**United States Department of State**

***Washington, D.C. 20520***

**FY 2015 Asia Regional Program (ARP) Regional Operational Plan (ROP)**

The following elements included in this document, in addition to "Budget and Target Reports" posted separately on www.PEPFAR.gov, reflect the approved FY 2015 ROP for Asia Regional Program (ARP).

1) *FY 2015 ROP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

   **Note that PEPFAR summary targets discussed within the SDS were accurate as of ROP approval and may have been adjusted as site-specific targets were finalized. See the "COP 15 Targets by Subnational Unit" sheets that follow for final approved targets**.

2) *COP 15 Targets by Subnational Unit* includes approved ROP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

**Approved FY 2015 ROP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the "FY 2015 Country Operational Plan Budget and Target Report."**

# PEPFAR ASIA REGIONAL PROGRAM

# REGIONAL OPERATIONAL PLAN 2015

# FY16 STRATEGIC DIRECTION SUMMARY

**8 June 2015**

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# Goal Statement

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

Based upon extensive analyses of epidemiological and program performance data, ARP has developed a Regional Operational Plan (ROP) for FY16 that features a dramatically refined priority population and geographic focus, while committing to a vision of sustainable, strong national and regional networks and systems for HIV epidemic control.

Working across USG agencies and collaboratively with host-country government counterparts, implementing partners, civil society organizations (CSOs), and multilateral organizations, the FY16 plan will accelerate epidemic control in fifteen provinces with the highest HIV rates and lowest ART coverage among priority populations in China (15 urban communities in six of 31 provinces), Laos (three of 17 provinces), and Thailand (six of 77 provinces).

The ARP will concentrate its efforts on collaboration and technical assistance that improves HIV testing and treatment among MSM and transgender (TG) women in those priority areas.

FY16 activities will build upon a tradition of successful ARP investments in 1) innovative, scalable, and more effective approaches for HIV epidemic control and 2) technical assistance that converts successful approaches into national policies and commitments to scale up; reinforces laboratory and strategic information capacity to guide and improve program implementation and quality; and secures the financial, systems, and human resource capacity needed for broader implementation.

ARP will continue to apply this approach in FY16, but with a sharp focus on maximizing the prevention and treatment benefits of antiretroviral medications in the populations facing the greatest HIV infection or transmission risks in priority settings, while ensuring effective clinical and laboratory services and monitoring and evaluation for all populations in those provinces.

To achieve this critical pivot with limited resources, and reflecting its analysis of epidemiological and program data, ARP will narrow the geographical scope of ARP activities to settings with the highest HIV infection burdens and lowest service coverage, concentrate on the key drivers of the epidemic in those provinces, and improve alignment of our USG agency investments to achieve greater impact.

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

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

# 1.0Epidemic, Response, and Program Context

### 1.1 Summary statistics, disease burden and country or regional profile

China

China is the most populous nation in the world with an estimated 1.36 billion population in 2013. China has the world's second largest economy, and its GNI per capita of $6,560 qualifies it as an upper middle income country. As China's economy has grown rapidly, large disparities in wealth have emerged. China now has more than 200 billionaires as well as 99 million persons living in poverty (<$1.25 per day). China's urban-dwelling population has tripled since the late 1970s, including 250 million rural-to-urban migrant workers. Most migrants belong to a "floating population" that lacks local registration status, which generally serves to exclude them from social welfare programs (including free ART and other HIV-related services) where they live and work. Immigrants, whose numbers have also surged during China's economic expansion, are similarly excluded from social services.

China's most recent (2011) published estimate of HIV prevalence was 0.058%. In that year there were an estimated 780,000 HIV-infected adults and children, 48,000 new HIV infections, and 28,000 HIV-related deaths. As of 2011, 352,000 persons had been diagnosed with HIV, reported to the case surveillance system, and were presumed living (446,000 cumulative reported cases less 94,000 cumulative reported deaths). Of these, there were 330,000 people living with HIV (PLHIV) who had initiated HIV care (reported $CD_4$ count considered a proxy for care), and among them 170,000 were receiving ART. Of those receiving ART, 103,000 (13% of estimated HIV-infected population) had laboratory evidence of viral suppression at least once within 12 months of starting ART. Approximately 15 million women give birth in China each year; in 2013 0.1% was diagnosed with HIV, and mother-to-child transmission (MTCT) was 6.7%.

The ratio of male to female PLHIV in China is 3:1. Most PLHIV in China are adults under 50 years of age; there were fewer than 10,000 children diagnosed with HIV in China in 2011, and 21% were 50 years of age or older. PLWH's residences are geographically concentrated in five southern and western provinces, as well as in areas of central China affected by the plasma donor HIV outbreak of the 1990s.

Over 100,000 new diagnoses of HIV were reported in China in 2014. Approximately two-thirds of newly-diagnosed HIV cases reported heterosexual sex as their sole HIV transmission risk factor; 25% reported male:male sex.[1] The annual total of new HIV diagnoses among persons 15-19 years of

[1] MSM- and drug use-related stigma may contribute to the number of cases attributed to heterosexual transmission despite a low proportion of female PLHIV.

age is double what it was five years ago, which suggests that incidence may be on the rise. National sentinel behavioral surveillance data indicate that HIV prevalence among MSM climbed from 1.4% in 2005 to 7.3% in 2013, while remaining stable among drug users at around 3.3%.

Since 2010, China's HIV treatment guidelines have included recommendations for treatment of HIV-infected individuals regardless of initial CD4 count for members of serodiscordant couples, pregnant women, or those who have TB or a hepatitis co-infection. In 2014, the Government of China (GoC) issued guidelines that have changed treatment eligibility criteria from CD4 <350 to CD4 <500. Discrimination against PLHIV persists as a major problem, as exemplified in recent media reports detailing the legal actions taken by Chinese PLHIV denied medical services, employment, and education. Efforts to mitigate HIV-related discrimination include the Red Ribbon Discussion Panel, which brings together leaders of HIV-focused community-based organizations (CBOs) and policy makers for information sharing and monthly televised HIV public service announcements in high-burden counties served by the "China CARES" program.

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

| **Total** | | | **<15** | | | | **15+** | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | **Female** | | **Male** | | **Female** | | **Male** | |
| | N | % | N | % | N | % | N | % | N | % |
| Total Population (2010) | 1,359,822 (thousands) | | 114,033 (thousands) | 8.4 % | 132,674 (thousands) | 9.8% | 541,606 (thousands) | 39.8% | 571,510 (thousands) | *42.0%* |
| Prevalence (%) | | 0.058% | | | | | | 223000/ 655639000 =0.034% | | 557000/ 704184000 =0.079% |
| AIDS Deaths (per year) | 28000 | | | | | | | | | |
| PLHIV (only by sex) | 780000 | | | | | | 223000 | | 557000 | |
| Incidence Rate (Yr) | | | | | | | | | | |
| New Infections (Yr) | 48000 | | | | | | | | | |
| Annual births | 18,454,700 | | | | | | | | | |
| % >= 1 ANC visit | | 95% | | | | | | | | |
| Pregnant women needing ARVs | 8000 | | | | | | | | | |
| Orphans (maternal, paternal, double) | | | | | | | | | | |
| TB cases (Yr) for 15+ | 1,393,000 | | | | | | 347,000 | | 1,046,000 | |
| TB/HIV Co-infection | 4,700 | | | | | | | | | |
| Males Circumcised | | | | | | | | | | |
| Key populations | | | | | | | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Total MSM* | 3,900,000 | | | | | | | | | |
| MSM HIV Prevalence | 284,700 | 7.3% | | | | | | | | |
| Total FSW | 2,520,000 | | | | | | | | | |
| FSW HIV Prevalence | 5,040 | 0.2% | | | | | | | | |
| Total PWID | 2,260,000 | | | | | | | | | |
| PWID HIV Prevalence | 142,380 | 6.3% | | | | | | | | |

*Table 1.1.2a China: Cascade of HIV diagnosis, care and treatment (12 months, 2013)*

| | | | | HIV Care and Treatment | | | | HIV Testing and Linkage to ART | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Total Population Size Estimate (#)** | **HIV Prevalence (%)** | **Total PLHIV (#)** | **In Care (#)** | **On ART (#)** | **Retained on ART 12 Months (#)** | **Viral Suppression 12 Months** | **Tested for HIV (#)** | **Diagnosed HIV Positive (#)** | **Initiated on ART (#)** |
| Total population | 1,359,822,000 | 0.058% | 780,000 | 330,000 | 170,000 | | 103,000 | 84,210,114 | 74,517 | 45,843 |
| Population < 15 years | | | | | | | | | | |
| Pregnant Women | 15,000,000 | 0.02% (BSS) | 8,000 | | | | | 8,000,000 | 5,300 | 3,922 |
| | | | | | | | | | | |
| MSM | 3,900,000 | 7.3% | | | | | | | | |
| FSW | 2,520,000 | 0.2% | | | | | | | | |
| PWID | 2,260,000 | 6.3% | | | | | | | | |

Laos People's Democratic Republic (Laos)

Although a lower middle income country, with a GNI per capita of 1,450 (USD) in 2013, the Laos economy has been steadily improving with ~8% GDP growth over the last five years. Of the estimated population of 7 million, more than half (55%) is below 20 years of age and more than a third (36.5%) live in urban areas. Much of the population lives in poverty, with inadequate access to water, sanitation, and health care. WHO has classified Laos as one of its health workforce crisis countries. Other areas of health system weakness include health financing, health management information systems (HMIS), health infrastructure, and planning and management of health services.

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

multiple partners; mainly men who traveled frequently for work and engaged commercial sex workers.

Understanding of the epidemic within the military has been limited, as the Lao People's Army was only included in the 2000/2001 and 2004 BBSS. However, high-risk behaviors identified in both surveys included regular alcohol consumption (50%), sex with sex workers (11.5%), and inconsistent condom use (81.8%) with significant rates of gonorrhea and chlamydia (2.9%-10%). Subsequent routine case reporting at ART sites suggests increasing numbers of infections amongst military personnel. A seroprevalence assessment within the Lao People's Army has recently been completed; the results will inform future investments and strategies.

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

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

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

| | Total | | <15 | | | | 15+ | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Female | | Male | | Female | | Male | |
| | N | % | N | % | N | % | N | % | N | % |
| Total Population[2] | 7,027,006 | | 1,106,177 | | 1,159,120 | | 2,391,448 | | 2,370,261 | |
| Prevalence (%) | | 0.18 | | 0.04 | | 0.04 | | 0.22 | | 0.27 |
| AIDS Deaths (per year) | 468 | | 27 | | 29 | | 172 | | 240 | |
| PLHIV | 12,529 | | 440 | | 461 | | 5,305 | | 6,323 | |
| Incidence Rate (Yr) | | 0.015 | | 0.005 | | 0.005 | | 0.020 | | 0.020 |
| New Infections (Yr) | 1,057 | | 54 | | 57 | | 384 | | 562 | |
| Annual births[3] | 181,000 | | | | | | | | | |
| % >= 1 ANC visit | 54.2 | | | | | | | | | |
| Pregnant women needing ARVs | 307 | | | | | | | | | |
| Orphans (maternal, paternal, double) | 158,839 | | | | | | | | | |

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

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

| Key Populations | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Total MSM[4] | 54,898 | | | | | | | | | |
| MSM HIV Prevalence[5] | | 1.6 | | | | | | | | |
| Total FSW | 14,490 | | | | | | | | | |
| FSW HIV Prevalence [6] | | 1.3 | | | | | | | | |
| Total PWID [7] | 1,280 | | | | | | | | | |
| PWID HIV Prevalence [8] | | 1.5 | | | | | | | | |

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

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

## Thailand

Although an upper-middle income country (with a GNI per capita of 5,340 USD in 2013), Thailand's economic growth has slowed in recent years compared to other developing East Asian countries. Poverty continues to be an important challenge, particularly among the estimated 52% of the population (64.9 million in 2014) that live in rural areas. Basic health systems infrastructure and access to clean water and sanitation are nearly ubiquitous.

Thailand is home to approximately 446,000 PLHIV. Overall HIV incidence has decreased, but incidence and prevalence remain high among key populations, particularly MSM and TG women and sex workers in larger urban areas. Based on the Asian Epidemic Model (AEM), 8,184 new HIV infections will occur during 2015; 43% through transmission among MSM, 11% among sex workers and their clients, and 11% among PWID.

[4] Source for this and for Total FSW was AEM 2013.

[5] 2014 IBBS among MSM (RDS sampling)

[6] 2014 IBBS among venue-based FSW (TLS sampling)

[7] 2014 UNOCD report

[8] 2010 survey in 2 provinces (Phongsalyand Houaphanh)

The AEM projects that 30% of new infections in 2015 will be through spousal transmission, especially (22%) from husbands to their wives. While it continues to be high, the proportion of all new infections that occur through spousal transmission is decreasing (down from nearly 38% in 2010) while this proportion is increasing among MSM (up from 33% in 2010).

As of the end of 2014, 349,816 PLHIV had registered for care with the government, 284,578 (81.3%) had started ART, 258,183 (73.8%) were continuing to take ART at the end of September 2014, and 191,920 (54.8%) had viral load results <50 copies/ml. Although the existing Thai health services infrastructure is robust, the quality of care and treatment remains inconsistent and services are directed nationally in an effort to provide access for all. Despite a strong national PMTCT program, MTCT remains above 2% in Thailand and there are leaks in the cascade for HIV-infected infants and HIV-infected mothers after delivery. A 2012 evaluation found that 39% of HIV-exposed infants born during 2008-2011 did not receive early infant diagnosis (EID) and only 157 (37%) HIV-infected infants received ART within one year of age.

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

| | Total | | <15 | | | | 15+ | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Female | | Male | | Female | | Male | |
| | N | % | N | % | N | % | N | % | N | % |
| Total Population[9] | 64,871,000 | | 5,847,000 | 9.01 | 6,107,000 | 9.41 | 27,483,000 | 42.37 | 25,434,000 | 39.21 |
| Prevalence (%)[10] | | 0.8 | | 0.0573 | | 0.0572 | | 0.69 | | 0.99 |
| AIDS Deaths (per year) | 20,494 | | 71 | | 74 | | 6,127 | | 14,197 | |
| PLHIV | 446,368 | | 3,780 | | 3,959 | | 189,782 | | 248,847 | |
| Incidence Rate (Yr) (Population age 15+) | | 0.015 | | 0.001 | | 0.001 | | 0.01 | | 0.02 |
| New Infections (Yr)[11] | 7,800 | | 51 | | 54 | | 1,944 | | 5,751 | |
| Annual births[12] | 776,370 | | | | | | | | | |
| % >= 1 ANC visit | 763,172 | 98.3 | | | | | 736,997 | 98.3 | | |
| Pregnant women needing ARVs | 4,827 | 0.62 | | | | | | | | |
| Orphans (maternal, paternal, double)[13] | 301,865 | | | | | | | | | |
| TB cases (Yr)[14] | 86,000 | | | | | | | | | |
| TB/HIV Co-infection[15] | | 13 | | | | | | | | |
| Key Populations | | | | | | | | | | |
| Total MSM[16] | 504,248 | 3 | | | | | | | | |

[9] NESDB, 2013, (Pop projection 2010-2040)
[10] For Prevalence (%), AIDS Deaths (per year), PLHIV, Incidence Rate (Yr), and New Infections: Adult > 15 years: AEM 2014 and Children <15: SPECTRUM 2014
[11] MOI 2013
[12] ANC and ARV data: Department of Health
[13] AIDS Access Foundation Survey report
[14] WHO 2012 (Register 60,000)
[15] TB and HIV concept note (GF) 2014
[16] Total MSM, FSW, and PWID: National Operation Plan for Ending AIDS 2015-2019

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| MSM HIV Prevalence[17] | 41,299 | 7.9 | | | | | | | | |
| Total FSW | 132,897 | | | | | | | | | |
| FSW HIV Prevalence | 2,698 | 1.99 | | | | | | | | |
| Total PWID | 40,300 | | | | | | | | | |
| PWID HIV Prevalence | 11,898 | 29.7 | | | | | | | | |

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

| | 2014: Estimated population | | | HIV Care and Treatment Cascade by Sep 2014 | | | | 2014: HIV Testing and Linkage to ART | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Total Population Size Estimate** | **HIV Prevalence** | **Total PLHIV alive** | **In Care[18]** | **On ART** | **Alive and retained on ART 12 Months** | **Viral Suppression[19]** | **Tested for HIV** | **Diagnosed HIV Positive** | **Initiated on ART** |
| | (#) | (%) | (#) | (#) | (#) | (#) | 12 Months | (#) | (#) | (#) |
| Total population | 64,871,000 | 0.80 | 446,368 | 349,816 | 284,578 | 258,183 | 191,920 | 639,209 | 18,060 | 14,201 |
| Population < 15 years | 11,954,000 | 0.06 | 7,739 | 6,255 | 4,875 | 4,498 | 3,094 | 18,061 | 284 | 195 |
| Pregnant Women | 800,000 | 0.62 | 4,960 | 3,761 | 2,694 | 1,405 | 734 | | | |
| Key populations[20] | | | | | | | | | | |
| MSM | 504,248 | 7.9 | 41,299 | 4,124 | 2,687 | 2,090 | 1,123 | 8,539 | 1,710 | |
| FSW | 132,897 | 1.99 | 2,698 | 503 | 347 | 246 | 146 | 3,944 | 77 | |
| PWID | 40,300 | 29.7 | 10,898 | 3,401 | 2,195 | 1,432 | 930 | 1,233 | 152 | |

## 1.2 Investment Profile

China

The goal of PEPFAR funding in China is provision of TA to the national HIV response. With the last of the grant money from Global Fund fully spent in 2014, the GoC now funds well over 99% of China's national HIV response. Merck Foundation provides $2 million annually for HIV programs in Chongqing, Fujian, and Sichuan, but plans to phase out all support by the end of 2016. The majority of PEPFAR dollars spent in China fund the staffing costs of CDC/China technical experts, who work closely with GoC counterparts at national, provincial, and local levels. PEPFAR China has three cooperative agreements, one with the HIV division of China's lead public health agency, the China Centers for Disease Control (China-CDC) and a second with a Chinese NGO devoted to PLHIV: AIDS Care China (ACC). The third is a cooperative agreement with I-TECH to develop a nursing for HIV/AIDS patients manual, which will be rolled out nationally by the end of FY 2016. The goal of the PEPFAR China's cooperative agreement with the China-CDC is provision of programmatic funds to carry out projects that serve the goal of TA for China's HIV response.

[17] MSM, FSW, and PWID HIV prevalence: AEM 2014
[18] Cumulative registered to care and had records in NAP-Plus since 2007
[19] Viral Suppression = <50 copies/ml for Thailand
[20] Only those who disclosed themselves or had records as KP since 2007

These cooperative agreement funds are distributed through the China-CDC's national office to implementing partners within the Chinese government in PEPFAR focus provinces.

China-CDC sits within the National Health and Family Planning Commission (NHFPC) of the GoC. Its HIV division (NCAIDS) is responsible for HIV surveillance, prevention programming, M&E, and training of public health professionals throughout China. It has offices at multiple jurisdictional levels: provincial, prefecture/city, and county. HIV treatment services and maternal/child health services are provided by two different agencies within the NHFPC: the Chinese public hospital system and the Maternal Child Health Agency. All NHFPC agencies function at the most local level (including provision of ART in some areas) through primary health centers (of three different levels based upon the size of the population they serve: county, township, and village) located throughout China.

*Table 1.2.1a China: Investment Profile by Program Area (2013)*

| Program Area | Total Expenditure (USD)[21] | % PEPFAR | % GF[22] | % GoC | % Other |
|---|---|---|---|---|---|
| Clinical care, treatment, and support | 360,000,000 | 0.12% | 5.15% | 94.46% | 0.27% |
| Community-based care | NA | | | | |
| PMTCT | 130,000,000 | 0.015% | 5.13% | 94.85% | 0 |
| HTC | NA | | | | |
| VMMC | NA | | | | |
| Priority population prevention | NA | | | | |
| Key population prevention | NA | | | | |
| OVC | NA | | | | |
| Laboratory | NA | | | | |
| SI, Surveys and Surveillance | NA | | | | |
| HSS | NA | | | | |
| **Total** | 720,000,000USD 100% | 1,500,000 USD 0.21% | 37,100,000 USD 5.15% | 680,000,000 USD 94.50% | 1,000,000 USD 0.14% |

[21] Due to the sensitive nature of government spending information, ARP is unable to obtain all exact expenditure amounts by program area from GoC.

