STRATEGIC TECHNICAL ALIGNMENT FOR RESULTS (STAR) PROCESS

PEPFAR Asia Regional Program

Regional Operational Plan

(ROP) 2017

Strategic Direction Summary

March 02, 2017

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1.0 Goal Statement

The goal of the PEPFAR Asia Regional Program (ARP) is to catalyze broad, sustained epidemic control by demonstrating effective approaches to reach, test, treat, and retain men who have sex with men (MSM), transgender (TG) women and other key populations in settings with the greatest burden of HIV in China, Laos, and Thailand. To achieve this goal, the ARP works with civil society and government partners to pilot and evaluate innovative interventions and sustainably scale-up effective interventions; supports the establishment of domestic financing mechanisms for non-governmental organizations (NGOs); and works with host governments to systematize the role of NGOs in the health system. The ARP also provides technical assistance and facilitates knowledge sharing to countries in the region and beyond.

Based on analyses of epidemiological and program performance data, the ARP has developed a Regional Operations Plan (ROP) for FY18-FY19 focused on geographic areas and populations where HIV transmission is highest and committed to advancing strong, sustainable national and regional responses to the HIV epidemic. This plan incorporates a coordinated agenda for implementation of the final two years of an approved $20 million PEPFAR Incentive Fund (PIF) to advance domestic investments in civil society leadership and end Thailand's dependence on support from the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund).

Working across USG agencies and collaboratively with host-country government counterparts, implementing partners, civil society organizations (CSOs), and multilateral organizations, the ARP will accelerate epidemic control in twenty-one provinces with the highest HIV rates and lowest ART coverage among priority populations in China (five of 31 provinces), Laos (three of 17 provinces), and Thailand (thirteen of 77 provinces, including seven provinces included as part of the PIF).

FY18-19 activities build on a tradition of successful ARP investments in four areas: first, innovative, scalable, and more effective approaches for HIV epidemic control; second, the inclusion and recognition of the role of civil society organizations in the HIV response and the facilitation of national domestic funding mechanisms to sustain their role long term; third the use of TA to convert successful, innovative approaches into national policies and commitments to scale up; and, lastly the regional/global sharing of those experiences.

The ARP will continue to apply this approach in FY18-FY19, but with a sharp focus on assisting country efforts to reach, test, treat, and retain MSM and TG women in care and expand access to pre-exposure prophylaxis (PrEP) in priority provinces through client-centered community and public HIV services that meet quality standards and are cost-effective to deliver and sustain. In doing so, the ARP anticipates it will help national programs maximize the prevention and treatment benefits of antiretroviral medications and optimize the care continuum.

To realize these achievements with limited resources, the ARP will focus its investments on settings with the highest HIV infection burdens, concentrate on the key drivers of the epidemic in those provinces, broker partnerships of mutual benefit between civil society and public sector stakeholders, and coordinate USG agency investments to maximize impact.

The ARP will assist the Government of China (GoC) to achieve sustained epidemic control through technical support of HIV-related program design and implementation, including modelling, testing, evaluating, and improving field implementation of new service models for men who have sex with men (MSM) living in urban areas of Chinese provinces with the country's largest HIV burden.

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

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

Central to these efforts is a recognition that valuable and valued partnerships between host-country governments and civil society – as well as among community members and clinicians – will be essential to develop and sustain the high-impact and ideally cost-saving solutions needed to fast track and sustain an end to the AIDS pandemic.

By demonstrating how cost-effective programming can achieve epidemic control among target populations in priority areas, while helping to strengthen the systems to support replication and scale-up of successful models by the country, the 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, the 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 to accelerate HIV epidemic control more broadly.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country or regional profile

China

China is the most populous nation in the world with an estimated 1.37 billion people in 2015[1]. It has the world's second largest economy, and its 2015 GNI per capita (Atlas method) of $7,930, ranks it 97 and qualifies it as a middle-income country. As China's economy has grown rapidly, large disparities in wealth have emerged. China now has more than 200 billionaires as well as 70-200 million persons living in poverty, depending on the poverty index used. Its 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 usually results in their exclusion from social welfare programs (including free ART and other HIV-related services) where they live for work. Immigrants, whose numbers have also surged during China's economic expansion, are similarly excluded from accessing social services.

China's most recent HIV epidemic estimate is that there are 850,000 persons with HIV infection in China[2]. By the end of September 2016, 653,865 persons in China had been diagnosed with HIV, reported to CDC, and were presumed living. Cumulative deaths among HIV-diagnosed persons[3] in China numbered 200,808. In 2015, 115,365 new HIV diagnoses were reported in China. As of September 2016, more than 96,000 persons had been reported newly-diagnosed with HIV in 2016. The current pace of reporting of new diagnoses suggests that China's 2016 total will exceed that of 2015. In 2014, 85,000 HIV-diagnosed persons initiated ART; by the end of March 2016, 398,000 were receiving ART, among 493,000 people living with HIV (PLHIV who had initiated HIV care (reported CD4 count considered a proxy for care). As of the end of 2014, 73% of those receiving ART had received at least one viral load test, and 90% of those tested were suppressed (VL<1000). Official estimates of the number of live births in China in 2015 range from 16.55 million[4] to 18.13 million[5]. There were 4,318 HIV-exposed babies born in China in 2014, and the mother-to-child transmission (MTCT) rate was 6.1%.[6]

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[1] World Bank- http://www.worldbank.org/en/country/china

[2] Xinhua news service. Dec 1, 2016. "China's anti-AIDS, HIV practices successful: experts"
[3] NHFPC - http://en.nhfpc.gov.cn/2016-12/05/c_70800.htm; China J AIDS STD Vol. 22 No. 11 November 2016 - Update on the AIDS/STD Epidemic in China and the main response in control and prevention in the third quarter of 2016

[4] China Daily. Jan 22, 2016. Demographic challenge calls for serious response." Accessible at: http://usa.chinadaily.com.cn/epaper/2016-01/22/content_23202445.htm
[5] UNICEF, State of the World's Children 2016 Statistical Tables. Accessible at: https://www.unicef.org/rightsite/sowc/pdfs/statistics/SOWC_Spec_Ed_CRC_TABLE%201.%20BASIC%20INDICATORS_EN_111309.pdf

[6]Unpublished data presented by Dr. Qiu Jie of China-CDC at the Consultation on NHFPC-Unicef Demonstration Programme on Elimination of MTCT of HIV, Syphilis, and Viral Hepatitis. Sept 22-23, Beijing, China

The male-to-female ratio of persons newly-diagnosed with HIV in China was 3.7 in 2015[7]. Most PLHIV in China are adults under 50 years of age, although new diagnoses in persons over 50 years of age or older have been increasing each year. PLHIV residences are geographically concentrated in five southern and western provinces, as well as in areas of central China affected by the plasma donor HIV outbreak of the 1990s[8].

Approximately two-thirds of newly-diagnosed HIV cases in 2015 reported heterosexual sex as their sole HIV transmission risk factor; 28% reported male:male sex.[9] The annual total of new HIV diagnoses among persons 15-24 years of age is four times what it was in 2010, which suggests that incidence may be on the rise, even if improved reporting may account for some of this increase. National sentinel behavioral surveillance data indicate that HIV prevalence among MSM climbed from 1.4% in 2005 to 8.0% in 2015, while remaining stable among drug users (injecting and non-injecting) at around 3.3%[10].

Since 2010, China's HIV ART guidelines have included recommendations for treatment of HIV-infected individuals regardless of initial CD4 count for members of sero-discordant couples, pregnant women, or those who have TB or a hepatitis co-infection. In 2014, China issued guidelines that changed treatment eligibility criteria from CD4 <350 to CD4 <500 for all HIV-diagnosed persons not in the categories above. A revision of guidelines that eliminates CD4 thresholds for ART initiation, i.e. Test and Start, was officially approved and issued by the Chinese National Health and Family Planning Commission (NHFPC) in June 2016.

To achieve epidemic control and its 90-90-90 targets by 2020, China must address a number of key ongoing challenges. China's public health data are insufficiently utilized and rarely disseminated, which limits the informed involvement of the many government and community sectors necessary for a comprehensive response. China's official key population denominator estimates are dated and implausibly low, which adversely affects resource allocation and program planning. China has also insufficient human resources for adequate HIV care and treatment delivery, a very narrow ART formulary with no single daily dose combination formulations available, limited viral load testing services, and little evidence of integration between TB and HIV programs. There is sub-optimal civil society engagement in planning and prevention outreach, and stigma and discrimination towards MSM and other key populations is widespread. Lack of adequate privacy protection has severely damaged trust between PLHIV and the government sector, especially among MSM and TG women.[11]

In spite of these challenges, there are some promising developments in China's HIV response in recent years. Since 2013, in addition to formal adoption of Test and Start, national and provincial

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[7] China J AIDS STD Vol. 22 No. 4 April 2016 - Update on the AIDS/STD Epidemic in China and main response in control and prevention in the first quarter of 2016
[8] 2015 China AIDS Response Progress Report, NHFPC
[9] China J AIDS STD Vol. 22 No. 2; Feb 2016 Update on the AIDS/STD Epidemic in China and main response in control and prevention in December 2015.
[10] 2015 China AIDS Response Progress Report, NHFPC
[11] NY Times, July 2016 – "China Investigating Data Leak and Swindling of HIV/AIDS Patients"

governments have established funding mechanisms that support community-based organizations in filling HIV service delivery gaps. China's HIV/AIDS Action Plan for the 13th Five-Year Period (2016-2020), the most recent MSM Intervention Guidelines (2016), high-level meetings, and joint PEFPAR-supported collaboration activities suggest that China will move forward on integrating PrEP in HIV prevention and control efforts. Finally, in 2016, China's Vice-Minister of Health, Wang Guoqiang, publicly emphasized national support for the Sustainable Development Goal target to end AIDS by 2030[12].

[12] UNAIDS, 2016- Accelerating and Innovating in China's AIDS Response

Table 2.1.1.a China: Key National Demographic and Epidemiological Data

Table 2.1.1 Host Country Government Results															
	Total		<15				15-24[13]				15+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population#	1.37 billion	N/A	111.3 mil	8.1	115.8 mil	8.4					491.8 mil	40.9	511.8 mil	*42.6*	Chinese Statistical Yearbook2016
HIV Prevalence (%)		0.06 [14]		N/A		N/A		N/A		N/A		N/A		N/A	Chinese NHFPC 2015
AIDS Deaths (per year)	24,827		N/A		N/A		N/A		N/A		N/A		N/A		Chin J AIDS STD Vol 22 No. 2 Feb 2016
# PLHIV	653,865		N/A		N/A		N/A		N/A		N/A		N/A		Chin J AIDS STD Vol 22 No.12 Nov 2016
Incidence Rate (Yr)		N/A		N/A		N/A		N/A		N/A		N/A		N/A	
New Infections (Yr)	N/A														
Annual births	18,134,000	N/A													UNICEF, State of the World's Children 2016 Statistical Tables[15]
% of Pregnant Women w/ at least 1 ANC visit	N/A	96%	N/A	N/A			N/A	N/A			N/A	N/A			UNICEF, State of the World's Children 2016 Statistical Tables[16]
Pregnant women needing ARVs	6,583														[17]
Orphans (maternal, paternal, double)	N/A														
Notified TB cases (Yr)	1,393,000														Unpublished data, China CDC
% of TB cases that are HIV infected	4,700														Unpublished data, China CDC
Estimated Population Size of MSM*	4,130,000														Unpublished estimate prepared in 2015 by

[13] China's National Statistics Center does not publish population estimates of this age group broken down by sex

[14] Chinese National Health and Family Planning Commission

[15] Accessible at: Https://www.unicef.org/rightsite/sowc/pdfs/statistics/SOWC_Spec_Ed_CRC_TABLE%201.%20BASIC%20INDICATORS_EN_111309.pdf

[16] Accessible at: https://www.unicef.org/rightsite/sowc/pdfs/statistics/SOWC_Spec_Ed_CRC_TABLE%201.%20BASIC%20INDICATORS_EN_111309.pdf Table 8

[17] Number of HIV+pregnant women identified in 2014. Source: Unpublished data presented by Dr. Qiu Jie of China CDC at the Consultation on NHFPC-UNICEF Demonstration Programme on Elimination of MTCT of HIV, Syphilis, and Viral Hepatitis. Sept 22-23, Beijing

															China CDC
MSM HIV Prevalence	330,400	8.0													2015 China AIDS Response Progress Report, Chart 2
Estimated Population Size of FSW	2,250,000														Unpublished estimate prepared in 2015 by China-CDC
FSW HIV Prevalence	4,500	0.2					N/A	N/A			N/A	N/A			2015 China AIDS Response Progress Report, Chart 2
Estimated Population Size of Transgender	N/A	N/A					N/A	N/A			N/A	N/A			
Transgender HIV Prevalence	N/A	N/A					N/A	N/A			N/A	N/A			
Estimated Population Size of PWID	1,920,000														Unpublished estimate prepared in 2015 by China-CDC
PWID HIV Prevalence	113,280	5.9													Unpublished data from China's National HIV Sentinel Surveillance System – 2015, China CDC
Estimated Size of Priority Populations (specify)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Estimated Size of Priority Populations Prevalence (specify)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*														

Table 2.1.2a China: Cascade of HIV diagnosis, care and treatment (12 months, 2014)[18]

Table 2.2.2a China: 90-90-90 Cascade: HIV diagnosis, treatment and viral suppression*											
Epidemiologic Data (2014)					HIV Treatment and Viral Suppression (2014)				HIV Testing and Linkage to ART within the last year (2014)		
	Population (#)	**HIV Prevalence (%)**	**Estimated PLHIV**	**Total PLHIV diagnosed (#)**	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression 12 Months**	**Viral Suppression Rate (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	1.37 billion	0.06	850,000	501,000	295,358	60%	195,104	66%	127,560,180	103,501	85,274
Population < 15 years											
15 – 24 year olds											
25+ year olds											
Pregnant Women	18,134,000		6,583								
**											
MSM	4,130,000	8.0									
FSW	2,520,000	0.2									
PWID	1,920,000	5.9									

[18] Unpublished data, NCAIDS 2014

Laos People's Democratic Republic (Laos)

Although a lower middle income country, with a GNI per capita of 1,740 (USD) in 2015 (World Bank), the Laos economy has been steadily improving with ~7% GDP growth for several years (2015). Of the population of 6.5 million (2015), 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 (0.29% in 2016) with an on-going epidemic among MSM. An estimated 6,722 PLHIV were diagnosed in 2016. For the same year, the estimated HIV prevalence among MSM aged 15+ years was 1.9% and 0.86% among female sex workers while it was 7.1% among PWID. HIV prevalence among PWID was estimated using results from a 2010 survey and using case reports for validation. More information about the impact of the HIV epidemic among TG women in Laos is needed. For this report, TG women are included as part of MSM.

In 2016, an estimated 4,727 adult and children PLHIV had been retained on ART for the previous 12 months. ART coverage was 70.3%. The Laos Centre for HIV/AIDS and STI (CHAS) reported that median CD4 counts upon entry to care were 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. However, in January 2016, Laos adopted a Test and Start policy to ensure all HIV positive persons can be immediately entered into care. In 2016, 237 children were on ART; while 356 HIV-positive pregnant women were in need of ARVs. Previously, PEPFAR-supported HIV testing at military bases and routine case reporting at antiretroviral treatment (ART) sites suggested increasing numbers of infections among military personnel, in particular men aged ≥25 years, although total numbers remain low. However, a 2015 survey of male military conscripts reported 2 positives (out of 1,051) among male military conscripts.

Although new HIV infections in the general population increased between 2010 (estimated 612) and 2014 (estimated 1,057), new estimated HIV infections decreased between 2014 and 2016 (from 1,057 to 682). With economic growth, increasing employment opportunities, cross-border migration, and an improved transport system, the HIV epidemic in Laos continues to evolve and reflects some trends of neighboring countries, namely, greater concentration among key populations. Of note, certain segments of the population report multiple sexual partnerships. The 2016 Laos Global AIDS Response Progress (GARP) report noted some occupations may utilize sex workers given their jobs require frequent travel (e.g., military conscripts, truck drivers, utility workers, etc.).

In 2015 Laos implemented WHO ART guidelines June 2013 to start ART in all PLHIV regardless of WHO clinical stage who have CD4 less than 500 cells/mm3. Starting 1 January 2016 Laos

adopted WHO's 2015 new recommendations: ART should be initiated in all adults living with HIV regardless of WHO clinical stage and at any CD4 cell count. The Government of Laos conducted a national implementation workshop ART Rapid Advice Guidelines Workshop October 2016 to facilitate implementation of the guidelines across all sites. As the Test and Start policy is fully implemented, the GoL expects to continue and accelerate progress toward the 90-90-90 targets.

