



**Asia Regional Program**  
**Country Operational Plan**  
**FY 2014**

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.



## Operating Unit Overview

### OU Executive Summary

#### Regional Overview

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The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Asia Regional Program (ARP) is a platform for targeted technical assistance (TA) and collaboration with national HIV programs in China, Laos, and Thailand and partners (including other PEPFAR programs) throughout Asia. The ARP is implemented through a closely coordinated U.S. Government (USG) interagency collaboration between the U.S. Agency for International Development (USAID), U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Defense (DoD), U.S. Department of State, and U.S. Peace Corps.

#### The HIV Epidemic in the Asia Region

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Asia is home to the largest number of people living with HIV (PLHIV) outside sub-Saharan Africa. In 2012, there were nearly five million PLHIV in Asia. While HIV programs in the region have made impressive progress, the pace of progress appears to have plateaued recently in some countries. Responses require renewed energy, focus, and innovation and there are promising signs of such responses that the USG has contributed to and will continue supporting. Examples of promising developments include updated national guidelines, including the possibility of earlier antiretroviral therapy (ART), innovative uses of rapid testing technologies for key populations, and combination prevention efforts that will allow for earlier identification and care and treatment for PLHIV, especially key populations.

Although the number of new HIV infections has fallen in the past decade (with some countries reducing infections by over 50% since 2001), the "number of new HIV infections across the region has remained largely unchanged in the past five years" (HIV in Asia and the Pacific: UNAIDS report 2013). Likewise, while the number of people accessing ART rose to 1.25 million people in 2012, the rate of increase in access to ART has stalled in recent years. HIV transmission continues to accelerate across borders, in urbanized areas, and among men who have sex with men (MSM), people who inject drugs (PWID), sex workers (SW) and their clients, and other key populations such as transgender persons (TG), migrants and refugees, and rural ethnic minorities. Despite substantial evidence that targeted investments in HIV prevention, testing, care, and treatment can prevent the spread of HIV among key populations, critical gaps persist. These gaps underscore the need to identify and implement innovative, life-saving approaches and practices, increase the coverage of effective programs that already exist, ensure that these programs are of the highest quality, make use of the tools that are available, adopt the latest guidelines and techniques, and build the country capacity needed for sustainable local ownership of the



HIV and AIDS response.

### PEPFAR Approach in the Region

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PEPFAR programs in China, Laos, and Thailand were combined under the umbrella of the ARP in the FY13 Regional Operational Plan (ROP). Under this umbrella, the ARP relies on each country program's specific strategies and relations with national mechanisms to guide cooperation between PEPFAR, the governments of China, Laos, and Thailand, and other partners combatting HIV in the region. At the same time, the ARP is a strong supporter of the regional pursuit of ambitious targets associated with their commitment to realize "Three Zeros" – zero new HIV infections, zero AIDS-related deaths, and zero HIV-related stigma and discrimination – by 2015. China, Laos, and Thailand have each pledged to reduce the number of new HIV infections in key populations by 50%, scale up ART coverage to 80% among PLHIV, and eliminate new HIV infections among children within the next three years. All activities supported by the ARP are aligned with USG principles and goals to develop national and local leadership and capacity, create an enabling policy environment, and integrate new activities into routine, sustainable systems. Coordination among civil society, governments, NGOs, the Global Fund, and other donors is facilitated by the ARP through participation in government and multilateral meetings, and active membership on Global Fund Country Coordinating Mechanisms (CCMs) and technical working groups.

At the regional level, the ARP is continuing to pursue the priorities that it set in 2013, namely: (1) increasing coverage and effectiveness of programs for key populations; (2) building capacity and strengthening national and community health systems to facilitate country ownership of an effective, sustainable HIV response; (3) expanding and improving quality of care and treatment for health and prevention; (4) improving the use of strategic information (SI) for evidence-based policies and decision-making; (5) increasing demand for and access to faster, high-quality HIV diagnosis; and (6) scientifically developing and sharing tools and approaches to help PEPFAR programs better plan, measure, and report on capacity building efforts, such as by refining capacity building frameworks and TA-based indicators, thus strengthening PEPFAR's ability to measure critical inputs related to TA achievements and progress to build country capacity at all levels.

Likewise, regional approaches and mechanisms that the ARP employed in 2013 (i.e., country-to-country technical collaborations, the Local Capacity Initiative, Key Populations Challenge Fund, Key Population Implementation Science, and the Health Research and Knowledge Management Mechanism) will continue forward in FY14-FY15, with a new USAID procurement (as a replacement to the existing CAP-3D project) anticipated for late FY15.