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

*Table 1.2.2a China: Procurement Profile for Key Commodities*[23]

*Table 1.2.3a China: Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives*[24]

| Funding Source | Total Non-COP Resources | Non-COP Resources Co-Funding PEPFAR IMs | # Co-Funded IMs | PEPFAR COP Co-Funding Contribution | Objectives |
|---|---|---|---|---|---|
| NIH | $1,350,000 | N/A | N/A | N/A | Ten grants were given to conduct research activities in areas including HIV vaccine, environmental health, mental health, malaria, and population health assessments. |
| Private Sector | $65,000 | $65,000 | 1 | $15,000 | The PPP supports a center at Zhaojue Hospital and established another at Xichang Infectious Diseases Hospital to Liangshan to train clinicians on AIDS clinical management to ultimately decrease HIV mortality and incidence. USG gives TA to build capacity for rural AIDS clinical treatment. |
| TOTAL | $1,415,000 | $65,000 | 1 | $15,000 | n/a |

Laos

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

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

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

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

[23] PEPFAR does not provide procurement in China

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

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

| Program Area | Total Expenditure (USD) | % PEPFAR | % GF | % GOL | % Other[25] |
|---|---|---|---|---|---|
| Clinical care, treatment, and support | 1,394,775 | - | 92.30 | 7.70 | - |
| Community-based care | | | | | |
| PMTCT | 80,173 | 48.64 | - | - | 51.36 |
| HTC | 166,396 | 6.01 | 42.34 | - | 51.65 |
| VMMC | | | | | |
| Priority population prevention - Youth | | | | | |
| Key population prevention | 2,526,121 | 38.12 | 41.10 | - | 20.78 |
| OVC | | | | | |
| Laboratory | | | | | |
| SI, Surveys and Surveillance | 437,467 | 12.12 | 75.57 | 0.00 | 12.32 |
| HSS | 4,961,259 | 1.05 | 43.81 | 35.07 | 20.08 |
| Other | 433,575 | 0.00 | 63.94 | 0.00 | 36.06 |
| **Total** | 9,999,766 (100%) | 1,116,974 (11.17%) | 5,176,879 (51.77%) | 1,846,957 (18.47%) | 1,858,956 (18.59%) |

*Table 1.2.2b Laos: Procurement Profile for Key Commodities*[26]

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

| Funding Source | Total Non-COP Resources | Non-COP Resources Co-Funding PEPFAR IMs | # Co-Funded IMs | PEPFAR COP Co-Funding Contribution | Objectives |
|---|---|---|---|---|---|
| USAID MCH | $0 | N/A | N/A | N/A | N/A |
| USAID TB | $0 | N/A | N/A | N/A | N/A |
| USAID Malaria | $0 | N/A | N/A | N/A | N/A |
| Family Planning | $0 | N/A | N/A | N/A | N/A |
| NIH | $0 | N/A | N/A | N/A | N/A |
| CDC NCD | $0 | N/A | N/A | N/A | N/A |
| Peace Corps | $0 | N/A | N/A | N/A | N/A |
| DOD Ebola | $0 | N/A | N/A | N/A | N/A |
| MCC | $0 | N/A | N/A | N/A | N/A |
| Private Sector | Not available | 0 | 0 | 0 | N/A |
| PEPFAR Central Initiatives | LCI: $280,000<br>USAID KPCF: $165,000<br>CDC KPCF: $60,000 | CDC KPCF: $60,000 | 2 (1 CDC, 1 USAID) | USAID LCI: $40,000<br>KPCF: $240,000<br>CDC KPCF: $10,000 | LCI: 1. To improve technical and organizational capacity of consortium partners to provide effective, cost-efficient, and sustainable technical assistance to enhance, broaden, and expand local and regional civil society advocacy efforts, and; 2. To improve capacity of local and regional civil |

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

[26] PEPFAR does not provide procurement in Laos

| | | | | | |
|---|---|---|---|---|---|
| | | | | | society organizations to successfully award and program small grants to advocate for improved programs and policies for key affected populations, as well as increase accountability of national HIV and AIDS responses.<br>KPCF: To help Laos develop, demonstrate, and disseminate enhanced intervention models to intensify HIV, STI, and TB case finding among MSM, TG, and other key populations and to support early and sustained access to prevention, care, and treatment services. |
| TOTAL | $505,000 | $60,000 | 2 | $290,000 | |

Thailand

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

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

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

| **Program Area** | **Total Expenditure (USD)** | **% PEPFAR** | **% GF** | **% RTG** | **% Other[27]** |
|---|---|---|---|---|---|
| Clinical care, treatment, and support | 193,823,307 | 0.04 | 1.60 | 98.36 | 0.01 |
| PMTCT | 2,341,539 | 1.47 | 0.00 | 98.18 | 0.35 |
| HTC | 2,386,610 | 0.00 | 0.00 | 99.99 | 0.01 |
| Priority population prevention - Youth | 3,584,625 | 1.31 | 89.31 | 8.41 | 0.97 |
| Key population prevention | 5,421,317 | 6.42 | 78.33 | 13.75 | 1.50 |
| OVC | 796,718 | 0.00 | 83.67 | 7.47 | 8.87 |
| SI, Surveys and Surveillance | 930,823 | 18.60 | 47.33 | 34.07 | 0.00 |
| HSS | 9,292,281 | 11.52 | 40.95 | 44.39 | 3.14 |
| **Total** | 218,577,221 (100%) | 1,116,974 (0.80%) | 5,176,879 (7.07%) | 1,846,957 (91.90%) | 1,858,956 (0.23%) |

[27] UN/WHO

*Table 1.2.2c Thailand: Procurement Profile for Key Commodities*[28]

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

| Funding Source | Total Non-COP Resources | Non-COP Resources Co-Funding PEPFAR IMs | # Co-Funded IMs | PEPFAR COP Co-Funding Contribution | Objectives |
|---|---|---|---|---|---|
| USAID MCH | $0 | 0 | 0 | 0 | N/A |
| USAID TB | $199,000 | $0 | 0 | $0 | USAID TB activities focused on supporting MDR-TB control; providing technical guidance on MDR-TB management; supporting TB SI; and strengthening national TB surveillance systems (M & E). |
| USAID Malaria | $358,000 | N/A | N/A | N/A | In FY 2014, USAID supported community-based malaria control services in high malaria transmission zones of eastern Burma, along the Thai border, as well as building partnerships with Thailand's Bureau of Vector-Borne Diseases (BVBD) for similar work on the Thai side of the Burmese and Cambodian borders. Supported the integration of malaria services into health promotion hospitals in Thailand. |
| Family Planning | $0 | N/A | N/A | N/A | N/A |
| NIH | $2,190,000 | N/A | 0 | 0 | Covers 11 awards to four Thai universities in various areas of research including MDR-TB, HIV, occupational health, dengue, and others |
| CDC NCD | $312,000 | $273,000 | 1 | $0 | Thailand MoPH coag one in which multiple non-HIV programs, including NCD, buy into. |
| Peace Corps | $2,300,000 | N/A | 0 | $0 | Thailand, Peace Corps addresses youth development with goal that Thai youth will be prepared for roles as healthy, productive citizens who contribute positively to their communities. The program also improves English teaching with the goal of assisting teachers, students, and community members in gaining access to personal, professional, and academic opportunities through English acquisition. |
| DOD Ebola | 0 | N/A | N/A | N/A | N/A |
| MCC | 0 | N/A | N/A | N/A | N/A |
| Private Sector | Not available | 0 | 0 | 0 | N/A |
| PEPFAR Central Initiatives | LCI: $420,000<br>USAID KPCF: $500,000<br>USAID KPIS: $700,000<br>CDC KPIS: $520,000<br>CDC KPCF: $240,000 | CDC KPIS: $500,000<br>CDC KPCF: $200,000 | 3 (1 CDC, 2 USAID) | USAID LCI: $60,000<br>KPCF: $400,000<br>KPIS: $500,000<br>CDC KPCF: $270,000 | LCI: 1. To improve technical and organizational capacity of consortium partners to provide effective, cost-efficient, and sustainable technical assistance to enhance, broaden, and expand local and regional civil society advocacy efforts, and;<br>2. To improve capacity of local and regional civil society organizations to successfully award and program small grants to advocate for improved programs and policies for key affected populations, as well as increase accountability of national HIV and AIDS responses.<br>KPCF: To help Thailand develop, demonstrate, and disseminate enhanced intervention models to intensify HIV, STI, and TB case finding among MSM, TG, and other key populations and to support early and sustained access to prevention, care, and |

[28] PEPFAR does not provide procurement in Thailand

| | | | | | |
|---|---|---|---|---|---|
| | | | | | treatment services.<br>KPIS: To evaluate the feasibility of a community-based Test and Treat approach that targets men who have sex with men (MSM) and transgender women (TG) populations through a model involving two linked strategies; 1) community-based service delivery settings and 2) enhanced community-based outreach interventions for increasing uptake of services. |
| TOTAL | $7,739,000 | $973,000 | 3 | $1,230,000 | CDC NCD and CDC DGHA Thailand contribute to the same IM (MoPH) |

**1.3 National Sustainability Profile**

ARP places a high priority on sustainable epidemic control and to that end conducted preliminary assessments of sustainability in China and Thailand, the two countries in ARP that receive the largest portion of regional PEPFAR funding.

China

China's sustainability index was calculated by USG staff to familiarize technical staff with the tool and the data inputs required. Findings reported here should be considered preliminary, having been generated without involvement of Chinese government partners, and approximate, given that a limited range of data was available.

*[REDACTED]*

PEPFAR China is working to improve access and demand by introducing rapid HIV diagnostics in settings serving key populations, and piloting feasibility of self-sample collection for a home HIV test. To improve human resource capacity, PEPFAR China established and supports (to a limited extent) three clinical training centers in three provinces that have trained more than 300 doctors cumulatively by end of 2014. To improve oversight and stewardship, PEPFAR supports ACC to provide high quality care and support services to PLHIV, which has enabled them to secure more government funding and scale up services. Finally, PEPFAR China technical staff work alongside counterparts in Chinese public health agencies to assist in QI efforts for surveillance, M&E, laboratory support, and HIV clinical services.

Thailand

Thailand's SID was prepared through a preliminary USG review of its assistance to the RTG and its agencies and institutions, publically reported national information, and data from national HIV systems. The Thai Government was not involved in the preparation of the SID, but results from the Site Improvement through Monitoring System (SIMS) above-site assessments that had been shared with the Thai Government were used to inform elements of the SID.

Of the 15 elements that were evaluated for Thailand, eleven were found to be "sustained" (light or dark green), with the *Performance Data* and *Resource Commitments* elements considered particularly sustained (dark green).

*[REDACTED]*Note that in general there were found to be limitations to the efficacy of the SID in Thailand where the policy environment is de-centralized. For example, an element may have had a high score when considering it at the national level, without reflecting the real-life quality or sustainability at lower levels of the health system.

### 1.4 Alignment of PEPFAR investments geographically to disease burden

China

Most (79%) of China's HIV diagnoses have been reported in residents of 9/31 provinces (Chongqing, Guangdong, Guangxi, Guizhou, Henan, Hunan, Sichuan, Xinjiang, and Yunnan) with a corporate population of 533 million (38% of China's ~1.4 billion population). Even within the most heavily affected Chinese provinces, there is substantial geographic variability in residence of PLWH at the time of diagnosis. This fact, combined with the rapid, ongoing urbanization and mobility of the Chinese population, challenge the identification of current geographic "hotspots" for HIV. Serial cross-sectional biobehavioral surveys point to steadily increasing HIV seroprevalence among MSM in China, with level or slightly declining HIV seroprevalence in recent years among PWID and FSW. Because most MSM in China reside in urban areas, the emerging geographic focus of HIV in China is urban gay men, especially in cities within provinces that have historically held the highest concentration of PLWH. Beginning in FY2015, PEPFAR-China will focus its field activities on urban MSM, with projects planned for 15 urban communities with a combined population of 60 million. With the exception of Tianjin, these urban communities are located in 5 of the 9 high HIV prevalence Chinese provinces: Guangxi, Guizhou, Hunan, Xinjiang, and Yunnan (Figure). Thirteen of the 15 urban communities have recent a HIV seroprevalence measurement drawn from a sample of MSM, which range from 7% to 25% (Table).

PEPFAR-China will continue to support two FSW-focused "reach, test, treat, and retain" field projects in border areas of Yunnan and Guanxi provinces through the end of FY'16 with the goal of achieving full implementation of province-wide "test-and-treat" policies for HIV-diagnosed cross-border FSWs prior to phase-out.

| Province | SNU (city) | Total population (millions) | *[REDACTED]* |
|---|---|---|---|
| Yunnan | Kunming | 7.3 | *[REDACTED]* |
| | Ruili | 0.2 | *[REDACTED]* |
| Guangxi | Nanning | 7.9 | *[REDACTED]* |
| | Liuzhou | 0.9 | *[REDACTED]* |
| | Beihai | 1.5 | *[REDACTED]* |
| Xinjiang | Urumqi | 3.5 | *[REDACTED]* |
| | Kashi | 0.7 | *[REDACTED]* |
| | Yining | 0.6 | *[REDACTED]* |
| Guizhou | Zunyi | 6.1 | *[REDACTED]* |
| | Xinyi | 0.8 | *[REDACTED]* |
| | Sandu | 0.3 | *[REDACTED]* |

| | | | |
|---|---|---|---|
| | Guiyang | 4.7 | *[REDACTED]* |
| Tianjin | Hongqiao | 0.5 | *[REDACTED]* |
| Hunan | Changsha | 7.2 | *[REDACTED]* |
| | Changde | 6 | *[REDACTED]* |

Laos and Thailand

According to an analysis conducted of 2014 ARP expenditure in Thailand, the majority (60%, 3.3 million USD) of non-M&O PEPFAR expenditure in Thailand was applied at the national level. An additional 6% was invested in country-to-country technical collaborations between Thailand and neighboring national HIV programs. Most (92%) of national-level expenditure was invested in HTC, CBCTS, and FBCTS (in that order), reflecting an emphasis on broadly expanding coverage and quality of HIV testing and treatment. Other national-level PEPFAR investments in Thailand were distributed across six other areas: HSS/SI, Surveillance, MSM/TG women, PMTCT, FSW, and Lab (in that order).

A third (34%, 1.9 million USD) of PEPFAR FY2014 expenditure in Thailand was at the sub-national (provincial) level. As with national-level expenditure, the majority was invested in HTC and CBCTS/FBCTS. Geographically, 78.2% of this investment was made in three provinces (Bangkok, Chonburi, and Chiang Mai) with the highest HIV prevalence, largest estimated numbers of MSM/TG women, and largest combined numbers of key populations (i.e., FSW, MSM/TG women, and PWID) in Thailand. ARP demonstration pilots and operational research initiatives (and central initiatives, such as Key Populations Challenge Fund/KPCF and Key Populations Implementation Science/KPIS) include these provinces within their geographic scope.

*[REDACTED] Figure 1.4.2.b-1 Thailand: Percent of PLHIV and Expenditure per PLHIV by SNU in 2014 (part 1 of 2)*

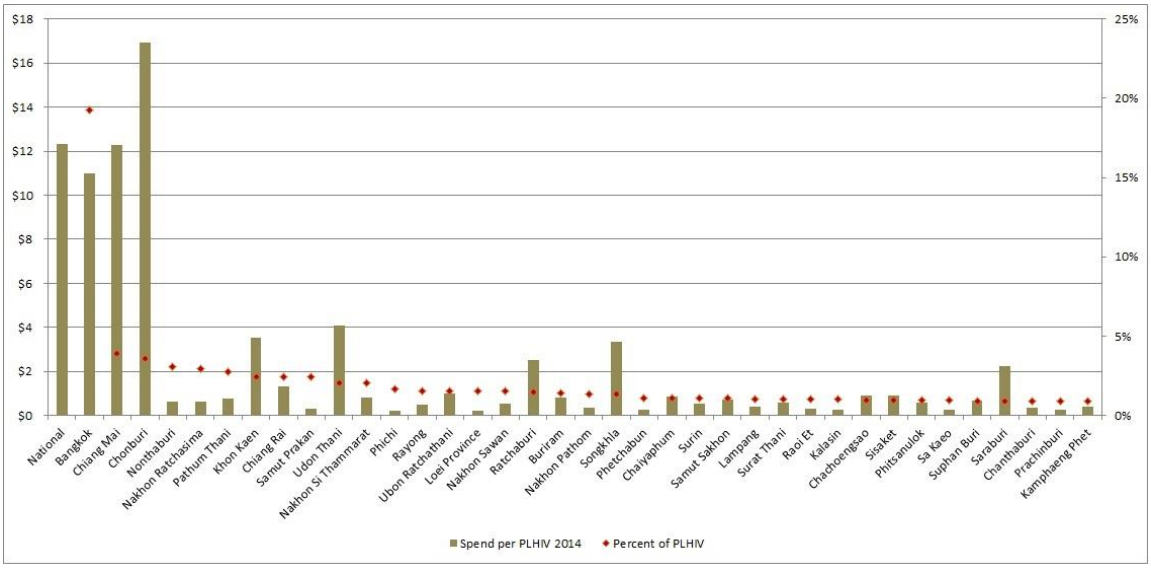



*Figure 1.4.2.b-2 Thailand: Percent of PLHIV and Expenditure per PLHIV by SNU in 2014 (part 2 of 2)*

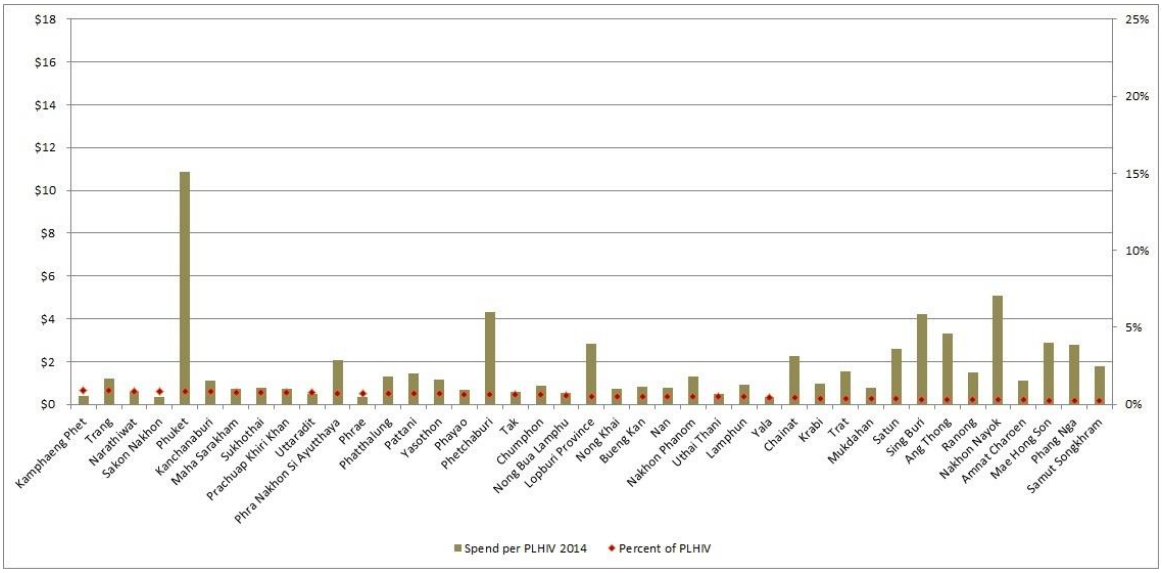


*Figure 1.4.4.b-1 Thailand: Total PEPFAR Expenditure and Total PLHIV by SNU in FY14 (part 1 of 2)*

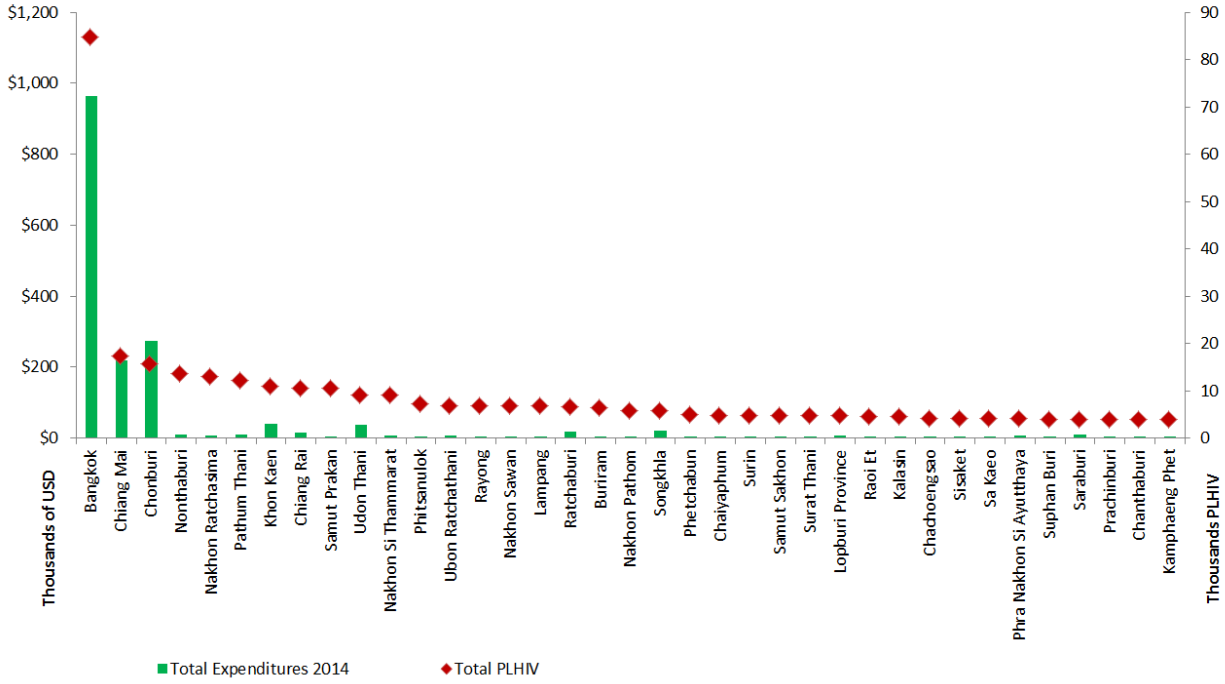
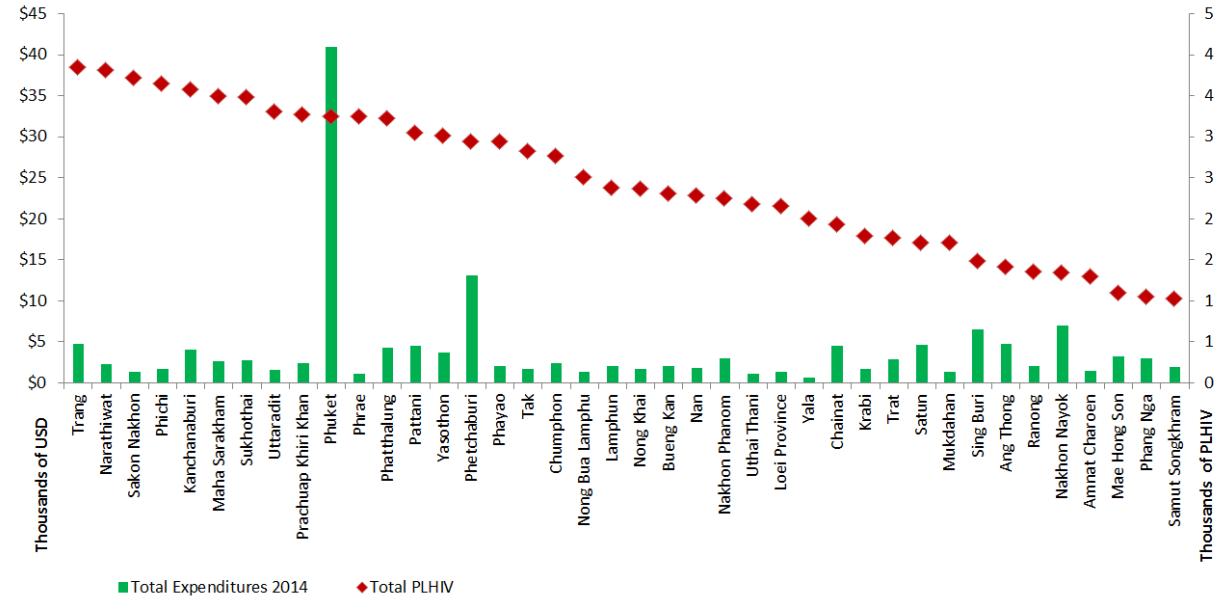



*Figure 1.4.4.b-2 Thailand: Total PEPFAR Expenditure and Total PLHIV by SNU in FY14 (part 2 of 2)*




## 1.5 Stakeholder Engagement

Since 2013, CDC has been the only PEPFAR implementing agency in China. PEPFAR China's primary stakeholder, the China-CDC, was engaged fully in the process of 2015 ROP development

through monthly meetings with PEPFAR China leadership throughout the year, along with frequent contact among project officers between meetings. PEPFAR China also engaged fully with groups from civil society and the private sector on ROP development. Several NGOs with a focus on MSM health in focus provinces were contacted regularly and provided input to planning. PEPFAR China's major NGO implementing partner, ACC, was also an active participant in the planning process. ACC communicated their suggestions for how to ensure PLHIV they serve are initiated and maintained on ART through regular discussions and site visits.

