village, township, and county levels of the three-tiered health system, this model successfully increased HIV testing to 97% of pregnant women, provided ARV prophylaxis to 87% of HIV-positive pregnant women, and reduced MTCT to 3% of HIV-exposed infants at USG-supported sites.

As part of the Four Frees and One Care policy, GOC provides PMTCT at a unit cost of $2,000 per patient. In FY10, GOC announced the expansion of the national PMTCT program from 333 to 1,156 high HIV prevalence counties and the integration of PMTCT for HIV, HBV, and syphilis with routine MCH services. The National Action Plan (2011-2015) includes PMTCT targets for testing 80% of pregnant women for HIV, providing ARV prophylaxis to 90% of HIV-positive pregnant women, and reducing MTCT to 5% of HIV-exposed infants. GOC has developed a national M&E plan for PMTCT and is in the process of implementing a tiered M&E system at the provincial, city, and county levels to guide implementation and support improvement. Through this implementing mechanism, U.S. CDC provides technical assistance (TA) on guidelines, manuals, and M&E.

Activities for FY12 include:

Continue to support clinicians to conduct active case finding at 112 sites in Guangxi

; Continue to support referral mechanisms between MCH, CDC, and hospital systems to ensure retention

; Promote PITC at pre-marriage health screenings to increase HIV diagnosis and CD4 testing prior to delivery

; Support Guangxi BOH to scale-up PMTCT to all 109 counties

; Support NCWCH to supervise PMTCT scale-up at provincial and local levels

; Provide TA to improve national PMTCT database as well as data collection, analysis, and utilization at all levels

; Provide TA to evaluate feasibility and acceptability of repeat HIV testing in late pregnancy and/or at delivery

; Strengthen linkages between MMT, PMTCT, and ART in Guizhou.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	59,239	0

Narrative:

This implementing mechanism supports in-service training for county-level clinicians at two Rural AIDS Clinical Training Centers in Lixin, Anhui and Luzhai, Guangxi. In FY11, the Lixin Rural AIDS Clinical Training Center was transitioned to local ownership, but U.S. CDC will continue to provide technical assistance on second line ART. In FY12, U.S. CDC will continue to support the Luzhai Rural AIDS Clinical Training Center, including accomodation and stipends for trainees. In order to gain hands-on experience, trainees provide treatment services such as adherence counseling and clinical monitoring under the supervision of clinicians at county and township hospitals.

This implementing mechanism also supports clinicians in five counties in Henan to provide clinical monitoring, CD4 and viral load testing, and adherence counseling as part of a comprehensive care and treatment model. This model also includes PLHA support groups to improve adherence and retention.

The partner, NCAIDS, tracks and evaluates clinical outcomes of the National Free ART Program, including sites supported by this implementing mechanism, through the national treatment database. U.S. CDC provides technical assistance on data analysis and utilization.

Local CDCs provide free CD4 and viral load testing for treatment monitoring. In 2010, the Ministry of Finance approved reimbursement to PLHA for the cost of transportation and meals to access facility-based CD4 testing in order to improve retention.

This implementing mechanism includes technical assistance to scale up the Essential Care Package (ECP), which includes adherence counseling, clinical monitoring, and CTX prophylaxis. It also supports referral mechanisms to strengthen linkages between HIV prevention, care, and treatment services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	31,594	0

Narrative:

This implementing mechanism does not include direct provision of pediatric HIV treatment. GOC covers pediatric treatment under the National Free ART Program.

This implementing mechanism supports in-service training for county-level clinicians to provide pediatric HIV treatment at two Rural AIDS Clinical Training Centers in Lixin, Anhui and Luzhai, Guangxi. It also includes technical assistance to implement EID by dried blood spot at 6-8 weeks of age in 7 provinces through a network of specialized laboratories and to improve pediatric HIV data collection, analysis, and utilization.