A key tenet of the ARP program is working with governments to develop innovative models, monitor them



to determine cost and effectiveness, and scale them up with public sector investment. In addition to fostering successful adoption, scale-up, and ownership of model programs, the ARP supports dissemination of successful models through country-to-country technical collaborations (CCTCs) between countries. This increasingly successful provision of CCTC to other PEPFAR countries serves several critical functions. First, PEPFAR benefits from successful models developed and implemented in HIV programs, and adapted in the broader PEPFAR context. Second, this activity provides a road map to developing successful models of TA/collaboration between PEPFAR countries, regionally and beyond. Third, as Asian programs build their capacity to provide assistance themselves (both as a donor and as a TA provider), the ARP plays a substantial role in cultivating national mechanisms and mentoring government and locally employed ARP staff in the provision of TA to other countries. This activity maximizes the contributions of PEPFAR technical and capacity-building investments and increases the sustainability of PEPFAR results in the region.

#### PEPFAR FY14 Priorities for the ARP

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The ARP has already begun to respond to the priorities PEPFAR set for the ARP, as outlined in its FY14 funding level letter. The region is building on PEPFAR's commendation of ARP efforts to measure accountability and impact, continuing its pursuit of improved metrics and indicators while introducing new evaluation and reporting systems in its effort to develop a more exact science of TA. Country-by-country (rather than joint) portfolio reviews were conducted. The collection, analysis, and submission of approved pipeline for each ARP agency was carried out as a precursor to interagency ROP allocation decisions and planning. Lastly, the ARP adhered to the welcome guidance provided by PEPFAR on structuring its Executive Summary and other elements of this ROP.

#### Other PEPFAR-funded Activities in the Region

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In addition to PEPFAR-funded activities detailed in this 2014-2015 Regional Operational Plan (ROP), the region also receives PEPFAR funding through two Central Initiatives:

- Key Populations Challenge Fund (KPCF): The ARP consulted with the leadership of Thailand's National AIDS Management Center (NAMC) and the Laos Center for HIV/AIDS and Sexually Transmitted Infections (CHAS) to identify a combination package of innovative activities to achieve the following objectives: 1) Increased case finding (HIV, sexually transmitted infections [STI], and tuberculosis [TB]) per contact; 2) Reduced cost per case identified; 3) Increased CD4 cell count on entry to care; 4) Improved retention in prevention, care, and treatment; and, 5) Improved treatment adherence. KPCF activities began in FY13 and will continue through FY15.
- Key Population Implementation Science (KPIS): In 2013, the ARP was awarded a KPIS grant to assess an HIV Test and Treat Model among MSM in facility-based and community-based settings in Thailand



and Laos. Potential sites are being assessed for the study and a protocol is being written. In FY14-FY15, the ARP will use KPIS funding to work with the Thai Red Cross on an MSM Test-and-Treat Pilot, which will help inform efforts to accelerate access to HIV testing and treatment in Thailand, which is now a goal of the Thai national program. The results of this work will be disseminated throughout the region. The Ministry of Public Health (MOPH) and National Health Security Office (NHSO) are actively involved in the study planning and results will inform potential implementation of test and treat strategies in Thailand. This signals a major change in Thailand's position towards HIV treatment, with Thailand moving to a leadership position in Asia in early access to ART. The ARP has been closely involved in this effort.

## China

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### Epidemiology

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While national HIV prevalence in China is low (0.058%), the epidemic remains concentrated in certain regions and populations. Prevalence is over 6% among key populations such as PWID and MSM. In 2008, HIV prevalence among MSM was over 10% in several southwestern cities. Also, while ethnic minorities comprise less than 8% of the total population, they contribute 37.4% of reported cases, many of which are concentrated in provinces in the south and west of China. Out of the 31 provinces in China, six high prevalence provinces represent over 75% of the cumulative national total of reported HIV cases.

### National response

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Unlike most other PEPFAR country programs, the Government of China (GOC) funds approximately 95% of the HIV/AIDS response, with national goals of reducing HIV incidence by 25% and HIV mortality by 30% by 2015 (from 2010 levels). To achieve these goals, China has several policies that define their response: (1) the "Four Frees and One Care policy" provides free voluntary counseling and testing (VCT), ART, prevention of mother-to-child transmission (PMTCT), and education for children orphaned by AIDS; (2) the "Circular on Further Strengthening AIDS Notifications" of prioritizes strengthening care and support for people living with HIV (e.g. palliative care, poverty alleviation, anti-discrimination); and (3) the "Five Expands, Six Strengthens" policy prioritizes coverage of comprehensive interventions for key populations, HIV testing and counseling, and PMTCT. In addition, GOC began pursuing the treatment as prevention (TasP) strategy for discordant couples in 2012. In spite of these efforts, migration patterns of key populations (e.g. MSM, FSW) for employment or due to stigma presents challenges in targeting key populations for interventions and/or care and treatment.