In Laos and Thailand, ARP plans and implements all of its activities in collaboration with Laos and Thai government institutions, multilaterals, international agencies, civil society, and domestic and international NGOs responding to the HIV epidemic in the two countries. To that end, in FY15 ARP consulted with stakeholders through formal and informal, ad hoc and regular, project-specific, and national strategic meetings and discussions. Plans and priorities described in this ROP reflect these exchanges and consensus that was reached.

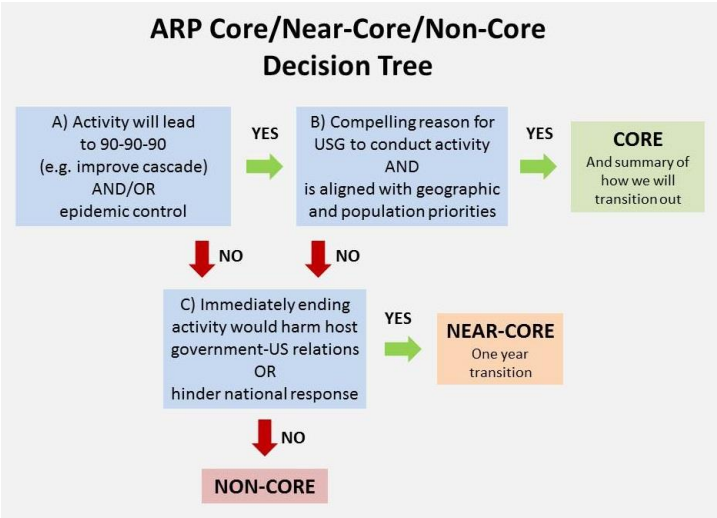
Civil society was heavily engaged in these discussions and actively participated in FY15 strategy setting and project design, implementation, and review efforts, heavily informing ROP 2015 plans and priorities.

As a voting member of the Global Fund CCM in Laos and a donor observer on the CCM in Thailand, ARP plans are aligned with the Global Fund. ARP plans and priorities presented in this ROP were refined and finalized with Government stakeholders during a national consultative process in Laos (in early March) and in Thailand through a series of consultations leading up to the Thai Ministry of Public Health's HIV Sub-steering Committee meeting in mid-March, at which time final feedback from these core national stakeholders was used to reach consensus on work plans for FY16.

## 2.0 Core, Near-Core and Non-Core Activities

During ARP Portfolio Review in February 2015, participants from PEPFAR implementing agencies discussed PEPFAR's vision, analyzed the China, Laos, and Thailand contexts and epidemics, and reviewed the alignment of PEPFAR FY15 investments to the epidemics in those countries. Agencies then reached consensus the priority populations and geographical locations for FY16 activities within those three countries.

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



Participants used the tool to reach determine whether current and planned PEPFAR implementing agencies were *Core*, *Near-core*, or *Non-core*. The analysis was subsequently refined during the ROP review process.

These discussions led to a number of important ARP decisions, including:

- The phase-out of Peace Corps activities in FY16. Peace Corps will not participate as a partner agency in the ARP in FY17.
- The Department of Defense will review the results of the recently completed seroprevalence assessment within the Lao People's Army to determine the need for future participation in the ARP.
- A concentration of efforts on improving the cascade for MSM and TG women in priority geographic areas.
- The determination to end several activities that were considered to be non-core.
- The decision to concentrate several more broadly focused activities (e.g., covering the general population or the entire country) on priority areas and populations.
- The decision to eliminate some agency core activities (because they were potentially redundant to another agency's) and shift that investment to activities that would increase the epidemic impact of PEPFAR's work.

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

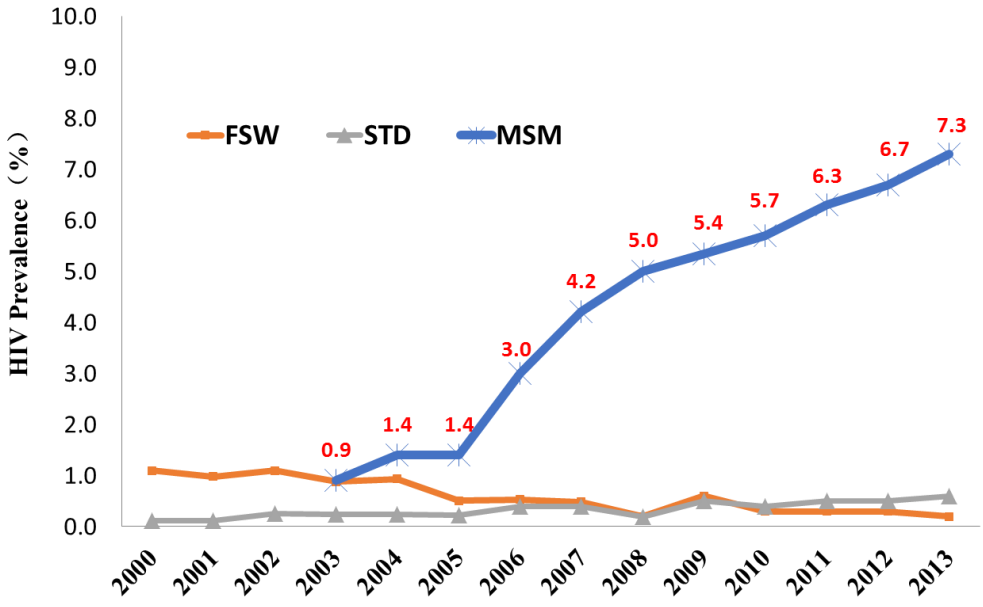
# 3.0 Geographic and Population Prioritization

**China**

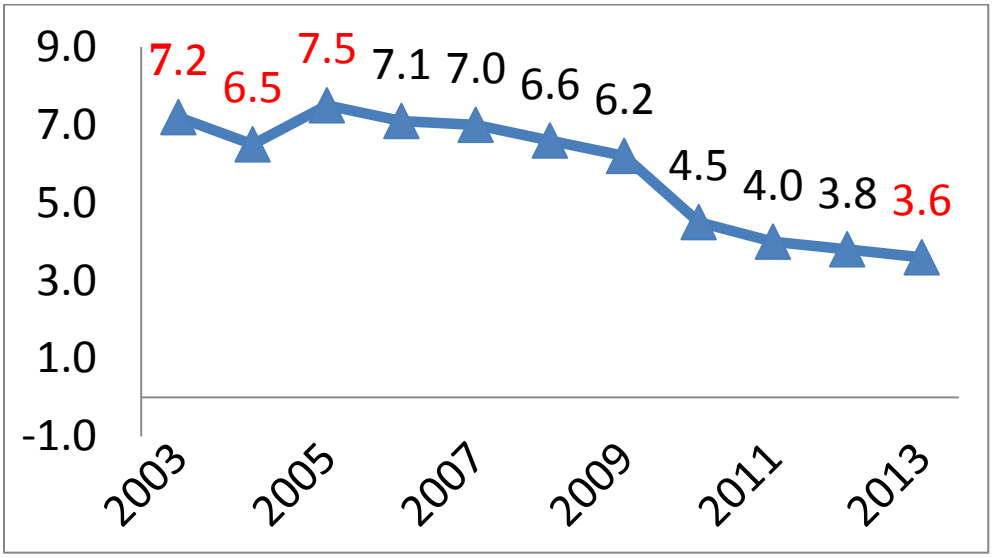
Several data sources informed the priority-setting process: HIV case surveillance data, national HIV treatment database, HIV sentinel surveillance among key populations, PEPFAR program data, and published studies that used these and other data sources.

These sources collectively point to the presence of an HIV epidemic in China that is concentrated among high-risk populations (MSM, PWID, and female sex workers) and in specific geographic regions. HIV sentinel surveillance, which measures serial cross-sectional HIV prevalence among key populations, indicates a steady rise in HIV prevalence among MSM over the last ten years, and declining seroprevalence among FSW and PWID. HIV-related stigma poses serious challenges to PLHIV, and the capacity of NGOs to mobilize against HIV is limited. PEPFAR China thus focuses its TA in these areas and primarily among MSM.

*HIV seroprevalence among FSW, MSM, and clients visiting STD clinics in China, 2000-2013, HIV Sentinel Surveillance*



*HIV seroprevalence among PWID*
*in China, 2003-2013, HIV Sentinel Surveillance*




To maximize its impact in controlling the epidemic, in FY16 PEPFAR China will devote its resources to pilot projects intended to demonstrate the feasibility and effectiveness of strategies for reaching MSM for testing, treatment, care, and prevention, as well as for guideline support and policy development at national and provincial levels to optimize the response based upon findings of these pilot project and evolving international standards.

**Laos and Thailand**

In both Laos and Thailand, the HIV burden is concentrated among MSM and TG women in urban settings. According to official government estimates based on the AEM, 43% of new infections in Thailand in 2015 and more than 35% percent of new infections in Laos are forecast to occur among MSM and TG women in the coming years – with proportional increases in new infections occurring among these populations over time.

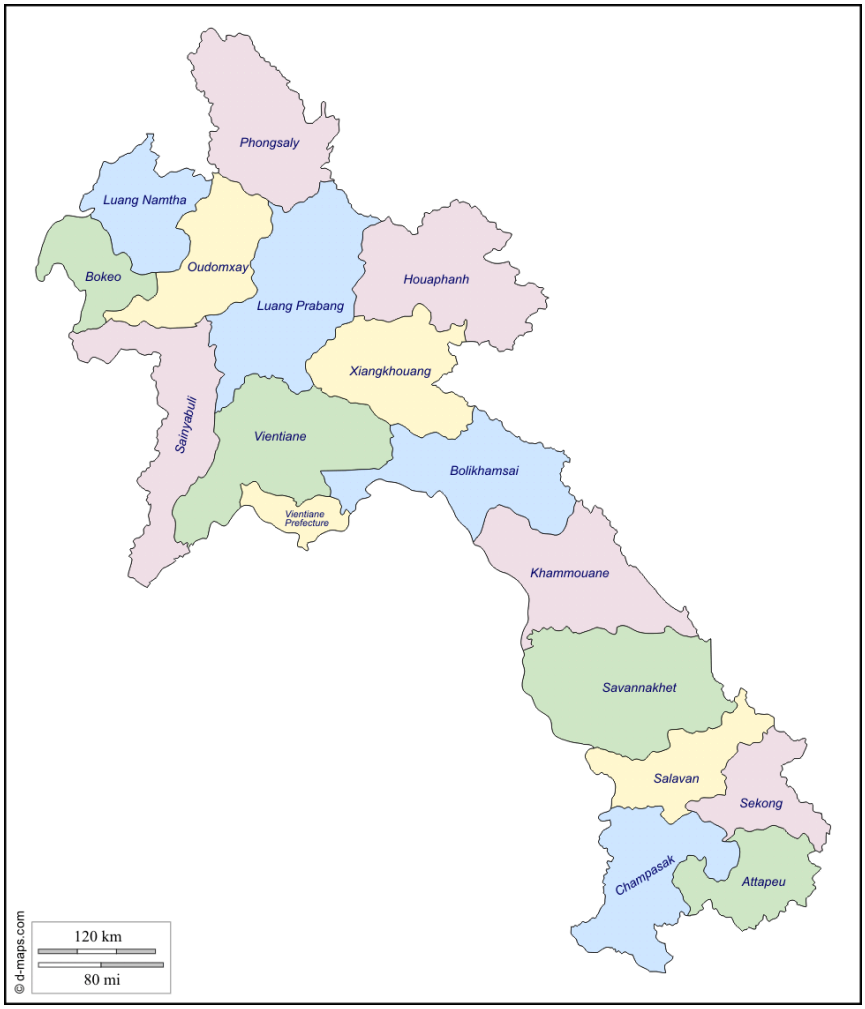
In addition, population size estimates and IBBS data indicate that the HIV burden among MSM and TG women is greatest in specific provincial and municipal settings. For example, the RTG estimates the number of at-risk MSM in Bangkok to be at least four times larger than the number in Chonburi, the province with the second-highest MSM population size estimate. While the national HIV prevalence estimate among MSM in Thailand is 7.9%, the estimated prevalence among MSM in Bangkok is more than 24%. In Laos, MSM size estimates are not available, but the government estimates that the population sizes are greatest in Vientiane Capital, Champasak, and Savannakhet, the three provinces with the highest estimated HIV prevalence among MSM (3.9%, 1.2%, and 0.7%, respectively).

In Thailand, only 26% of MSM are estimated to have had an HIV test and received their result in the past year – a testing rate that is lower than for any other key population. Low testing rates in

this population signify particularly low treatment coverage in a population in which antiretroviral-based prevention strategies could have great benefits. Furthermore, once diagnosed with HIV infection, only 44% of MSM in Thailand are registered for care, a registration rate that is lower than for any other population and almost 50% lower than the case registration rate for PWID who are diagnosed with HIV.

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

In Thailand, ARP will collaborate to improve the quality and efficiency of clinical and community programming targeting MSM and TG women in Bangkok, Chiang Mai, Chonburi, Songkla, Khon Kaen, and Udonthani (see *Figure 1.4.1b-1*). While not a priority province for ARP, targeted activities will be conducted in Phuket to achieve greater epidemic control. For example, HIV prevalence estimates among MSM in Bangkok, Chiang Mai, Chonburi, and Phuket are particularly high – from 24.4% to 23% to 8% to 14% respectively – and an estimated 35% of all targeted MSM and TG women beneficiaries reside in these provinces.




These settings reflect a constricted geographical focus from previous years – with the elimination of service delivery activities in a number of other provinces and populations – while maintaining a footprint necessary to sustain ROP-supported activities that are critical to the success of special initiatives like the KPIS and KPCF projects. ARP was specifically asked to leverage ROP resources in budgeting for these activities. In Thailand, ARP implements KPCF in Bangkok, Khon

Kaen, Phuket, and Udonthani. KPIS activities are implemented in Bangkok, Khon Kaen, and Udonthani.

In Laos, ARP will similarly collaborate to improve cascade outcomes for MSM and TG women in clinical and community settings in Vientiane, Champasak, and Savanakhet (see insert map), as well as military and their family members who are otherwise unable to access health facilities.

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

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

# 4.0 Program Activities for Epidemic Control in Priority Locations and Populations

## 4.1 Targets for priority locations and populations

China

PEPFAR China's targets reflect its program orientation of technical collaboration with the GoC. As such, targets typically reflect the estimated outputs of field activities where a new intervention strategy is being piloted. Outputs such as number of persons tested and number of persons treated therefore reflect the small, pilot scope of such projects where the intent is not (for example) treatment coverage, but rather demonstration of the feasibility and effectiveness of a new strategy for case finding and linkage-to-care. PEPFAR-China utilizes the required PEPFAR indicators to monitor the output of pilot programs, but evaluates their outcome using custom indicators as well as other means of assessing their impact on national HIV policy. Many approaches have been and continue to be supported by PEPFAR China to help GoC scale up and increase ART initiation. A one-stop strategy (defined as consolidation of usually disparate HIV services in one place, at one time) is promoted to reduce loss-to-follow-up during referral processes. Treatment as prevention strategy for high risk populations including FSW and MSM is promoted, and in2014, GoC raised the CD4 count threshold eligibility criteria for initiating ART from 350 to 500 copies/ml to allow earlier treatment initiation. USG pilots models of comprehensive HIV interventions (HIV testing, treatment, care, prevention and referral services) that are initiated and sustained by outreach activities done in partnership between CBOs and local health department staff. among MSM (primarily) as well as 2 FSW-focused). USG helped ACC established three ART clinics in border towns that serve migrants who, as non-Chinese citizens, are not covered by free HIV services policies.

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

Challenges that may hinder PEPFAR China from reaching targets are: sustained (since February 2014) crackdown by local governments on commercial sex work; inadequate communication and cooperation between GoC sectors; stigma against MSM and PLHIV; low CBO capacity; unstable, remote, and migrant PLHIV.

HIV testing is counted by tests performed, not number of individuals tested; testing records are not standardized and few facilities digitize them. HIV-positive cross-border FSW referred to treatment in their home countries are difficult to trace. Many provinces and lower levels have not

conducted key population size estimates. USG will provide necessary TA and encourage Hunan province to conduct estimates using the China ART program platform.

PEPFAR China's primary TA custom indicators for which FY2015 targets were developed from each project officer's regular TA activities include:

1. 3 new or revised national HIV/AIDS/STI-related guidelines released by the GoC with technical collaboration from USG
2. 3 of pilot innovative models for HIV/AIDS response
3. 6 scientific information products released
4. 1 country provided TA by GoC with technical collaboration from USG

National technical guidelines are expected to improve quality of each step in the epidemic cascade. The innovative models are often used to test new service delivery mechanisms or technologies which also lead to improved quality and coverage of prevention, care, treatment, and so on. The scientific information products and countries to which GoC and PEPFAR jointly provide TA are efforts enabling GoC to share experiences and lessons learned internationally.

*Table 4.1.1a: China: ART Targets in Priority Sub-national Units for Epidemic Control*[29]

| SNU | Total PLHIV | Expected current on ART (2015) | Additional patients required for 80% ART coverage | Target current on ART (in FY16) *TX_CURR* | Newly initiated in FY 16 *TX_NEW* |
|---|---|---|---|---|---|
| Ruili County | 3,513 | 200 | N/A | 150 (Ruili Better Clinic target) | 30 |
| Longchuan County | N/A | 20 | N/A | 30 (Longchuan Better Clinic) | 0 |
| Mengsheng Township | N/A | 50 | N/A | 50 (Mengsheng Better Clinic) | 50 |

*Table 4.1.2a: China: MSM Newly Initiating ART in Priority Districts from TA support via the NCAIDS IM (FY 16)*

*Note: no treatment targets were set for these because these are community sites*

| Entry Streams for ART Enrollment | Tested for HIV (in FY16) | Identified Positive (in FY16) | Enrolled on ART (in FY16) |
|---|---|---|---|
| Beihai City | *[REDACTED]* | *[REDACTED]* | - |
| Nanning City | *[REDACTED]* | *[REDACTED]* | - |
| Liuzhou City | *[REDACTED]* | *[REDACTED]* | |
| Honghuagang District | *[REDACTED]* | *[REDACTED]* | - |
| Guiyang City | *[REDACTED]* | *[REDACTED]* | - |
| Sandu County | *[REDACTED]* | *[REDACTED]* | - |
| Xinyi City | *[REDACTED]* | *[REDACTED]* | - |
| Changde City | *[REDACTED]* | *[REDACTED]* | - |
| Changsha City | *[REDACTED]* | *[REDACTED]* | - |

| | | | |
|---|---|---|---|
| Hongqiao District | *[REDACTED]* | *[REDACTED]* | - |
| Kashi City | *[REDACTED]* | *[REDACTED]* | - |
| Yining City | *[REDACTED]* | *[REDACTED]* | - |
| Tianshan District | *[REDACTED]* | *[REDACTED]* | - |
| Ruili City (MSM) | *[REDACTED]* | *[REDACTED]* | - |
| Kunming City | *[REDACTED]* | *[REDACTED]* | - |
| **Total** | *[REDACTED]* | *[REDACTED]* | |

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

| SNU | Population Size Estimate (priority SNUs) | Coverage Goal (in FY16) | FY16 Target |
|---|---|---|---|
| Beihai City | *[REDACTED]* | 62.5% | *[REDACTED]* |
| Nanning City | *[REDACTED]* | 2.5% | *[REDACTED]* |
| Liuzhou City | *[REDACTED]* | 35.0% | *[REDACTED]* |
| Honghuagang District | *[REDACTED]* | 35.7% | *[REDACTED]* |
| Guiyang City | *[REDACTED]* | 38.1% | *[REDACTED]* |
| Sandu County | *[REDACTED]* | *[REDACTED]* | *[REDACTED]* |
| Xinyi City | *[REDACTED]* | 46.9% | *[REDACTED]* |
| Changde City | *[REDACTED]* | 62.5% | *[REDACTED]* |
| Changsha City | *[REDACTED]* | 60.0% | *[REDACTED]* |
| Hongqiao District | *[REDACTED]* | 75.0% | *[REDACTED]* |
| Kashi District | *[REDACTED]* | 25.0% | *[REDACTED]* |
| Yining City | *[REDACTED]* | 20.0% | *[REDACTED]* |
| Tianshan District | *[REDACTED]* | 66.7% | *[REDACTED]* |
| Ruili City (MSM) | *[REDACTED]* | 25.6% | *[REDACTED]* |
| Kunming City | *[REDACTED]* | 64.0% | *[REDACTED]* |
| **Total** | *[REDACTED]* | **20.6%** | *[REDACTED]* |

Laos

Reliable data about key population size estimates at the provincial level in Laos is not available. Therefore, setting targets and measuring progress towards epidemic control among MSM and TG women in the three ARP priority provinces (Champasak, Savannakhet, and Vientiane) is challenging. In particular, data related to the cascade for TG women is limited in Laos. It is anticipated that ARP activities in FY16 will shed greater light on this epidemic and inform future approaches and investments in improving the cascade for that population.

In FY16, ARP will provide TA to build national and provincial capacity to report such estimates in FY17. ARP activities will strengthen surveillance and HMIS systems at central level and the three high burden provinces, with QI training and supervision to improve the cascade of care in the four respective ART sites. It is anticipated that a total of 1,044 key populations ages 15 and above will receive HIV testing and counseling (HTC) services and received their test results. HTC services will be provided by Community-Based Supporters (CBS) in three cities – Vientiane, Champasak, and Savannakhet. CBS will provide high-quality HIV testing and counseling service including risk assessment, providing rapid HIV screening test with an approved oral fluid test

(OraQuick) and referring directly clients with a reactive test to confirmatory testing and an ART center. FY14 results showed HIV prevalence among MSM and TG was 1.8%. In FY16, as USAID will implement a new Enhanced Peer Mobilizer model and Social Network Strategy, it is anticipated that USAID will reach more highest-risk MSM and TG networks. It is estimated that among those tested for HIV in FY16, 57 individuals will be diagnosed with HIV positive. This gives an overall positive rate of 5.5% and at least 90% are expected to be on ART. We will also focus our work in strengthening surveillance and HMIS system at central and the 3 high burden provinces and also do the QI for improving care cascade in the 4 ART sites.