Table 2.1.1.b Laos: Key National Demographic and Epidemiological Data

Table 2.1.1 Host Country Government Results*															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	6,464,527		1,079,408		1,124,774		679,453		697,462		1,475,524		1,407,906		The 4th Population and Housing Census (PHC) 2015, adjusted with UN population data sheet in Spectrum
HIV Prevalence (%)		0.29		0.04		0.04		0.11		0.10		0.28		0.37	National Report on HIV Estimation and Projection, January 2017 Modelling (AEM adjusted Spectrum)
AIDS Deaths (per year)	380		22		23		10		8		120		198		
# PLHIV	11,546		382		398		738		688		4,162		5,178		
Incidence Rate (Yr)		0.11		0.005		0.005		0.02		0.02		0.0116		0.0095	
New Infections (Yr)	682		50		52		158		118		171		133		
Annual births	195,248														MoH Statistic report, 2015, Laos MoPH, (The 4th Population and Housing Census (PHC) 2015 observed 177,675 live births).
% of Pregnant Women with at least one ANC visit	177,675	91	N/A	N/A			N/A	N/A			N/A	N/A			MoH Statistic report, 2015, Laos MoPH,
Pregnant women needing ARVs	356														Modelling (Spectrum), 2016
Orphans (maternal, paternal, double)	201,607		N/A				N/A				N/A				Modelling (Spectrum), 2016
Notified TB cases (Yr)	4,534		N/A		N/A		N/A		N/A		N/A		N/A		TB Department, Laos MoPH, 2015
% of TB cases	310	6.83	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	TB Center, Laos MoPH,

Table 2.1.1 Host Country Government Results*															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
that are HIV infected															2015
Estimated Population Size of MSM*	49,974														AEM modelling, 2016 (Calculated from adjusted HIV prevalence observed by IBBS among MSM and TG in sentinel provinces).
MSM HIV Prevalence	945	1.89													AEM modelling, 2016 (Adjusted prevalence observed by IBBS among MSM and TG in sentinel provinces).
Estimated Population Size of FSW	13,403														AEM modelling, 2016 (Calculated from adjusted HIV prevalence observed by IBBS among FSW in sentinel provinces).
FSW HIV Prevalence	114	0.86					N/A	N/A			N/A	N/A			AEM modelling, 2016 (Adjusted prevalence observed by IBBS among FSW in sentinel provinces).
Estimated Population Size of Transgender	(Included in MSM)						N/A	N/A			N/A	N/A			
Transgender HIV Prevalence	(Included in MSM)						N/A	N/A			N/A	N/A			
Estimated Population Size of PWID	1,570														Laos KP Size Estimation in AEM, CHAS, 2016
PWID HIV Prevalence	117	7.12													AEM modelling, 2016
Estimated Size of Priority	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

Table 2.1.1 Host Country Government Results*															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Populations (specify)															
Estimated Size of Priority Populations Prevalence (specify)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*														

Table 2.1.2a Laos: Cascade of HIV diagnosis, Care and Treatment

Table 2.1.2 90-90-90 cascade: HIV diagnosis, Care and Treatment and Viral Suppression

	Epidemiologic Data[1, 2]				HIV Treatment and Viral Suppression[3]			HIV Testing and Linkage to ART Within the Last Year (2016)[4]		
	Total Population Size Estimate[1] (#)	HIV Prevalence[1] (%)	Estimated Total PLHIV[1] (#)	PLHIV diagnosed[2] (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	6,464,527	0.29	11,546	6,722	4,727	70.3	73.6	13,288	160	56
Population less than 15 years	2,204,182	0.04	780	356	237	66.5	69.6	68	5	1
15-24 year olds	1,376,915	0.10	1,426	1,316	428	32.5	56.5	4,417	51	23
25+ year olds	2,883,430	0.32	9,340	5,049	4,062	80.4	75.7	8,804	104	32
Key Population Results for National Reports (15+ only)										
MSM	49,974	1.89	945	334	296	88.7	58.1	49	24	21
FSW	13,403	0.86	114	83	50	60.3	56.0	821	8	5
PWID	1,570	7.12	112	8	6	73.2	83.3	1	1	0

Data sources:

1. National HIV Estimation and Projection Report, 2017, Centre for HIV/AIDS and STIs (CHAS), Laos Ministry of Health (MOH).
2. MERS, National Monitoring System for Voluntary Counseling and Testing (VCT), Prevention and Case-based Surveillance, CHAS, Laos MoH, updated as of Dec 31. 2016.
3. HIVCAM, National HIV Patient Monitoring System, CHAS, Laos MoH, Updated as of Dec 31. 2016.
4. MERS and HIVCAM results for 2 PEPFAR priority provinces (Vientiane Capital and Champasak) where MERS with the Unique Identification Code (UIC) was scaled up. Linkage of MERS and HIVCAM results were reported.

Thailand

Although an upper-middle income country (with a GNI per capita of 5,720 USD in 2015, World Bank), Thailand's economic growth has slowed in recent years compared to other developing East Asian countries. Poverty continues to be an important challenge, particularly among the ~50% of the population (65 million total population in 2015) that live in rural areas. Basic health systems infrastructure and access to clean water and sanitation are nearly ubiquitous.

In Thailand, 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), 6,342 new HIV infections occurred during 2016; 44% through transmission among MSM, 10% among sex workers and their clients, and 11% am6ng PWID.

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

There were an estimated 452,183 (Asian Epidemic Model, January 2017) PLHIV in Thailand. As of November 2016, 409,310 PLHIV had been diagnosed, 283,970 of those diagnosed were receiving ART (69%), and 229,448 of those receiving ART had viral load results <1000 copies/ml (National AIDS Program-Plus [NAP-Plus] data, September 30, 2016). In sum, about 69% of all PLHIV in Thailand are currently receiving HIV treatment.

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 disproportionately high burdens of new and existing HIV infections in key populations, critical gaps in access to services persist among these groups. For example, of an estimated 36,708 HIV-infected MSM in Thailand, only 22,186 received ART in 2016. In the same year, estimated ART coverage was 60.4%. There were an estimated 5,093 TG Women; 3,078 TG women were on ART (NAP-Plus, November 2016) while ART coverage for TG women was 60.4%.

In June 2016, Thailand met World Health Organization criteria for the elimination of mother-to-child HIV transmission (i.e., mother-to-child transmission rate <2%), but leaks persist in the cascade for HIV-infected infants and HIV-infected mothers after delivery. A 2012 evaluation found that 39% of HIV-exposed infants born during 2008-2011 did not receive early infant diagnosis (EID) and only 157 (37%) HIV-infected infants received ART within one year of age. Data from August 2014 through December 2015 showed that the proportion of HIV-infected infants receiving ART within one year of age increased to 79%. However, the infant AIDS-related mortality among these infants was 17%.

Table 2.1.1.a Thailand: Key National Demographic and Epidemiological Data

Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	65,323,148		5,690,889		5,949,799		4,478,002		4,582,823		23,426,531		21,195,104		Population Census (February 2013), National Economic and Social Development Board
HIV Prevalence (%)		0.69		0.05		0.05		0.22		0.34		0.80		1.10	National Report on HIV Estimation and Projection, January 2017 Modelling (AEM adjusted Spectrum)
AIDS Deaths (per year)	16,608		40		42		78		156		5,863		10,429		
# PLHIV	**452,183**		2,689		2,763		9,738		15,549		188,531		232,915		
Incidence Rate (Yr)		0.0098		0.0007		0.0007		0.0173		0.0457		0.0056		0.0101	
New Infections (Yr)	6,342		37		40		774		2,085		1,296		2,110		
Annual births	679 502	1.04													National Health Statistics, bureau of Policy and Strategy, 2015
% of Pregnant Women with at least one ANC visit	496,295	98.7	N/A	N/A			N/A	N/A			N/A	N/A			PHIMS, Department of Health, MoPH, 2016 (496,295 had ANC among 503,000 delivered)
Pregnant women needing ARVs	3,889	0.57													Modelling, 2016 Estimated from ANC prevalence as of 0.57% as of estimated pregnant women from estimated number of live birth in 2016.
Orphans (maternal, paternal,	1,289,614		801821				487795				0				Modelling (Spectrum)

Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
double)															
Notified TB cases (Yr)	66,176		N/A				NA		N/A		N/A				TBCM, TB Cluster, Department of Disease Control, 2015
% of TB cases that are HIV infected	7,819	11.8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	TBCM, TB Cluster, Department of Disease Control, 2015
Estimated Population Size of MSM*	517,164	N/A													Thailand KP Size Estimation, DDC, 2016 (By multiplication for age-adjusted men who have active anal sex with men). Estimated as 2.5% of male 15-59 year old.
MSM HIV Prevalence	36,708	7.09													AEM modelling, 2016 (The observed median HIV prevalence from IBBS = 9.2% in 2014 and 6.9%in 2016 (Unofficial report).
Estimated Population Size of FSW	131,063	N/A													Thailand KP Size Estimation, DDC, 2016 (By annual mapping survey and multiplication to adjusted invisible or under survey) Estimated as 0.6% of female 15-59 year old.
FSW HIV Prevalence	2,403	1.83					N/A	N/A			N/A	N/A			AEM modelling, 2016 (The observed median HIV prevalence from IBBS = 1.1% and 3.3% in 2014 for venue- and non-venue FSW respectively.
Estimated	247,174	N/A					N/A	N/A			N/A	N/A			Thailand KP Size

Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Population Size of Transgender															Estimation, DDC, 2016 (By multiplication for TG and TG who have active anal sex with men). Estimated as 1.2% of male 15-59 year old.
Transgender HIV Prevalence	5,093	2.06					N/A	N/A			N/A	N/A			AEM modelling, 2016 (The observed median HIV prevalence from IBBS among higher risk TG and TG SW = 12.7% in 2014 and 12%in 2016 (Unofficial report).
Estimated Population Size of PWID	42,000	NA													Thailand KP Size Estimation, DDC, 2016 (Using scaling up method by NAMc in 2014)
PWID HIV Prevalence	7,499	17.8													AEM modelling, 2016 (The observed median prevalence observed from IBBS, BoE, 2014 = 19.0%)
Estimated Size of Priority Populations (specify)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Estimated Size of Priority Populations Prevalence (specify)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*														

Table 2.1.2b Thailand: Cascade of HIV diagnosis, care and treatment

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*

	Epidemiologic Data				HIV Treatment and Viral Suppression[2-3]			HIV Testing and Linkage to ART Within the Last Year (2016)[2]		
	Total Population Size Estimate[1] (#)	HIV Prevalence[1] (%)	Estimated Total PLHIV[1] (#)	PLHIV diagnosed[2] (#)	On ART (#)	ART Coverage[4] (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	65,323,148	0.66	452,184	409,310	283,970	69.4	80.8	659,653	18,596	*9,952*
Population less than 15 years	12,248,754	0.04	5,452	4,985	3,219	64.6	76.6	12,785	163	*N/A*
15-24 year olds	9,661,025	0.26	25,287	28,971	16,686	57.6	62.6	173,779	3,847	*N/A*
25+ year olds	43,413,369	0.97	421,445	375,354	274,914	73.2	82.0	498,041	14,528	*N/A*
National level results (15+ only)[1, 3]										
MSM	517,164*	7.09*	36,708*	NA	22,186*	60.4	NA	22,639[#,$]	4,321[#]	*N/A*
FSW	131,063*	1.83*	2,403*	NA	1,669*	69.5	NA	13,673[#]	190[#]	*N/A*
PWID	42,000*	17.8*	7,499*	NA	4,481*	59.8	NA	1,607[#]	187[#]	*N/A*
Transgender (TG)	247,174*	2.06*	5,093*	NA	3,078*	60.4	NA	*N/A*		
Asia Regional Program Priority Provinces (15+ only in the 6 priority provinces)[3]										
MSM + TG	162,347*	8.1*	13,109*	*N/A*	4,975[$]	*N/A*	*N/A*	13,716[$]	1639[$]	1,617[$]
MSM	*145,668**	*8.4**	*12,252**	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
TG (with active anal sex)	*16,679**	*5.1**	*857**	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
FSW	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	3,200	40	*N/A*

Data sources:

1. National HIV Estimation and Projection Report, 2017, Thailand Ministry of Public Health.
2. National AIDS Program (NAP) database web-report, National Health Security Office ((NHSO) (as of November 2016)).
3. PEPFAR 2016 Annual Program Results Report in 7 priority provinces (Bangkok, Chiangmai, Chonburi, Udornthani, Khonkhan, Songkhla and Phuket) and from selected sites within the three priority provinces.
4. For key populations, ART coverage was calculated using the number on ART and the Estimated Total PLHIV as data for PLHIV Diagnosed were not available.

*Estimated using AIDS Epidemic Model (AEM) or AEM with observed HIV prevalence.

[#]NAP web-report, NHSO (as of September 30, 2016).

[$]Data available only from hospitals in PEPFAR-supported provinces. The MSM/TG may access ART at other hospitals.

2.2 Investment Profile

China

The Government of China provides 99% of the funding for its national HIV response, with a reported increase in prevention and treatment funding at both central and local levels each year since 2010[19]. The objective of PEPFAR support in China is mainly the provision of technical assistance (TA) to strengthen the national and subnational response in order to achieve effective, sustainable epidemic control. The majority of PEPFAR funds in China support the staffing costs of technical experts, all of whom work closely with local counterparts on a set of annually agreed upon activities based on prior year performance and current strategic plans.

The ARP China currently has two main cooperative agreements through the U.S. CDC - one with the HIV division of China's lead public health agency, the Chinese Center for Disease Control and Prevention (China CDC); a second with a Yunnan province-based community-based organization, AIDS Care China (ACC), whose mission is to improve community-based care and support for marginalized groups living with HIV. China CDC sits within the National Health and Family Planning Commission (NHFPC). Funds are distributed through its national office to various divisions of its lead HIV programming agency, the National Center for AIDS/STD Control and Prevention (NCAIDS), and to provincial and city/county level CDCs in PEPFAR priority geographic areas. Provincial and local CDCs distribute funds to MSM-focused community-based organizations according to the dictates of the current annual plan. NCAIDS has affiliated offices at multiple jurisdictional level CDCs across China, and is mainly responsible for HIV surveillance; prevention, care and treatment programming; M&E; and public health professional capacity development. HIV treatment services and maternal/child health services are provided by two different agencies within the NHFPC: the public hospital system and the National Center for Women's and Children's Health (NCWCH). All NHFPC agencies function at the most local level (including provision of ART in some areas) through China's three-tiered primary health care system (three levels based upon the size of the population they serve: county, township, and village).

The ARP China will have at least one 'to be determined' (TBD) implementing partner in FY18, plus a follow-on agreement with China CDC in FY19. The China CDC agreement will align with China's 13th Five-Year Strategy for HIV Prevention and Treatment[20]. It will sharpen its support on national and field activities, alongside critical PEFPAR TA, to enhance capacity, systems, and policy - while sharing key lessons learned in the region and globally.

[19] China 2015 AIDS Response Progress Report; China's progress towards the MDGs 2013 Report
[20] Xinhua, China Daily Asia. "China issues 5-year plan on HIV/AIDS prevention"

Table 2.2.1a China: Investment Profile by Program Area (2014[21])

Program Area	Total Expenditure (US $)[22]	% PEPFAR**	% GF[23]	% GoC	% Other
Clinical care, treatment, and support	322	**<1**	**0**	**>99**	**UNK**
Community-based care	UNK	UNK	0	UNK	UNK
PMTCT	216	0	0	100	UNK
HTC	86.3	<1	0	>99	UNK
VMMC	N/A	N/A	N/A	N/A	N/A
Priority population prevention	UNK	0	0	UNK	UNK
Key population prevention	35.5	1.6	0	98.4	UNK
OVC	UNK	0	0	UNK	UNK
Laboratory	6.0	2.9	0	97.1	UNK
SI, Surveys and Surveillance	3.3	3.0	0	97.0	UNK
HSS	UNK	UNK	0	UNK	UNK
Total	**$ 964,761,906***	<1%	0	>99%	UNK

*Total does not include provincial government funding contribution.

Table 2.2.2a: China (Procurement Profile for Key Commodities) - PEPFAR does not provide procurement in China, but does fund a limited amount of commodities (rapid test kits, lab reagents, condoms, viral load commodities) that are used in site demonstration projects.

[22] Data presented here are obtained from China NCAIDS, Feb. 2017.
[23] Global Fund closed out of in China in 2013 and no longer provides any funding for HIV activities in China.

Table 2.2.3a China: USG Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Table 2.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources (US$)	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	0	N/A	N/A	N/A	
USAID TB	$500,000	N/A	N/A	N/A	TA to improve MDR-TB diagnostics, treatment access, and treatment completion.
USAID Malaria	0	N/A	N/A	N/A	N/A
Family Planning	0	N/A	N/A	N/A	N/A
NIH	N/A	N/A	N/A	N/A	There are 28 active grants at the time of writing. These are collaborative activities with US-based PIs, and focused on HIV vaccine, HBV/HCV or TB co-infection.
CDC (Global Health Security)	0	N/A	N/A	N/A	China is a member of the U.S.CDC GHS Agenda, but does not receive funds for it. There are CDC/GH funds for other technical collaborations (e.g. TB, influenza).
Peace Corps	N/A	N/A	N/A	N/A	Strengthening English language learning by working with the Ministry of Education, and via volunteer placements in colleges, technical schools and universities.
DOD Ebola	0	N/A	N/A	N/A	N/A
MCC	0	N/A	N/A	N/A	N/A
Total	**$500,000**	N/A	N/A	N/A	

Laos

In recent years the policy/political environment in Laos has increasingly supported the national HIV response. However, 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.

In 2015, the overall Laos HIV expenditure reported in the Global AIDS Response Progress (GARP) report was 5.4million USD. However, donor funded breakdowns suggest calendar year expenditures of 10 million USD. While donor funding for HIV was reduced in recent years, domestic funding did not increase to compensate. Overall funding for HIV in Laos remained steady between 2014 and 2015, as a result.

The 2016 Global AIDS Response Progress (GARP) report did not include results for the Host Government's contribution to the HIV epidemic. Of all non-domestic resources reported for 2015, the majority came from Other Sources ($4,196,642), followed by the Global Fund ($3,268,381 USD), PEPFAR ($1,849,802), and the Asian Development Bank ($1,275,289). In 2014, the GARP reported 81.5% of the funding for the National HIV Program came from external sources. In 2015, $3,163,260 of all national HIV program expenditures were for clinical care, treatment and support, followed by support for health systems strengthening ($3,016,694), and key populations prevention ($584,410).

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

Table 2.2.1b Laos: Investment Profile by Program Area

Table 2.2.1 Laos Investment Profile by Program Area

Program Area	PEPFAR*	ADB	GF%	% Host Country	Other Sources**
Clinical care, treatment and support	$164,167	N/A	$1,449,509	N/A	$1,549,584
Community-based care, treatment, and support	$7,578	N/A	N/A	N/A	$71,389
HTS[1]	$59,409	N/A	N/A	N/A	$63,590
Priority population prevention	$0	N/A	N/A	N/A	$0
Key population prevention	$196,340	N/A	N/A	N/A	$388,070
PMTCT	$46,744	N/A	N/A	N/A	$0
OVC	$0	N/A	N/A	N/A	$0
Laboratory	$0	N/A	N/A	N/A	$0
SI, Surveys and Surveillance	$127,366	N/A	$156,805	N/A	$201,505
HSS	$1,092,528	N/A	$1,662.07	N/A	$1,922,504
Blood safety	$0	N/A	N/A	N/A	$0
HIV/AIDS research	$155,670	N/A	N/A	N/A	$0
Other	$0	N/A	N/A	N/A	$0
Total	$1,849,802	$1,275,289	$3,268,381	$2,511,495	$4,196,642
Total All Investments		**$5,471,931*** **			

*PEPFAR expenditures from PEPFAR Expenditure Analysis, 2015 NASA reporting. FY2015 PEPFAR expenditures reported for NASA include the Cost of Doing Business.
**Other sources include GFATM, AFD/Esther, UNAIDS, WHO, FHI360 and PSI.
***Total expenditures reported in Lao PDR GARP2016 includes partial PEPFAR and other source funding including Host Government (not reported for 2015 in GARP by Program Areas). As a result, the total expenditures are under reported and not indicated here.
[1]N/A is not applicable or not reported.

Table 2.2.2b – Laos Narrative

The ARP procures a limited supply of commodities to support our site-level investments in innovative demonstration projects. These demonstrations are designed and implemented in close collaboration with national-program counterparts, and all of the antiretroviral medications for treatment reflect in-kind contributions from other-than-PEPFAR sources. In FY 18, the ARP estimates that it will seek $40,000 in support for procurement of condoms and lubricant through USAID central procurement outside of the ROP budget. The ARP also estimates that it will spend $15,000 on procurement of rapid HIV test kits.