### Other donors/factors

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Given the national context, the PEPFAR investment in China emphasizes improving capacity and quality of the host government's HIV/AIDS response. The USG response is well-integrated with that of GOC, with a long-standing, on-the-ground collaboration with the China Centers for Disease Prevention and Control's National Center for AIDS/Sexually Transmitted Disease Control and Prevention (NCAIDS). Gates Foundation, Global Fund, and USAID closed out HIV/AIDS work in China in 2013, and while GOC funds fill the financial gap, US CDC continues to provide TA in the absence of these organizations and works to ensure that best practices and lessons learned from these collaborations can be shared openly and transparently with the global community.

PEPFAR support

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In order to improve the quality and coverage of HIV/AIDS services and to cover gaps in China's HIV/AIDS response, the priorities for PEPFAR investment in China are: (1) continued TA to develop and scale up innovative pilot interventions with a focus on high risk and high prevalence populations and geographic areas; (2) strengthening health systems and building health worker capacity to conduct surveillance, utilize data for policy-making, and build linkages across health institutions; and (3) addressing important scientific questions that can be answered most effectively in China, but have global implications for the HIV/AIDS response.

Laos

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Epidemiology

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Laos is a low HIV prevalence country with infection focused among PWID, FSW, and MSM. While Laos has sustained a relatively low-level HIV epidemic, with an estimated adult HIV prevalence of 0.2% and approximately 1000 new infections in 2013, HIV and other infectious disease risks are increasing. An estimated 12,008 PLHIV were living in Laos at the end of 2013. A total of 3,632 (30.2%) had registered for care. Among all PLHIV, an estimated 5,082 were eligible for ART. Of those, 2,559 (50.4%) were continuing ART at the end of 2013. A reported 163 children were on ART in 2012; 49 HIV-positive pregnant women received ARVs to prevent MTCT in 2012. A 2011 survey estimated that HIV prevalence among FSW had increased from 0.4% (in 2008) to 1.0% (in 2011). The same study found increases in rates of chlamydia and gonorrhea. A 2011 integrated biological and behavioral surveillance (IBBS) survey conducted among TG found that 4% of individuals surveyed were infected with HIV. Rates of case detection among TG visiting program sites offering HIV testing in the past year were lower, suggesting gaps in access to services among those individuals facing the greatest infection risks. HIV prevalence among the Laos military (Laos People's Army [LPA]) is unknown. It is noteworthy that Laos recently revised upwards its estimate of smear-positive TB cases to 606 per 100,000 individuals, as TB is a



leading killer of PLHIV.

#### National response

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Since 2010, the policy and political environment in Laos has increasingly supported the national HIV response. The secretariat of the Laos National Committee for the Control of AIDS – the Center for HIV/AIDS and STIs (CHAS) – is responsible for the implementation of the response, which is guided by the Laos National Strategic and Action Plan for HIV/AIDS/STI Control and Prevention (NSAP) for 2011-2015. The NSAP calls for vigilance in light of the “potential for a concentrated epidemic” among FSW and their clients, MSM, and PWID. Two national priorities are a) to keep HIV prevalence in the general population and most-at-risk populations below 1% and 5% respectively, and b) to improve the quality of life of PLHIV. There is a burgeoning, progressive involvement of civil society in the HIV response, especially in the areas of prevention, care, and support. Despite these positive signs, Laos continues to rely heavily on external support, both technically and financially, for its HIV response. From 2009-2011, the expenditure on HIV increased from US\$6 million in 2009 to US\$11.74 million in 2011, funded predominantly by external sources (7.4% of the response funded with domestic resources in 2011). Of all non-domestic resources for the HIV response, the Global Fund provides the largest share, at 64.4% in 2011 (followed by bilateral agencies such as Australia and the U.S. at 15.7%). Nearly 40% of that HIV expenditure in 2011 was spent on prevention, followed by management and human resources.