Thailand

We calculated targets based on estimated number of PLHIV by sub-national units (provinces) using Asian Epidemic Model (AEM), estimated number of key population from Thai National AIDS Operational Plan (2014-2016), the number of PLHIV in care and treatment from the National AIDS Program Reports (NAP). Six priority provinces were selected based on high PLHIV burden and where we are implementing PEPFAR key population prevention and care program to support RTG and Global Fund activities. According to the 90x90x90 goal we will target area where key populations and PLHIV are likely to receive HIV care and estimated target population size in those areas. We will do targeted TA in high volume hospitals in the six provinces (10 out of 37 hospitals in Bangkok and 1-2 hospitals for the rest 5) to cover at least 25% of PLHIV in each province. The targeted interventions for recruitment will be focused on key populations to promote HIV testing. For treatment and retention will be for all PLHIV receiving care and specific intervention for key population in the targeted area. We will include HIV-infected pregnant women, male partners, infants, children as priorities populations according to Thailand's strategies of Ending AIDS and Elimination of Mother-to-Child transmission). These groups will be recruited under routine services. PEPFAR will do targeted cascade monitoring for retention, viral suppression and quality improvement of all PLHIV receiving care in the priority provinces (Q1-2).

We will focus our target to reach key population for 50% (ranging from 25-80%) in these 6 provinces which in the past out targets based on high HIV prevalence provinces and resource available only. The FY16 target to identify HIV-infections in key population has increased 3 folds from the results reported in FY14 (approximately 700 to 2500). We targeted 90% of newly identified PLHIV will be on ART using marketing campaign of Test and Treat for community) and Ending AIDS for HCWs (Q3-5). We analyzed 2014 results that identify low yield of HIV-infection in Key pop due to we did not reach high risk MSM/TG. We assume that we can reach more high risk MSM/TG in 2016 resulting from recently available data of key population by province and target mapping activities done in Bangkok during 2014-2015 (Q6). Challenges in meeting the targets might be related to fear of target population to receive HIV testing in health care setting because of past perception of stigma and discrimination and differences in health insurance policies which affect the ability to access to care (Q7). We anticipated that data in the National AIDS Program database has some limitations. This database does not cover private or self-payment services, may be under registered newly identified and incomplete data entry of type of populations (e.g. general v.s key pop). These prevent tracking of these populations, inability to

track sub-group of key population once they were registered in care. We will work with health facilities and the NHSO to train HCWs for more complete data entry and definitions to increase coverage of registration and accuracy of data to monitor the complete of care cascade. In addition the estimated number of key populations may be under estimated. We plan to work with the national estimation working group to verify SNU data (Q8).

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

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

| SNU | Total PLHIV (AEM) | Expected Current on ART end of Sep 2015[30] | Additional patients required for 80% ART coverage (80% coverage - currently on ART) | Target current on ART (in FY16) *TX_CURR*[32] | Overall Target in PEPFAR sites[31] | PEPFAR Site Targets (in FY16) Tx_New |
|---|---|---|---|---|---|---|
| Bangkok | *[REDACTED]* | 35,152 | 14,128 | 8,325 | 2,826 | ***1332*** |
| Chiangmai | *[REDACTED]* | 12,107 | 2,413 | 88 | 482 | ***81*** |
| Chonburi[33] | *[REDACTED]* | 13,823 | (888) | 120 | - | ***109*** |
| Khonkaen | *[REDACTED]* | 8,257 | 854 | 759 | 854 | ***74*** |
| Songkhla[33] | *[REDACTED]* | 6,074 | (754) | 68 | - | ***24*** |
| Udonthani | *[REDACTED]* | 6,413 | 1,184 | 475 | 1184 | ***47*** |
| **Total** | *[REDACTED]* | **81,825** | **29,284** | **9,835** | **5,346** | **1,667** |

[30] Expected PLHIV on ART was estimated from the number of PLHIV on ART at the end of 2014 plus newly initiated ART in 2014 plus 10% on ART in private hospitals or research programs (Bangkok, Chiangmai, Chonburi) and 5% in Khonkaen, Songkhla and Udonthani

[31] Estimation based on 20% of PLHIV will receive care in PEPFAR supported sites in each province

[32] Estimated for Key Population only

[33] Total PLHIV estimated in Chonburi and Songkhla may be under estimated. Thailand plans to re-estimate and verify the PLHIV numbers in 2015

*Table 4.1.2c Thailand: Entry Streams for newly initiating ART Patients in Priority Provinces (FY16)*

| Areas & Populations | Test | Identified Positive | Enrolled on ART[34] |
|---|---|---|---|
| **Bangkok** | ***29,353*** | ***1,694*** | ***1,332*** |
| PMTCT - pregnant women | 12,119 | 100 | 95 |
| Partners of pregnant women | 7,066 | 47 | 42 |
| MSM/TG | 9,212 | 1,522 | 1,195 |
| STI clients (MSM/TG or FSW) | 974 | 25 | - |
| **Chiangmai** | ***1,750*** | **300** | **81** |
| MSM/TG (USAID) | 1,750 | 300 | 81 |
| **Chonburi** | ***3,826*** | ***489*** | ***109*** |
| MSM/TG | 2,250 | 382 | 109 |
| STI clients (MSM/TG or FSW) | 1,576 | 107 | - |
| **Khonkaen** | ***303*** | ***40*** | ***74*** |
| MSM/TG | 263 | 39 | 30 |
| STI clients (MSM/TG or FSW) | 40 | 1 | - |
| Routine HTC program | | | 44 |
| **Songkhla** | ***800*** | ***65*** | ***24*** |
| MSM/TG (USAID) | 600 | 60 | 17 |
| STI clients (MSM/TG or FSW) | 200 | 5 | - |
| Routine HTC program | | | 7 |
| **Udonthani** | ***952*** | ***131*** | ***47*** |
| MSM/TG (CDC) | 488 | 122 | 47 |
| STI clients (MSM/TG or FSW) | 464 | 9 | - |
| **Total** | **37,002** | **2,729** | **1,667** |
| PMTCT - pregnant women | 12,119 | 100 | 95 |
| Partners of pregnant women | 7,066 | 47 | 42 |
| MSM/TG | 14,563 | 2,425 | 1,479 |
| STI clients (MSM/TG or FSW) | 3,254 | 147 | - |
| Routine HTC program | | | 51 |

*Table 4.1.3c: Thailand: Target Populations for Prevention Intervention to Facilitate Epidemic Control*

| Areas & Populations | Target high risk MSM/TG[35] | Coverage Goal | FY16 Target |
|---|---|---|---|
| Bangkok | 36,105 | | 12,620 |
| MSM/TG | 36,105 | 32% | 11,470 |
| STI client MSM/TG, FSW | | | 1,150 |
| Chiangmai (50) | 6,528 | | 2,320 |
| MSM/TG | 6,528 | 36% | 2,320 |

[34] Target at least 90% of identified HIV+ will be on ART

[35] Targeted only MSM/TG population while pregnant women, male partners, STI clients will be recruited in routine system where programs are implemented. Key Population targets do not include KPCF and KPIS activities.

| | | | |
|---|---|---|---|
| Chonburi (20) | 7,145 | | 4,220 |
| MSM/TG | 7,145 | 42% | 2,970 |
| STI client MSM/TG, FSW | | | 1,250 |
| Khonkaen (40) | 3,864 | | 100 |
| MSM/TG | 3,864 | 1% | 50 |
| STI client MSM/TG, FSW | | | 50 |
| Songkhla (90) | 5,973 | | 1,044 |
| MSM/TG | 5,973 | 13% | 794 |
| STI clients MSM/TG, FSW | | | 250 |
| Udonthani (41) | 2,830 | | 880 |
| MSM/TG | 2,830 | 11% | 300 |
| STI clients MSM/TG, FSW | | | 580 |
| Total | 62,443 | | 21,184 |
| MSM/TG | 62,443 | 28% | 17,620 |
| STI clients MSM/TG, FSW | | | 3,280 |

### 4.2 Priority population prevention

China

In FY16, PEPFAR will assist in national technical prevention guideline revisions for MSM, with the goal of developing a national recommended standard package of evidenced-based HIV prevention services for MSM. PEPFAR-China will collaborate to pilot programs that reach MSM for HIV testing, diagnose HIV-infected MSM early in the course of the disease, and facilitate prompt linkage to care, treatment, and sustained viral suppression. The goal of PEPFAR/China's field activities is introduction and demonstration of successful models for HIV prevention and control among MSM that can be scaled up to become province-wide and nationwide efforts. PEPFAR China aims to provide evidence from evaluation of its pilot activities that encourage GoC to take ownership of successful prevention models. To achieve a sustainable response, PEPFAR will contribute to the scale-up of pilot programs that have demonstrated effectiveness.

Though the national response is targeting priority populations, not all prevention methods and services are accepted and used widely by the intended beneficiaries. A more vibrant CBO sector that is engaged in HIV prevention and control is needed. China's CBO sector is relatively weak and its activities have been disrupted by the withdrawal of the Global Fund

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

Laos and Thailand

Beyond focusing in the right places and working with the right populations, ARP will make measurable contributions to epidemic control in Laos and Thailand by doing the right things. To improve "three 90s" HIV cascade outcomes while reducing unit costs among MSM and TG women in priority urban settings, ARP will pursue enhancements to prevention programming that are inspired by the increasing evidence of the prevention benefits of antiretroviral medications and the recognition that services and systems that are better equipped to assess and improve rates of key population reach, testing, treatment, and retention are critical to maximizing these benefits.

First, in recognition of the need to demonstrate sustained support for beneficiaries across the cascade of HIV prevention to care to treatment services, ARP will pilot confidential service linkage and referral systems in Thailand and Laos in FY16. These systems will be deployed in quality-assured and marketed service coalitions of MSM- and TG women-friendly community and clinical providers that are promoted through targeted social and other media. Real-time referrals and confirmation of successful linkages across providers; automated client reminders; community and clinical health worker tasking, and tracking of pay-for-performance incentives for contributions to cascade outcomes will be achieved through the use of cell-phone based communication technologies. SIMS visits conducted in the past year demonstrated opportunities to improve compliance with CEE 19.3 pertaining to the making and tracking of successful referrals from community prevention activities to clinical HIV services. These new systems will produce community-level dashboards that will allow partners and stakeholders to track and improve meaningful beneficiary outcomes across the HIV cascade routinely and collaboratively.

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

The community-based supporters will be trained to mobilize beneficiaries as "peer motivators" to refer their peers and partners to HIV testing with simple voucher systems inspired by respondent-driven sampling techniques. For each successful referral of an individual who is a newly tested in the past six months the referring individual will receive a small incentive. Peer mobilizers who make no successful referrals will receive no incentives. The performance of the community-based supporters will be evaluated and incentivized in part on the basis of the number of newly identified and newly engaged in care HIV-infected individuals they are able to reach though their

peer mobilizers. This will encourage the community-based supporters to seek partnerships with peer mobilizers situated in networks with elevated HIV infection burdens, and to routinely swap out peer mobilizers who do not help to link HIV-infected individuals to services for those who do. Community-based supporters and HIV counseling staff will also be trained in the use of simple risk assessment tools that will help them to make appropriate HIV service referrals, and to identify and counsel HIV-uninfected individuals who might benefit from pre-exposure prophylaxis (PrEP). PrEP is available commercially in Thailand. To mitigate stigma and discrimination that may serve as barriers to HIV service uptake among priority populations, ARP will provide training to health care providers in priority geographic settings. These efforts will feature "south-to-south" collaboration between the Laos and Thai programs – based upon foundations established through previous ARP activities in these areas.

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

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

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

### 4.3 Voluntary medical male circumcision (VMMC)

N/A

### 4.4 Preventing mother-to-child transmission (PMTCT)

<u>China</u>

As the national PMTCT program becomes increasingly effective, PEPFAR China is sustaining support for PMTCT only at the national level, and in support of data utilization efforts that will help to inform the overall understanding of the epidemiology of HIV in China. In FY16, PEPFAR China will provide TA to Beijing-based technical staff of the Maternal Child Health agency of the NHFPC and in doing so strengthen data management and utilization for monitoring

implementation of option B+ and providing necessary inputs for China's national HIV epidemic estimates.

Laos and Thailand

In 2014, with TA from ARP, the Thai Government published 'Thailand National Guidelines on HIV/AIDS Treatment and Prevention 2014'. The new guidelines recommend ART for HIV-infected adults including pregnant women regardless of CD4 count (option B plus) and ART and EID for infants born to HIV-infected mothers. ARP aims to assist Thailand to ensure that HIV-infected women and their children receive ART according to national guidelines and are supported through the continuum of care.

In Thailand, 40% of HIV-infected pregnant women are lost from the care cascade after delivery and the MTCT rate remains above 2%. While reducing its overall investment in PMTCT activities, with the aim to transition further from this work in FY17, ARP will provide TA to assess implementation of and identify barriers to B plus and the retention of young women in the continuum of care in priority provinces and Bangkok in FY16. ARP will also provide TA to MOPH to identify and support provinces with high MTCT rates and transition this model to the Thai Government with financial assistance from UNICEF in 2016.

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

An estimated 150 HIV-infected infants are born to HIV-infected pregnant women in Laos annually; however there is low uptake of antenatal services and HIV counseling and testing by pregnant women. In addition, there are a limited number of HCWs in MCH settings who are knowledgeable and have the skills to provide PMTCT services with the linkage of HIV-infected pregnant women to HIV care in a timely manner.

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

### 4.5 HIV testing and counseling (HTC)

China

Expanding HTC is a GoC priority and considered a core activity for PEPFAR China, with an emphasis on improving case detection among key populations. PEPFAR China technical staff will

assist the GoC in evaluating the yield of its current HIV testing strategies and enhancing its HTC approach.

China currently relies heavily on provider-initiated counseling and testing (PITC) for case detection in areas with higher HIV disease burden, and more innovative strategies targeted to key populations are rarely employed.

In FY16, PEPFAR China will introduce and assess innovative testing models that expand options for accessing convenient, reliable, accurate, and private HIV testing, particularly for MSM. PEPFAR-China will work with national and subnational partners to pilot HIV test self-sample collection techniques as well as oral fluid based self-testing. PEPFAR-China intends to utilize successful new methods for self sample collection and HIV self testing to improve venue-based testing of key populations (e.g. MSM in bars or bathhouses). USG is working with GoC to improve diagnostic testing accuracy and efficiency through support for testing algorithm guideline development, which will allow for adoption of a broader range of high-quality HIV antibody detection technologies in China. The new HIV testing algorithm under consideration would facilitate a decrease in the proportion of screening-test-positive but unconfirmed HIV cases – a growing problem that affects MSM in particular.

PEPFAR will encourage CBO involvement in HTC and patient referral services and help improve their capacity for service delivery and GoC funding acquisition. With PEPFAR China support, local China-CDCs have established VCT via outreach to high-risk groups in community settings (e.g., karaoke establishment, bathhouse, club, bar), conducted by CBOs' peer educators.

Laos and Thailand

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

Performance data from ARP partners engaged in prevention outreach activities in Thailand indicate that 10-20% of individuals referred to HTC services are infected with HIV. However, the proportion of individuals reached who were referred to HTC by these partners rarely exceeded 30%, suggesting that partners may be working in the right places, but need to employ more effective strategies to increase demand and remove barriers to HTC uptake.

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

- ARP will introduce peer recruitment strategies at existing testing sites to encourage those seeking testing to refer their peers and partners. By providing small incentives to HIV testing clients for referrals, ARP hopes to increase rates of testing and case identification.

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

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

- Achieving and demonstrating substantial increases in HIV testing uptake in priority settings and populations will be bolstered by new investments in 1) mobile technology-based linkage and referral systems and 2) enhanced outreach approaches, detailed in section 4.2, "priority population prevention." Per the SIMS requirements, all individuals who are diagnosed with USG support will receive follow-up and assistance in accessing HIV care and treatment services. In Thailand, the national program will procure HIV testing kits generally, and we have helped establish mechanisms for community testing partners to receive test kits from public sector hospitals, who then apply for reimbursement with the National Health Security Office to recuperate their costs. In Laos, ARP will procure oral-fluid test kits to support the pilot application of oral fluid screening through community partners to accelerate rates of testing uptake and diagnosis among MSM and TG women.

- ARP will support Lao People's Army facility-based HIV testing to soldiers and new recruits in many military bases throughout the country, focusing particularly on higher risk areas with shared borders.

- Spousal HIV transmission was responsible for an estimated 30% of new HIV infections in 2015 in Thailand (AEM 2005-2025). Couples HIV testing and counseling (CHTC), recommended by the Thai Government during ANC, provides an opportunity to identify HIV discordant couples, provide prevention with positive and risk reduction counseling, and to identify new PLHIV and ensure they are referred and maintained in the continuum of HIV care. Although only 25% of couples received CHCT services at ANC in 2014, 1,128 HIV-infected partners were identified. ARP will provide TA to the Thai MOPH to assess the implementation of and identify barriers to CHTC services in priority provinces and Bangkok.

### 4.6 Facility- and community-based care and support

China

In 2014, with PEPFAR China support, China's HIV treatment guideline was revised to include treatment eligibility at a CD4 level of <500. In FY16, PEPFAR will assist rural clinicians and nurses, as well as provincial HIV program managers and technical staff in focus provinces, to implement recommendations of this new guideline via trainings and HIV nursing handbook development. PEPFAR China will work with a domestic NGO, ACC, to provide care and adherence support via HIV-positive peer educators in focus provinces.

Laos and Thailand

As of September 2014, 349,816 PLHIV had registered for care with the Thai government and 284,578 (81.3%) had started ART. Despite this strong response, gaps in HIV testing, adherence to ART, and retention in care remain particular challenges among MSM, TG women, and other key populations. ARP is working with local partners to expand HIV testing among key populations, improve the quality of care across the continuum of care cascade, and address stigma and discrimination using community meetings, peer outreach, and a web presence with a goal of bringing more people in for HIV testing, keeping HIV-infected persons in care, and reducing HIV-related morbidity and mortality. ARP is also working with the Thai government to improve the quality of HIV, STI, and TB testing to build local capacity for quality HIV and HIV-related disease care for MSM, TG women, and FSW in priority areas. ARP is also working with local partners to ensure HIV-infected Lao migrants have access to ART and care services and HIV-infected pregnant women migrants have access to PMTCT services.

In Laos, at the end of 2014, 5,933 PLHIV had registered for care, of which 5,007 were on ART. ARP is working with the Lao government to improve the quality of HIV testing, care, and PLHIV follow-up in the care cascade in four ART clinics in three priority provinces. In addition, ARP will consider reasonable PEPFAR investments in national systems, protocols, and capacity – such as targeted TA for laboratory or SI efforts – where they are needed to achieve measurable outcomes in priority populations and settings or broader epidemic control.

### 4.7 TB/HIV

China

Given the scale of the TB burden in China, inadequate attention to TB/HIV issues will jeopardize optimal timing of ART initiation among TB-infected PLHIV. A common issue found during SIMS visits was suboptimal TB/HIV co-infection case management; TB/HIV patients either do not receive ART during and after TB treatment due to referral delays, or they cannot access free TB treatment due to atypical TB manifestations. Nonetheless, TB/HIV is no longer considered a core for PEPFAR-China, and no FY16 TB/HIV field activities are planned.

Laos and Thailand

In FY16, ARP will continue to help pilot, with PEPFAR/Vietnam, an enhanced TB infection control intervention for healthcare facilities in Thailand and Vietnam that provide services to both HIV and TB clients. Other TA will focus on establishing operational and informational linkages between national HIV and TB management information systems and working in Bangkok to improve the quality of TB/HIV testing. As a modest investment with substantial impact, ARP will provide TA in Laos to introduce HIV testing in TB clinics in its three priority provinces.

### 4.8 Adult treatment

China

In addition to HIV treatment guideline revision and implementation mentioned above, PEPFAR China will continue through FY16 to support efforts of provincial governments to ensure treatment coverage of cross-border populations, many of whom are FSWs and, lackingChinese citizenship, are not eligible for free ART. In order to assess the magnitude of the implications of a shift in provincial health policy to free HIV treatment of non-Chinese citizens, PEPFAR China will assist with cross border key population size estimation in Yunnan. Cross border size estimation is also expected to elucidate the magnitude of the cross-border MSM in Yunnan, a population that has been growing according to anecdotal reports. PEPFAR China will support high-quality training and management of peer educators who are employed to conduct outreach to test cross-border FSWs, link those diagnosed to care with prompt initiation of ART regardless of CD4 count and support adherence and viral load monitoring.

Laos and Thailand

ARP works closely with the RTG and other stakeholders in Thailand to maximize PLHIV access to ART, and retention in the continuum of care cascade, while ensuring that quality services are delivered in a sustainable fashion in priority provinces and Bangkok. The 'Thailand National Guidelines on HIV/AIDS Treatment and Prevention 2014' recommend ART for HIV-infected adults regardless of CD4 count, signaling a major change in Thailand's posture towards HIV treatment, with Thailand becoming a leader in Asia in providing PLHIV early access to ART.

In FY16, ARP will continue to work with the MOPH and CBOs to ensure that MSM, TG women, and other key populations in key provinces can access services. ARP will provide focused TA to improve M&E and information systems, implement quality improvement (QI) programs for care and laboratory services.

Following successful ARP-supported pilot and scale-up, the MOPH adopted HIVQUAL-T as a standard national QI tool for health facilities that can also be used for hospital accreditation. ARP will end financial support for the program in 2016. ARP will continue to provide targeted TA to build the QI capacity of local leadership and health care providers and strengthen the evidence-base that helps to retain PLHIV in the continuum of care cascade. Disease specific certification (DSC), a nationally initiated movement to apply the HIVQUAL-T model across the spectrum of facilities involved in the continuum of HIV testing, care, and treatment, will be advanced with TA from ARP in FY16.

ARP has historically provided TA to the RTG to improve the quality of HIV counseling and testing services nationally. In FY16 ARP will focus these efforts on its priority populations and provinces.

In FY15, ARP worked with the government of Bangkok and local CBOs to create MSM clinics in eight hospitals. The clinics aim to provide HIV services free of stigma and discrimination, increase HIV testing among MSM, and support HIV-infected MSM to stay in the continuum of care cascade. Efforts are underway to increase community awareness and support for the activity including peer outreach, a website, and community meetings.

Migrant registration data in October 2014 showed that there were 213,689 registered Lao migrant workers with 9,150 dependents in Thailand and surveillance among Lao migrants found an HIV prevalence of 0.8%. With support from the Global Fund and the Lao Government, nine clinics in Lao are able to provide ART, CD4, and viral load testing. Lao migrants in Thailand do not have easy access to these services and healthcare providers along the border do not have training or experience in HIV treatment. In FY16, ARP will help establish and assess the success of the first system for cross-border HIV patient referral along the Laos-Thai border.

In Laos, ARP will concentrate on improving the quality of adult care at four ART sites in three priority provinces in Lao, working with the Government of Laos to strengthen the quality of HIV care from HIV testing to viral suppression.