Table 2.2.3b 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	$125,000	N/A	N/A	N/A	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	$947,000	N/A	N/A	N/A	Provision of essential malaria commodities, technical assistance to strengthen national malaria surveillance systems appropriate for malaria elimination, and monitoring malaria drug resistance.
USAID Nutrition	$2,750,000	N/A	N/A	N/A	Providing integrated nutrition, hygiene, and sanitation to improve nutritional status of women and children in Laos such as procurement and nationwide distribution of selected public health nutrition commodities.
Family Planning	$0	N/A	N/A	N/A	N/A
NIH	$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
TOTAL	$3,822,000	$0	0	$0	

Thailand

Thailand has made substantial domestic investments to end AIDS. Almost 90% of the approximately $240 million in FY2015 national program expenditures were from domestic public sources, according to the 2016 National AIDS Spending Assessment (NASA). A national social health insurance (SHI) scheme managed by the National Health Security Office (NHSO) supports the provision of free antiretrovirals to all Thai citizens. Per 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.

The ARP resources contributed about 5.3% of the total resources available to the national HIV response in 2015. Per Thailand's 2016 NASA, 66% of all expenditures that year were associated with clinical care, treatment, and support. In contrast, only 6.5% of all expenditures were devoted

to key population prevention, priority 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.

Thailand is currently programming about $20 million in support for HIV and TB programming through one-year no-cost extensions of civil-society and public sector Global Fund grants until December 2017. While this support does not amount to a large proportion of the total national program budget, it does (in combination with PEPFAR support) constitute the majority of annual investments in the civil-society response and in programming for and by key populations facing the greatest HIV risks. Amid uncertainty about continued Global Fund investments in Thailand and in response to requests for support from both government and civil-society stakeholders, the ARP team developed and was awarded a three-year, $20 million PEPFAR Incentive Fund (PIF) award, to assist in the transition of Global Fund programming to domestic financing.

In the interim, it is now clear that Thailand will be eligible for additional Global Fund support, and local civil-society and government stakeholders are vigorously engaged in discussions about whether Thailand should apply for a "transition" award that will end Global Fund support to Thailand over a three-year period, or a full proposal in case funding is needed beyond three years to safeguard support for the civil-society response. Regardless of the outcome of these discussions, the ARP team is committed to achieving as much progress towards transition as is possible during the PIF implementation period, and is working closely with all stakeholders on the development of a detailed plan and timeline for transition that can be written into the new Global Fund grant and that articulates a shared vision for success and mutual accountability among domestic stakeholders.

Table 2.2.1c Thailand Results from the Fiscal Year 2015 National AIDS Spending Assessment.

Program Area	Total Expenditure	PEPFAR %[1]	Global Fund%	Host country %	Other %[2]
Clinical care, treatment and support	$158,357,383	0.2%	1.8%	97.9%	0.0%
Community-based care, treatment, and support	$4,459,543	0.0%	0.0%	100.0%	0.0%
HTS	$7,876,572	18.9%	5.1%	75.9%	0.1%
Priority population prevention	$2,144,418	0.0%	3.4%	95.8%	0.7%
Key population prevention	$2,811,948	34.3%	22.7%	40.0%	2.9%
PMTCT	$1,029,209	3.7%	0.0%	96.3%	0.0%
OVC	$0	0.0%	0.0%	0.0%	0.0%
Laboratory	$0	0.0%	0.0%	0.0%	0.0%
SI, Surveys and Surveillance	$7,232,731	63.8%	19.3%	16.3%	0.6%
HSS	$39,150,864	0.5%	2.0%	97.3%	0.2%
Blood safty	$0	0.0%	0.0%	0.0%	0.0%
HIV/AIDS Research	$3,202,464	8.1%	0.0%	80.0%	11.9%
Other	$14,566,471	33.2%	40.1%	26.0%	0.6%
Total	$240,831,603	5.3%	5.0%	89.4%	0.3%

[1]PEFPAR expenditure analysis data by program area provided by the Office of the Global AIDS Coordinator (OGAC) was used to calculate percentage of total expenditures for PEPFAR. FY2015 PEPFAR expenditures reported for NASA include the Cost of Doing Business.
[2]Other Investment Profile data reported from Thailand Global AIDS Response Progress (GARP) report, 2014-2015.

PEPFAR does not provide procurement in Thailand, but does fund a limited amount of commodities to support innovative pilot studies.

Table 2.2.2c – Thailand (Procurement Profile for Key Commodities)

Table 2.2.2 Procurement Profile for Key Commodities*

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs (n-PEP)	$20,000	N/A	N/A	N/A	N/A
Rapid test kits	$250,000	N/A	N/A	N/A	N/A
Other drugs		N/A	N/A	N/A	N/A
Lab reagents	$70,000	N/A	N/A	N/A	N/A
Condoms*	$385,000	N/A	N/A	N/A	N/A
Viral Load commodities	$27,000	N/A	N/A	N/A	N/A
MAT		N/A	N/A	N/A	N/A
Other commodities (reagents for TB and HCV)	$53,000	N/A	N/A	N/A	N/A
Total	$805,000	N/A	N/A	N/A	N/A

*Condoms and Lubricants supplies are provided from USAID central procurement outside of the ROP budget. (In FY 17, no central procurement was requested for condoms as the Global Fund provided condoms for all PEPFAR partners. However, depending on the funds commitment from GFATM in FY 18, the donation from the USAID central procurement might be required).
[1]N/A is not applicable or not reported.

Table 2.2.3c Thailand, Fiscal Year 2016, 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	$275,000	$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	$ 1,094,000	N/A	N/A	N/A	Provision of essential malaria commodities, technical assistance to strengthen national malaria surveillance systems appropriate for malaria elimination, and monitoring malaria drug resistance.
Family Planning	$0	N/A	N/A	N/A	N/A
NIH	$9,117,262	N/A	0	0	Covers 18 awards to four Thai universities and other entities in various areas of research including MDR-TB, HIV, occupational health, dengue, and others. Fogarty International Center awards are included under NIH direct awards. NIH funding for CDC Offices and Centers is also included and incorporates support for the CDC / NCHHSTP HIV research project in Thailand (e.g., Young MSM Cohort study). PEPFAR Thailand collaborates with CDC / NCHHSTP (technical collaboration) on some NIH supported activities. Data from https://projectreporter.nih.gov/reporter.cfm abstracted on February 12, 2017.
Peace Corps	$2,400,000	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
TOTAL	$12,886,262	$0	0	0	

2.3 National Sustainability Update

There are no key changes to the ARP countries that will lead to changes in the assessment by the SID.

2.4 Alignment of PEPFAR investments geographically to disease burden

By the end of 2015, China ranked the top 10 (of 31) provinces, in order - Yunnan, Sichuan, Guangxi, Henan, Guangdong, Xinjiang, Chongqing, Guizhou, Hunan and Zhejiang - according to reported cases of people living with HIV/AIDS individually (see Figure 2.4a). These provinces accounted for 77.1% of the total number of cases of people living with HIV/AIDS reported nationwide[24]. Even within the most heavily affected Chinese provinces, there is substantial geographic variability in PLHA residence at the time of diagnosis. This, combined with the rapid, ongoing urbanization and mobility of the Chinese population[25], continue to challenge the identification of and adequate service provision to China's geographic HIV "hotspots".

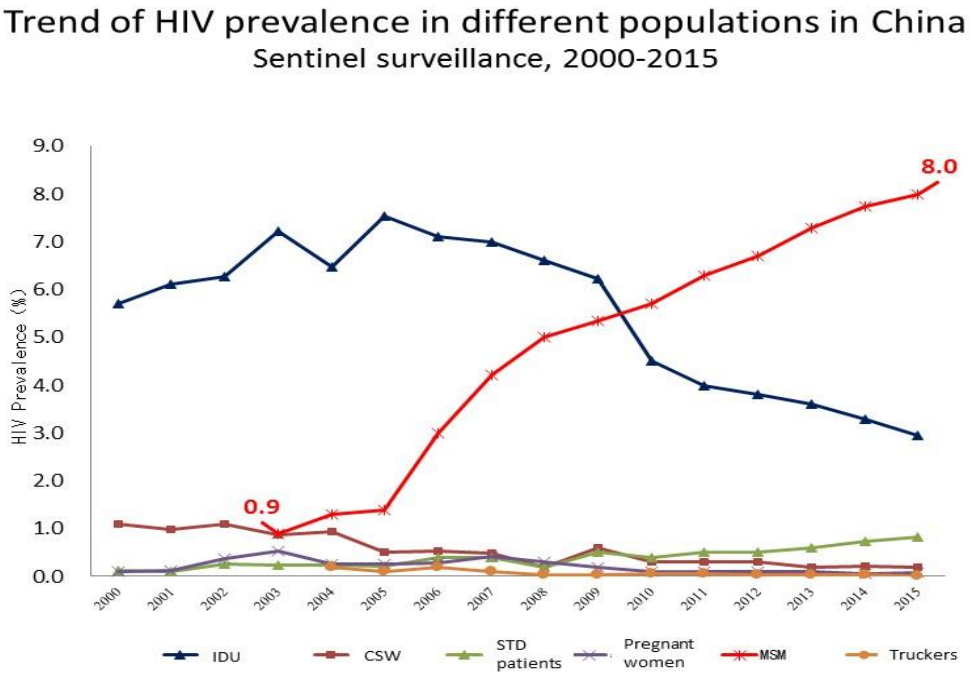
[24] 2015 China AIDS Response Progress Report
[25] Including MSM; Guodong, M, et al. 2015. "Hidden and mobile: A web-based study of migration patterns among MSM in China."

Figure 2.4a - Geographic Distribution of People Living with HIV/AIDS in China, 2015 (NCAIDS, 2016)

Serial cross-sectional bio-behavioral surveys point to 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 geographic focus of PEPFAR support in FY18-19 in China remains on urban MSM, especially in cities of provinces that have historically held the highest concentration of PLHA. Since 2015, the ARP China has increasingly focused support to site[26] and above-site activities for urban-based MSM (Figure 2.4b below), with FY2018-19 support continuing in 16 urban sites. With the exception of Tianjin, these communities in Yunnan, Guangxi, Guizhou, Xinjiang, and Hunan are located in five of the ten high HIV prevalence Chinese provinces noted earlier. A 2016 expenditure analysis found that more than 75% of PEPFAR expenditures by partners were applied at the sub-national level. The majority of these expenditures were invested in KP-MSMTG (32%), CBCTS (24%), HTC (21%), and LAB (11%), which reflects its focus on MSM as the priority key population, linkages to care and treatment, and finding more undiagnosed, including key related laboratory activities.

[26] ARP China defines "site" as a group of community and facility settings delivering HIV-related care (VCT center, CBO, ART / STI clinics, hospital)

Figure 2.4b – Trends in HIV prevalence among different population groups in China (NCAIDS, 2016)

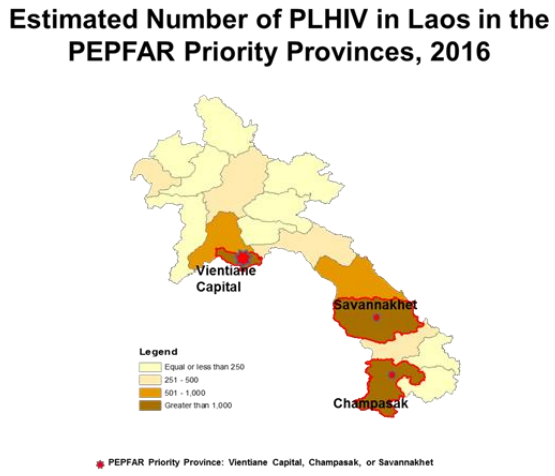


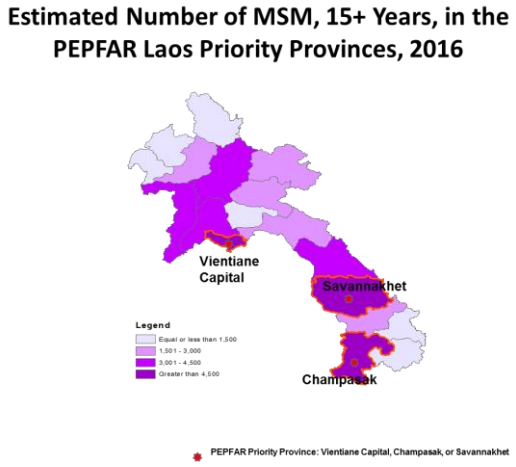
<u>Laos</u>

According to an analysis conducted of FY2016 the ARP expenditure in Laos, approximately one-quarter (23%, 373,100 USD) was applied at the national level. Expenditures across all program levels were primarily invested in KP-MSMTG, CBCTS, HTC, FBCTS, and SURV (in that order), reflecting a focus on MSM and TG women as priority populations, coverage and quality of HIV testing and treatment, and on strategic information and health systems strengthening. Other national-level PEPFAR investments in Laos were distributed across other areas including cross-cutting PM to SI, IC, KP-PWID, KP-FSW, and cross-cutting PM to HSS.

More than half of the (54%, 868,155 USD) of PEPFAR FY2016 expenditures in Laos were at the sub-national (provincial) level. As with expenditures across all program areas, the majority of the expenditures were invested in KP-MSMTG, CBCTS, HTC, and FBCTS (in that order). Geographically, all (100%) of the sub-national investment was made in four areas and the military (Vientiane Province, Champasak, Savannakhet, Vientiane Capital, and Military). Most areas have the largest estimated numbers of PLHIV, largest estimated numbers of MSM and TG women, and largest combined numbers of key populations (e.g., MSM and TG women) in Laos. An additional 23% (380,928 USD) was invested in country-to-country technical collaborations with Thailand and neighboring national HIV programs or at the Above National level.

Figure 2.4c – Estimated Number of PLHIV and MSM in Laos in the PEPFAR Priority Provinces, 2016





Thailand

According to an analysis conducted of FY2016, the ARP expenditures in Thailand showed that about one-third (28%, 1.7 million USD, or 1,745,351 of 6,153,958) was applied at the national level. Expenditures were primarily invested in KP-MSMTG, HSS to SI, FBCTS, and HTC. Expenditures in these areas reflect an emphasis on efforts to continue expanding coverage and quality of HIV testing and treatment including a focus on MSM and TG women as priority populations. These areas also reflect the effort to generate evidence to inform policy and improve HIV services more effectively such as test and treat study and Tangerine clinic. Other PEPFAR investments in Thailand were distributed across other key areas: cross-cutting PM to SI, CBCTS, Lab, PEP, PMTCT, KP-FSW, and SURV.

More than half (65% of 6,153,940 million USD) of PEPFAR FY2016 expenditures in Thailand were at the sub-national (provincial) level. As with expenditures across all program areas, the majority was invested in KP-MSMTG, FBCTS, HTC, CBCTS, LAB, PEP, HSS To SI, and Cross-cutting SI To HSS. Geographically, 59% of the sub-national investment was made in four provinces (Bangkok, Chiang Mai, Chonburi, and Songkhla); most of which have the largest estimated numbers of PLHIV, largest estimated numbers of MSM and TG women, and largest combined numbers of key populations (i.e., FSW, MSM, TG women, and PWID) in Thailand.

The ARP demonstration pilots (i.e., Key Populations Challenge Fund) include the priority provinces within their geographic scope. An additional 6% was invested in Cross-Country Technical Collaborations (CCTC) between Thailand and neighboring national HIV programs (e.g., Laos, China) or at the Above National level.

Figure 2.4d – Estimated Number of PLHIV in Thailand in the PEPFAR Priority Provinces, 2016

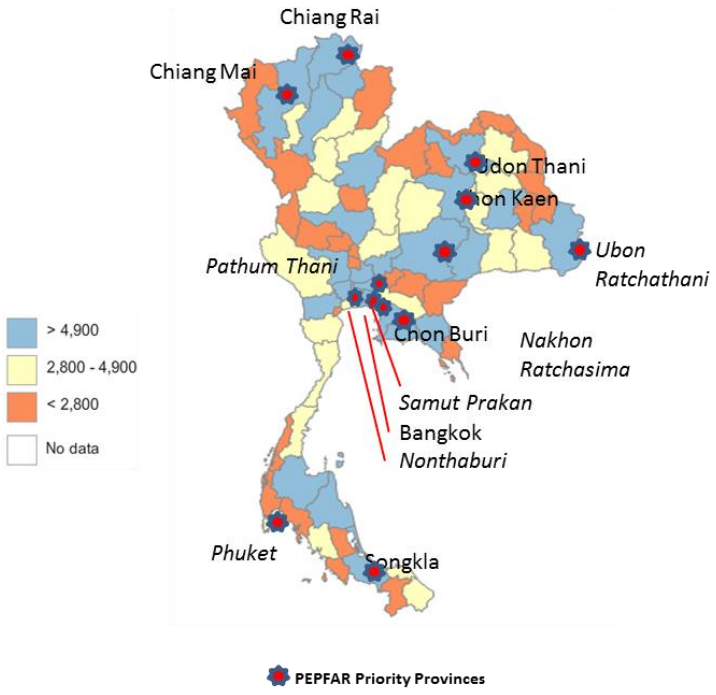


Figure 2.4e – Estimated Number of High Risk MSM, by Province, 2016

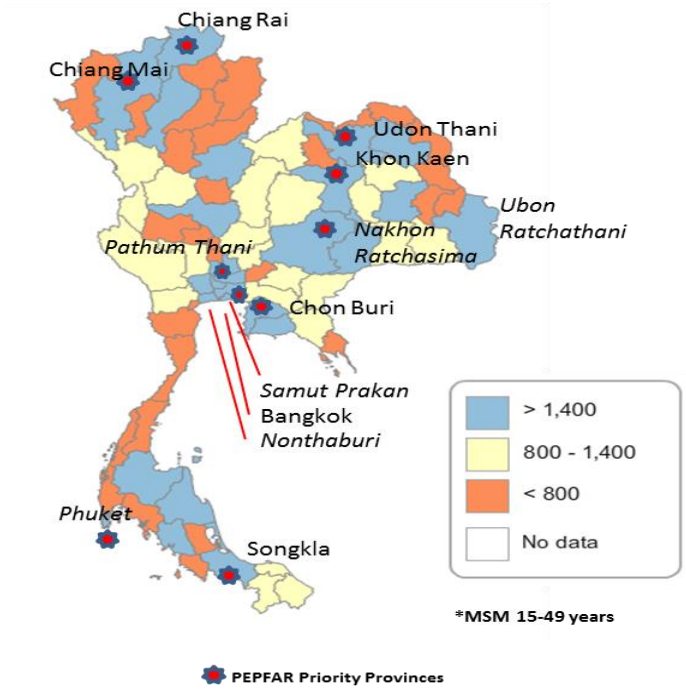
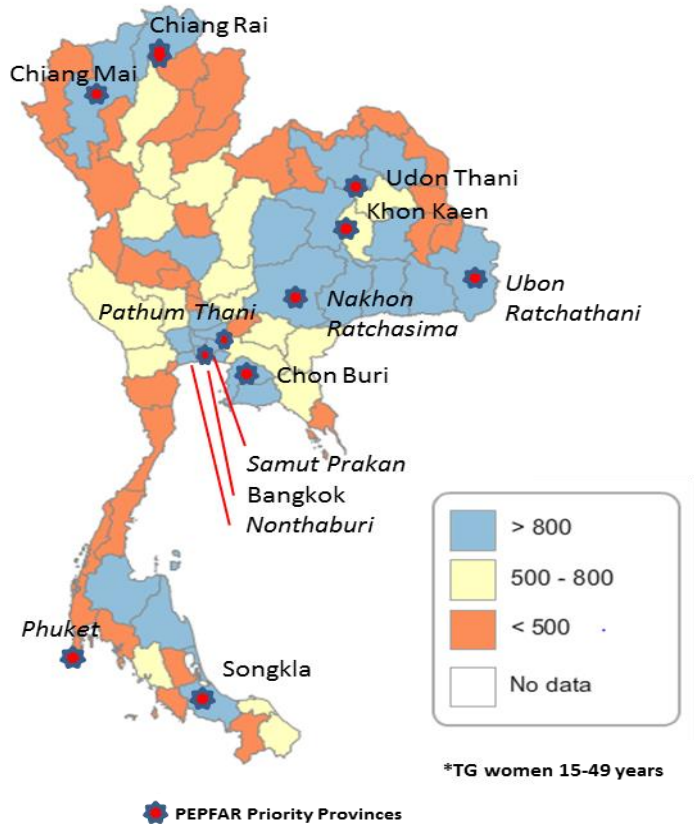


Figure 2.4f – Estimated Number of TG Engaged in Sex, 15-59 years by Provinces, 2016



2.5 Stakeholder Engagement

U.S. CDC has been the only PEPFAR agency in China since 2013. The ARP China's primary stakeholder, China CDC, offered input via national monthly and annual planning consultations in Q1-Q2 FY17, and through frequent phone / e-mail communication with subnational counterparts. Eighteen civil society groups (CSOs/CBOs) in PEPFAR priority regions were also engaged throughout FY16. CDC also held a variety of stakeholder meetings with multi-lateral agencies (WHO, UNAIDS, UNDP), private companies (Danlan), as well as Gates Foundation and U.K. Embassy (Public Health Evaluation). This engagement continues after ROP17 review through periodic communication and meetings with government and CBO partners at all levels, including quarterly site visits alongside SIMS.