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	New Mechanism: N/A

Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 50,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	50,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The purpose of this implementing mechanism is to build the capacity of clinicians and program managers at sub-national levels. In FY12, U.S. CDC and I-TECH will collaborate to add leadership and management training, qualitative research training, and case study methods to the curriculum of the Provincial Program Management Training Program, which provides provinical level HIV/AIDS program managers with one month of classroom instruction and five months of hands-on learning through rotations in NCAIDS divisions and the field. U.S. CDC and I-TECH will also collaborate to improve the quality of in-service training for clinicians in HIV/AIDS and to evaluate the performance of the national HIV/AIDS training program, which consists of 14 national HIV/AIDS clinical training centers that provide 3 months of residential training on HIV care and treatment to clinicians.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	50,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Impact/End-of-Program Evaluation

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	HBHC	5,000	0

Narrative:

This implementing mechanism will improve the quality of in-service training for clinicians in adult HIV care, including clinical monitoring, cotrimoxazole prophylaxis, and STI diagnosis and treatment. I-TECH will provide technical assistance to evaluate the national HIV/AIDS training program after its curriculum was updated in FY11.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	2,500	0

Narrative:

This implementing mechanism will improve the quality of in-service training for clinicians in pediatric HIV care, including OI prevention and treatment. I-TECH will provide technical assistance to evaluate the national HIV/AIDS training program after its currciulum was updated in FY11.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	35,000	0

Narrative:

This implementing mechanism addresses the lack of capacity at sub-national levels to manage operational and fiduciary functions. I-TECH will provide technical assistance to develop leadership and management training, qualitative research training, and case studies for the Provincial Program Management Training Program, which provides provincial HIV/AIDS program managers with one month of classroom instruction and five months of hands-on learning through rotations in NCAIDS divisions and the field.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	5,000	0

Narrative:

This implementing mechanism will improve the quality of in-service training for clinicians in adult HIV treatment, including first and second line ART regimens, clinical monitoring, and adherence support. I-TECH will provide technical assistance to evaluate the national HIV/AIDS training program after its currciulum was updated in FY11.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	2,500	0

Narrative:

This implementing mechanism will improve the quality of in-service training for clinicians in pediatric HIV treatment, including first and second line ART regimens, clinical monitoring, and adherence support. I-TECH will provide technical assistance to evaluate the national HIV/AIDS training program after its currciulum was updated in FY11.

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 Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: United Nations Joint Programme on HIV/AIDS	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 100,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

U.S. CDC and UNAIDS will continue to collaborate on priority activities consistent with USG strategy and in support of the Chinese national HIV/AIDS program. Particular areas of collaboration in FY12 will include support for civil society engagement in the national response to HIV/AIDS and population size estimation for MARPs. In terms of civil society engagement, this year will be a critical one for China. In response to findings from the Global Fund Secretariat, China will be identifying a civil society sub-recipient for a significant portion of its Global Fund resources and that sub-recipient will be expected to rapidly transition to principal recipient status. Civil society is not well-developed in China, and those organizations that engage in Global Fund programming will need significant support in developing their technical and management capacities. A specific focus for collaborative work between U.S. CDC and UNAIDS will be the development of HIV/AIDS program monitoring and evaluation (M&E) approaches and training for civil society organizations. U.S. CDC and UNAIDS are uniquely positioned to do this work, as a result of U.S. CDC's close institutional relationship with China CDC (the current principal recipient for Global Fund) and technical abilities, and UNAIDS' normative role and leadership in China's Global Fund Country Coordination Mechanism (CCM). U.S. CDC and UNAIDS will also continue to collaborate on issues related to the CCM and the development of strategic information to help inform policy guidance and technical support to the Government of China (GOC).

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
OHSS	Civil society organizations	40000	UNAIDS will support the soon to be identified civil sociey Global Fund sub-recipient and other CSOs by building capacity in M&E.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,600

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

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
Governance and Systems	HVSI	60,000	0

Narrative:

This implementing mechanism will support program monitoring, evaluation, and reporting by civil society organizations (CSOs). In particular, UNAIDS will coordinate the development of M&E guidelines for CSOs, including core indicators, reporting formats, processes and systems to integrate civil society contributions into the national reporting system.