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

The USG PEPFAR team was awarded a KPIS grant to assess an HIV test-and-treat model among MSM and TG women in facility and community-based settings in Thailand. The intervention works with local partners in facilities and communities to launch innovative peer-driven efforts to

increase demand for HIV testing among MSM and TG women. Peers provide HIV testing in community-based drop-in centers and clinicians provide ART at the same sites in an effort to overcome the stigma and discrimination barriers that exist in some public sector ART sites.

### 4.9 Pediatric Treatment

The Thailand National Guidelines on HIV/AIDS Treatment and Prevention 2014 recommend ART for all children <1 year old, for children 1-5 years old with CD4<25%, and for children 5-15 years old with CD4<500 (1).

While transitioning away from pediatric-specific activities, in FY16 ARP will work with the Thai MOPH and four regional pediatric HIV training sites to establish an Active Case Management Network. The project will identify newly HIV-infected infants, assure they are linked to an HIV care program, and initiate ART as soon as possible according to the national guidelines. ARP will provide TA to the regional sites to use NAP data to assess provincial cascade data for HIV-infected youth and use the data to keep youth in the cascade of care. ARP is uniquely positioned through its strong relationships with the four regional sites that have network connections with pediatric clinics in all 77 provinces.

In 2013, 75% of HIV-infected children and adolescents in pediatric HIV clinics were ten years old or older and 20% were 15 years or older. Comprehensive models to transition HIV-infected youth to adult HIV care services are lacking. ARP, working with local partners, has developed guidelines and tools for providers to use to help transition HIV-infected youth from pediatric to adult HIV care services. These activities, implemented in Bangkok, address important health, psychological, and prevention-with-positives challenges HIV-infected youth face as they move through adolescence to adulthood. ARP will provide targeted TA to assess the impact of the model and tools, and coordinate with the Thai Government to assess and potentially scale-up the guidelines nationally.

### 4.10 OVC

N/A

# 5.0 Program Activities to Sustain Support for Other Locations and Populations

### 5.1 Sustained package of services in other locations and populations

China

At the United Nations High-Level Special Meeting in September 2003, GoC announced five commitments in the fight against HIV/AIDS, later known as the 'Four Frees and One Care' policy, which was implemented starting 2004. The standard package of services includes:

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

Laos

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

Thailand

Thailand established a universal health care system in 2002 that provides ~99.5% of Thai nationals with health protection and nearly free access to a wide range of health services, including a comprehensive package of HIV testing, treatment, care, and support services. In 2014, Thailand became the first country in Asia to offer HIV treatment to every person living with HIV. In addition, the government also funds key laboratory services, including EQA for HIV serology and $CD_4$ testing, VL testing, HIV prevention services such as outreach and STI services, a pediatric HIV care network, molecular testing for EID, and HAART for PMTCT.

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

As China, Laos, and Thailand are technical collaboration/TA model countries, PEPFAR support has historically maintained a consistent focus on a limited number of priority locations and populations.

In ROP 2015, these focus geographic areas were narrowed in China from 5 provinces with 225 million people to fifteen urban communities with 60 million people, in Laos from 8 to 3 (of 18 total) provinces, and in Thailand from 30+ to 6 (of 77 total) provinces. These geographic areas have the highest HIV incidence and lowest ART coverage among priority populations, and prioritizing PEPFAR support in these areas will accelerate epidemic control.

# 6.0 Program Support Necessary to Achieve Sustained Epidemic Control

## 6.1 Laboratory strengthening

China

PEPFAR China's support for laboratory activities is focused on improving capacity for early diagnosis of HIV infection (first "90"). In FY16, PEPFAR will support revision of HIV testing guidelines to include new options for confirmation of HIV diagnosis that reduce the burden associated with obtaining a confirmatory test, and thereby facilitate higher case confirmation rates. USG is assisting in the design and implementation of pilot projects to assess the use of point-of-care and self-testing HIV diagnostic methods. USG will also support the use of 4th generation assays in high-risk settings among MSM to facilitate identification of acute HIV and improved case ascertainment. PEPFAR will also assist the GoC in its planned transition to a new HIV incidence assay. This support will help the GoC measure their progress towards epidemic control.

| 1. Brief Activity Description | Deliverables | | Budget codes and allocation ($) | | 6. Implementing Mechanism(s) ID | 7. Relevant Sustainability Element and Score | Impact on epidemic control | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2. 2015 | 3. 2016 | 4. 2015 | 5. 2016 | | | 8. HIV Testing | 9. Linkage to Care (LTC) | 10. ART uptake | 11.*Other Combination prevention | 12. Viral suppression |
| Examine utility of Cyto-Chex preserved CD4 cells for lab QC of CD4 enumeration: The in-house whole blood preparation specimens potentially make QC/QA of CD4 numeration simple and easy, especially for the labs in provinces with high HIV burden. | Complete pilot in Guangxi<br>Develop manuscript | Apply Cyto-Chex tubes for PT of CD4 enumeration in Guangxi;<br>QC/QA using Cyto-Chex tubes in other GAP program provinces if the pilot successful. | *[REDACTED]* | *[REDACTED]* | China CDC/ NCAIDS 16622 | | | | | | Improved QC/QA of CD4 enumeration; contributing to greater likelihood of viral load suppression |
| Evaluate feasibility of new model using paired DBS and urine sample for HIV detection in China. The model | Collect data from MSM, FSW | Data analysis and manuscript development; expand application to 5 PEPFAR focus | *[REDACTED]* | *[REDACTED]* | China CDC/ NCAIDS 16622 | | Improve HIV cascade by increasing | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| screens for and confirms HIV infection simultaneously. The activity investigates the acceptability of self-sample collection among MSM, FSW. | | provinces if the pilot successful | | | | | testing efficiency | | | | |
| Verification of HIV-1 Antibody Indeterminate using Nucleic Acid Analysis to explore the characteristics of the indeterminate samples. | Data collection | Data analysis and manuscript development | *[REDACTED]* | *[REDACTED]* | China CDC/ NCAIDS 16622 | | Increased early diagnosis of HIV infection | | | | |
| Evaluation of a proposed laboratory HIV testing algorithm with nucleic acid testing for early identification of HIV infection among MSM | | | *[REDACTED]* | *[REDACTED]* | | | | | | | |
| Evaluation of a new POCT for HIV-1 viral load. | Data collection | Data analysis and manuscript development, | *[REDACTED]* | *[REDACTED]* | China CDC/ NCAIDS 16622 | | Increased early diagnosis of HIV infection | | Increased early treatment and ART effectiveness monitoring | | |
| Evaluation of dry powder reagents for CD4 testing in central and layer laboratories | Data collection and manuscript development | Expansion the reagent to 5 GAP provinces to improve the performance and quality of CD4 enumeration | *[REDACTED]* | *[REDACTED]* | China CDC/ NCAIDS 16622 | | | | Increased early treatment and ART effectiveness monitoring | | Improved QC/QA of CD4 enumeration; contributing to greater likelihood of viral load suppression |

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| Development of manual and guideline on HIV serological testing and quality control | Manual or guideline published or released | | *[REDACTED]* | *[REDACTED]* | China CDC/ NCAIDS 16622 | | Improved performance of HIV testing and improved quality<br>Increased early diagnosis of HIV infection | | | | |
| Study on incidence assay transition from BED to avidity for HIV incidence estimation | Data collection using samples collected from 2011 to 2015 | Data analysis and application for HIV incidence estimation of 2016 and afterwards. | *[REDACTED]* | *[REDACTED]* | China CDC/ NCAIDS 16622 | | | | | Increased reliability in monitoring and responding to the HIV epidemic. | |

Laos

Laos faces challenges with laboratory infrastructure, supply chain, and human resources for HIV, CD4, and viral load testing. To improve the quality of laboratory services, ARP will focus on laboratory strengthening activities in three priority provinces.

| **1. Brief Activity Description** | **Deliverables** | | **Budget codes and allocation ($)** | | **6. IM ID** | **7. Relevant Sustainability Element and Score** | **Impact on epidemic control** | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **2. 2015** | **3. 2016** | **4. 2015** | **5. 2016** | | | 8. HIV Testing | 9. Linkage to Care | 10. ART uptake | 11.Other Combination prevention | 12. Viral suppression |
| Training | | | | | | | | | | | |
| Provide training for rapid HIV testing in 3 priority provinces | Train 20 staff at 3 priority provinces to support increase access to quality HIV testing | Train 10 staff at 3 priority provinces to monitor the quality of HIV testing and diagnosis | *[REDACTED]* | *[REDACTED]* | 17092<br>17858 | | x | | | | |
| Provide rapid HIV testing DSD and on-site training at Lao military | Provide HTC for 5025 soldiers with | TBD | *[REDACTED]* | *[REDACTED]* | 17084 | | X | X | | | |

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| clinical care sites | concurrent training of clinical lab personnel, ensuring 100% linkage to clinical MoH ART sites for all positives | | | | | | | | | | |
| Provide training on CD4 testing and quality assurance to improve the knowledge, skills and practices of facility-based staff from 3 priority provinces to improve HIV clinical monitoring | Train 25 staff from 4 ARV sites in 3 priority provinces to monitor the quality of clinical laboratory services | Train 12 staff from 4 ARV sites in 3 priority provinces on specimen management and referral system | *[REDACTED]* | *[REDACTED]* | 17092<br>17858 | | | x | | | |
| Train and build capacity of the national center for laboratory and epidemiology (NCLE) to do HIV viral load testing to support the country program to monitor the effectiveness of ARV treatment program | N/A | Train 3 NCLE staff on HIV viral load testing and quality assurance | *[REDACTED]* | *[REDACTED]* | 17092<br>17858 | | | | | | x |
| Update and coach the NCLE staff to implement HIV serology EQA program, and to implement data analysis to assess the quality of HIV rapid testing | Trained 3 NCLE staff on quality of HIV serology EQA program to strengthen the national HIV serology EQA program<br>and to use EQA data to monitor and improve the laboratory performance | Train 3 NCLE staff to use EQA data to monitor and improve the laboratory performance | *[REDACTED]* | *[REDACTED]* | 17092<br>17858 | | x | | | | |
| Site supervision | | | *[REDACTED]* | *[REDACTED]* | | | | | | | |
| • Direct onsite monitoring and technical assistance to ensure and improve the performance of HIV rapid testing, CD4 testing and specimen | • Improved the quality of HIV testing, sample management and referral system<br>• Used EQA data to | 1.Improved and strengthened the quality of HIV testing, sample management and referral system | *[REDACTED]* | *[REDACTED]* | 17092,<br>17858 | | x | x | | | |

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| management and referral system by staff in 3 priority provinces.<br>• Direct onsite coaching on laboratory and quality assurance to support the national IBBS program among MSM and FSW | monitor and improve lab performance on HIV rapid testing and CD4 count | 2. Used EQA data to improve the quality of lab performance<br>3. Improved and increased the quality of HIV clinical monitoring (CD4 and HIV viral load testing)<br>4. Monitored and supported the national IBBS on STI and HIV testing to ensure the quality of data | | | | | | | | | |

Thailand

Thailand's new "Ending AIDS" strategy presents a clear mission for HIV prevention and treatment that includes a package of integrated services for MSM and TG women, from HIV testing with same-day-test results through the continuum of care. Supporting this, ARP will focus on:

- Ensuring quality rapid HIV testing by providing in-service training and monitoring the quality of laboratory performance with internal and external assessments.
- Providing direct supervision to laboratories to ensure the quality of HIV testing and specimen management for CD4, HIV viral load, and HIV drug resistance testing.
- Ensuring quality molecular screening for MDR TB using an external quality assessment (EQA) program, and strengthening TB national and regional reference laboratories to provide quality services.
- Ensuring quality STI screening using an EQA program, and strengthening STI national and regional reference laboratories to provide quality STI laboratory service that includes HIV testing.
- Promoting laboratory continuous quality improvement activities for HIV diagnosis, treatment, and care by strengthening laboratory quality management systems and laboratory accreditation
- Supporting surveillance and monitoring for HIV drug resistance (HIVDR).

| 1. Brief Activity Description | Deliverables | | Budget codes and allocation ($) | | 6. IM ID | 7. Relevant Sustainability Element and Score | Impact on epidemic control | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2. 2015 | 3. 2016 | 4. 2015 | 5. 2016 | | | 8. HIV Testing | 9. Linkage to Care | 10. ART uptake | 11.Other Combination prevention | 12. Viral suppression |
| Training | | | | | | | | | | | |
| HIV rapid testing for counselors and lab technicians to support increase uptake of HTC among KP at 5 priority sites | trained/retrained 20 staff at 5 priority sites to ensure the quality of HIV diagnosis | Trained 10 trainers at 5 priority sites to monitor the quality of HIV testing and diagnosis | *[REDACTED]* | *[REDACTED]* | 17860, 17859 | | x | | | | |
| Laboratory quality management essential elements to increase access to timely and accurate results to support clinical monitoring especially on CD4 and viral load testing, and laboratory accreditation | trained 100 laboratory staff from 9 target provinces to ensure the quality of clinical laboratory services | trained 100 laboratory staff from 5 priority sites and 8 target provinces to ensure the quality of lab services to support clinical monitoring | *[REDACTED]* | *[REDACTED]* | 17860, 17589 | | x | x | | | x |
| HIV Drug resistant testing to support surveillance and monitoring HIV drug resistance (HIVDR) projects | | Quality HIV clinical monitoring and surveillance data | *[REDACTED]* | *[REDACTED]* | 17860 | | | | | X? | |
| Ensuring the quality of laboratory testing to support national HIV incidence estimation to evaluate the effectiveness of HIV intervention program | N/A | Trained 72 staff from 32 priority/target provinces on specimen management and referral system | *[REDACTED]* | *[REDACTED]* | 17860 17859 | | | | | X? | |
| National TB reference laboratory staff on quality requirements to ensure the quality of MDR-TB molecular testing EQA program | Trained 6 lab senior staff at the TB national and regional reference labs to develop a high quality of national EQA program and to monitor quality of TB labs | Trained 30 laboratory staff at the TB national and regional reference laboratories to implement, use EQA data to monitor and improve the laboratory performance | *[REDACTED]* | *[REDACTED]* | 17860 17859 | | | x | | | x |
| National STI reference laboratory | Trained 4 | Trained 40 | *[REDA* | *[REDAC* | 17860 | | | x | | | |

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| on quality requirements to ensure the quality of STI screening EQA program | laboratory senior staff at the STI national reference laboratory to develop a high quality of national EQA program and to monitor the quality of STI laboratories<br>Trained 80 laboratory staff from 6 priority provinces and 50 target sites to implement and use EQA data to monitor and improve the laboratory performance | laboratory staff from 6 priority provinces and 50 target sites to use EQA data to monitor and improve the laboratory performance | *CTED]* | *TED]* | 17859 | | | | | | |
| Site supervision | | | | | | | | | | | |
| Direct onsite monitoring and TA to ensure and improve the performance of staff | Ensured quality of testing and sample mgmt. through improvement of EQA results<br>Ensured and increased quality of HIV clinical monitoring (CD4 and HIV viral load testing) | Improved and maintained the quality of testing thru improvement of EQA results<br>Ensured and increased the quality of HIV clinical monitoring | *[REDA CTED]* | *[REDAC TED]* | 17860<br>17859 | | x | x | | | x |
| Policy | | | | | | | | | | | |
| Evaluation and regulation strategies on introduction of new CD4 POC test to ensure the quality of CD4 results | Policy drafted / adopted by Thai government | Implementation nationwide by the government | N/A | N/A | | | | x | | | |

### 6.2 Strategic information (SI)

China

National guidelines for HIV epidemic estimation were updated in 2013. The National Guideline for HIV Case Reporting System will be updated in 2015.

In FY2016, PEPFAR China's SI priorities will include increasing the use of national/subnational surveillance data to identify unmet needs in the HIV response; monitoring efforts to increase testing coverage among key populations for earlier diagnosis; prompt initiation of treatment following HIV diagnosis, maintenance of viral suppression among those started on treatment, and decreased HIV-related mortality and HIV transmission. PEPFAR China's SI activities are crucial to identifying the national and focus provinces' epidemic trends and behavioral risk in key populations that inform strategies for epidemic control.

To increase quality and ensure sustainability of data management and use, in FY16 PEPFAR will provide TA to revise and improve national surveillance guidelines, increase capacity for data analysis and use, and promote dissemination of data by assisting with the development and publication of manuscripts in peer-reviewed scientific literature.

SI activities supported by PEPFAR in FY16 will include assistance to improve the quality of national and subnational surveillance system and national HIV epidemic estimation; all of which are core because data quality and estimations are required to evaluate progress on epidemic control.

| 1. Brief Activity Description | Deliverables | | Budget codes and allocation ($) | | 6. Implementing Mechanism(s) ID | 7. Relevant Sustainability Element and Score | Impact on epidemic control | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2. 2015 | 3. 2016 | 4. 2015 | 5. 2016 | | | 8. HIV Testing | 9. Linkage to Care | 10. ART uptake | 11. Other Combination prevention | 12. Viral suppression |
| Improve the quality of national/sub-national surveillance system | Update national sentinel surveillance operational manual | Updated M&E national case-reporting system<br><br>Evaluation of the national case reporting system | *[REDACTED]* | *[REDACTED]* | China CDC/ NCAIDS 16622 | | Improved data quality across the cascade | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| Provide TA on the national HIV epidemic estimation | Introduce new methods of HIV incidence estimation and risk population size estimation | Report and/or manuscript on revised national care cascade from HIV diagnosis, linkage to care and ART | *[REDACTED]* | *[REDACTED]* | China CDC/ NCAIDS 16622 | | Improved data quality across the cascade | | | | |
| Provide TA to the monitoring and evaluation to the National HIV Care Program | Finalize the development of ME guideline for National HIV Care Program | Conduct monitoring to National Care Program sites to improve the quality of service delivery and assess program performance | *[REDACTED]* | *[REDACTED]* | China CDC/ NCAIDS 16622 | | Improved quality of services across the cascade | | | | |
| Provide direct and TA supports to develop protocols and provide comments during field visits of special surveys | Protocols development and implement of special survey | Protocol development and implement special survey | *[REDACTED]* | *[REDACTED]* | China CDC/ NCAIDS 16622 | | Improved data quality across the cascade | | | | |
| Conduct SIMS visit and M&E to NCAIDS sites | Conduct SIMS visit and regular program monitoring | Conduct SIMS visit and regular program monitoring | *[REDACTED]* | *[REDACTED]* | China CDC/ NCAIDS 16622 | | x | x | x | | x |
| Conduct SIMS visit and M&E to ACC sites | Conduct SIMS visit and regular program monitoring | Conduct SIMS visit and regular program monitoring | *[REDACTED]* | *[REDACTED]* | ACC 16576 | | x | x | x | | x |

<u>Laos</u>

Lao PDR currently has limited technical expertise and human capacity to implement its surveillance, M&E, and HMIS. PEPFAR will continue to support surveillance for key populations and pregnant women, and also support the implementation of a monitoring system to assess access to prevention, care and treatment services. ARP will assist provincial and Central MOH HIV care providers and program managers who received M&E training and software programs for HIV prevention, testing, and treatment in 2015 to strengthen the quality of data entry, analysis, data interpretation, and their use of data for quality improvement.

| 1. Brief Activity Description | Deliverables | | Budget codes and allocation ($) | | 6. Implementing Mechanism(s) ID | 7. Relevant Sustainability Element and Score | Impact on epidemic control | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2. 2015 | 3. 2016 | 4. 2015 | 5. 2016 | | | 8. HIV Testing | 9. Linkage to Care (LTC) | 10. ART uptake | 11.Other Combination prevention | 12. Viral suppression |
| Implementing real time HIV cascade monitoring system (CommCare) | 1. Introduced CommCare HIV cascade real time monitoring system in three ARP supported provinces.<br><br>2. Established baseline data to track people entering HIV cascade services and recorded in pilot sites in three provinces. | Utilized real-time cascade data to monitor outcomes, program implementation, and facilitate evidence-based program improvement. | *[REDACTED]* | *[REDACTED]* | 17309 | | x | x | x | x | x |
| Providing technical support for adaptation and implementation of stigma and discrimination assessment tools in Laos | 1. Revised stigma and discrimination assessment tools incorporating S&D index and legal environment assessment (LEA) tools for Laos. | 1.Completed survey<br>2.Survey findings incorporated in national plan | *[REDACTED]* | *[REDACTED]* | 17059 | | x | x | x | x | |
| Technical assistance (TA) to Laos MoPH to implement the program-based monitoring and surveillance systems and the utilization of data for the HIV program planning and quality improvement | 1. Helped establish national and provincial working group on M&E with Centers of HIV/AIDS, Laos MoPH.<br>2. Designed and piloted a national program monitoring to monitor facility-based HIV prevention-to-care and treatment services.<br>3. Developed and piloted a standard operational procedure (SOP) on using monitoring results to improve cascade of prevention, care, and | 1. Build capacity of national and provincial technical working group on M&E to monitor HIV epidemics and program responses in 3 ARP priority provinces.<br>2.Scale up and improve quality of the national and provincial program monitoring to achieve the timeliness, reliable, standardized and streamlined monitoring data to monitor HIV epidemics and prevention-to-care and treatment | *[REDACTED]* | *[REDACTED]* | 17092, 17858 | | X | X | X | X | X |

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| | treatment retention in 3 ARP priority provinces and 4 additional national priority province, encompassing 9 ART sites.<br>4. Provided TA to implement IBBS among MSM in 3 ARP priority provinces and 1 additional national priority province.<br>5. Built capacity of 30 central and provincial resource persons on analysis of SI data, and interpretation to describe HIV epidemics and responses. | cascade.<br>3. Increase capacity of provincial HIV team (community outreach management & clinician team) to analyze the cascade data and interpret for interventions to close the gaps.<br>4. Build capacity of central and provincial surveillance managers to review the 2014 IBBS among MSM and plan for the 2016-17 rounds. | | | | | | | | | |

Thailand

Although Thailand has a strong surveillance and monitoring system, barriers include a limited number of technical experts and staff to interpret and use data to design strategies that effectively improve program quality. In FY16, ARP will focus on strengthening the implementation of surveillance and program monitoring to ensure data quality. ARP will also promote use of SI data by provincial team in six priority provinces to analyze PLHIV targets, monitor provincial HIV care cascade, identify gaps, and develop QI program to achieve 90-90-90 goals (and Thailand's *Ending AIDS* goal). Provincial networks (e.g., of AIDS program management officers and HIV care providers) will be trained on demand creation for HIV testing, recruitment, cascade improvement concepts, country goals, and setting provincial targets.