In Laos and Thailand, the 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.

In 2016-17 the ARP regularly consulted with stakeholders through formal and informal, ad hoc and regular, project-specific, and national strategic meetings and discussions throughout the year. In China, Laos, and Thailand, the ARP also held special stakeholder planning sessions (with civil society, communities, government, and multilaterals/international agencies): first to discuss and gather stakeholder input on proposed strategic directions and initiatives for PEPFAR in FY17 and, later, to review and finalize those plans together. Careful effort was made to actively engage these stakeholders in strategy setting and project design, implementation, and review efforts. The plans and priorities described in this ROP reflect these exchanges and consensus that was reached.

Furthermore, as a voting member of the Global Fund CCM in Laos and a donor observer on the CCM in Thailand, the ARP plans are aligned with and designed to work in concert with the Global Fund. Although the Global Fund planned to end funding to Thailand in December 2016, Global Fund support will continue at least through 2017; funding plans are currently being discussed. The three-year, $20 million PIF concept was developed by a task force comprised of representatives from civil society, CBOs, the principal recipients of both the government and the civil-society Global Fund HIV and TB grants, UNAIDS, and the Thai Ministry of Public Health. PEPFAR planning and implementation in Thailand is now integrally coordinated with domestic and Global Fund resources as part of the national response by multi-sectoral task force led by the Department of Disease Control and with accountability to the Thai Country Coordinating Mechanism.

PEPFAR staff also continues to play an active role in consultations with civil society networks in the implementation of a regional concept note focusing on "Sustainable HIV Financing in Transition" (SHIFT) in Indonesia, Malaysia, the Philippines, and Thailand. Led by regional civil-society networks, this work focuses on advocacy for sustained financing of civil-society HIV programming, and complements the ARP efforts to advance optimization and sustainability of national responses.

3.0 Program Activities for Epidemic Control

3.1 Description of strategic outcomes

To accelerate and sustain HIV epidemic control in Thailand, China, Laos, and across the region, the ARP prioritizes investments in the achievement of three strategic objectives:

1. *Strategic objective 1*: Catalyze broader, sustained epidemic control by demonstrating more effective approaches to reach, test, treat and retain MSM and TG women in settings with the greatest burden of HIV in China, Laos, and Thailand.
2. *Strategic objective 2:* Support the establishment of domestic financing mechanisms and systematizing the role of NGOs, strengthening the links between NGOs and the health system in PEPFAR-supported areas in China, Laos and Thailand

3. *Strategic objective 3:* Provide key technical assistance (TA) and facilitate knowledge sharing, among countries in the ARP and beyond.

To accelerate access to quality, non-discriminatory HIV services for MSM and TG women, the ARP will continue its strategic investment and technical assistance and collaboration at national and subnational levels in FY18-19. Support is focused on activities described in the Focused Outcome and Impact Table, FOIT (Appendix B). Activities, both site and above-site, at national and subnational (provincial levels) are captured under the three overarching Strategic Objectives for the ARP. Given the region's concentrated epidemic - among MSM and TG, including youth - and based on gaps and barriers identified since ROP16, the ARP selected key outcomes or each Strategic Objective that are essential to collectively meeting 90-90-90 and achieving epidemic control, as well as in measuring impact in priority geographic areas by FY19 and beyond.

As a STAR region with modest monetary contribution in proportion to domestic HIV funding, surveillance data are triangulated from multiple sources, and then reviewed to assess data quality, utilization and understand potential epidemic trends. This is done alongside the understanding that PEPFAR's contribution is mainly TA to catalyze changes in the enabling environment and to strengthen partnership and capacity over time, not necessarily to directly correlate attribution with changes in national and provincial data, especially if reviewed over one to two fiscal years for project pathways that may take years. The ARP instead focuses mainly on program level data captured in the following strategic outcomes over time:

To link activity-level investments to these overarching objectives in a way that facilitate routine performance monitoring and management, the ARP has worked interagency and across countries to develop strategic outcomes supporting each objective.

For **Strategic Objective 1, *strategic outcomes*** include:

1.1. Increase access to and uptake of high-quality HIV testing and linkages to and retention in care and early ART for MSM and TG women in community-based and facility settings in PEFPAR priority regions
1.2. Expand access to and uptake of quality HIV pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) information and care by MSM and TG women
1.3. Strengthen local capacity and health systems including: laboratory quality control and improvement systems, survey development, M&E, utilization of strategic information, information sharing networks, information systems that provide real-time cascade information to health care providers and public health officials, and HIV policy

<u>China</u>

ARP China's support for SO1 site-level activities in 16 sites/communities (FOIT Activity groups 1.01 and 1.03) includes partner demonstration projects that promote and strengthen existing evidence-based HIV services (e.g. HTS, PrEP, nPEP, assisted partner services), as well as catalytic, innovative pilot approaches (e.g. online/social media linkages, HIVST models, quality

improvement, earlier/increased frequency of viral load testing) in FY18. All site-level activities are linked to critical above-site work (e.g. meetings with and workshops held to train staff, providers, and build systems – laboratory, SI, referrals - that will lead to policy and practice change (e.g. PrEP, TB-HIV TPT). This includes PEPFAR staff engaged at both site and above-site levels to provide technical support (FOIT Column K) and facilitate linkages to help partners meet strategic outcomes 1, 2, and 3 above. Above-site work plus PEPFAR TA ensure all the successful elements to enable site implementation – private, confidential, non-discriminatory policies and care, competent lay providers, health systems infrastructure, coordinated site level partnerships, reliable and utilized data, and tailored PEPFAR mentoring. In FY18, PEPFAR supports two key pilots, 1) a viral load project in Yining, Xinjiang, and 2) scale-up of BlueD's mobile linkages to HTS, early treatment and care. These are detailed in Section 3.2 and Appendix B.

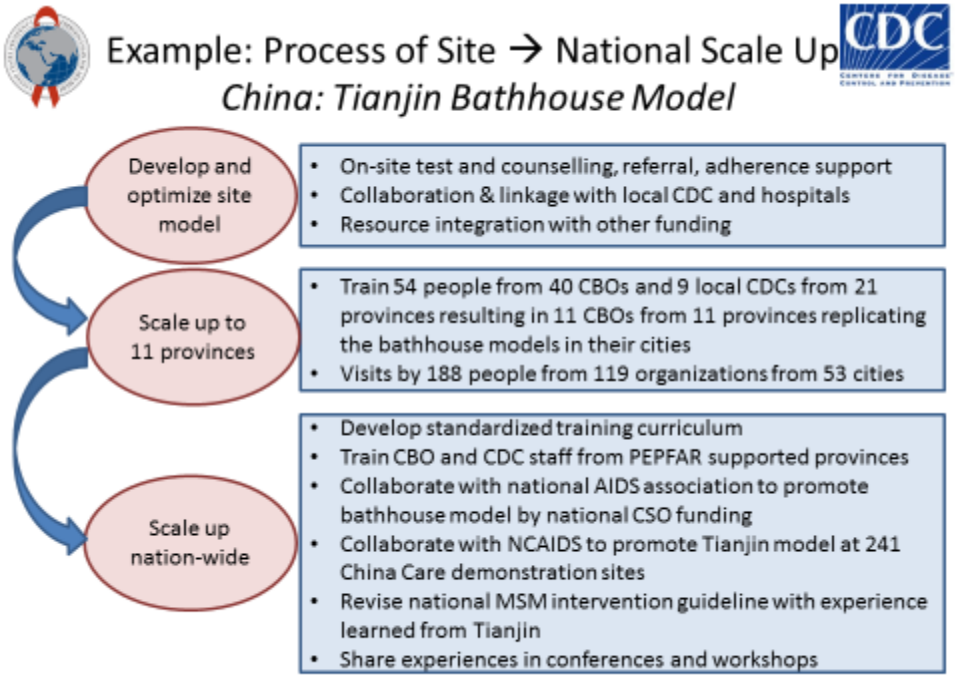
ARP China measures site and above-site progress initially through outputs verified by PEPFAR or other project indicators (Appendix B1 Columns O, P, and Q). For example, in the first 1-2 years by examining contribution through changes in HTS uptake (disaggregated where available, by gender and service delivery points), coverage, confirmatory test rates, viral load tests, clinical cascades (site and provincial level, where available), and SIMS. It also relies on longer-term (years 2 -5) internal analyses and performance evaluations[27] to determine success (or failure), including the use of mobile application client satisfaction surveys (e.g. BlueD); assessment of replication within the same province or expansion over time in other provinces (e.g. Bathhouse VCT around Tianjin city, then to Xinjiang province); measureable increases in matching domestic (provincial) funding; policy changes; or through other process indicators that reflect increased partner capacity. These can include meetings among stakeholders discussing changes in policy, systems and manuals needed for optimal PrEP provision, more rigorous and multiple sources used to estimate incidence or MSM population size, revisions in technical guidelines that align with up-to-date WHO recommendations (e.g. HIVST), changes in site-level referral systems or data management, the extent of qualitative data methods and analysis applied to inform programming (e.g. Guizhou barriers to ART), relevant presentations in annual meetings, or the quality of program designs or publications from partners.

Given the nature of scaling up[28] innovative projects and the time often needed to effect policy and practice change, most PEPFAR-supported activities in China, which are already implemented and owned by partners, can continue over many years, often through the life of existing cooperative agreements. Activities are adapted, or undergo transitions during a five-year period based on results of periodic PEPFAR review processes (SAPR/APR, SIMS). Projects evolve based on success (or failure), as well as when there are enough enabling factors for new interventions to be layered onto existing program platforms. For example, site-level HIV prevention activities evolve into above-site CBO-to-CBO technical and organizational capacity building work, as seen by the Tianjin Bathhouse VCT platform that has been long established and expanded to new geographic areas, including other non-PEPFAR provinces, and directly impacted national HIV plans, policies,

[27] U.S. CDC Evaluation Framework; PEPFAR 2015 Evaluation Standards of Practice

[28] Cooley, L & Linn, J. (2014). MSI, Results for Development Institute, Sept 2014- *Taking innovations to Scale: Methods, Applications, and Lessons.*

technical guidelines, especially those affecting MSM and TG women, and capacity since 2011 (see figure).



Laos and Thailand

Site-level investments in Laos and Thailand to achieve these outcomes include but are not limited to demonstrations of: 1) peer- and social-network-driven enhancements to improve the performance of outreach programming; 2) peer-led, peer-driven recruitment, mobile, and self-testing approaches to expand access to HIV diagnosis, linkages to care, and linkages to other prevention services; 3) support for PrEP promotion and service delivery expansion; 4) introduction of point-of-care diagnostics for HIV, TB, sexually transmitted infections, and hepatitis C virus (HCV) into strategic sites for key populations; 5) differentiated care models to improve the quality and efficiency of HIV services, 6) site support for viral load testing sites; and 7) site support for information systems to improve confidential client support and overall HIV cascade performance.

Above-site investments focus on technical assistance to: 1) institutionalize policies and practices to mitigate stigma and discrimination as barriers to health service access; 2) support the interface of site-level data systems with national data systems to support near real-time tracking of HIV cascade performance and achievements; 3) improve the relevance of educational and referral tools, with a particular emphasis on promotion of the benefits of PrEP and early access to antiretroviral treatment; 4) ensure comprehensive quality improvement and information transfer systems for health facilities and laboratories.

Taken together, site-level and above-site investments aim to demonstrate and institutionalize more effective and efficient approaches to accelerate and sustain epidemic control. Site-level activities provide practical experience and promote the local ownership and leadership needed to bring successful innovations to scale. Above-site activities help to advance the normative, policy, and structural environment needed for these innovations to take root and thrive as sustainable solutions.

To track and verify progress towards the achievement of the outcomes associated with strategic objective 1, the ARP will monitor progress towards the "three 90s" in key populations at both the site and the national level. We will also monitor median CD4 cell count per mm^3 upon entry to care among key populations and will track closely unit costs associated with the achievement of reach, HIV testing, HIV treatment, and retention outcomes for key populations to promote efficiency as well as performance gains. The ARP will apply site improvement monitoring system (SIMS) tools, as well as other assessment strategies to promote quality in HIV systems and services in priority sites, and nationally. The ARP will work closely and routinely with subnational and national partners to review progress, implement course corrections, and develop future plans based on increasingly precise and relevant data.

For **Strategic Objective 2, *strategic outcomes*** include:

2.1 Support the establishment of domestic financing mechanisms and systematizing the role of NGOs, strengthening the links between NGOs and the health system in PEPFAR-supported areas in China, Laos and Thailand.

<u>China</u>

ARP China's support for SO2 activities in FY18-19 (FOIT Activities 2.01-2.02) entail mainly PEPFAR staff time and investment through technical consultation at national and provincial levels with NCAIDS, and via the TBD mechanism in FY18 to engage CBOs to meet strategic outcome 2.1 above. ARP China will continue to examine changes in local funding and processes that demonstrate increasing coordination and engagement with CBOs in HIV planning and service delivery by the end of FY2019. PEPFAR will monitor changes in national and subnational funding mechanisms for CBOs; matching provincial funds for site-level activities; government communications that mention CBOs (such as the 13th Five-Year Action Plan for HIV in early 2017); meetings and conferences that formally solicit MSM-focused community-based organizations' (CBO) direct participation in planning or to invite their presentation of lessons learned, public statements from multi-lateral organizations (WHO, UNAIDS, UNDP); and other qualitative measures among partners evaluating partners, site-level, and cross-sector coordination and delivery through internal impact analyses, evaluation, and personal communication with partners.

<u>Laos and Thailand</u>

In Laos and Thailand the ARP works to mobilize domestic resources to further advance and sustain progress through its investments in support of strategic objective 2. Community

leadership has been at the core of historical progress in the fight against HIV, and enhancing this leadership is critical to achieving the ambitious global vision to "fast track" an end to AIDS as a public-health threat over the next five years. As external donor financing declines, sustained support for the community response to HIV is particularly vulnerable in many countries across the region in the absence of institutionalized systems to facilitate domestic investments in community leadership. The ARP invests in the leadership of community, and in the development of systems for domestic financing of community partners, to generate models for equal partnerships of mutual benefit between civil society and the public sector to accelerate and sustain epidemic control.

Site-level investments in Laos and Thailand to achieve this outcome include: 1) costing exercises and cost-effectiveness analyses to provide insights on the value for money in community investments; 2) demonstration of innovative models of engaging key populations and community members to provide or link beneficiaries to HIV services as part of the health system; 3) establishment of provincial mechanisms to coordinate HIV program planning and implementation with the leadership of community members; and, 4) technical assistance to support the grant-making and grant-management capacity of regional and provincial public-sector institutions to civil society organizations.

Above-site level investments aligned to this outcome include: 1) technical assistance to support national and subnational certification systems for civil society HIV service providers; 2) the establishment of training platforms and networks to build the capacity of civil-society organizations to provide high-quality HIV services and meet certification standards; and 3) national and sub-national health information system support to enable public sector reimbursement and pay-for-performance grant-making schemes for non-governmental organizations.

The ARP will monitor the contributions of these activities towards the stated objective and outcome by tracking: 1) measurable increases in national/provincial funding mechanisms and funding for NGOs in PEPFAR priority geographic areas; and, 2) national and sub-national HIV program formal engagement of non-governmental organizations in planning, implementation, reporting, and grant-making processes.

For **Strategic Objective 3, *strategic outcomes*** include:

3.1 Provide TA and facilitate the sharing of lessons learned among government and non-government partners and other stakeholders in the ARP, the region, and globally

Under this Strategic Objective, the ARP will coordinate to share lessons learned regionally and globally. Methods and activities to share lessons include:

1. The ARP and representatives of regional countries will meet annually to identify regional priorities and plan joint activities;

2. Partner with existing regional networks (e.g., MSM/TG networks, laboratory networks, health care provider networks, etc.) to convene virtual and in-person consultations to share lessons learned;
3. Leverage bilateral workshops, meetings, and conferences to advance practice and policy;
4. Convene an annual technically-focused regional meeting to advance priority topics: a) community- and key-population-led health services; b) domestic financing for civil society; c) transition planning from external donor financing; d) advancements in laboratory services; and, e) HIV pre-exposure prophylaxis;
5. Knowledge sharing: protocols, guidelines, research findings, tools, policy documents, etc.;
6. Organize study tours for regional representatives; and
7. Include the Substance Abuse and Mental Health Services Administration regional representative in activity planning for PWID.

China

Finally, recognizing that learning from its demonstration and innovative activities must transcend site and above-site levels, including its 14 national borders, ARP China will continue to support activities under SO3 (FOIT Activities 3.01-3.02) through performance evaluation, technical exchange, and regional TA through FY18-19. Following joint publications, hosting the first annual meeting convening, study visits/TA to/from China NCAIDS and CBOs, ARP China will continue to measure progress in FY18-19 for strategic outcome #3.1 above. This includes measuring the number and quality of external evaluations supported, the extent of findings utilized by partners for resource allocation and current/follow-on program design, the extent of regional technical consultation, support and knowledge sharing meetings, and the extent and quality of project protocols, abstracts and publications developed with government and CBO partners. Year 1 outcomes in this area will also help PEPFAR ensure the most strategic alignment of its investment and TA to partners, especially as project support evolves in FY19 based on FY17 program results analyzed by this time next year.