In addition, UNAIDS will build the capacity of national and provincial staff to track and assess HIV/AIDS expenditures and provide technical support to provinces on data collection and analysis for the HIV/AIDS expenditure tracking exercise.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	40,000	0

Narrative:
Civil society is not well-developed in China, which limits the engagement necessary to further increase coverage and improve quality of HIV prevention, care, and treatment services. This implementing mechanism will support civil society engagement in Global Fund programs by building the capacity of civil society organizations, particularly in monitoring and evaluation, and by documenting their contribution to the national response to HIV/AIDS. This implementing mechanism will also improve strategic planning and resource utilization by building the capacity of national and provincial staff to track and assess HIV/AIDS expenditures. The lack of comprehensive and rigorous assessment of HIV/AIDS spending is a key gap in China's national strategic information. UNAIDS will support the roll-out of an HIV/AIDS expenditure tracking exercise in eight provinces and produce a report on HIV/AIDS expenditure assessment with recommendations to improve resource utilization at national and provincial levels.

Implementing Mechanism Details

Mechanism ID: 13186	**Mechanism Name: Population Services International**
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	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,543,637	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,543,637

Sub Partner Name(s)

Pact, Inc.	Research Triangle International	Yunnan Association of STI and AIDS Prevention and Control

Overview Narrative

In China under the USAID PSI CAP-3D (Control and Prevention of Infectious Diseases: HIV, Tuberculosis, and Malaria) Project, FY 2012 will be characterized by the continuation of technical assistance (TA) to existing program sites focusing on community capacity building for sustainability, with a specific focus on the Continuum of Prevention to Care to Treatment (CoPCT) model site at Luzhai; the consolidation of other Cooperating Partner (CA) sites (that are scheduled for close-out at the end of FY 2012) and proven approaches into the CAP-3D project as appropriate (where funding allows, after a timetable has been agreed with CAs, a comprehensive evaluation to identify the sites which require further support has been conducted, and the type of assistance they require has been identified), and; an eventual exit from China in FY 2013 leaving behind sustainable interventions implemented by strong local, organizations. PSI/China will implement the CAP-3D project in close collaboration with our partners, the Yunnan Association of STI and AIDS Prevention and Control (SAA), Pact, and Research Triangle International (RTI). The following target groups will be served: 1) MSM, 2) PWID, 3) PLHIV in the following hotspots: Kunming, Mengzi, Gejiu, Nanning, and Luzhai.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HVOP	Provincial level government	0	As needed/requested, provide HIV-related technical assistance to the provinical government for GF implementation.
IDUP	Provincial level government	0	As needed/requested, provide HIV-related technical assistance to the provinical government for GF implementation.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Mobile Population
TB
Workplace Programs

Budget Code Information

Mechanism ID:	**13186**		
Mechanism Name:	**Population Services International**		
Prime Partner Name:	**Population Services International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	154,364	0

Narrative:

GHCS (State) = $154,364

In FY12, PSI/China will collaborate with the other CAs and local partners to continue prioritizing the collection of strategic information, packaging and documentation and dissemination of programmatic research which demonstrates the success of the USAID funded intervention models. The following SI activities are scheduled during FY12:

• IDU RBT survey, covering Kunming, Gejiu, Nanning and Luzhai
• MSM qualitative assessment in Kunming and Nanning to explore the intervention/services gaps with regards to prevention, care and availability of health products, including the need for MSM targeted condoms and lubricants and effective distribution
• Second round of MSM RBT in Kunming, Nanning and selected hotspots in Honghe Prefecture
• CoPCT process evaluation in Luzhai in collaboration with the other CAs and local partners, under the lead of RDMA
• Promote the adaptation of MIS system across PSI/China supported program sites as well as that of local partners to promote the effective tracking of referral linkages using the MIS training manuals
Building Local Capacity to Collect and Use Strategic Information (SI)
During FY12, PSI/China will continue to build the capacity of local organizations to use SI tools and results to inform program interventions, while simultaneously implementing quantitative studies to inform, monitor and improve project implementation, through trainings, and the dissemination of research methodology and findings etc. A special focus will be placed on operational research, which documents new ways of implementing the CPP and CoPCT.
Pact will specifically provide TA on M&E training to select CBOs and public health care providers in Yunnan. Two modules of M&E trainings will be delivered in FY12 to the selected CBOs to develop a community-based approach to M&E with increased skills and ownership, in full compliance with relevant donor requirements.
The first module of M&E training will be delivered to select CBOs in Q2 or Q3 with follow up mentoring. The content includes: Introduction to M&E for Me; Logic models; Stakeholder analysis.
The second module of M&E training will be delivered to select CBOs in Q3 or Q4 with follow-up mentoring. The content includes: M&E questions; M&E indicators; M&E protocols; M&E flow charts
Disseminating Strategic Information for Scale Up and Advocacy
• Under the leadership of USAID/Beijing, publish research and program papers in the Chinese Journal of STI and AIDS Prevention, to promote the use of SI for program scale up and advocacy for the CPP replication.
• Disseminate SI at local, national and international conferences/meetings (e.g. the bi-annual MSM network meetings in Yunnan and Guangxi, and the Harm Reduction network meeting in Yunnan, the NCAIDA meeting in Beijing, and the Annual Conference of International Harm Reduction Association in Australia etc).
• Review and package findings from PSI/China's social marketing research series (conducted between 2003 ¡V 2009) for dissemination among local partners.
• PSI will collaborate fully with the US CDC office in Beijing to promote the CPP model at the national level through experience sharing meetings and study trips to PSI CAP-3D sites in Yunnan and Guangxi for CDC personnel.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	46,309	0

Narrative:

GHCS (State) = $46,309
Please see above description of the inclusion/integration of HIV counseling and testing services as a part of the CPP.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	849,000	0

Narrative:

GHCS (State) =$849,000

PSI/China will adopt a blended and staged approach to the effective implementation of the Comprehensive Prevention Package (CPP) in during FY12. The only services that will be delivered directly by PSI/China at the beginning of FY12 are the Huxianghao Ba (HXH) Drop in Center (DiC) and Sisterhood Health Home (SHH) DiC in Mengzi, and the activities at these sites will gradually be transitioned to local ownership in FY12. The support PSI/China has provided to existing programs sites (e.g. Kangxin Home in Mengzi and the Poplar Tree in Gejiu) have allowed these partners to implement the CPP model directly and the contribution PSI/China will make at these sites will also gradually be reduced as their fundraising capacity is increased in FY12. These sites will be transitioned to local ownership or under SAA's umbrella in FY12. Finally, investments in the organizational and technical capacity of SAA (and in turn the CBOs they will support) to implement the CPP will be increased in FY12. PSI/China likens this approach to a pendulum swinging gradually, but firmly, towards increased implementation of the CPP model by strong, locally owned and operated organizations (either via SAA or as a result of USAID's investments) by the end of FY12.
Pact will play an important role in helping to build the capacity of the SAA according to the results of the organizational assessment and the organizational capacity development plan produced in FY11. This work will center around the institutional capacity of SAA, including capacity development approaches, technical and organizational capacity areas, training methods, mentoring and coaching, and utilization of monitoring and evaluation methods. Early in FY12, using agreed selection criteria and an open and transparent call for EOIs selection process, 3-4 CBOs working in Kunming will be identified (serving MSM, PWID, and PLHIV populations). SAA and Pact will then develop Organizational Capacity Development (OCD) road maps for these CBOs and follow up on their implementation by SAA. It is hoped an additional CBO in the Hongehe area will be added towards the end of FY12. It is envisioned the support provided by CAP-3D international partners will contribute to SAA's development as the

premier capacity building organization in the area of HIV/AIDS in Yunnan and position them well for future funding opportunities for alternate donors. This is especially critical as the national SAA (based in Beijing) has just been selected as the China Global Fund Civil Society Sub-Recipient. Pact's FY12 budget for carrying out these activities has been supplemented by PSI/China's country budget.
RTI will also play an important role in promoting the value and benefits of the CPP model to external stakeholders and provide trainings on stigma & discrimination (S&D) reduction within MARP communities and ensure the legal rights of PLHIV and PWIDs are promoted during S&D reduction training with law enforcement agencies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	493,964	0