Laos currently has limited technical expertise and human capacity to implement its surveillance, M&E, and HMIS. Increasing SI requirements (such as the introduction of new surveillance activities and efforts to improve data quality and analysis) are straining host country technical and management capacities. There is a lack of a systematic approach to SI gathering and use, particularly for MSM. Human capacity to use SI for evidence-based strategic planning for program improvement and policy advocacy is also limited. According to the Laos National Strategy and NSAP, strengthening SI (including surveillance and M&E) is a high priority, focusing on increasing capacity of Laos MOPH to implement and maintain SI using local resources. In addition, high-quality SI is needed to better describe, monitor, and evaluate HIV epidemics and national responses and for translating this evidence into action plans and policy documents that promote increased government financing and other resource mobilization.

Although the National Center of Laboratory and Epidemiology (NCLE) has developed a national biosafety program and aims to establish a national laboratory quality program to improve the quality of laboratory services, laboratory practices across various programs are currently not well standardized. This lack of coordination between program, service facilities, and national level has created challenges in strengthening and improving the quality of laboratory services.



Other donors/factors

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Economic growth in Laos has been steady at around 8% since 2010; in 2011, Laos was elevated to the status of a lower middle-income country by the World Bank. Despite this economic growth and national efforts to reduce the proportion of the population living under poverty line, however, the poverty gap continues to grow, with most poor living in rural areas; these gaps are reflected in access to education, food, and health care, particularly among women and girls.

PEPFAR support

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In FY14-FY15, priorities for ARP support to Laos include: 1) strengthening the effectiveness and the continuum of HIV prevention to care and treatment among key populations, especially MSM, and 2) strengthening routine integrated monitoring and surveillance systems in order to facilitate evidence-based decision-making for program improvement.

Thailand

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Epidemiology

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Thailand is home to approximately 460,000 PLHIV (about 10% of all of the PLHIV in Asia). Bangkok contributes to 25% of the estimated 12,000 new HIV infections a year in Thailand. Although overall HIV incidence has decreased, incidence and prevalence remains high among key populations. Thailand's HIV epidemic is now concentrated among these key populations. Based on the Asian Epidemic Model (AEM), 8,184 new HIV infections will occur during 2015; 41% through transmission among MSM, 11% among FSW and their clients, and 10% among PWID. Prevalence is lower among MSM who sell sex and in TG, suggesting challenges in reaching less "visible" key populations as individuals more frequently connect and engage in risk behaviors outside of traditional "hotspots."

Despite a strong national PMTCT program, MTCT remains above 2% in Thailand and there are leaks in the HIV care continuum of care cascade for HIV-infected infants. A 2012 evaluation of the national early infant diagnosis (EID) program found that 39% of HIV-exposed infants born during 2008-2011 did not receive EID, and only 157 (37%) HIV-infected infants received ART within one year of age. These issues need to be addressed to reach the national targets of zero new HIV-infections in infants and zero HIV-related deaths and are consistent with PEPFAR priorities of eliminating MTCT and addressing low pediatric ART coverage worldwide.

National response



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Thailand is a middle income country with a population of 68 million. The first case of AIDS was reported in Thailand in 1984 and the epidemic peaked in the mid-1990s with an estimated 160,000 new infections per year, focused among sex workers, their children, and their clients. The Royal Thai Government (RTG) appropriately focused HIV prevention efforts on a 100% condom use effort and PMTCT in the 1990s, leading to a decline in new infections.

In Thailand, domestic funding for HIV (85% in 2012) is far above the global average (53% in 2012), but has not increased significantly in recent years (83% in 2007). Providing effective care for PLHIV is a major goal of Thailand's National HIV/AIDS Strategy for 2012–2016, reflected in the inclusion of 'zero AIDS deaths' by 2016 as one of three national goals (along with 'zero new infections' and 'zero discrimination and stigma' for PLHIV). A total of 388,833 PLHIV in 2013 had accessed government health benefits; of those, 331,357 were eligible for ART. Among those eligible, 286,214 (86%) had started ART and 227,451 (69%) were continuing to take ART at the end of September 2013. Rates of reported condom use are relatively high among both female and male SW, but are lower among MSM and PWID. About 75% of PWID report always using sterile injecting equipment. Rates of HIV testing uptake are critically low in all key populations. About 56% of FSW and 28% of MSM report receiving an HIV test in the past year.

In 2012, the MTCT rate in Thailand was 2.1%. An estimated 30% of HIV-exposed infants did not receive EID, however, and less than 30% of HIV-infected infants received early ART (within six month of age), meaning they and their families lost a critical opportunity to access life-saving treatment and other HIV services. Thus, despite being a middle-income country with a history of excellence in addressing the HIV epidemic, difficult gaps have emerged and need to be addressed to control the epidemic in Thailand. The work of the ARP in Thailand focuses on these gaps.

