



China
Operational Plan Report
FY 2011



Operating Unit Overview

OU Executive Summary

Background

1.33 billion people, 56 ethnic minority groups among them, live in China's 31 provinces, which include five autonomous regions. According to Ministry of Health (MOH) and UNAIDS estimates, there were approximately 740,000 people living with HIV (PLHA) in 2009, with 190,000 in need of antiretroviral treatment (ART). Case reporting data reflect 326,000 HIV cases had been reported by the end of 2009. Incidence has stabilized per the latest United Nations General Assembly Special Session report estimates, with 50,000 new infections in 2007 and 48,000 in 2009. Sentinel surveillance data show that HIV prevalence has remained stable among most key populations, including pregnant women, injecting drug users (IDUs) and sexually transmitted infection (STI) clients. However, HIV prevalence is increasing among female sex workers (FSWs) and, especially, men who have sex with men (MSM).

Initially, IDUs along drug trafficking routes and former plasma donors in rural communities in East-Central China accounted for most HIV infections. Per 2009 estimates, however, homosexual transmission accounted for approximately one-third of new infections in China, while heterosexual transmission accounted for 40-45% of incidence. Cumulatively, 59% of the estimated 740,000 PLHA in China acquired the infection sexually, with 44% heterosexual and 15% homosexual transmission. The proportion of PLHA who are women has doubled in the past decade to 31%.

Geographic hot spots of at least 1% overall prevalence exist in areas of Anhui, Guangxi, Henan, Sichuan, Xinjiang and Yunnan provinces, with FPDs largely driving the epidemic in Henan and Anhui, and IDUs and FSWs driving the epidemic in the other four provinces. All told, these six provinces account for approximately 80% of all HIV infections in China. While overall national prevalence remains low at 0.1%, prevalence is much higher in these hot spots, and national prevalence among most-at-risk-populations (MARPs) ranges from 2.1% for FSWs, to 5.5% for urban MSM, to 7.5% for IDUs, to 30% for FSWs who inject drugs. The program supports PEPFAR's 4-12-12 goal which is to provide 4 million people with antiretroviral treatment, 12 million with care, and prevent 12 million infections by 2014.

Adoption of Global Health Initiative (GHI) Core Principles

Though China is not a GHI-Plus country, the USG work in China exemplifies GHI's seven core principles. Because of their critical nature, five of these core principles are highlighted in separate sections within the Executive Summary, with related activities in China described in further detail below. However, USG China HIV Team (USG) has also made significant strides in addressing the two remaining GHI core principles. First, in the area of improving metrics, USG will continue to support improvements to the national surveillance system by increasing the number of HIV sentinel surveillance sites, building the capacity of local staff and improving data quality and use in all 15 USG-supported provinces. Second, promoting research and innovation is an integral part of the technical assistance (TA) model USG implements in China. USG funding allows for flexibility to develop innovative approaches that, if proven effective, can be scaled up to provincial, national or even global levels. A description of the five additional GHI principles follows.

Sustainability and Country Ownership



China's rapidly evolving HIV/AIDS epidemic calls for a dramatic expansion of prevention, care and treatment services. In keeping with the core GHI principle of encouraging country ownership and investing in country-led plans, the USG HIV program in China has made significant strides in transitioning to a TA model that focuses on building the capacity of Chinese civil society partners and Government of China (GoC). In turn, this model strengthens GoC's ability to provide oversight and manage its national HIV response sustainably. With GoC providing close to 80% of total funding for in-country HIV/AIDS work, USG has a unique opportunity to both influence and support a strategic and integrated approach that is grounded in high quality data via this TA model.

While GoC does provide strong leadership and substantial funding for the national HIV program, the quality of HIV interventions is often lacking and technical capacity is limited, especially at prefecture, county, and local levels. However, GoC highly values USG-provided TA, and the working relationship between the two countries has strengthened considerably over the years. As a result, even with modest resources for a country of this size, USG TA exerts a strong, positive influence on GoC's HIV response at the national, provincial and local levels. US Centers for Disease Control and Prevention (US-CDC) and US Agency for International Development (USAID), the two USG agencies working on HIV in China, effectively use their respective comparative advantages for maximum impact: US-CDC's TA relationship with China Centers for Disease Control (China-CDC) at national and provincial levels focuses on best-practice guidelines and technical approaches, while USAID's TA relationships with provincial and local China-CDC, local non-governmental organizations (NGOs), and other implementing partners focus on developing implementation models for MARPs.