Laos and Thailand

In Laos and Thailand, the ARP invests to share and disseminate learning and advances from both site- and above-site experiences in support of strategic objective 3. These efforts are also designed to facilitate a sustained dialogue that helps inform and improve the ARP-supported practice while building the capacity of local and regional stakeholders to connect and lead over the long-term.

Site-level investments to achieve this outcome include: 1) the establishment of learning sites in both public facilities and in communities to develop and demonstrate advances in test and start, PrEP, transgender health, and other HIV-related services; and, 2) quarterly technical exchange visits in which participants from other countries in the region and around the world interact directly with the ARP-supported sites and partners to share developments and brainstorm solutions to challenges.

Examples of above-site level investments include: 1) regional training workshops on health workforce, viral load, laboratory capacity, and other topics, conducted in collaboration with the ARP host-country programs; 2) support for country-to-country technical assistance to institutionalize policies and practices to reduce stigma and discrimination as barriers to service uptake in health care settings; and, 3) national consultations to advance transgender health, PrEP expansion, HIV self-testing, applications of information communication technologies to improve practice, and other priority topics to accelerate epidemic control.

Progress towards the achievement of strategic objective 3 and its associated outcomes will be assessed by documenting: 1) the contributions of national and regional partners in scientific conferences and journals; 2) the adoption of proven service delivery and systems practices by other programs; and, 3) the development and broader utilization of protocols, curricula, and other resource materials generated with ARP support.

For each of the strategic objective areas, please refer to the FOIT for a full list of proposed activities by outcome area, along with activity-level milestones and targets.

3.2 Site level (rationale, geographic and population prioritization)

The ARP invests in site-level activities to pilot innovative models to improve the efficiency and effectiveness of activities to accelerate and sustain epidemic control in partnership with local stakeholders. Site-level investments: 1) advance the ARP's commitment to accountable achievement of life-saving results, 2) foster local and regional ownership in bringing solutions to scale, and 3) lend credibility to our efforts to share lessons and advances across borders through credible on the ground experience, tested tools and concrete data. These efforts are designed to demonstrate measurable improvements in outcomes and associated costs across the HIV cascade for key populations with the greatest needs. Across China, Thailand, and Laos, the ARP promotes advances in science and human capacity; communication and diagnostic technologies; epidemic intelligence; and our understanding of the differentiated needs of our clients, to inspire catalytic advances in practice across the region.

Site-level investments vary in scope and duration from short-term (one- to two-year) implementation science efforts designed to address specific questions that are critical to inform programming, to longer-term partnerships in learning sites that apply routine cascade performance data to foster continuous quality improvement and share lessons and skills with other national and regional stakeholders. In no country does the ARP fill critical unmet service gaps at scale with core ROP funds in lieu of host-country investments, but small sustained ARP investments in site-level technical collaboration play an important role in advancing and optimizing practice regionally and globally. Historically, the ARP site-level investments have already played a catalytic role in eliminating mother-to-child HIV transmission in Thailand, and in all three countries, accelerating adoption of test and start guidelines; expanding access to and investments in PrEP; inspiring and advancing pilots of HIV self-testing (HIVST) and peer-led test-

for-triage approaches to improve access to diagnosis and care; and applying social network and information communication technologies to focus and improve service coverage among populations with the greatest needs.

Over time, some site level investments will be transitioned to scale with domestic financing through above-site technical assistance from the Asia Regional Program. In particular, with PIF support in Thailand, the ARP will work to develop and demonstrate models that optimize community leadership in closing HIV service gaps, will build the capacity of a broader set of community partners to deliver these models, and will help establish domestic financing systems to transition civil-society programming from Global Fund and other development partner dependence. In other sites, the ARP envisions maintaining longer-term engagement to support these settings as incubators and champions of advances in practice across the region. The activity-by-activity vision for potential transition of both site- and above-site-level investments is included in the FOIT.

In term of technical focus, it is increasingly difficult to envision an end to AIDS in urban settings around the world without site-level "fast-track" development of better solutions to overcome barriers to HIV testing, treatment, pre-exposure prophylaxis (PrEP) and other prevention access among MSM and TG women. Site-level investments across all of the ARP countries with both core ROP and Key Populations Implementation Science (KPIS) special-initiative funding have established that affected communities can and must play a leading role to close key gaps in access to HIV services, helping to overcome the limited capacity of public sector clinicians and establishments to address critical barriers alone.

Community Engagement in HIV Testing, Test and Treat and PrEP

In FY18 in China, Laos, and Thailand, the ARP will further enhance community engagement in electronic and coupon-driven peer network recruitment approaches to improve HIV testing uptake among individuals facing the greatest HIV risks, and to ensure appropriate links to treatment or prevention services. In Thailand, the ARP will evaluate the results of the peer-driven intervention used for the KPIS-supported facility-based Test, Treat, and Prevent study and where the model has been effective will work with local authorities and community members to integrate this approach into standard protocols to expand HIV testing among MSM and transgender women. Applying a continuous quality improvement approach to assess the potential added value of innovations against historical performance, other community-based partners in both Thailand and Laos will introduce new online recruitment mechanisms and incentive structures to expand both the focus and the coverage of outreach efforts, while increasing successful referrals to and retention in HIV services.

In Laos, the ARP will implement an enhanced outreach approach that engages staff from community-based organizations to provide education, referral, case management, and support services across the continuum of HIV prevention, care, and treatment. To improve performance over traditional outreach models, these individuals will recruit peer mobilizers who are members

of the beneficiary community, and will engage these peers to refer their network members to HIV services, offering small incentives for successful referrals. The community-based staff will receive performance-based incentives to supplement their monthly salaries that are associated with finding HIV-infected individuals and linking them to care and treatment services, in the process encouraging staff to seek and partner with peer mobilizers situated in the highest-risk networks while constantly expanding program reach. These staff will also receive training on the use of a single oral-fluid HIV test for the purpose of screening, providing assisted referrals of all beneficiaries with reactive results to confirmatory testing with the full national HIV testing algorithm and to HIV care and treatment enrollment at the nearest antiretroviral treatment site. This approach will allow the community-based supporters to offer clients a non-invasive, accurate screening result in the community in 20 minutes with no blood draw, helping to overcome historical barriers to HIV testing uptake and early HIV diagnosis among key populations. In light of reports of high rates of HIV seropositivity among MSM and TG walk-in clients at HIV testing sites, the ARP will also support strategies to encourage these clients to engage in peer network recruitment, offering small incentives to clients who successfully refer members of their social and risk networks to HIV testing services. To the extent that these enhancements contribute to demonstrable improvements in program outcomes, the ARP will provide TA to help the national program to adopt these models into service protocols for other key populations.

FY18, the China program will expand its partnership and pilot projects with the Beijing-based gay men's social media network BlueD to carry out geo-targeted push-messaging to promote HIV testing among young men at MSM-friendly testing sites. BlueD has agreed to support HIV-test-promoting push-messaging efforts in other parts of China in which its platform is used as an appointment portal for HIV testing by local CBOs. The ARP China will work with its existing local MSM-oriented CBO partners to capitalize on this opportunity to promote its confidential HIV testing services through the highly-popular social media platform. The ARP China will support Yunnan provincial CDC leaders in carrying out an assessment of this testing outreach strategy by interviewing a subset of those persons who responded to BlueD push messaging. This site-level activity holds the promise of fueling a significant expansion of the BlueD push-messaging HIV-testing strategy that successfully reached thousands of young gay men in its initial stage.

Building on the experiences from the KPIS-supported community-based Test and Treat and PrEP studies in Thailand, key population-led community organizations will pilot new point-of-care test and treat approaches for sexually transmitted infections and HCV, as well as for TB diagnosis and linkages to care. As part of the HCV work, the ARP will aim to establish a community site to demonstrate HIV test and start among people who inject drugs (PWID) expanding historical ARP successes to benefit additional populations. All of these efforts will incorporate rigorous costing exercises to inform projections of potential efficiency gains.

Also, based on the KPIS-supported Test and Treat and PrEP study, the ARP will support PrEP expansion in FY18 by working with the Thailand MOPH to scale-up access to quality PrEP services at pilot PrEP2Start sites, and by supporting access to free PrEP at community sites made possible

in Thailand through a generous donation from HRH Princess Soamsavali, ensuring in both cases that appropriate data are collected for monitoring.

To overcome barriers to HIV testing, the ARP will focus in all countries during FY18 on the strategic implementation of novel HIV testing services. The ARP has worked with MOPH, BMA, and local health officials to increase HIV testing among MSM and TG women using pilot mobile, sauna, and health clinic-based HIV testing. The ARP will continue to expand access to HIV testing by working with partners to scale-up quality rapid HIV tests using national algorithms. Data from pilot sites showed that not all people diagnosed with HIV were successfully linked to care; the ARP will work with partners to ensure PLHIV are successfully linked to care. In Thailand, the ARP will work with MOPH, BMA, and provincial authorities to transition funding and oversight for the mobile clinics in FY18-19. Drawing upon the ARP's demonstration efforts of peer-led oral-fluid screening in Laos, a pilot offering participants a choice of peer-led oral-fluid screening or take-home oral-fluid self-testing will be implemented through community partners working with MSM and TG women in Thailand. Based on MOPH and BMA assessments of HIV self-testing in 2017, the ARP will provide technical assistance for piloting HIV self-testing in selected areas.

HIV Care and Retention

To improve linkages to HIV care and retention in the care cascade in Thailand, the ARP will work with provincial health offices and local authorities to develop and ensure local access to real-time health information using the NHSO National AIDS Program (NAP) data base and the MOPH 43 file system at pilot sites with plans to scale-up the system nationally. Site level support for community information systems to facilitate electronic referrals will complement this work and pave the way for confidential client support systems that enable pay for performance relationships with both civil society and public sector providers.

In Lao, the ARP has provided technical assistance to develop HIVCAM-Plus (HIV Care and ART Program Monitoring) an innovative electronic data system used to monitor HIV Counseling and Testing (HCT), care, antiretroviral treatment services. The system allows providers and public health officials to monitor the HIV cascade at all levels as well as progress toward the 90-90-90 targets. Working together with community-based staff and peer mobilizers, the ARP provided technical assistance to ensure clients who have a reactive oral fluid HIV test are referred to a facility for a confirmatory test and that information gathered in the community using the eCascade system are linked to HIVCAM-Plus providing real-time cascade data and ensuring clients receive needed HIV care. The ARP will continue to work with the Lao Government to monitor the performance of the system and the use of the data and scale-up eCascade-HIVCAM-Plus nationally.

In every country, ARP will partner with the public sectors and community members to explore and evaluate differentiated care models ensuring quality care consistent national standards. Planned activities include task sharing, fast track drug refills, community-based drug delivery through PLHIV groups and mobile services. Models will incorporate the use of data to monitor and improve care and will inform guideline development for differentiated care.

Viral Load

In Thailand, the ARP will provide technical assistance to viral load testing sites nationwide (52 sites) to ensure quality viral load testing and data dissemination to health care providers. Linking this site-level work to above-site efforts, the ARP will also provide technical assistance to Vietnam, Papua New Guinea, and other regional countries, as requested, to prepare for and complete ISO laboratory accreditation programs.

The ARP China will work with the Yining CDC and health bureau in Xinjiang on a pilot to expand access to viral load testing to all PLHIV, regardless of treatment status. China's current policy restricts free viral load testing to those PLHIV who have been on ART for at least 6 months. Yining will work with China/ARP to offer free viral load testing to all newly-diagnosed persons, as well as perform outreach to those PLHIV who have not had viral load testing in the last 12 months. The local CDC plans through this joint effort to demonstrate the utility of expanded viral load testing in understanding population-level viral load and hastening viral suppression among PLHIV. There is also a key role for its use in measuring transmission potential in key populations. This site level work will be able to inform the current discussion at national level regarding expanding the frequency of viral load testing for PLHIV.

Transition

With respect to site-level activity "transition plans," most of the ARP site-level activities are either expected to continue, or considered as "other" in FY18-19. This is because the ARP views site-level activities along a continuum – one over time built on significant partnerships with stakeholders representing government at national and local levels along with civil society and target populations who have historically all contributed a number of inputs (e.g. technical training, mentoring, catalytic funding) and can continue to do so into the future. Innovation projects, the majority of site-level investment, can also take time to generate results and show impact, especially before decisions to scale-up, whether it be to replicate in the same province, or expand to other parts of the country. Through all of its site-level work, the ARP will generate evidence of the value for money of investments in civil society and public sector enhancements in terms of improved cascade outcomes and reduced unit costs, and will advocate for increased host-country and other donor investments in the sector.

3.3 Critical above-site systems investments for achieving sustained epidemic control

China

The ARP emphasizes that alongside any site-level activity it supports, there are key complementary above-site activities needed in order to fully address barriers to HIV control in China (e.g. FOIT Activity 1.01 plus 1.02; 1.03 plus 1.04). Since ROP16, these include gaps in technical policy, human resource capacity (e.g. program staff turnover, limited HCW counseling skills), multi-sector service delivery coordination and referral systems, data reliability and

utilization, quality and frequency of diagnostic testing, privacy and confidentiality protection, and persistent stigma and discrimination. Some examples of these include stakeholder, planning or technical meetings, policy analysis, human resources support, workshops to refine analysis methods or counseling skills, consultation meetings, engaging international experts into partner trainings and mentoring, external evaluations, data quality assessments, and special surveys among MSM.

While China funds most of its HIV response, PEPFAR's above-site investment through a combination of these activities and U.S. CDC staff TA (See Section 4 and Appendix B) remains critical since the end of Global Fund support in 2013, and transition to refining and sustaining this domestic response, including adequate civil society engagement (Activity 2.01-2.02). This investment also ensures the enabling conditions (resources, political will, staff and agency capacity, policy) that allow site-level demonstration and catalytic innovative interventions to be implemented, learned from, and scaled up - as needed in the right places. As such, these activities can continue to generate results beyond 1-2 years.

Similar to site-level projects, above-site work is largely owned by partners, with intensive PEPFAR TA throughout the year, from planning to implementation to evaluation. As a result, activity transition plans are communicated usually after annual results review towards the end of a program implementation year, and in the context of a five-year cooperative agreement and national five-year plans. At site, provincial and national meetings, PEPFAR examines results alongside counterparts, including to what extent their counterparts demonstrate increased capacity for rigorous program design, implementation, and learning. Can the partner fund a higher proportion of, sustain using locally driven TA, or scale-up the model, site, training, or system? Or how have they actually changed a related policy over time?

Taking a closer look at China's HIVST example - activities include both site and above site work (Activity 1.03-1.04). PEPFAR will work with the China CDC to refine long-term plans, utilize site-level collected data (over 1-3 years), build partnerships and promote coordinated HIV care systems, and then inform recommendations for national policy change. Transition plans are based on a number of factors: the current enabling environment, a cumulative analysis of results (since ROP15) alongside existing policy and regulatory gaps, laboratory capacity development, stakeholder coordination, market demand for quality HIVST kits, and lack of client education materials and systems for referrals to timely ART and care. The ARP China will monitor impacts in all of the above areas over time, from kit evaluation, to IEC and referrals systems, to technical guideline updates, and ultimately, to policy and reagent management recommendations to the Chinese FDA.

<u>Laos and Thailand</u>

In Laos and Thailand the ARP invests in above-site activities to address critical system gaps including stigma and discrimination; the lack of real time cascade data for MSM, TG women, and other populations at high risk of HIV infection; easily accessible and timely educational and

referral information about HIV and available HIV resources; and comprehensive quality improvement and information transfer systems for laboratories.

Stigma and discrimination continue to contribute to the spread and severity of the HIV epidemic, while constraining access to antiretroviral medications and other advances that have enabled us to envision an end to AIDS. Studies have demonstrated that stigma serves as a barrier to HIV testing and treatment uptake, to disclosure of sero-status and consequent access to social support and adoption of prevention behaviors, and to medication adherence. Unfortunately, stigma and discrimination are perpetuated by many influences – ranging from individual attitudes; to social and community norms; to environmental, policy, and legal factors. This complexity requires efforts to mitigate stigma and discrimination to operate on many different levels, and with multiple audiences. To date, the ARP has prioritized health care settings as an entry point to mitigate stigma and discrimination that may serve as barriers to HIV service uptake among priority populations. Working closely with public-sector providers in high HIV-burden settings in Thailand and Laos, the ARP has helped to institutionalize processes in which community members and health care providers to plan together to "assess, address, and reassess" stigma and discrimination through routine planning cycles. This approach supports flexibility to address the most relevant or emergent needs in diverse settings over time, while also providing a sustainable platform for the adoption and improvement of assessment and response systems in health provider and health site accreditation processes. Thailand has already invested domestic resources to sustain these efforts, and the ARP has played an important role in building partnerships for technical exchange between Thailand and Laos with domestic financing. Looking ahead into FY18, the ARP plans to further expand above-site level low-cost TA beyond clinical facilities into community sites focused on meeting the needs of key populations. These efforts will help community members to better understand and apply evidence-based approaches to mitigate stigma and discrimination. This expansion should help overcome critical barriers to HIV testing, treatment, and other prevention service uptake among key populations who previously may have had limited or no interaction with the formal health sector.

To expand access to HIV educational information and information about services, the ARP will work with partners to develop a web-based, app, and/or social media-based educational tools that will provide access to HIV care and prevention self-learning modules and to peer educators. The tool will have modules for risk assessment, HIV testing and testing sites, PrEP and PrEP sites, PEP and PEP sites, Test and Start and basic information about HIV. The ARP will work to ensure that the information complements information on other web-based tools including Buddy station and Adams Love.

In an effort to increase HIV testing and to improve the linkages in care, the ARP will provide technical assistance to MOPH and BMA to develop national and provincial coaching teams (as described in the national HIV Disease Specific Certification [DSC] guidance) to support the Reach, Recruit, Test, Treat, and Retain (RRTTR) strategy. The ARP will support and provide technical assistance for provincial, regional, and national meetings to disseminate knowledge and experience about RRTTR activities. The ARP will also provide technical assistance to MOPH to

develop educational and marketing tools for PrEP and detailed guidance for the implementation and monitoring of PrEP use and support provincial, regional, and national meetings to disseminate knowledge and experience about the use of PrEP.

The ARP will support the development and dissemination of national and provincial solutions to support confidential electronic client referrals across clinical and community sites and "real-time cohort monitoring." Rather than creating new databases and platforms, these solutions will aim to link existing platforms, using unique client identifiers as "keys" to track and support individual clients across the continuum of care. These unique identifiers will link to national and provincial databases that are currently based on national identification numbers to preserve client confidentiality while establishing interoperability across different existing platforms.