Although Thailand has a strong surveillance and monitoring system in place, three major barriers exist that limit the effectiveness of the national program, including: 1) limited technical expertise and staff capacity to implement quality surveillance systems, especially for key populations; 2) scattered and non-harmonized monitoring systems make it challenging to monitor the overall programmatic response; and 3) shortfalls in capacity to interpret and use data to design strategies that effectively improve program quality and guide program planning and implementation. Advocacy skills to facilitate local leadership are also limited.

Thailand has a well-structured laboratory and referral system, but the limited number and capacity of laboratory personnel and imparity of resource mobilization place some challenges on system improvement and program sustainability. All hospitals provide basic laboratory testing, including HIV serology, while tertiary hospitals offer more complex tests and serve as reference laboratories for CD4,



HIV viral load, and drug resistance testing. Demand for HIV laboratory services often outstrips supply and test results can be delayed.

#### Other donors/factors

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No other donor is currently focused on increasing the quality and efficiency of national responses to HIV/AIDS in this PEPFAR region by specifically investing in, introducing, and evaluating innovations to increase impacts and reduce costs. In FY14, the ARP will continue to engage with and provide TA to support the MOPH, NHSO (major financier of HIV services), and other bodies governing and coordinating the HIV response in Thailand, as well as continuing to support Global Fund planning, implementation, and performance. Of note, PEPFAR is only one part of an extensive Thailand and regional health cooperation matrix conducted by CDC, USAID/RDMA, and the U.S. Armed Forces Research Institute for Medical Sciences (AFRIMS). The Thailand MOPH–U.S. CDC Collaboration (TUC) works on TB, emerging infections, influenza, malaria, immigrant and refugee screening, HIV research (non-PEPFAR), non-communicable diseases, and epidemiologic training and investigation. USAID/RDMA provides health development and public health disease prevention work in the region, including Thailand, for control of malaria, TB, avian influenza, and other emerging pandemic infections. The U.S. National Institutes of Health (NIH) has a long history of collaborations with Thailand, and the National Institute of Allergy and Infectious Diseases (NIAID) currently funds over 30 projects in Thailand in infectious diseases (HIV/AIDS, H1N1, malaria, and dengue fever), many through major HIV/AIDS Clinical Trials Networks. ARP staff informally discuss and consult with NIH staff and NIH grantees on research development and results, and also collaborate with the non-PEPFAR HIV research unit on data analysis, dissemination, and programmatic implications of research results.

#### PEPFAR support

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Thailand has been a regional and global leader in its historically innovative and effective HIV responses, ranging from early recognition for its “100 Percent Condom Use Program” to landmark research on preventing MTCT and implementing measurably successful programs based on research findings. Many of the successful models and innovative approaches implemented in Thailand were founded on and benefitted (and continue to benefit) from ARP assistance. ARP has contributed to Thailand recognizing and moving to substantially address the current phase of the epidemic, concentrated in difficult to reach and stigmatized groups, evidenced by changes in ART policy, pilot programs to address earlier identification of infections and treatment of HIV, and innovative methods for rapid HIV testing. As a result of ARP assistance, Thailand is increasingly conducting systematic surveillance and collecting HIV-related data from national health and financing systems to inform continuum of response (COR) models. ARP provided TA to the Thailand MOPH and stakeholders to draft and implement 2010 national guidelines for



ART, increasing the threshold for ART use from a CD4 count of 200 to 350. Thailand had been viewed by many as a 'late adopter' of the CD4 <350 copies/mL threshold for ART initiation and this policy evolution and others described below demonstrate the high impact of ARP TA. Thailand now uses data from national systems to drive HIV program and policy improvements, such as to accelerate access to HIV testing and treatment for HIV-exposed infants and to more rapidly ART adopt/implement international guidelines that lower the threshold for ART access. In FY14-FY15, priorities for PEPFAR support to Thailand include: (1) ensuring that high-quality data is available for policy work on ART guidelines, retention along the continuum of treatment and care, combination prevention programs, eliminating MTCT, and implementation of rapid testing models; (2) provision of TA for the design, demonstration, scale-up, and integration of programs and policies to improve identification of HIV-positive cases, initiation of treatment, and retention; and (3) building government and non-governmental sector capacity to maximize and sustain the response.