The USG vision is that, in five years, GoC will have the technical capacity and financial ability to manage, coordinate and provide policy oversight for the implementation of an effective, high quality national HIV/AIDS program. To achieve that vision, over the next five years, the USG expects to continue to provide intensive targeted TA and capacity building to GoC and its civil society partners by: strategically adapting and testing models proven in other settings for use in China and then turning them over to GoC and other implementers for roll out; supporting state-of-the-art HIV surveillance efforts; providing critical policy input; building the capacity of targeted health care workers (HCWs); improving the quality of HIV services; and strengthening key elements of the health care system at national, provincial and local levels. A successful example comes from two Guangxi pilot sites, at Pingxiang and Ningming, where USG has transitioned 3,500 patients from direct USG financial support to GoC support with limited continuing TA. USG will focus its assistance primarily in high-burden provinces, while still providing a moderate level of TA to other GoC-designated provinces, and will continue to tailor its assistance to the specific needs of each province.

The USG estimates that an additional \$3 million per year for TA for the bilateral program would meaningfully impact the quality of GoC and Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) HIV implementation for the foreseeable future.

Integration across USG

The USG China HIV Team is a close collaboration between State Department, USAID, and US-CDC. The strengths of the program include: the State Department's experience in advocacy and public affairs; USAID's experience in developing models for service delivery in resource-constrained settings that include civil society mobilization as well as private-public partnerships; and US-CDC's ability to introduce international best practice and innovation to the public sector health system. Both USAID and US-CDC have positioned themselves to work with the national government to replicate effective models on a national scale. Beyond PEPFAR, the National Institutes of Health's research mandate in China helps develop capacity and infrastructure for HIV research relevant to China. All HIV/AIDS efforts are coordinated through the United States Mission to China HIV/AIDS Committee, which is led by the Ambassador and meets quarterly. The Embassy's Environment, Science, Technology and Health



Section, comprised of State officers and the Health Attaché, acts as secretariat for the committee. The GHI encourages USG implementers to increase impact through strategic coordination and integration, and the USG continues to strive toward that goal, with recent collaboration allowing for the 2010 opening of the Luzhai Rural AIDS Clinical Training Center.

Health Systems Strengthening and Human Resources for Health

Consistent with a core GHI principle, USG supports targeted new and continuing efforts to strengthen China's health system. In FY11, USG will continue to support capacity-building activities, including assisting the National Center for AIDS/STD Control and Prevention (NCAIDS) divisions with annual work plans, providing program management training and assisting with local-level capacity development. USG will assist the Guangxi and Anhui Health Bureaus and provide TA support to 15 provincial China-CDCs in conducting workshops on developing local strategy, action and implementation plans. In Yunnan, USG will expand the use of technical tools and training materials to strengthen antiretroviral (ARV) management and will provide follow-up support.

The USG has made training a central part of its national response, and, to that end, cooperated with local government in Anhui and Guangxi to support the Lixin and Luzhai Rural AIDS Clinical Training Centers, respectively, with the aim of training physicians at county and township levels in quality ART provision, including first- and second-line and opportunistic infection (OI) services to PLHAs. Opened in 2010, the Luzhai Center allows USG to conduct research, promote stigma reduction activities, provide social support and develop the capacity of rural providers to provide prevention, care and treatment, all from one focal geographic location. The placement of the new Luzhai Center in this high-HIV prevalence area will help define best practices for ART services to rural and small-city MARPs and strengthen referral services, in addition to instructing physicians in HIV care, support and treatment for MARPs. In FY11, USG will support the Lixin Center in conducting outreach to surrounding counties in Anhui province and training on second-line ARV therapy for patients failing first-line therapy. Approximately 90% of graduates of this 12-week program are now providing ART and OI diagnosis and treatment services in their hometowns, and USG will provide continued TA for FY11.

USG will also assist GoC in conducting several three-to-five day workshops on HIV/AIDS that include counseling and testing, laboratory technology and quality assurance (QA), surveillance, prevention, care and treatment, with the plan of training a total of 10,000 health care providers in FY11. Additionally, USG conducts a biannual Provincial Program Management Training, from which 80% of graduates are supervising HIV/AIDS programs at the county or provincial level, per a December 2008 survey.

Chinese health infrastructure operates vertically through the national, provincial and county levels, and provides prevention, care and treatment services to PLHA. However, China-CDC, tuberculosis (TB), maternal and child health and hospital administration systems each operate independently, from national to local levels. USG is aware of this lack of integration, especially in rural settings, and is attempting to strengthen cooperation at all levels, in particular in Luzhai, Lixin, and five counties in Henan. USG is also supporting the National AIDS Reference Laboratory (NARL) in conducting workshops, an in-services training program on QA and control of CD4 and viral load (VL), DNA PCR early infant diagnosis (EID) using dried blood spots, and ARV drug-resistance testing.