| **1. Brief Activity Description** | **Deliverables** | | **Budget codes and allocation ($)** | | **6. Implementing Mechanism(s) ID** | **7. Relevant Sustainability Element and Score** | **Impact on epidemic control** | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **2. 2015** | **3. 2016** | **4. 2015** | **5. 2016** | | | 8. HIV Testing | 9. Linkage to Care (LTC) | 10. ART uptake | 11.Other Combination prevention | 12. Viral suppression |
| Implementing real time HIV cascade monitoring system (CommCare) | 1.Introduced CommCare HIV cascade real time monitoring system in | Utilized real-time cascade data to monitor outcomes, program | *[REDACTED]* | *[REDACTED]* | 17309 | | x | x | x | x | x |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| | three ARP supported provinces.<br>2. Established baseline data to track people entering HIV cascade services and recorded in pilot sites in three provinces. | implementation, and facilitate evidence-based program improvement. | | | | | | | | | |
| Technical support for operational research and intervention model development on stigma and discrimination against KPs in 4 provinces | 1. Supported research using stigma and discrimination tools developed in 2014, also incorporating S&D index and legal environmental assessment tool.<br>2. Provided technical support to Thai MoPH to develop intervention models | 1. Completed operational research on stigma and discrimination against MSM/TG<br>2. Integrated stigma and discrimination questions into the national IBSS | *[REDACTED]* | *[REDACTED]* | 17059, 17815 | | x | x | x | x | |
| Test & Treat study | 1. Developed research protocol<br>2. Developed research data collection tools 3. Enrolled KPs across the cascade | 1. Continued enrollment of KPs<br>2. Analyzed data | *[REDACTED]* | *[REDACTED]* | 17059, 17815 | | X | X | X | X | x |
| Cohort analysis to determine factors associated with HIV cascade entry, retention and loss among MSM/TG | 1. Developed research protocol/IRB approval<br>2. Conducted retrospective cohort approach using life-grid analysis. | Completed study and utilized data to inform design of more effective cascade linkage and retention strategies. | *[REDACTED]* | *[REDACTED]* | 17059, 17815 | | X | X | X | X | |
| Study on acceptability/feasibility/willingness to pay for oral fluid testing | 1. Developed research protocol/IRB approval<br>2. Data collection tools developed/tested | 1. Collected data<br>2. Analyzed data | *[REDACTED]* | *[REDACTED]* | 17059, 17815 | | X | X | X | X | |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| Technical assistance to MoPH for cost-effectiveness of PrEP among MSM/TG | 1. Protocol/data collection tools developed | 1. Costing data collected/analyzed | *[REDACTED]* | *[REDACTED]* | 17059, 17815 | | X | X | | X | |
| TG Center of Excellence to develop appropriate TG service model | 1. Established TG Center<br>2. Protocol/service package developed | 1. Data collected/analyzed | *[REDACTED]* | *[REDACTED]* | 17059, 17815 | | X | X | X | X | X |
| Technical assistance to implement the program-based monitoring and surveillance systems and the utilization of data for the HIV program planning and quality improvement | • Helped establish subnational technical working group on M&E with Royal Thai Government.<br>• Implemented the revised information system to strengthen the standardized and streamlined program monitoring at national, subnational and site levels.<br>• Developed and piloted a SOP on using M&E to improve early access to care and treatment, ART retention and HIV drug resistance prevention in 2 regions, and provided capacity building for of the regional QI teams in 12 regions of Thailand.<br>• Implemented IBBS among non-venue | • Improve quality of the existing management information system to achieve the timeliness, reliable, standardized and streamlined program monitoring data to monitor HIV program responses among key population.<br>• Strengthen provincial mechanism to regularly regular review SI and provide TA to increase SI-informed program planning and advocate for the adoption of innovative interventions among key population in 6 ARP provinces. Provide trainings to provincial HIV team (community outreach management & clinician team) to analyze the cascade monitoring data and design interventions to close the gaps.<br>• Strengthen quality of IBBS among MSM, | *[REDACTED]* | *[REDACTED]* | 17860, 17859 | | x | x | x | x | x |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | sex workers and piloted the operational procedure to refer surveillance clients to prevention and care services.<br>• Implemented the centralized and online HIV information bank to facilitate the access of SI for policy decision and program planning. | venue-based sex workers and injecting drug users), and strengthened the referral of surveillance clients to prevention and care services. | | | | | | | | | |

## 6.3 Health System Strengthening (HSS)

China

| 1. Brief Activity Description | Deliverables | | Budget codes and allocation ($) | | 6. Implementing Mechanism(s) ID | 7. Relevant Sustainability Element and Score | Impact on epidemic control | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2. 2015 | 3. 2016 | 4. 2015 | 5. 2016 | | | 8. HIV Testing | 9. Linkage to Care (LTC) | 10. ART uptake | 11.*Other Combination prevention | 12. Viral suppression |
| ToT for provincial CDC staff on MSM size estimation using RDSA | 20 technical staff from 5 provinces trained | 100 provincial technical staff trained | *[REDACTED]* | *[REDACTED]* | China CDC/ NCAIDS 16622 | | x | x | | x | |
| Training for national and provincial CDC staff on surveillance data analysis and utilization | 100 technical staff trained | 100 technical staff trained | *[REDACTED]* | *[REDACTED]* | China CDC/ NCAIDS 16622 | | x | x | x | x | x |
| Human Resources | Personnel recruited to ensure PEPFAR smooth program management and coordination with NCAIDS/local CDCs | Personnel recruited to ensure PEPFAR smooth program management and coordination with NCAIDS/local CDCs | *[REDACTED]* | *[REDACTED]* | China CDC/ NCAIDS 16622 | | x | x | x | x | x |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Guideline/protocol/policy development | 1. MSM Intervention Manual<br>2. Contact Tracing Manual<br>3. National Free ARV Manual 4th Revision<br>4. Manual for IPT among HIV/AIDS patients<br>5. Quality assurance for HIV serological test<br>6. National Guideline for HIV Testing | 1. National Sentinel Surveillance Operations Manual Revision<br>2. HIV Antibody Test Manual Revision<br>TBD | *[REDACTED]* | *[REDACTED]* | China CDC/ NCAIDS 16622 | | x | x | x | x | x |

Laos

Recently, Lao PDR developed a new National Strategy and Action Plan covering 2016-2020 with 3 main components (enabling environment, increase coverage and improve quality of prevention interventions, increase quality and coverage of treatment). ARP conducted a review of their portfolio and used the definitions of core, near-core and non-core as a guiding principle when planning future activities in response to this National Plan; non-core activities were phased out. For Lao PDR, ARP will continue to support two types of activities: 1) ones that have a national impact such as support to national health information systems, surveillance efforts, capacity building at the central level; 2) ones related to specific program implementation. The latter will be limited to three priority provinces: Vientiane Capital, Champasak, and Savannakhet.

ARP will continue to help Lao PDR to better monitor and track people across the treatment cascade. Efforts will focus on how to improve the utilization and performance of the existing national database systems (MERS and HIVCAM) and link it with COMCARE system that will be introduced in the near future and plans to capture HIV/AIDS testing and referral data program data at the community level. Agency efforts around MSM program implementation in these three provinces will be better coordinated to avoid duplication.

ARP will specifically look to address low testing rates among MSM and TG women, decrease the proportion of people lost to follow up, and help ensure effective linkages to treatment. With KPIS, KPCF and LCI central initiative funding in Laos, ARP will be able to increase targets, and introduce innovative activities to improve HIV testing rates among MSM and TG women in high burden geographic areas. Activities and expected results are included in the program area summary.

Strengthening HIV laboratory services (EQA for HIV serology and CD4) and technical assistance for PMTCT services, couples HIV testing and counseling training will be more focused. Finally, ARP was requested to support HIV testing for TB patients at TB clinics in priority provinces.

| 1. Brief Activity Description | Deliverables | | Budget codes and allocation ($) | | 6. Implementing Mechanism(s) ID | 7. Relevant Sustainability Element and Score | Impact on epidemic control | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2. 2015 | 3. 2016 | 4. 2015 | 5. 2016 | | | 8. HIV Testing | 9. Linkage to Care | 10. ART uptake | 11.Other Combination prevention | 12. Viral suppression |
| Technical assistance to increase uptake of HTC and yield among MSM and TG women | - Training on field-based delivery of rapid HIV testing by trained community counselors<br>- Training on HTC referral options and improved HIV cascade performance<br>- Introduced social network testing at six HTC sites<br>- Introduced peer mobilizer model to extend outreach coverage | • Training on oral fluid HIV screening by peer mobilizers<br>• Training to strengthen quality of behavior change communication to create demand<br>• Training on sauna-based HIV testing | *[REDACTED]* | *[REDACTED]* | 17309 | | x | x | x | | |
| Technical assistance to local partners to forecast supplies for HTC and clinical services | • Train staff and develop inventory checklists | Train logistic managers at each site on supply tracking and forecasting<br>Conduct supportive supervision visits to ensure stock, identify areas of weakness, and develop performance improvement plans | *[REDACTED]* | *[REDACTED]* | 17309 | | x | x | x | x | X |
| Strengthen capacity of the national and provincial program managers on SI-informed policy decision and program planning | • Developed a harmonized management system across multi-sectoral agencies to monitor HIV intervention | Strengthen the harmonized management and coordination across multi-sectoral agencies for program monitoring in 3 prioritized provinces. | *[REDACTED]* | *[REDACTED]* | 17092, 17858 | | X | X | X | X | X |

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| | responses<br>• Developed a guideline on projection of HIV epidemics and using results for policy decision and strategic plan. | Built capacity of national and provincial program managers on projection of HIV epidemics and using results for policy decision and strategic plan at 3 prioritized ARP provinces. | | | | | | | | | |
| Strengthen South-South technical collaboration between Thailand and Laos Ministry of Health (Laos site) | • Drafted the bilateral Thailand-Laos Country Joint Action Plan of cross-border AIDS Alleviation.<br>• Help establish advisory & technical working groups | • Refine the complimentary interventions to strengthen HIV prevention, care and ART among KP at 3 set of twin cities where are ARP prioritized provinces<br>• Set up the harmonized monitoring system across border. | *[REDACTED]* | *[REDACTED]* | 17092, 17585 | | | | | | |

<u>Thailand</u>

Efforts are underway to help Thailand better monitor and track people across the cascade, specifically looking to address low testing rates among MSM and TG women, decrease the proportion of people lost to follow up, and help ensure effective linkages to treatment, given the Royal Thai Government's new Test and Treat policy. Strengthening systems needed to sustain this work is central to the design of all activities, with FY16 HSS programs focused in priority geographic areas and targeted national-level efforts needed to support future scale-up and broader epidemic control. With cross border issues arising from the nascent ASEAN open market and free movement of labor force between countries, ARP plans to facilitate the formal agreement on HIV/AIDS interventions between Thailand and Laos MoPH. Development of a formal Bilateral Thai-Laos Joint Action Plan was begun in FY15 with the goal of optimizing resources, ensuring complementary work plans, and minimizing duplication of interventions. In Fy16, ARP plans to facilitate join planning and information exchange through country-to-country collaborations between Thailand and Laos, focusing on strengthening referral systems in order to prevent uninterrupted ARV treatment access for migrant workers and introducing technical knowledge and

experiences on governmental health fund allocation for HIV. Linkage and sharing of monitoring data between countries will support monitoring of the cascade of care. Developing and sustaining the Bilateral Joint Action Plan is an area of increasing future concern that will need some careful planning and constitute areas for potential support both at the policy and technical levels.

| 1. Brief Activity Description | Deliverables | | Budget codes and allocation ($) | | 6. Implementing Mechanism(s) ID | 7. Relevant Sustainability Element and Score | Impact on epidemic control | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2. 2015 | 3. 2016 | 4. 2015 | 5. 2016 | | | 8. HIV Testing | 9. Linkage to Care | 10. ART uptake | 11.Other Combination prevention | 12. Viral suppression |
| Technical assistance to increase uptake of HTC and yield among MSM and TG women | • Training on field-based delivery of rapid HIV testing by trained community counselors<br>• Training on Expanding HTC referral options and improved HIV cascade performance<br>• Training on peer mobilizer model to extend outreach coverage<br>• Training on social network testing for six HTC sites | • Training to introduce oral fluid HIV screening by peer mobilizers<br>• Training to strengthen quality of behavior change communication to create demand<br>• Training on sauna-based HIV testing | *[REDACTED]* | *[REDACTED]* | 17309 | | x | x | x | | |
| Implementing real time HIV cascade monitoring system (CommCare) | 1. Trained community-based organizations on CommCare HIV cascade real time monitoring in four ARP supported provinces. | 1. Utilized real-time cascade data to monitor outcomes, program implementation, and facilitate evidence-based program improvement. | *[REDACTED]* | *[REDACTED]* | 17309 | | x | x | x | x | x |
| Technical support for operational research and intervention model development on stigma and discrimination against KPs in 4 provinces | - | 1. Capacity building CBOs and health care providers on use of stigma and discrimination tools developed in 2014, also incorporating S&D index and legal environmental | *[REDACTED]* | *[REDACTED]* | 17059, 17815 | | x | x | x | x | |

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| | | assessment tool.<br>2. Provided technical support to Thai MoPH on development of intervention models | | | | | | | | | |
| Test&treat study | - | 1. Training of CBOs on research protocol and enrollment of KPs across the cascade | *[REDACTED]* | *[REDACTED]* | 17059, 17815 | | X | X | X | X | x |
| Cohort analysis to determine factors associated with HIV cascade entry, retention and loss among MSM/TG | - | 1. Capacity building for health researchers on data analysis for informing design of effective cascade linkage and retention strategies. | *[REDACTED]* | *[REDACTED]* | 17059, 17815 | | X | X | X | X | |
| Study on acceptability/feasibility/willingness to pay for oral fluid testing | - | 1. Capacity building for health researchers on development of research protocol and data collection | *[REDACTED]* | *[REDACTED]* | 17059, 17815 | | X | X | X | X | |
| Technical assistance to MoPH for cost-effectiveness of PrEP among MSM/TG | - | 1. Capacity building for CBOs on PrEP provision and follow up | *[REDACTED]* | *[REDACTED]* | 17059, 17815 | | X | X | | X | |
| TG Center of Excellence to develop appropriate TG service model | - | 1. Capacity building of health care providers | *[REDACTED]* | *[REDACTED]* | 17059, 17815 | | X | X | X | X | X |
| Strengthen capacity of the national and program managers on SI-informed policy decision and program planning | • Developed a harmonized management system and increased coordination between health and non-health multi-sectoral agencies to monitor HIV intervention responses (Joint key performance indicators and AIDS Zero Portal). | • Set up a harmonized management system and strengthen multi-sectoral coordination for program monitoring at 6 prioritized provinces<br>• Build capacity of provincial program managers on projection of HIV epidemics and using | *[REDACTED]* | *[REDACTED]* | 17860, 17859 | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| | • developed a guideline on projection of HIV epidemics and using SI for policy decision and strategic plan. | SI for policy decision and strategic plan at 6 prioritized ARP provinces. | | | | | | | | | |
| Strengthen South-South technical collaboration between Thailand and Laos Ministry of Health (Thailand site) | • Drafted the bilateral Thailand-Laos Country Joint Action Plan of cross-border AIDS Alleviation.<br>• Help establish advisory & technical working groups | • Refine the complimentary interventions to strengthen HIV prevention, care and ART among KP at 3 set of twin cities where are ARP prioritized provinces<br>• Set up the harmonized monitoring system across border. | *[REDACTED]* | *[REDACTED]* | 17056, 17859 | | | | | | |

# 7.0 Staffing Plan

**China**

PEPFAR China's current staffing aligns well with core/near-core/non-core decisions, since project officers have technical expertise and experience involving key populations programming. No factors are anticipated to change the cost of doing business, other than inflation in China that increases prices generally. Staff will be utilized to meet SIMS requirements while performing site visits that were already planned. This may extend the duration of the site visit but is not anticipated to increase the frequency of the site visits unless serious unexpected deficiencies are found. PEPFAR China has only one existing unfilled position for which recruitment is currently ongoing. This position is expected to be filled with a native English speaker with public health monitoring and evaluation (M&E) experience. This new staff member will help meet increased M&E needs, including SIMS. China is a TA/TC country in which a large portion of staff time is dedicated to providing TA. Most TA goals are currently met solely by USG staff rather than external partners.

**Laos and Thailand**

USAID optimized staffing to focus on TA/developing local capacity in the region, especially given the increasingly limited fiscal environment. USAID/RDMA hired a USPSC Regional HIV/AIDS and TB Technical Advisor in FY14. No new positions are proposed and the cost of doing business will remain constant in the next cycle. Existing staff are being utilized to meet SIMS requirements. Technical assistance to Global Fund programs, other regional PEPFAR programs and host country governments will be provided through USG staff, while TA in other areas, to varying degrees, will be provided by both USG staff and implementing partners where most appropriate.

# APPENDIX A

## China

**Table A.1a: China: Program Core, Near-core, and Non-core Activities for COP 15**

| Level of Implementation | Core Activities | Near-core Activities | Non-core Activities |
|---|---|---|---|
| | YUNNAN | | |
| Site level | | Treatment as prevention and bilateral referral mechanism development among cross-border female sex workers.<br>Development of local policy for providing free ART to Burmese. Phase out after one year | |
| | Comprehensive interventions among MSMs including early case finding, NGO involvement, and manual development to NGOs to use social media to conduct intervention approaches | | |
| | Using RDS method to estimate population size of Burmese living in a cross-border area (Ruili County), by key population status<br>GUANGXI<br>" Treatment as Prevention" including condom promotion for MSM involving CBO for Rapid Test and one to one support to PLHIVs , set up a referral mechanism between HTC, STD and ART clinics . ( Beihai and Liuzhou) , learning the experience for scaling up in some cities .<br>TA on data analysis and utilization on provincial surveillance data for guidance local planning. | GUANGXI<br>"Test and Treat "and strengthening linkages and referral (HTC,STI, ART) and referral bilateral referral mechanism development among lower fee female sex workers including cross-border FSWs for improving the cascade ( Ningming and Du'an ), TA for scaling up to whole provinces covered 40% of estimated FSW and improving the cascade including VL suppression rate. | Pingxiang and Longzhou FSW intervention moved to non-core due to low yield |
| | HUNAN | | |
| | Explore comprehensive intervention strategy among MSM in Changsha and Changde | | Study on the serology status and the behavior among college student in Changsha |
| | GUIZHOU | | |
| | 1. Exploring MSM intervention through STD clinics as platform in Xinyi and Zunyi<br>2. Promote HIV/STD intervention and HCT among MSM population in Guiyang | | Scale-up HIV testing and treatment in Renhuai and Yuping<br>4. Comprehensive intervention among low |

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|---|---|---|---|
| | 3. Extending VCT service through community pharmacies in Sandu, with promotional efforts geared to MSM | | FSWs and clients in Honghuagang , Zunyi |
| | Promote NGO engaging in quality improvement of treatment and care services for PLHIV. | | |
| | | | |
| | YUNNAN | | |
| Sub-national level | | | Capacity building to healthcare staffs on clinical management TB/HIV co-infected patients |
| | HUNAN | | |
| | Capacity building for data analysis and utilization | | |
| | TRAINING<br>Training for rural clinicians on ART treatment and OIs management.<br>LAB<br>1. Examination of the utility of Cyto-Chex preserved CD4 cells for lab quality control of CD4 enumeration in Guangxi, China<br>2. Evaluation of the feasibility of new model using DBS plus urine for HIV detection among MSM in Yunnan<br>3. Evaluation of the acceptability of self-sample-collection (DBS and urine) for HIV detection in Guangxi<br>4. Verification of HIV-1 Antibody Indeterminate<br>using Nucleic Acid Analysis<br>5. Evaluation of a proposed laboratory HIV testing algorithm for early identification of HIV infection among MSM | | |
| | HUNAN | | |
| National level | National epidemic estimation<br>Improve the quality of national/sub-national surveillance system | | |
| | Training for provincial and below level CDC management staff on comprehensive HIV/AIDS Program management.<br>Training for CDC technical staff based on their needs by ITECH.<br>LAB<br>1, Evaluation of the feasibility of new model for HIV diagnosis involving self-sample collection (urine) with DBS for confirmatory testing<br>2, Evaluation of a new POCT for HIV-1 viral load.<br>3, Support development of plan for incidence assay transition from BED to avidity for HIV incidence estimation | LAB<br>1, Evaluation of dry powder reagents for CD4 testing in layer laboratories<br>2, Development of manual and guideline on HIV serological testing and quality control | |

| Table A.2a: China: Program Area Specific Core, Near-core, and Non-core Activities for COP 15 | | | |
|---|---|---|---|
| | Core Activities | Near-core Activities | Non-core Activities |
| HTC | (GUIZHOU) Extending VCT service through community pharmacies in Sandu, with promotional efforts geared to MSM<br><br>(TIANJIN) On-site VCT with oral fluid rapid tests for bathhouse MSM<br><br>(XINJIANG) Exploring effective ways to deliver prevention and care services to MSM (including Uyghur MSM), and promoting linkage among CBOs, local CDCs and hospitals<br><br>(GUANGXI )TA for conducting comprehensive interventions including teat and treat program MSM in Beihai and Liuzhou | (GUANGXI) low-fee and cross-border (Vietnamese) FSW in Ningming and Du'an to establish a referral mechanism for HTC, STD, ART, | (GUIZHOU) PITC in Yuping and Renhuai<br><br>(XINJIANG) Couples HIV counseling and testing (CHCT) in Urumqi (Xinshi District and Shuimogou District), Hami, Shanshan, Kuche and Xinhe<br><br>Pingxiang and Longzhou FSW intervention moved to non-core due to low yield |
| Care and Treatment | Promote NGO engaging in quality improvement of treatment and care services for PLHIV.<br>(GUANGXI)<br>TA for comprehensive interventions (test and treat) to MSM in Beihai and Liuzhou , | (GUANGXI)<br>Treatment as prevention and bilateral referral mechanism development among cross-border female sex workers<br><br>TA for low-fee and cross-border (some Vietnamese) FSW project in Ningming and Du'an aims to establish a referral mechanism for HTC, STI, ART and care services for improving cascade | (GUIZHOU) Scale-up HIV testing and treatment in Renhuai<br><br>Capacity building to healthcare staffs on clinical management TB/HIV co-infected patients<br>(LTT) |
| Prevention | (YUNNAN) Using RDS method to estimate population size of Burmese living in a cross-border area in Ruili<br>Comprehensive interventions among MSMs including early case finding, NGO involvement, and manual development to NGOs to use social media to conduct intervention approaches<br><br>(HUNAN) Explore comprehensive intervention strategy among MSM in Changsha and Changde<br><br>(GUIZHOU) Exploring MSM intervention through STD clinics as platform in Xinyi and Zunyi<br>Promote HIV/STD intervention and HCT among MSM population in Guiyang<br><br>(TIANJIAN) Piloting a model of comprehensive intervention for | (GUANGXI)<br>TA for low-fee and cross-border (some Vietnamese) FSW project in Ningming and Du'an . USG aims to establish a referral mechanism for ART and care especially for foreign FSW (no access to free services), to be scaled up by local government | (HUNAN) Study on the serology status and the behavior among college student in Changsha<br><br>Comprehensive intervention among low FSWs and clients in Honghuagang, Zunyi<br>Contact tracing in Yuping |