Narrative:

GHCS (State) = $493,964
PSI/China will continue to provide TA to existing PWID program sites in Yunnan and Guangxi, focusing on local partner capacity building efforts to enable them to gradually effectively implement the full package of CPP model services, while preparing for the gradual transition of mature PWID CPP intervention program sites to local ownership.
PSI/China will strengthen its partnerships with the local health bureaus and collaborate with them on the development of community detoxification and rehabilitation programs in Kunming. The operational and day-to-day management of the PSI/China operated HXH DiC will be gradually transitioned to local ownership during FY12. PSI/China will, however, continue to support the DiC with the provision of TA.
PSI/China will support two peer-led PWID grassroots groups, the Kangxin Home in Mengzi and the Poplar Tree in Gejiu, to promote community-based targeted PWID BCC interventions, while documenting standard operating procedure (SOP) and lessons learned for future TA to the other peer-led PWID grassroots groups. PSI/China will work with local Government of China (GoC) partners to gradually transition these two CBOs to local ownership or under SAA's umbrella, while promoting the two programs as focal sites for targeted and essential HIV prevention/control services to PWIDs in Honghe prefecture.
In order to improve linkages between the IPC prevention outreach work and care/treatment services, PSI/China will continue to work with community health centers, private health clinics and public health hospitals on a clinical health network (CHN) in Kunming.
PSI/China will continue to promote targeted community-based PWID activities using peer-led IPC intervention and strengthen the referral linkages to care, treatment, and support in Nanning. PSI/China will support Wangzhou Community Center to refine the community rehabilitation model site, while promoting the replication of the Wangzhou model in Heng Yang Bei, Bei Hu Bei as well as 12 other Community Rehabilitation Centers in Qingxiu and Xingning Districts in Nanning. In addition, PSI/China

will increase the provision of TA to Shu Guang Jia Yuan PWID grassroots group in Nanning. Finally, PSI/China will support Nanning CDC to conduct TOTs among inmates at Nanning No.1 and No. 2 Detoxification Centers, providing them with trainings on BCC and IPC on harm reduction and HIV prevention as well as information for the existing care, treatment and support services to prepare them for release and return back to the communities. PSI/China will continue to provide TA to Luzhai PHB, local Luzhai CDC, and Narcotics Control Committee with the aim of establishing the Chengxi rehabilitation center as a model, locally owned site for community-based PWID intervention in Luzhai, based on lessons learned from the Wangzhou site in Nanning. To complement the CoPCT model, particular efforts will be made to link the prevention services at the community rehabilitation centers with the existing care and support services. PSI/China will integrate USAID-supported PWID interventions in the MMT clinic, community rehabilitation centers, and the compulsory detoxification center in Luzhai, with local partners to ensure long-term sustainability. A special focus will be placed on enhancing coordination among CAs to ensure those PWID sites whose support from other CAs will cease in FY12 will continue to receive support until they are ready to be transitioned to local owner

Implementing Mechanism Details

Mechanism ID: 13980	**Mechanism Name: Engaging Local NGOs**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: AIDS Care China	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 448,090	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GAP	448,090

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The purpose of this implementing mechanism is to engage local non-governmental organizations (NGOs) in the national response to HIV/AIDS by building their capacity to deliver high quality HIV care and treatment services to vulnerable populations in Southwestern and Western China. The grantee will demonstrate and document a model for service delivery by local NGOs and develop tools to strengthen the capacity of other local partners to replicate the model. The grantee will collaborate with Chinese government agencies, hospitals and clinics to increase early HIV detection and ART initiation, improve adherence and retention, and minimize loss to follow-up by supplementing government treatment services with adherence counseling, support groups, and other activities.