Provincial health offices will also receive technical support and assistance to establish a "single plan" to manage, review, and share provincial HIV cascade performance data made available through these solutions, generating real-time dashboards that highlight progress, outstanding priorities, and opportunities for program improvement. Client risk assessment questionnaires that are integrated into these solutions will help facilitate appropriate service referrals and will generate better information about social and behavioral factors that are associated with HIV risk. Clients that so choose can opt to receive appointment reminders and other forms of support via cell phone. Provincial health offices will receive support to convene quarterly performance review meetings that include all community and clinical stakeholders, with the intent of identifying collaborative solutions to improve program performance and efficiency.

The ARP will work with MOPH to develop detailed differentiated care guidelines that ensure quality care (consistent with DSC), strengthen national viral load testing networks, and use data to monitor and improve care. The ARP will advocate for and provide technical assistance to MOPH and other partners to develop HIV self-testing guidance, to encourage partner HIV testing among MSM and TG PLHIV (based on ANC-based partner testing experience), and to develop a real-time HIV cascade data system using NAP and 43 file system including laboratory data ensuring data is available to health care providers. To strengthen the HIV treatment and care cascade among HIV-infected infants, children, and adolescents, the ARP will work with the MOPH and NHSO to ensure that key indicators from the national monitoring system are integrated into routine national AIDS program database and routine MOPH monitoring system and data are used for program improvement and the ARP will provide technical assistance to ensure perinatally HIV-infected adolescents successfully transition to adult HIV care services. The ARP will provide technical assistance to viral load testing sites nationwide (52 sites) to ensure quality viral load testing and data dissemination to health care providers.

The ARP activities have demonstrated the capacity of community organizations to promote and provide high-quality HIV clinical services to key populations facing the greatest HIV risks, but limited awareness and policy barriers associated with accreditation and certification constrain scale up of these advances. In FY18, the ARP will support the development, demonstration, and dissemination of accreditation standards and systems for community organizations to provide

high-quality outreach, support, and clinical services. It will also establish a civil-society-led capacity-building platform to help a broader set of organizations to meet these standards.

To foster domestic investments in high-quality and accredited civil-society services, the ARP will partner with public sector entities at both the national and the subnational levels to demonstrate and disseminates models of reimbursement to community organizations and private clinics for the provision of HIV-related services. These efforts will enhance the capacities of relevant Thai provincial administrative bodies to sustainably partner with and finance community organizations to accelerate epidemic control. The ARP will provide both technical assistance and sub-grants to provincial health offices to establish meaningful, equitable, and transparent processes for community engagement that allows resources to be allocated strategically and monitored effectively.

The ARP will provide technical assistance to support Thai government efforts to establish and external quality assessment program for HIV and related diseases and advocate for and provide technical assistance to MOPH to establish laboratory accreditation standards for HIV testing in community settings. The ARP will also provide technical assistance to support Thai government efforts to validate and implement innovative HIV incidence assays.

The ARP will provide technical assistance to the Thailand international training center (ITC), MOPH to disseminate lessons learnt from Thailand and thr ARP projects for regional and international audiences (e.g., EMTCT of HIV and syphilis validation, Pediatric and adolescent comprehensive HIV treatment and care training course).

The ARP will continue to provide technical assistance to Vietnam, Papua New Guinea, and other regional countries Health Ministries to build capacity for in-country coaching for ISO laboratory accreditation programs.

3.4 Description of how PEPFAR will support greater sustainability

China

In keeping with the PEPFAR Sustainability Action agenda[29], the ARP China, the China CDC and all partner CBOs remain committed to sharing the responsibility of delivering an AIDS-free generation. PEPFAR remains aligned with China's 2016-2020 strategic plan for HIV/AIDS, which also recognizes the need for working with CBOs and civil society to meet 90-90-90 by 2020. In spite of long-standing widespread stigma, discrimination, and ongoing legal policy challenges in China[30], PEPFAR remains committed to broad participation with a wide variety of stakeholders at national (host government, WHO, UNAIDS, UNICEF, Gates Foundation, China CDC

[29] https://www.pepfar.gov/about/agendas/sustainability/index.htm

[30] NY Times April 2016 – "Clampdown in China restricts 7,000 foreign organizations"; South China Morning Post, Aug 2016 – HIV/AIDS patients still face rejection and discrimination in China's leading hospitals.

Associations, UK Embassy) and subnational levels (local CDC, CBOs) in order to ensure that site and above-site work can effectively find more undiagnosed MSM and TG women and reduce HIV incidence and morbidity. China partners welcome PEPFAR's proven experience with leveraging partnerships and local funding, fostering national-subnational linkages, and supporting its own demonstration projects. PEPFAR support in FY18 expands sustained access and care options for MSM and TG women by building provider and CBO capacity for high quality services, strengthening health systems and operations for service coordination (among local CDC, CBOs, hospitals, ART and STI clinics), revising technical guidelines/manuals, protocols and publications, and, ultimately, beyond FY19, by harnessing more reliable data to impact the policy and regulatory environment.

Laos

The Laos HIV response is primarily donor funded. In 2011, a report showed the Government of Laos (GoL) funded only 7.4% of the response. However, the GoL and partners are dedicated to building capacity while ensuring sustainable systems are in place to support progress toward 90-90-90 and Ending AIDS by utilizing innovative models and lessons learned to build and strengthen public health systems.

During FY18-19, the ARP will continue collaborating with the GoL, CSOs and other stakeholders to implement innovative models and testing approaches to strengthen the Laos HIV response; this includes collaborating with CSOs to strengthen and integrate interventions. The ARP will support efforts to improve the quality of HIV testing, care (including viral suppression), and PLHIV follow-up in the care cascade. TA to strengthen laboratory capacity via capacity building on and integration of quality improvement (e.g., EQA) activities will be supported. The ARP will provide TA to continue strengthening health management information systems (e.g., eCascade, HIVCAM, MERS) and data linkage methodologies. Activities to strengthen the analytic skills of public health staff via classroom training and supportive supervision / mentoring will be supported. These activities will build sustainable skills to ensure the availability of high-quality data for epidemic monitoring and program planning. The ARP will also collaborate with the GoL and stakeholders on the development and initial implementation of a national plan for sustainability and transition.

Thailand

The ARP is working side-by-side with MOPH and BMA officials and civil society to implement and learn from innovative strategies to reach, test, treat, and retain MSM and TG in the priority provinces. For example, lessons learned from implementation of PrEP (KPIS) at facility sites is being used to scale-up access to PrEP in nine clinics in seven provinces with financial support from the Thai Government and technical support from the ARP.

Working in close partnership with civil-society and host-country government stakeholders in Thailand, the ARP is implementing an ambitious three-year, $20 million central PEPFAR

Incentive Fund (PIF) plan in Thailand to enhance the contributions and leadership of community partners in ending AIDS while mobilizing domestic investments to sustain this leadership as part of the health system. This effort focuses on four work streams supported by both USAID and CDC mechanisms: 1) HIV service and system optimization; 2) health information systems enhancements; 3) civil society capacity building and accreditation; and 4) national and subnational health financing systems. Though the PIF, the ARP strives to generate valuable lessons to accelerate smart investments and the transition to domestic financing in countries across the region, while building the ownership and experience of local stakeholders in Thailand to help lead this regional change.

4.0 Management and staffing considerations

An analysis of the ARP staffing footprint confirmed that the ARP's staffing is a sufficient mix of business and programmatic positions, focused on priority technical areas while ensuring that PEPFAR 3 priorities of accountability are achieved. Changes did occur among all agencies, resulting in an overall decrease of the staffing footprint from ROP 16.

Adjustments were made to align staffing with technical and administrative priorities while recognizing the limited fiscal environment. PEPFAR China modified their internal staffing chart to a more flat structure to further maximize effectiveness and efficiency to achieve program goals. Currently, China has 14 full time PEPFAR staff including 1 USDH, 1 EFM, 1 ASPPH fellow and 11 LES. They provide 93% of LOE for direct technical support (7 staff provide 100% technical support). China removed a long-standing vacant position (Epidemiology & Strategic Information Chief), as it was difficult to fill due to low salary. CDC Thailand/Laos is dropping one full FTE contractor lab position. It will fill four vacant FSN positions- an SI Senior Epidemiologist, a Deputy Care & Treatment Chief, a Coordinator recently made vacant, and a Sr. Program Management Assistant, vacant 6 months. The latter is at the interview stage but is on hold due to the hiring freeze. Of the 45 PEPFAR funded CDC Thailand/Laos FTEs, 35.3 (78%) are for direct technical support (24.5 FTE Thailand activities; 6.5 FTE for centrally funded Thailand activities; 4.3 FTE for Laos activities as shown in column K in the FOIT tables). USAID has 14 individuals equivalent to 9.1 FTE working on PEPFAR. There are seven full time PEPFAR staff including 1 USDH, 1USPSC, and 5 FSNs providing 55% of LOE for direct technical support (4 staff provide full-time TA). Currently, three out of five FSN positions are vacant - Deputy Team leader, a HIV clinical specialist, and a Key population specialist. USAID also has a partially funded vacant Program Management Assistant position. The recruitment of these positions is delayed due to the hiring freeze. They will provide both technical and program management support to fulfill PEPFAR requirements and business processes. In addition, one USAID USDH is also designated as the PEPFAR Coordinator for Asia Regional Program.

Within the STAR ARP context, PEPFAR China's USG staff will continue working in collaboration with host government and NGO/CBO partners to provide TA in activities focused on target populations in focused geographic areas, strengthening strategic information system and evaluation to the program. As for USAID, TA to GF programs, other regional PEPFAR programs and host country governments will be provided through USG staff while TA in other areas, to varying degrees, will be provided by both USG staff and implementing partners. From its office located on the Ministry of Public Health campus, CDC Thailand leverages its long technical partnership with the Thai Ministry of Public Health (MOPH), the Bangkok Metropolitan Administration (BMA) and the Lao Center for HIV/AIDS and STIs (CHAS) to deploy its largely Thai technical experts to work side-by-side with the MOPH, CHAS and other partners on the major PEPFAR-supported activities in these 2 countries. The types of activities CDC staff typically assist with and build capacity in include: designing innovative interventions and developing operational protocols to integrate them into existing service delivery models; evaluating interventions and programs and developing recommendations based on the findings; providing consultation on new technical issues; training on new laboratory and surveillance techniques; providing technical inputs into national HIV policies and guidelines; conducting advanced program and economic analysis and modeling; developing prototypes for new data collection platforms; writing manuscripts and other knowledge dissemination activities; organizing and hosting study tours and regional meetings to facilitate wider implementation in the region; and strategic planning. Through this close technical partnership between PEPFAR and the governments of Thailand and Laos, the process of translating promising innovations into policy and practice for rapid impact is greatly accelerated. Thai government staff (IM partner) also provides ad hoc TA to other regional governments. Existing USG staff from USAID and CDC Thailand/Laos will continue to conduct required SIMS visits.

There is no major change to CDC China's CODB from ROP16. Currently, the exchange rate is at a favorable level to local currency but the exchange rate will be a big factor affecting future CODB. USAID's CODB is expected to increase due to the addition of two new staff and annual salary increases while CDC Thailand/Laos CODB has increased slightly from ROP 16, due to increased LES salary and benefits and an overall increase in CDC cost share.

APPENDIX A

A.1 Planned Spending in 2017 - Thailand

Table A.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$0	**$9,361,400**	**$9,361,400**

*Data included in Table A.1.1 should match FACTS Info records, and can be checked by running the "Summary of Planned Funding by Agency" report

Table A.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
HBHC	Adult Care and Support	$623,302
HLAB	Lab	$265,357
HTXS	Adult Treatment	$879,977
HVCT	Counseling and Testing	$1,098,228
HVMS	Management and Operations	$2,789,089
HVOP	Other Sexual Prevention	$1,034,015
HVSI	Strategic Information	$1,120,685
HVTB	TB/HIV Care	$61,376
MTCT	Prevention of Mother to Child Transmission	$7,451
OHSS	Health Systems Strengthening	$1,420,658
PDCS	Pediatric Care and Support	$39,283
PDTX	Pediatric Treatment	$21,979
TOTAL		**$9,361,400**

*Data included in Table A.1.2 should match FACTS Info records, and can be checked by running the "Summary of Planned Funding by Budget Code" report

A.1 Planned Spending in 2017 - China

Table A.1.1 Total Funding Level

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

*Data included in Table A.1.1 should match FACTS Info records, and can be checked by running the "Summary of Planned Funding by Agency" report

Table A.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
HBHC	Adult Care and Support	$278,041
HLAB	Lab	$185,629
HTXS	Adult Treatment	$325,229
HVCT	Counseling and Testing	$645,624
HVMS	Management and Operations	$865,777

HVOP	Other Sexual Prevention	$620,835
HVSI	Strategic Information	$634,886
HVTB	TB/HIV Care	$54,156
MTCT	Prevention of Mother to Child Transmission	$0
OHSS	Health Systems Strengthening	$389,823
PDCS	Pediatric Care and Support	$0
PDTX	Pediatric Treatment	$0
TOTAL		**$4,000,000**

*Data included in Table A.1.2 should match FACTS Info records, and can be checked by running the "Summary of Planned Funding by Budget Code" report

A.1 Planned Spending in 2017 - Laos

Table A.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$0	**$1,668,600**	**$1,668,600**

*Data included in Table A.1.1 should match FACTS Info records, and can be checked by running the "Summary of Planned Funding by Agency" report

Table A.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
HBHC	Adult Care and Support	$68,680
HLAB	Lab	$70,297
HTXS	Adult Treatment	$263,061
HVCT	Counseling and Testing	$330,290
HVMS	Management and Operations	$118,874
HVOP	Other Sexual Prevention	$182,847
HVSI	Strategic Information	$259,983
HVTB	TB/HIV Care	$3,722
MTCT	Prevention of Mother to Child Transmission	$706
OHSS	Health Systems Strengthening	$366,088
PDCS	Pediatric Care and Support	$2,732
PDTX	Pediatric Treatment	$1,320
TOTAL		**$1,668,600**

*Data included in Table A.1.2 should match FACTS Info records, and can be checked by running the "Summary of Planned Funding by Budget Code" report

A.2 Resource Projections FY2018 –FY2019

Projected resources were based on multiple data sources and methods for estimating resource needs as described below. Some methods were utilized by all Asia Regional Program countries while other methods were applied by some county offices. Lump sum budgeting approaches were employed while pipeline was applied as required.

Target-based Budgeting:

Thailand

Although Unit Expenditure (UEs) were not utilized in developing the FY 2018 and 2019 budgets, UEs were reviewed to understand expenditures and partner performance in this area and to identify potential areas for efficiencies. In FY2017, PEPFAR received additional "Game Changer Funds" to support the transition of the Global Fund in Thailand. PEPFAR resources and targets will be combined with those of the Global Fund to support the country ownership strategy, intervention programs, promotion of CSO engagement, and harmonization of host government health information systems. In addition, there is also an opportunity to leverage additional resources from National Health Security Office (NHSO) to support CSOs for HIV/AIDS activities. UEs generated from the FY2016 EA analysis may not be a best input for projecting resource needs.

Laos

The UEs (i.e., KP_PREV, HTC) for the FY2016 EA were high but did not reach the level of an outlier. Again for FY2016, the UEs may not reflect the actual cost of each activity. Specifically, they may not reflect the actual cost of each activity as both direct service delivery and technical assistance results were captured in the same program. In addition, one IP also referred clients to non-PEPFAR supported sites which resulted in leakage in the PEPFAR cascade (e.g., lost to follow-up). Therefore, Lump Sum Budgeting methodology was used to plan the budget for FY2018 and FY2019. For a second Laos IP, UEs could not be generated from the EA data. Lump sum costs were estimated from the approaches below.

Lump Sum Budgeting

Thailand and Laos

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

The lump sum budget calculation is split into two parts. For USG Management and Operations (M&O), resources required for FY2018 and 2019 were based on historical expenditures, plus future plans, including additional travel costs for SIMS visits. Resource projections were calculated for each activity and for each Implementing Mechanism (IM) based on previous and current project budgets and work plans (as appropriate), program descriptions, expected activities, outcomes, outputs, and results, considering the remaining funds after subtracting M&O and target-based budgets. The estimates of each budget-code category was based on the percentage of specific work required by each IM's activity under that budget code multiplied by the total estimated budget of each mechanism. The cost categories of M&O are based on historical data, travel costs, personnel costs including estimated cost of living increases, time allocated to budget code based on projected activities and estimates from the Technical Assistance Monitoring System (TAMS). TAMS is a business management tool used to monitor and track staffing resources for technical assistance activities including staff time spent, travel and per diem, and alignment with programmatic goals and objectives.

China

The FY18 budget is projected based on PEPFAR China historical financial information and program planning with partners. The budget calculation consisted of two parts, USG M&O and resources projected for Implementing Mechanisms (IMs). Several methods were used to estimate the cost of M&O. These include projecting by FY18/FY19 program plan, reviewing staffing pattern, referring to historic spending levels for travel and staff time, rigorous efforts on cost control, considering inflation and exchange rates, and reviewing for any applied pipeline. By these methods, the proposed projection for M&O remains at same level to last year. Resources proposed for IMs are estimated based on lump sum budgets of activities designed with partners for FY18/FY19. In projecting resources, China analyzed partners' previous implementation outcomes (SARP/APR), historical expenditure s (EA2016), and considered leveraging national/local matching funds for prioritized activities and proposed work plans.

APPENDIX B

Focused Outcome and Impact Table (FOIT), saved as a separate excel worksheet by country.