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|---|---|---|---|
| | bathhouse MSM in Tianjin, and scaling up to other cities.<br><br>(XINJIANG) Exploring effective ways to deliver prevention and care services to MSM (including Uyghur MSM), and promoting linkage among CBOs, local CDCs and hospitals<br><br>(GUANGXI)<br>TA for comprehensive services including test and treat ,prevention interventions to MSM in Beihai an Liuzhou, | | |
| Program/system support | (SI) TA on national epidemic estimation<br>Improve the quality of national/sub-national surveillance system<br>Capacity building for data analysis and utilization | | |
| HSS | Training for rural clinicians on ART treatment, adherence counselling and support and OIs management for providing quality of the care and treatment service as a result of improving cascade.<br><br>Training for provincial and below level CDC management staff on comprehensive HIV/AIDS Program management.<br><br>Training for CDC technical staff based on their needs by ITECH and LE staff. | | |

**Table A.3a: China: Transition Plans for Non-core Activities**

| **Transitioning Activities** | Type of Transition | Funding in FY 15 | Estimated Funding in FY 16 | # of IMs | Transition End date | Notes |
|---|---|---|---|---|---|---|
| PITC in Renhuai | Handed over to government | *[REDACTED]* | 0 USD | 1 | September 30, 2015 | |
| PITC in Yuping | Changing intervention type to contact tracing | *[REDACTED]* | 0 USD | 1 | | Will change to alternative intervention before program launch |
| Pingxiang FSW HTC and prevention | Closing site | *[REDACTED]* | 0 USD | 1 | September 30, 2015 | |
| Longzhou FSW HTC and | Closing site | *[REDACTED]* | 0 USD | 1 | September 30, 2015 | |

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| prevention | | | | | | |
| **Totals** | | *[REDACTED]* | 0 USD | | | |

## Laos

| Table A.1b Laos: Program Core, Near-core, and Non-core Activities for COP 15 | | | |
|---|---|---|---|
| **Level** | **Core** | **Near-core** | **Non-core** |
| **Site** | Improving the quality of HIV care and treatment services, focusing on increasing early recruitment to ART, and improving cascade of treatment among key population (i.e., MSM, TG women, sex workers) | | |
| | Provide TA to support introduction and quality assurance of HIV testing in TB clinics in three priority provinces | | |
| **Sub-national** | Strengthening the utilization of program monitoring data (MERS and HIVCAM) and provincial surveillance data to determine areas needed for provincial program improvement and build capacity of site providers to be able to use MERS and HIVCAM for quality case management services. | | |
| | Development and demonstration of enhanced social network recruitment and support approaches to improve HIV cascade outcomes among MSM and TG women in priority communities in three provinces | | |
| | | | Support for community-based drop-in centers for MSM and TG women |
| | Piloting peer-led community screening among MSM and TG women using oral fluid HIV tests | | |
| | | | Strengthening capacity for MSM prevention in Lao |
| | Piloting electronic client management, referral, and cascade improvement system across community and clinical providers | | |
| | Training of healthcare workers to mitigate stigma and discrimination in priority HIV service delivery sites for MSM and TG women in three provinces | | |
| | Strengthening Laos national program planning, management, and monitoring/surveillance for children, adolescents, and young women | | |
| | Improving the quality and sustainability of HIV and HIV-related laboratory testing in labs supporting HTC for MSM, TG women, and sex workers | | |
| **National / Above-national** | Strengthening national HIV MIS for monitoring of program responses (MERS and HIVCAM) to capture routine national HIV data on facility-based HIV prevention, counseling, care and treatment, and increasing capacity of program managers on utilization for program planning and | | |

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| | quality improvement | | |
| | Strengthening the capacity of national HIV program staff to conduct HIV surveillance and monitor/improve the national response | | |
| | Conduct HIV testing and counseling among active military and recruits | | |
| | Strengthen and improve the Lao People's Army HIV/AIDS knowledge base and information system | | |
| | Strengthening capacity of HIV laboratory testing within the Lao People's Army by procuring HIV test kits | | |
| | | Distribute SABERS results in a workshop for Lao People's Army commanders | |
| | Procure condoms for military and recruits | | |

| Table A.2b Laos: Program Area Specific Core, Near-core, and Non-core Activities for COP 15 | | | |
|---|---|---|---|
| **Program area** | **Core Activities** | **Near-core Activities** | **Non-core Activities** |
| **HTC** | Conduct HIV testing and counseling to active military and recruit soldiers. | | |
| | Piloting peer-led community screening among MSM and TG women using oral fluid HIV tests | | |
| | Provide TA to support introduction and quality assurance of HIV testing in TB clinics in three priority provinces | | |
| **Care and Treatment** | Improving the quality and sustainability of HIV Treatment and Care in ART clinics serving MSM, TG women, and sex workers | | |
| | Training of healthcare workers to mitigate stigma and discrimination in priority HIV service delivery sites for MSM and TG women in three provinces | | |
| **Prevention** | Strengthening and improve the Lao People's Army HIV/AIDS knowledge base and information system | | |
| | Procure condoms for military and recruits | | |
| | | | Support for community-based drop-in centers for MSM and TG women |
| | | | Strengthening capacity for MSM prevention in Lao |
| | Development and demonstration of enhanced social network recruitment and support approaches to improve HIV cascade outcomes among MSM and TG women in priority communities in three provinces | | |

| Table A.3a Laos: Transition Plans for Near-core and Non-core Activities | | | | | | |
|---|---|---|---|---|---|---|
| **Transitioning Activities** | **Type** | **Funding / COP 15** | **Funding / COP 16** | **# of IMs** | **Transition End** | **Notes** |
| Support for community-based drop-in centers for MSM and TG women | Non-core | 0 | 0 | N/A | FY15 | ARP will phase out our support for drop-in centers in FY15. These centers have historically featured high operating and unit costs, and have not proven particularly effective in improving rates of HIV diagnosis and linkages to care and treatment among MSM and TG women. |
| Strengthening capacity for MSM prevention in Lao | Non-core | 0 | 0 | N/A | FY15 | This will be eliminated and not included in the ROP, as it overlaps with the geographical area, focus, and population of USAID. Instead, the resources from this will be re-allocated to concentrate on other areas that support and enhance the USAID prevention activity in VT City. |
| Distribute SABERS results in a workshop for Lao People's Army commanders | Near-core | 0 | 0 | 1 | FY16 | Distribution of SABERS results will not directly/indirectly lead to epidemic control, but not distributing these results would be counter to the response. This will finish in FY16. |
| Totals | | 0 | 0 | 1 | | |

## Thailand

| Table A.1c Thailand: Program Core, Near-core, and Non-core Activities for COP 15 | | | |
|---|---|---|---|
| **Level** | **Core** | **Near-core** | **Non-core** |
| **Site** | Preventing new cases of HIV among infants and accelerating the cascade for HIV-infected children and adolescents in priority areas | | |
| | Improving the quality of HIV care and treatment services, focusing on increasing early recruitment to ART, and improving cascade of treatment among key population (i.e., MSM, TG women, and sex workers). | | |
| | Development and demonstration of a clinical HIV service delivery model tailored for TG women | | |
| **Sub-national** | Strengthening HIV surveillance systems and the use of monitoring data for HIV program planning and improvement in 6 ARP prioritized provinces. | | |
| | Assisting efforts to get to zero new HIV infections and zero AIDS-related death among children and adults, such as promoting NAP, EWI reports, and PHIMS report use for program improvement | | |

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| | Preventing new infections and accelerating the cascade for young women | | |
| | Assistance for Positive Health Promotion among MSM in Bangkok to strengthen continuum from prevention to care by improving coordination between prevention and treatment and care programs. | | |
| | Reducing prejudice, stigma, and discrimination in HIV health services and counseling for key populations in priority provinces. | | |
| | Building systems and capacity that generates demand and increases uptake of testing and other HIV services among key populations, with an emphasis on improving the cascade for MSM | | |
| | | Technical assistance to assist in transition of planned MSM activities from Global Fund to Thailand support | |
| | | Improving the quality of STI and STI-related programs for key populations in Global Fund provinces | |
| | | Strengthening HIV quality and linkages to care through disease-specific certification and hospital accreditation | |
| | | Improving quality management systems for STI laboratory testing for priority population | |
| | Improving linkages between TB and HIV management information systems and staff in Bangkok | | |
| | Strengthening the quality of laboratory services with an emphasis on access to quality services among key populations | | |
| | | Improving Quality Systems in Hospital Laboratories to support HIV clinical monitoring in Chonburi and Chonburi's laboratory network | |
| | | Building capacity for planning and management of HIV projects targeting key and vulnerable populations | |
| | Peace Corps Small Grants for stigma reduction, outreach to key populations, and prevention with positives | | |
| | | | Social franchising partnership with the National Health Security Office to establish sustainable, quality private- |

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|---|---|---|---|
| | | | sector HTC services in Bangkok |
| | | Support targeted (social and mid-level) media and events to generate demand for HIV testing and treatment services among MSM and TG women | |
| | | | Study on feasibility/acceptability/willingness to pay for the oral fluid screening test (peer testing model) among MSM/TG. |
| | | | A qualitative study among MSM and awareness of PrEP, demand for PrEP, perceived risks and benefits. |
| | Development and demonstration of enhanced social network recruitment and support approaches to improve HIV cascade outcomes among MSM and TG women in priority communities in four provinces | | |
| | Piloting peer-led community screening among MSM and TG women using oral fluid HIV tests | | |
| | Development and demonstration of a PrEP service delivery model in conjunction with the implementation of the KPIS-supported community test and treat study | | |
| | | Cohort analysis to determine factors associated with HIV cascade entry, retention and loss among MSM and TG women | |
| | | Training of healthcare workers to mitigate stigma and discrimination in priority HIV service delivery sites for MSM and TG women in four provinces | |
| | Piloting electronic client management, referral, and cascade improvement system across community and clinical providers | | |
| **National / Above-national** | Establishing systems to monitor coverage, cascade, and HIV drug resistance in Thailand, and the human resource capacity to use these monitoring results for program quality improvement | | |
| | Strengthen quality of IBBS among MSM, venue-based sex workers and injecting drug users), and strengthened the referral of surveillance clients to prevention and care services. | | |

| | | | |
|---|---|---|---|
| | | | Determination of a local misclassification rate for estimating HIV-1 incidence using IgG-Capture BED-EIA and Limited-antigen Avidity EIA in HIV-infected persons |
| | | | Technical assistance and inputs for development of Global AIDS Response Progress report, summarizing national epidemics, responses, progress |
| | | Provide TA to help develop, promote adoption, and secure financing for Thailand's national FSW and MSM task-shifting workplan | |
| | | Assess PMTCT progress and assist government efforts to reduce MTCT. | |
| | Improving the cascade for HIV-positive adolescents, improving their treatment adherence, and reducing their risk behaviors (prevention with positives) as they transition to adult care services | | |
| | | | Assist development of a national task shifting policy |
| | Supporting HIV-related health security in the Greater Mekong Subregion through stronger HIV and HIV-related laboratory quality management systems, quality assurance programs, and lab accreditation | | |
| | Assistance to strengthen the capacity of Thailand’s International Training Center on AIDS, TB, STIs (ITC) to sustain and accelerate epidemic control in the Greater Mekong Subregion | | |
| | | Piloting enhanced TB infection control in facilities that provide services to TB and HIV clients | |
| | Improving HIV monitoring and responses through linkages with TB systems. | | |
| | Establishing systems and practices for higher quality HIV treatment and referrals at the borders between Laos and Thailand | | |

| Table A.2c Thailand: Program Area Specific Core, Near-core, and Non-core Activities for COP 15 | | | |
|---|---|---|---|
| **Program area** | **Core Activities** | **Near-core Activities** | **Non-core Activities** |
| **Care and Treatment** | Establishing systems and practices for higher quality HIV treatment and referrals at the borders between Laos and Thailand | | |
| | Improving the cascade for HIV-positive adolescents, improving their treatment adherence, and reducing their risk behaviors (prevention with positives) as they transition to adult care services | | |
| | Development and demonstration of a clinical HIV service delivery model tailored for TG women | | |
| | Assisting efforts to get to zero new HIV infections and zero AIDS-related death among children and adults, such as promoting NAP, EWI reports, and PHIMS report use for program improvement | | |
| | Assistance for Positive Health Promotion among MSM in Bangkok to strengthen continuum from prevention to care by improving coordination between prevention and treatment and care programs. | | |
| | | Training of healthcare workers to mitigate stigma and discrimination in priority HIV service delivery sites for MSM and TG women in four provinces | |
| | Reducing prejudice, stigma, and discrimination in HIV health services and counseling for key populations in priority provinces. | | |
| | | Strengthening HIV quality and linkages to care through disease-specific certification and hospital accreditation | |
| | | Improving the quality and laboratory capacity of STI programs for key populations in Global Fund provinces | |
| **HTC** | Piloting peer-led community screening among MSM and TG women using oral fluid HIV tests | | |
| | | Technical assistance to assist in transition of planned MSM activities from Global | |

| | | | |
|---|---|---|---|
| | | Fund to Thailand support. | |
| | | Building capacity for planning and management of HIV projects targeting key and vulnerable populations | |
| | | | Social franchising partnership with the National Health Security Office to establish sustainable, quality private-sector HTC services in Bangkok |
| | | Support targeted (social and mid-level) media and events to generate demand for HIV testing and treatment services among MSM and TG women | |
| | | | Study on feasibility/acceptability/willingness to pay for the oral fluid screening test (peer testing model) among MSM/ TG women. |
| **Prevention** | | Assessing PMTCT progress and assisting government efforts reduce MTCT. | |
| | Preventing new cases of HIV among infants and accelerating the cascade for HIV-infected children and adolescents in priority areas | | |
| | Peace Corps Small Grants for stigma reduction, outreach to key populations, and prevention with positives | | |
| | Development and demonstration of a PrEP service delivery model in conjunction with the implementation of the KPIS-supported community test and treat study | | |
| | | | A qualitative study among MSM and awareness of PrEP, demand for PrEP, perceived risks and benefits. |
| | Development and demonstration of enhanced social network recruitment and support approaches to improve HIV cascade outcomes among MSM and TG women in priority communities in four provinces | | |
| | Building systems and capacity that generates demand and increases uptake of testing and other HIV services among key populations, with an emphasis on improving the cascade for MSM | | |

| | | | |
|---|---|---|---|
| | Preventing new infections and accelerating the cascade for young women | | |

| Table A.3c Thailand: Transition Plans for Near-core and Non-core Activities | | | | | | |
|---|---|---|---|---|---|---|
| **Transitioning Activities** | **Type** | **Funding / COP 15** | **Funding / COP 16** | **# of IMs** | **Transition End** | **Notes** |
| Technical assistance to assist in transition of planned MSM activities from Global Fund to Thailand support | Near-core | *[REDACTED]* | *[REDACTED]* | 0 | FY16 | Targets MSM in GF provinces, aims to increase HIV testing and provides ART training. Has softened the blow of the Global Fund departure; it took substantial investment up front but now mechanism is in place to support these provinces after transition away in FY16. This project will be sustainable, even as Global Fund discontinues support further. |
| Improving the quality of STI and STI-related programs for key populations in Global Fund provinces | Near-core | *[REDACTED]* | *[REDACTED]* | 0 | FY16 | Activity aims to complete improvements to the quality of STI and STI-related services for key populations in FY16, and to evaluate the project, capture and disseminate the results, and document the model that was used for sharing. The ARP will transition away from this work in FY16. |
| Strengthening HIV quality and linkages to care through disease-specific certification and hospital accreditation | Near-core | *[REDACTED]* | *[REDACTED]* | 1 | FY16 | During FY16 ARP will focus USG support on priority provinces with reduced USG support of non-priority provinces as part of its transition process. |
| Improving quality management systems for STI laboratory testing for priority population | Near-core | *[REDACTED]* | *[REDACTED]* | 1 | FY16 | In FY16 this will be re-focused on four priority provinces, with an emphasis on support for key populations in those areas. The project will proceed to transition out in FY16. |
| Improving Quality Systems in Hospital Laboratories (Saraburi) | Near-core | *[REDACTED]* | *[REDACTED]* | 1 | FY16 | This is outside the geographic focus area so while the activities are core, in that faster and higher quality test results improve the cascade, ARP will transition away from this work in FY16. |
| Building capacity for planning and management of HIV projects targeting key and vulnerable populations | Near-core | *[REDACTED]* | *[REDACTED]* | 1 | FY16 | This activity is not core in that it does not directly/indirectly lead to epidemic control or 90-90-90 and therefore the activity will be ended after FY16. |
| Social franchising partnership with the National Health Security Office to establish sustainable, quality private-sector HTC services in Bangkok | Non-core | *[REDACTED]* | *[REDACTED]* | 1 | FY15 | Direct USAID support for these activities will end with the end of the CAP-3D agreement in FY15, and no new funding is requested. ARP anticipates that participating private providers will continue to provide services and receive reimbursement for testing as needed from the National Health Security Office. |
| Support targeted (social and mid-level) media and events to generate demand for HIV testing | Non-core | *[REDACTED]* | *[REDACTED]* | 1 | FY16-FY17 | ARP anticipates that a short-term, targeted effort to promote the life-saving benefits of HIV testing and counseling will be instrumental in improving HIV service uptake among MSM and |

| | | | | | | |
|---|---|---|---|---|---|---|
| and treatment services among MSM and TG women | | | | | | TG women. These efforts will be conducted in coordination with the national HIV program, and should be transitioned to domestic resources within the next one to two years. |
| Study on feasibility/acceptability/willingness to pay for the oral fluid screening test (peer testing model) among MSM/TG women. | Non-core | *[REDACTED]* | *[REDACTED]* | 1 | FY15 | Following meetings with Thai MoPH counterparts, it seems clear that the national program would prefer that USAID support an oral fluid screening demonstration project -- rather than a formative assessment -- to improve rates of diagnosis and linkages to treatment among MSM and TG women. Details on this activity are included on a separate line below. |
| A qualitative study among MSM and awareness of PrEP, demand for PrEP, perceived risks and benefits. | Non-core | *[REDACTED]* | *[REDACTED]* | 1 | FY15 | Resources planned for this formative work will instead be invested to support the PrEP demonstration and cost-effectiveness study detailed on a separate line below. Data on client perceptions of the risks and benefits of PrEP and on willingness to pay will be collected as part of the demonstration study. |
| Cohort analysis to determine factors associated with HIV cascade entry, retention and loss among MSM and TG women | Near-core | *[REDACTED]* | *[REDACTED]* | 1 | FY16-FY17 | This will involve a retrospective cohort approach conducted by Inform Asia using a life-course approach, and should be completed in one to two years. Results will help inform design of more effective HIV cascade linkage and retention strategies. |
| Training of healthcare workers to mitigate stigma and discrimination in priority HIV service delivery sites for MSM and TG women in four provinces | Near-core | *[REDACTED]* | *[REDACTED]* | 1 | FY16-FY17 | This activity will ensure that healthcare workers in priority HIV service delivery sites for MSM and TG women in Bangkok, Chiang Mai, Chonburi, and Hat Yai are trained to mitigate stigma and discrimination that may serve as a barrier to service uptake. ARP anticipates that this work can be transitioned to and sustained by the Thai MOPH within the next one to two years. |
| Determination of a local misclassification rate for estimating HIV-1 incidence using IgG-Capture BED-EIA and Limited-antigen Avidity EIA in HIV-infected persons | Non-core | *[REDACTED]* | *[REDACTED]* | N/A | FY15 | This project will be finalized in FY15 and additional work will be conducted by Thai counterparts. |
| Technical assistance and inputs for development of Global AIDS Response Progress report, summarizing national epidemics, responses, progress | Non-core | *[REDACTED]* | *[REDACTED]* | N/A | FY15 | Based on feedback from the portfolio review and in response to guidance from ROP 2015 guidance from OGAC, this project will not be included in the ROP and instead the ARP will rely on other agencies and national stakeholders to finalize this work. |
| Provide TA to help develop, promote adoption, and secure | Near-core | *[REDACTED]* | *[REDACTED]* | 0 | FY16 | This will bring more appropriate services closer to the priority populations, Improves sustainability. But there will not be a |

| | | | | | | |
|---|---|---|---|---|---|---|
| financing for Thailand's national FSW and MSM task-shifting workplan | | | | | | compelling reason for USG to support this work after FY16 so will transition away during 2015-2016. This activity is restricted to TA from CDC technical experts. |
| Assessing PMTCT progress and assisting government efforts reduce MTCT. | Near-core | *[REDACTED]* | *[REDACTED]* | 0 | FY16 | The project will include TA to support a UNICEF evaluation of the efforts to eliminate MTCT, intended to provide the evidence required to complete elimination (which is currently not available, as the majority of babies are born in private institutions). The project will complete in FY16 and any follow-up activities transitioned to the government. |
| Assist development of a national task shifting policy | Non-core | *[REDACTED]* | *[REDACTED]* | 0 | FY15 | As this project is in its final stages, and based on feedback from the portfolio review and in response to guidance from OGAC for FY15, this project will not be included in the ROP and instead final work transitioned to national partners. |
| Piloting enhanced TB infection control in facilities that provide services to TB and HIV clients | Near-core | *[REDACTED]* | *[REDACTED]* | 0 | FY16 | This activity will lead to improved TB/HIV outcomes and fewer deaths among PLHIV. The activity is on-going with PEPFAR matching funding from other sources, in Vietnam and Laos. PEPFAR's support for this project will end in FY16. |
| Totals | | *[REDACTED]* | *[REDACTED]* | | | |

# APPENDIX B

## B.1 Planned Spending in 2016

China

| Table B.1.1a: China: Total Funding Level | | |
|---|---|---|
| **Applied Pipeline** | New Funding | Total Spend |
| **$US 0** | **$US 4,000,000** | **$US 4,000,000** |

| Table B.1.2a: China: Resource Allocation by PEPFAR Budget Code | | |
|---|---|---|
| **PEPFAR Budget Code** | **Budget Code Description** | **Amount Allocated** |
| MTCT | Mother to Child Transmission | 0 |
| HVAB | Abstinence/Be Faithful Prevention | 0 |
| HVOP | Other Sexual Prevention | 905,260 |
| PWIDP | Injecting and Non-Injecting Drug Use | 0 |
| HMBL | Blood Safety | 0 |
| HMIN | Injection Safety | 0 |
| CIRC | Male Circumcision | 0 |
| HVCT | Counseling and Testing | 551,113 |
| HBHC | Adult Care and Support | 418,286 |
| PDCS | Pediatric Care and Support | 0 |
| HKID | Orphans and Vulnerable Children | 0 |
| HTXS | Adult Treatment | 221,172 |
| HTXD | ARV Drugs | 0 |
| PDTX | Pediatric Treatment | 0 |
| HVTB | TB/HIV Care | 0 |
| HLAB | Lab | 201,428 |

| | | |
|---|---|---|
| HVSI | Strategic Information | 254,650 |
| OHSS | Health Systems Strengthening | 194,932 |
| HVMS | Management and Operations | 1,253,159 |
| **TOTAL** | | **4,000,000** |

## Laos and Thailand

| **Table B.1.1b: Laos and Thailand: Total Funding Level** | | |
|---|---|---|
| **Applied Pipeline** | New Funding | Total Spend |
| **$US 81,000** | **$US 12,449,000** | **$US 12,530,000** |

| **Table B.1.2b Laos and Thailand: Resource Allocation by PEPFAR Budget Code** | | |
|---|---|---|
| **PEPFAR Budget Code** | **Budget Code Description** | **Amount Allocated** |
| MTCT | Mother to Child Transmission | 116,000 |
| HVAB | Abstinence/Be Faithful Prevention | 0 |
| HVOP | Other Sexual Prevention | 985,731 |
| PWIDP | Injecting and Non-Injecting Drug Use | 6,447 |
| HMBL | Blood Safety | 18,837 |
| HMIN | Injection Safety | 0 |
| CIRC | Male Circumcision | 0 |
| HVCT | Counseling and Testing | 1,964,956 |
| HBHC | Adult Care and Support | 1,448,489 |
| PDCS | Pediatric Care and Support | 145,756 |
| HKID | Orphans and Vulnerable Children | 0 |
| HTXS | Adult Treatment | 651,320 |
| HTXD | ARV Drugs | 0 |
| PDTX | Pediatric Treatment | 87,038 |

| | | |
|---|---|---|
| HVTB | TB/HIV Care | 212,141 |
| HLAB | Lab | 450,982 |
| HVSI | Strategic Information | 2,288,995 |
| OHSS | Health Systems Strengthening | 1,426,600 |
| HVMS | Management and Operations | 2,726,708 |
| **TOTAL** | | **12,530,000** |

**B.2 Resource Projections**

China

EA data were used to calculate the expenditures in FY14 in cost categories. Taking into account cost extension for the IMs and budget cycles (different from ROP cycles), percentage of program areas were calculated, and then the results were multiplied by total available funds this year. This was compared to expenditures in program management database system and costs were adjusted accordingly. Adjustments: ROP budget codes are different from EA cost categories. Program management fees in EA are distributed to program areas according to the characteristics of work, and, as in EA, capacity building costs were included into HSS. However, according to ROP budget code guidance, trainings were distributed to different program areas. Further adjustments were made according to 2016 program priorities.