The funding opportunity announcement (FOA) will be published in March 2012. Eligibility is limited to local partners, with preference given to local indigenous NGOs that are not affiliated with an international NGO or Chinese government agency. Award is anticipated for September 2012.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	343,170

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**13980**
Mechanism Name:	**Engaging Local NGOs**
Prime Partner Name:	**AIDS Care China**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	109,090	0

Narrative:

The grantee will facilitate support groups for PLHA at public hospitals and clinics to improve adherence and retention. PLHA will be linked to treatment, CD4 and viral load tests at program sites and other facilities. By the end of FY13, 8,000 HIV-infected individuals will participate in PLHA support groups.

The grantee will also pilot screening and treatment to prevent cervical cancer in HIV-positive women. Techniques will be determined with the grantee, local government, and other experts after award, depending on the location of sites and other factors. See and treat' will be the standard operating procurer as it is more appropriate in rural areas.By the end of FY13, 200 HIV-infected women will receive screening for cervical cancer and treatment as necessary.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	134,500	0

Narrative:

Civil society is not well-developed in China, which limits the engagement necessary to further increase coverage and improve quality of HIV prevention, care, and treatment services. This implementing mechanism will support civil society engagement in the national response to HIV/AIDS by building the capacity of the grantee and other local NGOs to deliver high quality HIV care and treatment services to vulnerable populations in Southwestern and Western China. The grantee will demonstrate and document a model for service delivery by local NGOs and develop tools to strengthen the capacity of other local NGOs to replicate the model.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	70,000	0

Narrative:

The grantee will provide HIV testing and counseling at public hospitals and clinics for sexual partners and family members of PLHA. By the end of FY13, 12,000 individuals will receive HIV testing and counseling. Individuals who test positive for HIV will be linked to care and treatment. The grantee will track and follow up with HIV-positive individuals who do not appear for appointments.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Treatment	HTXS	134,500	0

Narrative:

The grantee will provide treatment literacy education, adherence counseling and support for people living with HIV/AIDS (PLHA) in public hospitals and clinics. The grantee will also support comprehensive case management services for PLHA, including scheduling follow-up visits for CD4 and viral load tests and tracing patients who miss appointments. By the end of FY13, 8,000 HIV-infected individuals will receive treatment literacy education, adherence counseling and support. The percentage of ART patients lost-to-follow-up in the last 12 months will be less than 5%.

The grantee will also train lay counselors to deliver treatment literacy education and provide counseling. By the end of FY13, 5 lay counselors will be trained. Site coordinators will provide on-site supervision and collect data for program monitoring.

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	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Computers/IT Services		4,468			4,468
ICASS		3,224			3,224
Management Meetings/Professional Developement		4,580			4,580
Non-ICASS Administrative Costs		14,520			14,520
Staff Program Travel		13,814			13,814
USG Staff Salaries and Benefits		115,757			115,757
Total	**0**	**156,363**	**0**	**0**	**156,363**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services	computers and IT services	GHP-State		4,468

ICASS	ICASS cost	GHP-State		3,224
Management Meetings/Professional Developement	Management meetings	GHP-State		4,580
Non-ICASS Administrative Costs	Annual rental & utilities; annual office support cost sharing	GHP-State	Since HIV/AIDS team of Office of Public Health based in RDMA will overall manage China program from FY2013, 20% of their total non-ICASS administrative costs will be shared by China program funding. USAID Non-ICASS Administrative Costs breakout as follows; 1. Estimate Annual rent and utilities = 9,340 2. Annual office support cost share = 5,180 (IT equipment, Printing, Office Supplies and Material, Vehicle rental, Courier Services and Other Miscellaneous Services)	14,520

Prevention

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Capital Security Cost Sharing	45,000				45,000
Computers/IT Services	94,000				94,000
ICASS	140,000				140,000
Institutional Contractors	67,500				67,500
Management Meetings/Professional Developement	52,500				52,500
Non-ICASS Administrative Costs	584,000				584,000
Staff Program Travel	213,000				213,000
USG Staff Salaries and Benefits	1,254,000				1,254,000
Total	**2,450,000**	**0**	**0**	**0**	**2,450,000**

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

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GAP		45,000
Computers/IT Services		GAP		94,000
ICASS		GAP		140,000
Management Meetings/Professional Developement		GAP		52,500
Non-ICASS		GAP		584,000

Administrative Costs				