Focused Outcome and Income Table (FOIT)
Asia Pacific Region
China

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Strategic Objective 1: Catalyze broader, sustained epidemic control by demonstrating more effective approaches to reach, test, treat, and retain							
Demonstration site: key populations	NCAIDS/SITE- Ensure quality, coordinated HIV prevention interventions and linkages to ART and care, including 2 innovative pilot approaches (in Xinjiang and Yunnan).C7	a. Increased access to and uptake of quality HTS and KP prevention interventions for 17,850 MSM / TG women (all SNUs). Notable increase in yield by POART. See also 1.02, 1.03, 1.05, 1.07 and 2.01 activities. b. Quality protocol developed for Yining viral load pilot project; CVL baseline and HIV incidence collected; Reached 3000MSM/TG. Increased # VL tests in Yining. c. 50% of SNUs report measureable increase in confirmatory testing rates and reported CD4 count (as proxy for care); Average inc of 10% overall. d. 10% increase in # reached by BlueD, incl early data on linkages to HTS, conf test, ART and care. Mobile app survey findings on client satisfication. e. Guizhou youth survey conducted; Acceptability report disseminated by NCAIDS. Evidence of data utilization. SIMS baseline data for C_1.37 (266), set 1B Preventing HIV in Youth.	a. Project partner data reflect 10% increase in access to quality HTS, prevention interventions, and linkages to care compared to prior implementation year at SNUs. b. Yining data/report demonstrates utility of expanded VL coverage to understand CVL and measurement of transmission potential in key pops. VL project scale-up plan developed/shared. c. 75% of SNUs report measurable increase in confirmatory testing rates and reported CD4 count (as proxy for care); Average inc of 10% overall. d. Yr 5 plan includes scale-up for BlueD linkages system to HTS, confirmatory test, ART, care. e. Partners in Guizhou draft scale-up plan if successful. Documented improvement in SIMS CEE C_1.37 (266), set 1B.	KP_PREV, HTS_TST, PrEP_NEW	Program Indicator	Project data, plus site and provincial cascade data, when available (confirmatory tests, TX, reported CD4, and VL tests done) Special surveys (1.05), pre-post testing in HS (GZ)	$319,066
Systems: Health workforce (including CHWs)	NCAIDS/HRH- Strengthen local capacity and systems for quality, coordinated HIV self-testing models (HIVST) and timely linkages to care and ART (linked to 1.01 and 1.03)	a. 50% of SNUs implemented quality HTS and linkages to care and treatment, including innovative approaches, that meet ARP China minimum criteria* (private, confidential, non-discriminatory, tailored, documented referral, CBO-engaged). See also activities 1.09 and 2.01. b. Improved KSA/competency among ~80-100 lay providers of local CDC and CBOs trained (in site-level demo project related service quality improvmeent) for all SNUs, including Tianjin CBO-to-CBO study cohorts. c. 90% of all SNUs have at least light green for CEE C_1.20; 80% of all SNUs have at least light green for CEE C_1.23 (HIV proficiency testing and quality assurance)	a. 75% of SNUs are implementing quality HTS and linkages to care and treatment, including innovative approaches, that meet ARP China minimum criteria* (private, confidential, non-discriminatory, tailored, documented referral, CBO-engaged). b. Beneficiaries surveyed at 1-2 select sites report increased access to and improved quality of HIV service delivery. c. 95% of all SNUs have at least light green for CEE C_1.20; 90% of all SNUs have at least light green for CEE C_1.23. (HIV proficiency testing and quality assurance); Notable improvement in HTS link to care and confidentiality domains.		SIMS	Capacity building outputs / outcomes (# workshops, #s trained); Special surveys (1.05); Evaluation (3.01)	$118,735

Focused Outcome and Income Table (FOIT)
Asia Pacific Region
China

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Systems: Laboratory	NCAIDS/LAB- Support for demonstration projects evaluating HIVST kits and referral models (linked to 1.02)	a. Quarterly meetings demonstrate multi-stakeholder (CDC, CBO, lab, ART clinic) engagement in protocol development, planning and implementation. See also 1.04 activities. b. ~500 MSM/TG have access to quality HTS, including HIVST service and referral models.	a. Beneficiaries surveyed report increased access to quality HIVST, including linkages to confirmatory test, care, and treatment. Follow-on/Transition plans developed depending on project success/failure. b. 50% of all SNUs assessed with HIVST have at least light green for C_2.03 and CEE C_407 (service referral and linkage system)	HTS_TST	Program Indicator	Project data, plus site and provincial cascade data, when available (confirmatory testing rates, TX, reported CD4, and VL); Evaluation	$33,844
Systems: Laboratory	NCAIDS/LAB- Strengthen lab capacity and coordination for evaluating HIVST kits and referral models (linked to 1.03)	a. 50 local staff in at least 3 SNUs are trained in evidence-based HIVST, in compliance with recent WHO guidelines. Documented baseline of referral systems, and preliminary results show baseline referrals to confirmatory testing and enrollment. b. See also 1.12 (I-TECH IM activity/support for e-learning) c. Notable increase in quality of local HIVST plans and related protocols including site level and stakeholder engagement. At least 2 out of 3 PEPFAR SNUs submitted plans with confidential patient tracking system and QI checklist. d. HIVST referral card/materials developed and formative assessment (w/PLHIV and MSM) completed to refine product.	a. Scale-up plan developed with details for replicating or expanding HIVST referral system, including matching funds for top 5 areas with high market demand for HIVST reagent (non-PEPFAR provinces). 100% of supported SNUs submit results demonstrating confidential patient tracking system and QI checklists in use. b. Preliminary findings are shared in national level meeting, and demonstrate sound analysis and plan for data utilization, including: Recommendations for HIVST kit and policy drafted for CFDA, including: 1. Report of HIVST product quality 2. HIVST referral system recommendations 3. HIVST policy for reagent management		Program Indicator	Evaluation (3.01)	$50,000
Systems: Strategic information	NCAIDS/SI - Strengthen national and provincial capacity in surveillance, surveys, protocol/tool development, and use of findings that impact mutual prioritized programs for MSM and TG.	a. At least 8/10 surveys completed, including - qualitative reports from GZ APS and late diagnosis, NCAIDS Divisions of Integration; Epi Division; and Care/Tx. Linked to 1.01 and 1.02 b. Cohort analysis protocol approved, formative assessment conducted, site training provided, and participants enrolled in GZ + HN. Improved KSA in cohort methods in at least 1 SNU. c. Improved competency/KSA of provincial counterpart in qualitative data analysis, surveillance, survey development, and data quality assessment (DQA) and continous quality improvement (CQI) methods (see 1.13) in 75% of SNUs.	a. Related data, protocols, reports / PPTs reflect local capacity improved in qualitative data analysis surveillance, and data utilization - as evidenced by quality of reports and impact on next annual activities proposed and resource allocation. b. Cohort analysis baseline and interim data analyzed and shared, including impact on the provincal HIV response (MSM size estimation, epi data, surveillance) and resource allocation.	KP_PREV denomonator	Other	Capacity outputs/outcomes (#s trained, # workshops, # of surveys completed, #/extent of new surveys proposed); Evaluation	$349,395

Focused Outcome and Income Table (FOIT)
Asia Pacific Region
China

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Systems: Institutional Capacity Building	NCAIDS/HICD- Build local capacity and systems for strategic and program planning, national/subnational management, M&E, reporting, data utilization, and leadership/ management.	a. Notable improvement in SIMS Performance Management domain. Improved quality of partner progress reports and data reliability. b. 50% of SNUs report having at least 3 staff who have participated in Provincial Program Management Training Program and at least 1 SIMS visit. c. 100% of activity and expenditure reports, including any audits, received on time and improved quality; NCAIDS conducts 1-2 meetings with local CBOs to support financial management. d. Semi-annual review and annual OC meeting held, resulting in joint strategic cooperation discussion and way forward for next 5-year coag with NCAIDS.	a. Notable improvement in SIMS Performance Management domain. Improved quality of partner progress reports and data reliability. b. 100% of SNUs report having at least 3 staff who have participated in PPMTP and at least 1 SIMS visit. c. 100% of activity and expenditure reports, including any audits, submitted on time and satisfactory quality. CBO partners report increased opportunities with NCAIDS to strengthen financial management and processes. b. Partners at central and provincial levels develop transition plans that reflect Year 5 and follow-on strategic areas for technical collaboration.		Other	Expenditure analysis, Evaluation	$232,012
Systems: Governance (including policy)	NCAIDS/POL1- Promote up-to-date and evidence-based policy and guidelines/manuals for HIV prevention interventions targeting MSM/TG (HTS, PrEP). (linked to 1.01)	a. PrEP model feasibility report, plus criteria for 1-2 select sites; Partner increase in matching funds. b. Technical guideline recommendations reported at next annual meeting for key pop-targeted delivery of HTS, assisted partner services, PrEP and nPEP, online / offline services, referral systems. National guidelines revised to reflect new recommendations. c. Div of Exchange and Cooperation with China AIDS Association provide joint report/presentation of lessons learned from CBO involvement in HIV service delivery.	a. Reported data on access to and uptake of evidence based PrEP and quality services among key population in 1 of 2 sites selected by SAPR. 10% increase in uptake by APR. Acceptability findings shared, including client satisfaction. b. PrEP and nPEP technical guideline/manuals updated by partners at central level; Subnational distribution plan discussed at annual meeting. b. Providers at 50% of SNUs report increased access to up-to-date technical policies and manuals in line with national and international recommendations.	PrEP info / counseling (not enrolled)	Other	Special surveys; Evaluation	$60,000

Focused Outcome and Income Table (FOIT)
Asia Pacific Region
China

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Systems: Institutional Capacity Building	NCAIDS/TBHIV- Strengthen coordinated national / subnational response to improve TB/HIV SI, TPT policy / practice, and reduce TB-morbidity among PLHIV.	a. NCAIDS, NCTB, and CDC develop a sound protocol for a formative assessment, with key site(s) selection criteria and program recommendations outlined; Formative assessment conducted, and evaluation report shared among stakeholders. c. NCAIDS and NCTB hold 3-4 national/subnational (provincial, local) level meetings with stakeholders to develop guidelines for improved TB/HIV surveillance, M&E/reporting, and TPT.	a. Program materials are developed based on international recommendations (and findings from formative assessment), e.g., educational materials for HCWs and patients, TB/HIV TPT registers, and M&E tools. b. TPT access increased to eligible PLHIV in 1-2 select sites; Standard TPT register/tool drafted/is applied among PLHIV at sites, based on international recommendations; Measureable improvement in HCP practice and uptake of TPT tools and data systems at select sites. Transition plan communicated.	TB_TPT_PREV	Program Indicator	# of PLHIV screened for TB; # eligible; among those started, # finished TPT; Evaluation	$40,000
Other: specify in activity description	NCAIDS/POL2- Promote enabling environment for quality HIV service delivery, and reduce HIV and MSM/TG-related stigma and discrimination.	a. Completed Stigma index survey round 4 protocol/plan based on round 3 findings, including improved tools compared to prior year. Increase in matching fund for conducting round 4. b. Evidence of continued CBO and PLHIV engagement at national and subnational survey planning and implementation.	a. Round 4 index completed. Sustainability and transition plan completed. B. Data analysis improved, and findings utilized with 1-2 clear recommendations for related policy change.		Other	Evaluation	$30,000
Service delivery and quality improvement: key populations	TBD1a/CBO- Increase access to quality HTS and care, incl innovative approaches to improve referrals to confirmatory testing, care, and early ART.	a. Innovative service delivery model plan drafted and shared. b. XX/TBD MSM/TG women access quality services (HTS, care, linkages to ART and other services); c. Formative assessment conducted for proposed innovative service delivery model. XX uptake of innovation at 1 select site.	a. 10% increase in access to and uptake of quality services from prior implementation year. b. Feasibility assessment conducted at 1 additional site. c. Scale-up (replication vs expansion) plan developed and shared for Years 3-4.	KP_PREV, HTS, TX_NEW, TX_CURR, TX_RET, TX_PVLS	Program Indicator	Provincial cascade data; Evaluation	$300,000
Service delivery and quality improvement: key populations	I_TECH1- Develop e-learning curriculum and materials for lay providers (comprehensive HIV care) and MSM/TG women (quality HIVST methods and referrals).	Developed, piloted, and revised e-curriculum and materials, including learning result evaluation tools and indicators for quality improvement.	Improved capacity of lay providers in (rapid HTS, counseling and referrals); Increased KSA of clients in HIVST and referrals to care/tx; Tools shared with other platforms (national or provincial CDC system, MSM network).	KP_PREV; HTS_TST	Program Indicator	Evaluation, Pre-Post testing	$36,500
Systems: Institutional Capacity Building	I-TECH2- Develop and evaluate continuous quality improvement (CQI) program integrated with USCDC and implementing partners joint activities.	Increased KSA/competency of implementing partners on CQI methods and mentoring. CQI plan developed, with site criteria.	CQI findings from 1-2 sites shared. CQI scale-up plan developed. 70% of sites have at least light green for CEE A_9.05-9.06 (QM/QI system and consumer involvement).		Program Indicator	SIMS, Evaluation	$13,500

Focused Outcome and Income Table (FOIT)
Asia Pacific Region
China

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Strategic Objective 2: Support the establishment of domestic financing mechanisms and systematizing the role of NGOs, strengthening the links between NGOs and the health system.							
Systems: Governance (including policy)	TBD1c/HICD- Strengthen CBO organizational capacity and network, including health systems (SI, lab), local service coordination, and policy engagement. (linked to 2.01)	a. Organizational and technical capacity development needs assessment, including review of SOPs and guidelines (TBD and not limited to HIVST, CBO HTS QA/QC; PrEP, nPEP) completed. b. SIMS baseline assessment conducted alongside CBO partner. Results shared at next review meeting. c. Organizational and technical capacity development plan documented; including M&E and CBO networking building.	a. Increased CBO competency for organizational management, technical service delivery, M&E, multi-sector coordination, and engagement in policy, planning and reporting. b. CBO staff surveyed report engagement in local government HIV planning, implementation, and learning. c. Feasibility assessment conducted for outreach to other MSM-focused HIV CBOs in same province.		Program Indicator	Evaluation, Link to SIMS Community Tool, Community Management doman	$0
Strategic Objective 3: Provide technical assistance and facilitate knowledge sharing, between countries in the regional program and beyond							
Systems: Strategic information	NCAIDS/Reg1- Performance and formative evaluation of integrated projects; Inform regional technical exchange meetings.	a. Tianjin (bathhouse model and CBO-to-CBO study tour) evaluation completed; Findings shared at annual meeting. Includes assessment of replication in other SNUs. b. Series of meetings held to develop SOW for additional formative and performance evaluations, including SID implementation with stakeholders (NCAIDS, NARL, 1-2 CBOs, UNAIDS, NCAIDS Associations). c. Conduct needs assessment of border country / regional issues and TA needs.	a. Data quality assessments (DQA) conducted with local CDC/CBO partners at 70% of SNUs. b. Joint SOW for external evaluations of TBD priority collaboration for review (e.g PPMTP, BlueD, HIVST, PrEP) developed. c. Tianjin CBO and NCAIDS partners demonstrate findings utilized through scale-up and transition plans communicated (for next 5-year technical collaboration coag).		Other	Evaluation	$26,948
Other: specify in activity description	NCAIDS/Reg2- Provide regional technical assistance.	a. Lessons shared from PrEP, nPEP, HIVST, HIV surveillance at annual/provincial meetings (including external experts), 1-2 regional meetings, at least 2 joint abstracts, and drafts/publications. b. Inviting 2-3 regional PEPFAR colleague(s) first forum (regional AIDS conference) for Asia Regional exchange of lessons learned and TA workshops based on TA needs assessment; possible proposed topics: transition to domestic financing for CBOs since end of GF, HIV self-testing, PrEP and community involvement.	a. Increase in public communication of lessons learned from China demonstration projects, including joint publications, abstracts/conference presentations, and policy statements. B. Joined 2nd annual forum in region for Asia Regional exchange of lessons learned and TA workshops based on needs identified/requested. Report of lessons shared, and joint project for collaboration.		Other	Evaluation	$40,000
							$1,650,000

Focused Outcome and Income Table (FOIT)
Asia Pacific Region
Laos

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Strategic Objective 1: Catalyze broader, sustained epidemic control by demonstrating more effective approaches to reach, test, treat, and retain MSM and TG women in settings with the greatest burden of HIV in China, Laos, and Thailand.							
	1.1. Increase access to and uptake of high-quality HIV testing and linkages to care and early ART for MSM and TG women						$0
Demonstration site: key populations	Strengthen and expand the HIV test-for-triage approach among key populations (KP)	1. Increased technical support to strengthen referral to care, support and treatment services at all sites; 2. Enhanced linkage between community and facility services to achieve 70% HTC success rate; and 3. By the end of year one, SOPs, tools, and guidelines on self-testing will be completed and disseminated to all stakeholders.	1. One national workshop organized to disseminate self testing guidelines; and 2. Technical Assistance expanded to 3 Global Fund implementation sites.	KP_PREV, HTC_TST, TX_NEW			$350,000
Systems: Health workforce (including CHWs)	Provision of TA for integration of stigma and discrimination interventions into the community-based settings, focusing on KP.	1. Finalized and endorsed S&D tools by CHAS for use in 3 focused provinces; 2. S&D intervention package for KP in community settings implemented in 3 hospitals; 3. S&D materials and site level policy and SOP addressing S&D; 3. 3 training activities delivered at national level for health facility and community providers implementing; 4. 3 HIV service facilities accredited as S&D-free service providers.	1. S&D reduction interventions fully implemented and integrated in 15 HIV service facilities; 2. Improved understanding and increased application of evidence-based approaches to mitigate stigma and discrimination at community sites; 3. All 15 HIV service facilities accredited S&D-free.	HRH			$200,000
Systems: Health workforce (including CHWs)	Provision of TA to national program on strategic planning for PrEP	1. At least 4/quaterly meetings conducted to facilitate ongoing dialoguewith national counterparts to ensure partner engagement for implementing and maintaining the HIV response; 2. Supported participation of 4 staff from Center for HIV/AIDS and STI (CHAS) and community partners in regional activities on PrEP.	1. Integrated strategic direction on the use of PrEP for HIV prevention among Key Populations into the national AIDS strategic plan.	HRH, PREP_TA			$50,000

Focused Outcome and Income Table (FOIT)
Asia Pacific Region
Laos

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Strategic Objective 2: Support the establishment of domestic financing mechanisms and systematizing the role of NGOs, strengthening the links between NGOs and the health system.							
Strategic Objective 3: Provide technical assistance and facilitate knowledge sharing, between countries in the regional program and beyond							
	OC3: Improved sharing of lessons learned among stakeholders in Thailand and the region by the end of FY2019						$0
Systems: Health workforce (including CHWs)	1. Facilitate technical exchange on: 1) S&D; and 2) test for triage	1. 4-6 officers from the National Center for HIV/AIDS and STI (CHAS)supported to participate in Regional forum on S&D, test for triage and PrEP; 2. At least 3 technical training activities organized on test for triage which involves community-based supporters from Lao Pha to provide support to community partners in Thailand.	1. Continued support to at least 4-6 CHAS officers and 5 CBO staff to highlight experiences from Laos to other countries in the region through Regional forums.	HRH			$50,000