Laos and Thailand

USG provides technical assistance, capacity building, and other support to local partners, host government, and stakeholders through implementing partners and cooperative agreements with national institutions. In FY15, USAID's activities are performed by new implementing partners with a toolkit of new approaches, such as a new Enhanced Peer Mobilizer model and a test and treat strategy. Therefore, current EA data does not capture the cost per unit of the program. In FY16 CDC activities will be performed under the umbrella of new cooperative agreements with existing implementing partners, as well as a new mechanism.

USG utilizes the "top down cost estimating" methodology. While the precise quantities of cost units required for successful program fulfillment are not known, the general categories and overall scale allow for an "order-of-magnitude" estimation of the full spectrum of cost expected to be associated with the program. The calculation is split into two parts. For internal Management and Operations, the

team has consulted with its financial office to calculate resources required in FY16 based on historical expenditure, plus future plans, including additional travel cost for SIMS visits. Then, the team calculated resource projections for each mechanism based on the FY15 project budget and work plan, program description, expected activities, outcomes, outputs, and results, considering the remaining funds after subtracting M&O. The estimates of cost categories based on percentage of specific work required by each mechanism multiplied by total estimated budget of each mechanism. The cost categories of M&O are based on data generate from FACTINFO system.

## Asia Regional Program COP15 Targets by Province: Clinical Cascade

| | Number of individuals who received HIV Testing and Counseling services for HIV and received their test results | Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load | Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load | Number of adults and children newly enrolled on antiretroviral therapy (ART) | Number of adults and children currently receiving antiretroviral therapy (ART) |
|---|---|---|---|---|---|
| China/ Guangxi Zhuang Autonomous Region | 2,110 | - | - | - | - |
| China/ Guizhou Province | 1,400 | - | - | - | - |
| China/ Hunan Province | 700 | - | - | - | - |
| China/ Sichuan Province | - | - | - | - | - |
| China/ Tianjin City | 1,800 | - | - | - | - |
| China/ Xinjiang Uygur Autonomous Region | 2,150 | - | - | - | - |
| China/ Yunnan Province | 3,905 | 80 | 230 | 80 | 230 |
| Laos/ Attapue | - | - | - | - | - |
| Laos/ Bokeo | - | - | - | - | - |
| Laos/ Bolikhamxay | - | - | - | - | - |
| Laos/ Champasak | 2,136 | 124 | 601 | 115 | 575 |
| Laos/ Huaphan | - | - | - | - | - |
| Laos/ Khammoune | - | - | - | - | - |
| Laos/ Luangnamtha | - | - | - | - | - |
| Laos/ Luangprabang | - | - | - | - | - |
| Laos/ Oudomxay | - | - | - | - | - |
| Laos/ Phongsaly | - | - | - | - | - |
| Laos/ Saravan | - | - | - | - | - |
| Laos/ Savannakhet | 8,436 | 166 | 1,461 | 191 | 1,364 |
| Laos/ Sayaboury | - | - | - | - | - |
| Laos/ Sekong | - | - | - | - | - |
| Laos/ Vientiane Capital | 8,352 | 482 | 1,600 | 406 | 1,218 |
| Laos/ Vientiane Province | - | - | - | - | - |
| Laos/ Xaysomboun | - | - | - | - | - |
| Laos/ Xiengkhoung | - | - | - | - | - |
| Thailand/ Amnat Charoen | - | - | - | - | - |
| Thailand/ Ang Thong | - | - | - | - | - |
| Thailand/ Bangkok | 29,371 | 3,059 | 13,169 | 1,401 | 8,394 |
| Thailand/ Bueng Kan | - | - | - | - | - |
| Thailand/ Buri Ram | - | - | - | - | - |
| Thailand/ Chachoengsao | - | - | - | - | - |
| Thailand/ Chai Nat | - | - | - | - | - |
| Thailand/ Chaiyaphum | - | - | - | - | - |
| Thailand/ Chanthaburi | - | - | - | - | - |
| Thailand/ Chiang Mai | 1,750 | 325 | 450 | 81 | 88 |
| Thailand/ Chiang Rai | - | 7 | 328 | 9 | 79 |
| Thailand/ Chon Buri | 3,826 | 400 | 555 | 109 | 120 |
| Thailand/ Chumpon | - | - | - | - | - |
| Thailand/ Kalasin | - | - | - | - | - |
| Thailand/ Kamphaeng Phet | - | - | - | - | - |
| Thailand/ Kanchanaburi | - | - | - | - | - |
| Thailand/ Khon Kaen | 303 | 77 | 989 | 74 | 759 |
| Thailand/ Krabi | - | - | - | - | - |
| Thailand/ Lampang | - | - | - | - | - |
| Thailand/ Lamphun | - | - | - | - | - |
| Thailand/ Loei | - | - | - | - | - |
| Thailand/ Lop Buri | - | - | - | - | - |
| Thailand/ Mae Hong Son | - | - | - | - | - |
| Thailand/ Maha Sarakham | - | - | - | - | - |
| Thailand/ Mukdahan | - | - | - | - | - |
| Thailand/ Nakhon Nayok | - | - | - | - | - |
| Thailand/ Nakhon Pathom | - | - | - | - | - |
| Thailand/ Nakhon Phanom | - | - | - | - | - |
| Thailand/ Nakhon Ratchasima | - | - | - | - | - |
| Thailand/ Nakhon Sawan | - | - | - | - | - |
| Thailand/ Nakhon Si Thammarat | - | - | - | - | - |
| Thailand/ Nan | - | - | - | - | - |
| Thailand/ Narathiwat | - | - | - | - | - |
| Thailand/ Nong Bua Lam Phu | - | - | - | - | - |
| Thailand/ Nong Khai | - | - | - | - | - |
| Thailand/ Nonthaburi | - | - | - | - | - |
| Thailand/ Pathum Thani | - | - | - | - | - |
| Thailand/ Pattani | - | - | - | - | - |
| Thailand/ Phangnga | - | - | - | - | - |
| Thailand/ Phatthalung | - | - | - | - | - |
| Thailand/ Phayao | - | - | - | - | - |
| Thailand/ Phetchabun | - | - | - | - | - |
| Thailand/ Phetchaburi | - | 6 | 102 | 5 | 34 |

## Asia Regional Program COP15 Targets by Province: Clinical Cascade

| | Number of individuals who received HIV Testing and Counseling services for HIV and received their test results | Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load | Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load | Number of adults and children newly enrolled on antiretroviral therapy (ART) | Number of adults and children currently receiving antiretroviral therapy (ART) |
|---|---|---|---|---|---|
| Thailand/ Phichit | - | - | - | - | - |
| Thailand/ Phitsanulok | - | - | - | - | - |
| Thailand/ Phra Nakhon Si Ayutthaya | - | - | - | - | - |
| Thailand/ Phrae | - | - | - | - | - |
| Thailand/ Phuket | - | - | - | - | - |
| Thailand/ Prachin Buri | - | - | - | - | - |
| Thailand/ Prachuap Khiri Khan | - | - | - | - | - |
| Thailand/ Ranong | - | - | - | - | - |
| Thailand/ Ratchaburi | - | - | - | - | - |
| Thailand/ Rayong | - | - | - | - | - |
| Thailand/ Roi Et | - | - | - | - | - |
| Thailand/ Sa Kaeo | - | - | - | - | - |
| Thailand/ Sakon Nakhon | - | - | - | - | - |
| Thailand/ Samut Prakan | - | - | - | - | - |
| Thailand/ Samut Sakhon | - | - | - | - | - |
| Thailand/ Samut Songkhram | - | - | - | - | - |
| Thailand/ Saraburi | - | - | - | - | - |
| Thailand/ Satun | - | - | - | - | - |
| Thailand/ Si Sa Ket | - | - | - | - | - |
| Thailand/ Sing Buri | - | - | - | - | - |
| Thailand/ Songkhla | 800 | 73 | 216 | 24 | 68 |
| Thailand/ Sukhothai | - | - | - | - | - |
| Thailand/ Suphan Buri | - | - | - | - | - |
| Thailand/ Surat Thani | - | - | - | - | - |
| Thailand/ Surin | - | - | - | - | - |
| Thailand/ Tak | - | - | - | - | - |
| Thailand/ Trang | - | - | - | - | - |
| Thailand/ Trat | - | - | - | - | - |
| Thailand/ Ubon Ratchathani | - | - | - | - | - |
| Thailand/ Udon Thani | 952 | 50 | 500 | 47 | 475 |
| Thailand/ Uthai Thani | - | - | - | - | - |
| Thailand/ Uttaradit | - | - | - | - | - |
| Thailand/ Yala | - | - | - | - | - |
| Thailand/ Yasothon | - | - | - | - | - |
| Other_ Asia Regional Program | 5,200 | - | - | - | - |
| **Total** | **73,191** | **4,849** | **20,201** | **2,542** | **13,404** |

## Asia Regional Program COP15 Targets by Province: Key, Priority, Orphan and Vulnerable Children Indicators

| | Number of the target population who completed a standardized HIV prevention intervention including the minimum components | Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required | Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS |
|---|---|---|---|
| China/ Guangxi Zhuang Autonomous Region | - | 2,410 | - |
| China/ Guizhou Province | - | 1,800 | - |
| China/ Hunan Province | - | 2,800 | - |
| China/ Sichuan Province | - | - | - |
| China/ Tianjin City | - | 3,000 | - |
| China/ Xinjiang Uygur Autonomous Region | - | 2,900 | - |
| China/ Yunnan Province | - | 1,880 | - |
| Laos/ Attapue | - | - | - |
| Laos/ Bokeo | - | - | - |
| Laos/ Bolikhamxay | - | - | - |
| Laos/ Champasak | - | 448 | - |
| Laos/ Huaphan | - | - | - |
| Laos/ Khammoune | - | - | - |
| Laos/ Luangnamtha | - | - | - |
| Laos/ Luangprabang | - | - | - |
| Laos/ Oudomxay | - | - | - |
| Laos/ Phongsaly | - | - | - |
| Laos/ Saravan | - | - | - |
| Laos/ Savannakhet | - | 448 | - |
| Laos/ Sayaboury | - | - | - |
| Laos/ Sekong | - | - | - |
| Laos/ Vientiane Capital | - | 896 | - |
| Laos/ Vientiane Province | - | - | - |
| Laos/ Xaysomboun | - | - | - |
| Laos/ Xiengkhoung | - | - | - |
| Thailand/ Amnat Charoen | - | - | - |
| Thailand/ Ang Thong | - | - | - |
| Thailand/ Bangkok | - | 12,620 | - |
| Thailand/ Bueng Kan | - | - | - |
| Thailand/ Buri Ram | - | - | - |
| Thailand/ Chachoengsao | - | - | - |
| Thailand/ Chai Nat | - | - | - |
| Thailand/ Chaiyaphum | - | - | - |
| Thailand/ Chanthaburi | - | - | - |
| Thailand/ Chiang Mai | - | 2,320 | - |
| Thailand/ Chiang Rai | - | - | - |
| Thailand/ Chon Buri | - | 4,220 | - |
| Thailand/ Chumpon | - | - | - |
| Thailand/ Kalasin | - | - | - |
| Thailand/ Kamphaeng Phet | - | - | - |
| Thailand/ Kanchanaburi | - | - | - |
| Thailand/ Khon Kaen | - | 100 | - |
| Thailand/ Krabi | - | - | - |
| Thailand/ Lampang | - | - | - |
| Thailand/ Lamphun | - | - | - |
| Thailand/ Loei | - | - | - |
| Thailand/ Lop Buri | - | - | - |
| Thailand/ Mae Hong Son | - | - | - |
| Thailand/ Maha Sarakham | - | - | - |
| Thailand/ Mukdahan | - | - | - |
| Thailand/ Nakhon Nayok | - | - | - |
| Thailand/ Nakhon Pathom | - | - | - |
| Thailand/ Nakhon Phanom | - | - | - |
| Thailand/ Nakhon Ratchasima | - | - | - |
| Thailand/ Nakhon Sawan | - | - | - |
| Thailand/ Nakhon Si Thammarat | - | - | - |
| Thailand/ Nan | - | - | - |
| Thailand/ Narathiwat | - | - | - |
| Thailand/ Nong Bua Lam Phu | - | - | - |
| Thailand/ Nong Khai | - | - | - |
| Thailand/ Nonthaburi | - | - | - |
| Thailand/ Pathum Thani | - | - | - |
| Thailand/ Pattani | - | - | - |
| Thailand/ Phangnga | - | - | - |
| Thailand/ Phatthalung | - | - | - |
| Thailand/ Phayao | - | - | - |
| Thailand/ Phetchabun | - | - | - |
| Thailand/ Phetchaburi | - | - | - |

## Asia Regional Program COP15 Targets by Province: Key, Priority, Orphan and Vulnerable Children Indicators

| | Number of the target population who completed a standardized HIV prevention intervention including the minimum components | Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required | Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS |
|---|---|---|---|
| Thailand/ Phichit | - | - | - |
| Thailand/ Phitsanulok | - | - | - |
| Thailand/ Phra Nakhon Si Ayutthaya | - | - | - |
| Thailand/ Phrae | - | - | - |
| Thailand/ Phuket | - | - | - |
| Thailand/ Prachin Buri | - | - | - |
| Thailand/ Prachuap Khiri Khan | - | - | - |
| Thailand/ Ranong | - | - | - |
| Thailand/ Ratchaburi | - | - | - |
| Thailand/ Rayong | - | - | - |
| Thailand/ Roi Et | - | - | - |
| Thailand/ Sa Kaeo | - | - | - |
| Thailand/ Sakon Nakhon | - | - | - |
| Thailand/ Samut Prakan | - | - | - |
| Thailand/ Samut Sakhon | - | - | - |
| Thailand/ Samut Songkhram | - | - | - |
| Thailand/ Saraburi | - | - | - |
| Thailand/ Satun | - | - | - |
| Thailand/ Si Sa Ket | - | - | - |
| Thailand/ Sing Buri | - | - | - |
| Thailand/ Songkhla | - | 1,044 | - |
| Thailand/ Sukhothai | - | - | - |
| Thailand/ Suphan Buri | - | - | - |
| Thailand/ Surat Thani | - | - | - |
| Thailand/ Surin | - | - | - |
| Thailand/ Tak | - | - | - |
| Thailand/ Trang | - | - | - |
| Thailand/ Trat | - | - | - |
| Thailand/ Ubon Ratchathani | - | - | - |
| Thailand/ Udon Thani | - | 880 | - |
| Thailand/ Uthai Thani | - | - | - |
| Thailand/ Uttaradit | - | - | - |
| Thailand/ Yala | - | - | - |
| Thailand/ Yasothon | - | - | - |
| Other_ Asia Regional Program | - | - | - |
| **Total** | **-** | **37,766** | **-** |

## Asia Regional Program COP15 Targets by Province: Breastfeeding and Pregnant Women

| | Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results) | Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery |
|---|---|---|
| China/ Guangxi Zhuang Autonomous Region | - | - |
| China/ Guizhou Province | - | - |
| China/ Hunan Province | - | - |
| China/ Sichuan Province | - | - |
| China/ Tianjin City | - | - |
| China/ Xinjiang Uygur Autonomous Region | - | - |
| China/ Yunnan Province | - | - |
| Laos/ Attapue | - | - |
| Laos/ Bokeo | - | - |
| Laos/ Bolikhamxay | - | - |
| Laos/ Champasak | 1,800 | 5 |
| Laos/ Huaphan | - | - |
| Laos/ Khammoune | - | - |
| Laos/ Luangnamtha | - | - |
| Laos/ Luangprabang | - | - |
| Laos/ Oudomxay | - | - |
| Laos/ Phongsaly | - | - |
| Laos/ Saravan | - | - |
| Laos/ Savannakhet | 8,100 | 19 |
| Laos/ Sayaboury | - | - |
| Laos/ Sekong | - | - |
| Laos/ Vientiane Capital | 7,680 | 19 |
| Laos/ Vientiane Province | - | - |
| Laos/ Xaysomboun | - | - |
| Laos/ Xiengkhoung | - | - |
| Thailand/ Amnat Charoen | - | - |
| Thailand/ Ang Thong | - | - |
| Thailand/ Bangkok | 12,119 | 95 |
| Thailand/ Bueng Kan | - | - |
| Thailand/ Buri Ram | - | - |
| Thailand/ Chachoengsao | - | - |
| Thailand/ Chai Nat | - | - |
| Thailand/ Chaiyaphum | - | - |
| Thailand/ Chanthaburi | - | - |
| Thailand/ Chiang Mai | - | - |
| Thailand/ Chiang Rai | - | - |
| Thailand/ Chon Buri | - | - |
| Thailand/ Chumpon | - | - |
| Thailand/ Kalasin | - | - |
| Thailand/ Kamphaeng Phet | - | - |
| Thailand/ Kanchanaburi | - | - |
| Thailand/ Khon Kaen | - | - |
| Thailand/ Krabi | - | - |
| Thailand/ Lampang | - | - |
| Thailand/ Lamphun | - | - |
| Thailand/ Loei | - | - |
| Thailand/ Lop Buri | - | - |
| Thailand/ Mae Hong Son | - | - |
| Thailand/ Maha Sarakham | - | - |
| Thailand/ Mukdahan | - | - |
| Thailand/ Nakhon Nayok | - | - |
| Thailand/ Nakhon Pathom | - | - |
| Thailand/ Nakhon Phanom | - | - |
| Thailand/ Nakhon Ratchasima | - | - |
| Thailand/ Nakhon Sawan | - | - |
| Thailand/ Nakhon Si Thammarat | - | - |
| Thailand/ Nan | - | - |
| Thailand/ Narathiwat | - | - |
| Thailand/ Nong Bua Lam Phu | - | - |
| Thailand/ Nong Khai | - | - |
| Thailand/ Nonthaburi | - | - |
| Thailand/ Pathum Thani | - | - |
| Thailand/ Pattani | - | - |
| Thailand/ Phangnga | - | - |
| Thailand/ Phatthalung | - | - |
| Thailand/ Phayao | - | - |
| Thailand/ Phetchabun | - | - |

## Asia Regional Program COP15 Targets by Province: Breastfeeding and Pregnant Women

| | Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results) | Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery |
|---|---|---|
| Thailand/ Phetchaburi | - | - |
| Thailand/ Phichit | - | - |
| Thailand/ Phitsanulok | - | - |
| Thailand/ Phra Nakhon Si Ayutthaya | - | - |
| Thailand/ Phrae | - | - |
| Thailand/ Phuket | - | - |
| Thailand/ Prachin Buri | - | - |
| Thailand/ Prachuap Khiri Khan | - | - |
| Thailand/ Ranong | - | - |
| Thailand/ Ratchaburi | - | - |
| Thailand/ Rayong | - | - |
| Thailand/ Roi Et | - | - |
| Thailand/ Sa Kaeo | - | - |
| Thailand/ Sakon Nakhon | - | - |
| Thailand/ Samut Prakan | - | - |
| Thailand/ Samut Sakhon | - | - |
| Thailand/ Samut Songkhram | - | - |
| Thailand/ Saraburi | - | - |
| Thailand/ Satun | - | - |
| Thailand/ Si Sa Ket | - | - |
| Thailand/ Sing Buri | - | - |
| Thailand/ Songkhla | - | - |
| Thailand/ Sukhothai | - | - |
| Thailand/ Suphan Buri | - | - |
| Thailand/ Surat Thani | - | - |
| Thailand/ Surin | - | - |
| Thailand/ Tak | - | - |
| Thailand/ Trang | - | - |
| Thailand/ Trat | - | - |
| Thailand/ Ubon Ratchathani | - | - |
| Thailand/ Udon Thani | - | - |
| Thailand/ Uthai Thani | - | - |
| Thailand/ Uttaradit | - | - |
| Thailand/ Yala | - | - |
| Thailand/ Yasothon | - | - |
| Other_ Asia Regional Program | - | - |
| **Total** | **29,699** | **138** |