Coordination with Other Donors and the Private Sector

In adherence with the GHI core principle of engagement with multilaterals and the private sector, the USG collaborates closely with a number of other donors in China, including the UK Department for International Development, AusAID, Gates Foundation, the Merck Foundation and the Clinton HIV/AIDS Initiative (CHAI). USG has collaborated with CHAI on developing hands-on clinical mentoring and training to HCWs from rural areas, and the resulting training model has seen gradual replication in HIV high-burden

areas in Guangxi, Henan, Yunnan and Xinjiang. In FY10, CHAI and USG have also collaborated on piloting EID in several rural and remote prefectures and worked tirelessly to include EID in the National HIV Testing Guidelines. USG also collaborated with CHAI on linking existing health systems together to work toward closer compliance with the latest WHO Pediatric Treatment and Prevention of Mother-to-Child Transmission (PMTCT) Guidelines, particularly in the comprehensive PMTCT pilot program supported by CHAI in Xinjiang in 2010. Additionally, GM-China donated two vehicles via the CDC Foundation, one for use in Yunnan and one for use in Beijing.

USG also supports GoC in its relationship with GFATM and is one of two donor representatives to sit as a voting member on the Country Coordinating Mechanism. With a total portfolio of over \$900 million over the next six years under the Rolling Continuation Channel (RCC), including \$510 million for HIV, China is currently the fourth-largest recipient of GFATM resources. Major factors driving the success of GoC in winning these grants include the MOH's ability, with USG assistance, to write excellent proposals and China's well-developed health financing system for moving resources from the national level to provinces and localities. Given USG's HIV TA-based model, USG is uniquely positioned to provide TA to GoC to ensure quality implementation of GFATM HIV grants at these provincial and local levels.

Women- and Girl-Centered Approaches

The GHI recognizes the critical importance of addressing women and children's health needs, and encourages implementation of women- and girl-centered approaches. In China, this perspective is critically important, as 31% of PLHA are women, and 42% of PLHA receiving free ART are women. Developing and supporting interventions that target the unique needs of these women and other women at high infection risk is therefore a high priority. Women at especially high risk include FSWs, female IDUs, especially those also selling sex, and partners of male IDUs and MSM.

USG activities to address these priority groups have focused on the following key areas: strengthening systems to support HIV prevention and control among FSWs in China; care, treatment and other support for women living with HIV; and addressing the emerging needs of women with HIV in both high-prevalence areas and in areas to which they migrate. USG will support efforts to enhance HIV surveillance among FSWs through the national surveillance system and specialized surveys employing new sampling methods. In addition, USG will support the implementation of innovative interventions designed to reach the relatively neglected population of low-fee FSWs who are either street-based or operating from small businesses. USG will also continue to facilitate linkages between methadone maintenance treatment (MMT) and PMTCT programs, which are managed by two different units within the health system. Since the needs of female IDUs overlap both systems, pilots that increase integration are critically important for this population. Support for women who live in or migrate from high-prevalence areas will be a priority, including addressing their needs for care, treatment and other kinds of social support, including income generating activities. USG-supported couples' testing and counseling and outreach to female partners of MSM are also central to the USG/China team's response.

Programmatic Focus

FY11 funding focuses on the following programmatic areas to achieve PEPFAR's 4-12-12 goals:

1. Prevention: Prevention is a top priority at the core of USG assistance to the response. USG plays a key role in improving the quality of MARPs programming by supporting activities in 15 total provinces, seven directly, including the highest burden provinces of Guangxi and Yunnan, and eight via TA only. Although GoC has established HIV prevention interventions with MARPs, many continue to be fraught with quality and confidentiality concerns, with widely varying skill levels among implementers. USG programs therefore focus on building capacity and providing models that are evidence-based, highly targeted and non-discriminatory. To build local capacity for prevention, USG trains local sub-partners,



including local China-CDCs and NGO staff, in behavior change interventions, HIV prevention and working with MARPs. Training emphasizes improving the uptake of clinical services of MARPs, such as voluntary HIV counseling and testing (VCT), and diagnosis and treatment for STIs.

Based on the results of a 2009 USG assessment of service interventions, USG is actively refining the Comprehensive Prevention Package (CPP) model in Guangxi and Yunnan to more effectively reach higher-risk FSWs and is continuing development and testing of the CPP for MSM, who are a GoC priority. USG-supported analysis of a 2008-2009 national, 61-city MSM HIV survey documented rapidly rising HIV infection rates among MSM throughout China, with national prevalence at 5% and rates in many cities, including Chengdu, Chongqing, Guiyang and Kunming, between 10% and 20%. USG will focus efforts on providing TA to prevention projects implemented through GFATM and other sources, and provide support to counties funded under GFATM RCC for scale-up of behavior change models for MSM. With FY11 funds, USG will continue to provide TA to GoC to improve the quality of prevention models for FSWs, whose prevalence is estimated at 1-2% nationally, focused on those who earn lower incomes, are harder to reach, are IDUs, and/or are otherwise not well covered by other national or donor-supported programs. For FSWs who also inject drugs and are reached through the CPP sites in Guangxi and Yunnan, USG will ensure that appropriate messages and behavior change interventions for the dual risk of sex work and injecting drug use are included.