Focused Outcome and Impact Table (FOIT)
Asia Pacific Region
Thailand

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
	Strategic Objective 1: Catalyze broader, sustained epidemic control by demonstrating more effective approaches to reach, test, treat, and retain MSM and TG women in settings with the greatest burden of HIV in China, Laos, and Thailand.						
Demonstration site: key populations	BMA-Cascade: Promote 'Test, Start, and Retain' among MSM and TG; and quality laboratory services in BMA hospitals to monitor HIV care cascade	1. Use cascade data to ensure >80 PLHIV on ART and >80% virally suppressed; 2. >60% PLHIV at community sites linked to facility services; 3. SOPs and guidelines for self-testing and oral fluid HIV tests developed through discussions with civil society organizations;	1. Use cascade data for quality improvement and ensure >90% PLHIV on ART and >90% virally supressed 2. Mechanism(s) to pay nonART cost and/or policy change to support nonART cost in place 3. Model to scale-up PLHIV referral network and differentiated care developed 4. VL data from testing sites integrated into hospital databases and available to care providers to monitor HIV treatment outcomes in 8 BMA hospitals 5. Guidelines for PLHIV referral network, differentiated care, and disease specific certification in BMA hospitals and clinics disseminated and 25% (2 of 8) BMA hospitals have received HIV disease specific certification by the Thai Hospital Accreditation Institute	HTC_TST, Tx_New, Retention, VL_Supp	Program Indicator	1. # of PLHIV referred from BMA hospitals to other hosptials and health centers 2. # of stable PLHIV receiving differentiated ART delivery 3. # of hospitals receiving DSC 4. # new PLHIV receiving early ART (same day/within 2 weeks)	$79,286
Service delivery and quality improvement: general population	BMA-CareNet-HTS: Strengthen 'Test, Start, and Retain' and PrEP network among care providers in Bangkok	1. 41 health facilities in Bangkok participating in the ART network 2. HCWs in ART network demonstrate increased knowledge about Test and Start policy (increase >20% in pre- to post-training assessment) 3. PrEP service model implemented in at least 5 BMA health centers and PrEP uptake monitored; at least 20% of HIV negative high risk MSM and TG initiating PrEP 4. Do feasibility and acceptability of PrEP service assessment in at least 1 primary health care setting	1. 46 health facilities in Bangkok participating in the ART network 2. At least 50% of participating hospitals conducted at least one quality improvement activity for 'Test, Start, and Retain' 3. >90% of newly registered PLHIV in facilities start ART 4. BMA has scaled up PrEP service to least 10 sites; at least 40% of HIV negative high risk MSM and TG initiating PrEP 5. Based on feasibility, BMA making plans to scale-up PrEP service	SNU level: HTC_TST, PrEP_new, Tx_New	Program Indicator	1. Increased number of MSM, TG receiving HIV diagnosis in Bangkok 2. Increased in PLHIV on ART in Bangkok	$108,571
Systems: Strategic information	BSI+Lab: Enhancing and integrating laboratory health information system for cascade monitoring system in Bangkok	1. At least 50% of participating hospitals in Bangkok using clinical data to support HIV cascade monitoring 2. Data Quality Assurance protocol implemented in at least 50% of participating hospitals in Bangkok 3. Expand HIV testing to 13 BMA Community Health Centers	2. Provided TA to the Global Fund implementation sites.	HTC_TST, TX_NEW by MSM	Program Indicator		$62,143

Focused Outcome and Impact Table (FOIT)
Asia Pacific Region
Thailand

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Systems: Governance (including policy)	BCU: Manage and maintain accountability of BMA projects	1. 100% of approved BMA projects implemented as planned 2. 100% of program activities and financial reports submitted to CDC on time 3. >80% of approved budget spent	1. 100% of approved BMA projects implemented as planned 2. 100% of program activities and financial reports submitted to CDC on time 3. >80% of approved budget spent		Program Indicator		$50,000
Demonstration site: key populations	YMSM: Develop online reach to offline HIV test and retain tool for MSM and TG by modifying existing youth social media platform	1. MSM and TG virtual clinic (chat) online module developed using existing social media platform with additional marketing strategies to reach more young MSM and TG; and at least 100 visits to the online	1. At least 1000 visits to online site and 75 people linked for HIV testing. 2. Complete feasibility and effectiveness assessment of using existing social media platform to reach young MSM and	KP_PREV, HTC_TST, TX_NEW	Program Indicator	# of page views, # of QR codes generated, # of sites receiving clients referred from online sites, # of MSM and TG	$48,000
Service delivery and quality improvement: general population	Diff_Care (and ACC integration to routine) Develop model for differentiated care (task sharing from tertiary to community-based care)	1. Protocol and tools to assess need for differentiated care and tasks sharing developed 2. Differentiated care model developed and SOP drafted	1. Assessment of needs for differentiated care model expansion done 2. Assessment of the feasibility of the differentiated care model and workload of HCWs before and afer starting		Program Indicator	% of stable PLHIV who meet criteria for referral referred to community-based facilities Assesment of change in	$64,000
Demonstration site: key populations	PrEP2Start_(SL+Lab): Increase HIV tesing among MSM and TG with partner testing and strengthen linkage to ART using peer case manager	1. MSM and TG partner testing service implemented in at least 4 clinics 2. >70% of MSM and TG who test positive initiate ART in 4 sites (baseline 54%)	1. MSM and TG partner testing model expanded to at least 4 additional sites 2. >80% of positive MSM and TG initiate ART in 4 sites (baseline 54%) 3. Strengthen specimen referral system	HTC_TST, TX_NEW, PrEP_New, KP_PREV	Program Indicator	Partner testing model used at sites # MSM and TG initiating ART # hospitals integrating	$346,254
Systems: Health workforce (including CHWs)	PrEP2Start_AS: Scale-up PrEP service: optimize PrEP adherence and develop model for MSM and TG partner testing	1. Updated version of PrEP manual and education media for scale-up developed 2. Examine KPIS PrEP adherence, discuss PrEP adherence improvement with stakeholders	1. Costing and feasibility data of PrEP implementation available and used to advocate for free PrEP policy 2. PrEP adherence tools developed 3. Feasibility data of MSM and TG partner	PrEP_new, HTC_TST	National Indicator	PrEP adherence tools Feasibility data of MSM and TG partner testing	$153,466
Systems: Institutional Capacity Building	Care (Policy+Coach): Integration of HIV QI in National Disease Specific Certification (DSC)	1. National DSC quality management program drafted 2. DSC coaching activities conducted at >50% of hospitals that requested DSC 3. SOP for differentiated care drafted and	1. National DSC quality management plan completed 2. >50% of hospitals requested achieve DSC 3. SOP for differentiated care finalized		National Indicator	National level, SNU level: PrEP_new, HTC_TST, TX_New	$164,509
Systems: Laboratory	Lab_Strategy_TB_EQA Support MOPH to develop lab certification for community HIV testing and strengthen TB EQA program	1. Draft guidelines, training curriculum for HIV testing in community setting 2. Identified policy components to support HIV testing by community care providers 3. Standardized EQA protocol for	1. National DSC quality management plan completed 2. >50% of hospitals requested achieve DSC 3. SOP for differentiated care finalized		National Indicator		$52,000
Systems: Strategic information	SI_(SUR, DTU, MIS) + PS_ICT: Case-based surveillance, cascade monitoring, modeling, cost and impact analysis, EWI, regional staff capacity building	1. Expand and harmonized HMIS from 10 to 24 provinces with available data: HIV mobidity and mortality and HIV cascade monitoring 2. Develop guidelines and tools for epi modeling and size estimaton	1. At least 13 provinces use SI data and develop provincial operational plan for ending AIDS 2. Surveillance and program monitoring results available nationwide 3. Data quality assurrance guidelines				$257,143
Demonstration site: key populations	KPIS: Complete follow-up of study participants in Test, Treat, and Prevent HIV program, continue data cleaning and analysis	1. Complete follow up of study participants 2. Comlete preliminary data analysis and share results with hospital, provincial, and national stakeholders 3. Integrate findings in the national guidelines and SOPs to improve national Test and Start Program	1. Complete final data analysis 2. Submit reports and manuscripts for publication			#of MSM, TG initiated ART # MSM, TG received and adhere to PrEP Factors associated with PrEP adherence Number of new HIV-infections among PrEP	$0

Focused Outcome and Impact Table (FOIT)
Asia Pacific Region
Thailand

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Demonstration site: key populations	1. Expand targeted mobile HIV testing services and expand community HIV service network including private service providers (i.e. Pulse Clinic) to target highest-risk and underserved populations	1.Established new partnerships with one additional community partner in Bangkok to increase service uptake; 2. Identified additional 10 hot spot-based mobile testing services; 3. Completed and implemented SOP and capacity building activities; 4. Supported behavior change communication, commodities and	1. Ongoing data collection and analysis for dissemination at national level for policy advocacy; 2. Improved performance on HTC and TX uptake among KP.	KP_PREV, HTC_TST, TX_NEW			$351,614
Demonstration site: key populations	2. Pilot community-based oral fluid HIV screening as part of self-testing services	1. Launched oral fluid self-testing in four provinces; 2. Oral fluid HIV testing SOP developed 3. Developed oral fluid as a self- testing option materials and manual; 4. Conducted ongoing discussion among civil society organizations to inform development of SOPs, tools and guidelines for self-testing; 5. Contributed to development of policy and guidelines on oral fluid HIV test, followed up counseling measures appropriate for preventing adverse	1. Ongoing data collection and analysis for dissemination at national level for policy advocacy; 2. Expanded and scaled up in the incentive fund implementation.sites in additional 2 provinces.	KP_PREV, HTC_TST, TX_NEW			$234,410
Demonstration site: key populations	3. Provision of technical assistance for integration of stigma and discrimination interventions into community-based settings, focusing on KP	1. Expanded TA beyond clinical facilities into 7 community sites . 2. Integrated S&D intervention package for KP in community settings; 2. Developed S&D materials and site level policy and SOP addressing S&D; 3. Completed baseline assessment in priority provinces; 4. Developed and implemented capacity building package for health facility and community providers in 7 community sites in 4 provinces..	1. Stigma and discrimination reduction approaches developed and integrated in HIV service facilities; 2. Better understanding and increased application of evidence-based approaches to mitigate stigma and discrimination; 3. Improved access to HIV testing, treatment, and other prevention services among key populations.	HRH			$107,527
Demonstration site: key populations	4. Integrated community-based HIV viral-load testing, TB screening, STI screening services	1.Established and formalized linkage and network between HTC and STI services in priority provinces; 2. Installed POC STI in all priority provinces; 3. Capacity building on application of POC STI; 4. Increased TX uptake to 80% and VL suppression by 80%; 5. All site(1-2 sites) in Bangkok are able to submit VL samples.	1. Continued capacity building activities; 2. Analysis of effectiveness of referral networks from successful rate of STI treatment of those referred; 3. Disseminated results of analysis for advocacy; 4. Successful demonstration of community-led STI services for improving HIV cascade among KPs; 5. Increased TX uptake to 90% and VL suppression by 90%.				$234,409

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Demonstration site: key populations	5. Provision of TA for strengthening PWID services, including HIV testing and hepatitis C screening and treatment services	1.Established a collboration with GF and Ozone; 2. Assessed needs among PWID and HIV services; 3. Introduced a GeneXpert POC Viral Load machine to expand etiological diagnosis for other infections; 4. Implemented an integrated HIV, HBV, and HCV testing and treatment pilot study among PWID in Bangkok, Chiang Mai, and Songkhla; 5. Provided harm reduction and other services to 2,500 PWID.	1. Continued monitoring of service uptake and gaps; 2. Continued provided harm reduction services to additional new 500 PWID over the second year. PWID will be recruited into the study by and through the community-based civil society organizations (CSOs) implementing harm reduction services.	KP_PREV, HTC_DSD, TX_NEW_TA			$234,409
Demonstration site: key populations	6. Online-offline approach: demonstration of targeted online recruitment to offline HIV testing and treatment services	1. Developed webpage/ website for MSM, TGW community are online 2. Increased in number of webpage/ website viewed developed for MSM, TGW community are online and accessed 3. Improved marketing of HIV testing services that are designed for target populations (e.g. young MSM/TG	1. Developed and packaged ICT necessary for scale up; 2. Evaluated data and presented them to national stakeholders; 3. Increased number of tests from website referral by 30%.	KP_PREV, HTC_DSD, TX_NEW_TA			$164,087
Demonstration site: key populations	7. Provide TA to expand TG-focused services to other settings based on Tangerine Clinic experiences and lessons learned	No activity in FY18.	1. Ongoing analysis of clinical data of TG clients; 2. Expanded capacity building activities to other 5 sites for appropriate services for TG; 3. Improved quality to attract larger numbers of TG, and conducted important research in ARV and PrEP interactions with feminizing hormones; 4. Developed service promotion materials. 5. Package proven models to be shared and disseminated nationally and internationally	KP_PREV, HTC_DSD, TX_NEW_TA			$0
Demonstration site: key populations	8 . Enhance outreach and social network testing models to improve reach, relevance, testing and yield	1. Launched a site-based incentivized scheme: individual site-based implementing partners will be eligible for specific rewards based on their ability to achieve pre-determined cascade benchmarks; 2. Enhanced linkage of data in the 'eCascade' system correctly through continued capacity building activities in 7 sites in 4 focused provinces.	1. Expanded EPM in the other 4 additional sites under PIF.	KP_PREV, HTC_DSD, TX_NEW, TX_NEW_TA			$234,409

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Demonstration site: key populations	9. Conduct cost analyses of community-led HIV services and PrEP and with the Ministry of Health on appropriate financing models.	1. Endorsement obtained from the Health Financing Committee; 2. Developed protocol; 3. Costing data collection completed	1. Data analysis completed and disseminated; 2. Cost study results provided to national authorities, including NHSO to continue their positive trajectory toward funding local NGOs; 3. Cost study results used for development of costing standards and resulting in financing provided by the Thai GO to local community organizations	HRH			$97,205
Demonstration site: key populations	10. Development of differentiated care models	1. Defined differentiated care models and to roll these out in local hospitals and clinics in one site in Bangkok; 2. Introduced and explored the feasibility of PLHIV-centered care models based on (1) the different needs among PLHIV at different stages and (2) ART status (PLHIV newly diagnosed with advanced disease, newly diagnosed without advanced disease, and stable on ART)	1. Models evaluated; 2. Disseminated results to stakeholders, recommending frequency of visits based on clinical, CD4 and viral load status; 3. Involved in development of relevant national guidelines 4. Expand to 3 additional sites in 3 provinces.				$234,409
Demonstration site: key populations	11. Enhance promotion and availability of HIV pre-exposure prophylaxis (PrEP) through clinic and community-based service providers	1.Established collaboration with the Government Pharmaceutical Organization (GPO) as well as private pharmaceutical partners to obtain support for drug procurement and pharmacy services; 2. Expanded PrEP services, using videos and informational brochures, stakeholder meetings; 3. Launched a series of social media “mini-campaigns” to raise awareness of PrEP and to promote PrEP services; 4. Completed training for community-based partners and continued on-site mentoring/coaching for PrEP services at 7 sites.	1. PrEP included as part of a standard package of HIV services for MSM and transgender women for Thailand; 2. National guidelines on PrEP kept up-to-date.	KP_PREV, HTC_DSD, KP_PREP			$234,409

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Demonstration site: key populations	12. Enhance real time HIV cascade monitoring systems	1. Enhanced 'eCascade' system linked with the national real time cohort monitoring system; 2. Carred out an array of activities to analyze and fully leverage the data acquired during program activities; 3. Provided additional trainings so that partners can also access real-time data on their service delivery; 4. Expanded the network of partners and facilities that use the 'eCascade' app to at least in 3 selected Bangkok Metropolitan Authority (BMA) hospitals as well as to the TRC Anonymous Clinic	1. Provided support for development and dissemination of national and provincial systems including electronic client referrals across clinical and community sites and “real-time cohort monitoring.” 2. Established linkage of databases and platforms, using unique client identifiers as “keys” to track and support individual clients across the continuum of care; 3. Integrated data system for real time data monitoring across the HIV cascade.	HRH			$117,205

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Strategic Objective 2: Support the establishment of domestic financing mechanisms and systematizing the role of NGOs, strengthening the links between NGOs and the health system.							
Strategic Objective 3: Provide technical assistance and facilitate knowledge sharing, between countries in the regional program and beyond							
Systems: Health workforce (including CHWs)	ITC: Develop and promote an ASEAN center of excellence for international disease control training center including HIV/AIDS training	1. Integrate the ITC project into MOPH/DDC international training center with support from an annual government budget 2. New curriculum developed (e.g., Stigma and discrimination reduction in health care setting)	1. ITC conducting international trainings for regional participants consistent with an annual training plan			1. number of new training curricula developed to promote lessons learned sharing among regional countries 2. Increased funding of government to maintian	$36,000
Systems: Governance (including policy)	GAP_CB: Global TA to support Thai government officers to provide TA to regional countries	1. Organize at least 1 regional Quality Improvement workshop and/or quality of HIV viral load testing 2. Provide at least 1 quality improvement technical assistance visit to a regional country	1. Organize at least 1 regional Quality Improvement workshop and/or quality of HIV viral load testing 2. Provide at least 1 quality improvement technical assistance visit to a regional country				$178,628
Systems: Health workforce (including CHWs)	Annual Regional Forum on PrEP Implementation	1.Organized satellite sessions/workshops on community-led HIV services, PrEP implementation and retention innovations at the Asia Pacific AIDS & Co-Infection Conference 2017 in Hong Kong. 2. Conducted the first Annual Regional PrEP Implementation Meeting as part of the Bangkok International Symposium in HIV Medicine, hosted yearly by TRCARC. 3. Presented PrEP sub-study results; oral fluid operations research; eCascade and EPM; and other project implementation data; 4. Established collaboration with Magnet, San Francisco for twinning CBO approaches for experience sharing.	1. Conducted the 2nd Regional PrEP Implementation Meeting; 2. Reported progress in PrEP implementation in different countries in order to influence change in the region; 3. Evaluated data and disseminated results in indicence among MSM and TG.				$28,000
Systems: Health workforce (including CHWs)	Regional ICT Forum to enhance Health Outcomes	1. Conducted Asia Regional Consultation on ICT and social media innovations in promoting HIV Cascade interventions in Bangkok;					$28,000
Systems: Health workforce (including CHWs)	Regional Consultation for Enhancing Transgender Women Health	1. Highlighted/disseminated both the Tangerine Clinic and Sister's successes and advancements in providing HIV cascade services for TG women					$28,000

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Systems: Health workforce (including CHWs)	Regional Forum on HIV Self-Testing		1. Organized the first forum in the region to discuss self-testing strategies and application of different approaches in countries;				$0
Systems: Health workforce (including CHWs)	Regional/Global Workshop on Community-led Health Services	1. Conduct at least one regional workshop on the CLHS model and the components that make up a functional model including at least 6 regional countries.	1. Better understanding among CBOs and CLHS' stakeholders, including public sector and medical community, and able to refine the CLHS model; 2.Developed guidelines to follow in terms of the process of making CLHS legalized and accredited by the government in order to become eligible for country's financing mechanisms; 3. More CBOs are interested in implementing CLHS for different key populations affected by HIV and AIDS				$40,000
Systems: Health workforce (including CHWs)	Regional forum on service optimizations/innovations, community capacity building&accreditation, domestic health financing and HMIS	1. Stakeholders from 3ARP countries meet at least one time to exchange lessons learned from PIF; 2. Lessons and next steps for each country documented and disseminated	1. Action plans developed for addressing transition in each country; 2. Action plans dissemintatd/reviewed in the forum to obtain feedback and finalize the plans.				$80,000
Systems: Health workforce (including CHWs)	Study tours	1. Two study tours conducted on oral fluid screening/self testing, TG health, real time cohort monitoring and PrEP.	1. 2 study tours hosted on oral fluid screening/self testing, TG health, real time cohort monitoring and PrEP.				$20,000
Systems: Health workforce (including CHWs)	Regional learning network to improve the quality of HIV services	1. Conduct a regional QI needs assessment in ARP countries and at least 3 nonARP countries 2. Develop and reach agreement on a regional QI agenda that addresses the needs of regional participants 3. Conduct the first annual Regional QI workshop	1. Assess feedback and experience from the first QI meeting 2. Conduct 2nd QI meeting. 3. Work with stakeholders to identify local funding to sustainably support a regional QI network				$50,000