New PEPFAR policy (July 2010) on working with IDUs states: "PEPFAR supports a comprehensive HIV prevention package for IDUs which includes the following three central elements: (1) community-based outreach programs; (2) sterile needle and syringe programs (NSPs); and (3) drug dependence treatment, including medication-assisted treatment with methadone or buprenorphine and/or other effective medications as appropriate, based on the country context." While infection rates vary considerably in Yunnan, IDU HIV prevalence is over 50% in many counties. Given the continued importance of injecting drug use as a driver of China's HIV/AIDS response, USG will continue to support quality improvement processes for IDU interventions as GoC scales them up, including collaborating with GFATM to increase MMT enrollment. In FY10, USG evaluated IDU programs in Yunnan and Guangxi, and remains focused on addressing adherence issues among MMT enrollees, and refining the CPP model for IDUs by expanding pilot interventions using peers and family members for psychosocial support. USG will provide TA to help China-CDC evaluate its nationwide needle and syringe program, as well as strengthen Gejiu and Luzhai as Centers of Excellence for community-based and rural IDU interventions that GoC and others can scale up.

With FY11 funding, USG will enhance its community-based MMT adherence support model, assessing impact on MMT adherence rates and behavior, supporting further development of the program around two MMT clinics in Nanning and exploring the possibility of replication in other sites by local partners. USG will also support provincial MMT clinics and associated community groups and train outreach workers. Inadequate methadone dosing may predispose patients to drop out of the MMT program, resulting in a higher likelihood of continued injection drug use and other high risk behaviors for contracting HIV. A public health evaluation will look at the effectiveness of currently used moderate dosages versus internationally recommended higher dosages of methadone, with and without the inclusion of additional psychosocial services, on MMT retention, HIV, hepatitis-C virus and STI incidence, self-reported high risk behaviors and quality of life measures among IDUs attending 54 MMT clinics in three provinces.

Counseling, testing and knowing one's HIV status are critical to behavior change and the main entry point for care and treatment. Of China's estimated 740,000 PLHA as of 2009, only about 30% knew their HIV status, despite GoC expansion of free VCT service centers. GoC has now made testing and counseling one of the major components of its national comprehensive AIDS program, with more than 7,335 VCT sites established nationwide by the end of 2009. In spite of this progress, significant barriers to expanding VCT access and improving uptake remain, particularly among MARPs, including a lack of

awareness of the benefits of VCT, concerns about privacy, and fears of discrimination from health care staff and others.

USG is advocating for multiple testing and counseling models to strengthen HIV prevention efforts and facilitate case finding and case management as alternatives to the stand-alone VCT model government clinics and hospitals usually provide. USG will support model development of MSM, FSW and IDU community outreach, with referrals to VCT integrated in community-based drop-in centers in Yunnan and Guangxi. One promising model may be couples' counseling and testing, which studies show reduces HIV transmission, promotes behavior change and facilitates communication. In FY11, USG will pilot couples' counseling and testing in USG-funded provinces with higher HIV prevalence.

National HIV testing algorithms, however, which require confirmatory Western Blot testing for positive screens obtained via ELISA or rapid test, hamper timely receipt of test results at VCT sites. In addition, some domestic rapid test kits are considered unreliable, due to their inconsistent quality and a required two-week or longer waiting period. In FY11, USG will continue to advocate and support the use of reliable rapid HIV testing algorithms in China to improve uptake of counseling and testing services and to reduce loss to follow-up. USG will also strengthen TA for quality assurance and quality control of rapid test kits. In FY10, USG continued to advocate for linkage of HIV counseling and testing to other program components such as surveillance, peer education, STI services, and care and treatment. USG supported the establishment of linkage mechanisms to bridge VCT sites with local China-CDCs and provided counselor training, QA and quality improvement guidance.

Since the Chinese medical care system is detecting an increasing number of HIV cases, integration of HIV testing and counseling into routine medical care, known as provider-initiated HIV testing and counseling (PITC), is a crucial supplement to VCT. Since FY08, USG has actively advocated for PITC in targeted areas in China by helping China-CDC draft PITC technical guidelines and training materials, and supporting pilots in provinces with differing HIV prevalence levels, which showed integrating PITC into routine medical care in China is feasible. In FY11, scaled-up USG support will allow PITC to be piloted in additional provinces and will provide TA to GFATM RCC.

In 2010, USG helped develop and revise national PMTCT implementation guidelines. Of an estimated 17,309,000 annual deliveries, 4.0 million pregnant women in 453 relatively high-prevalence counties received HIV screening in 2009, more than double the 1.96 million women screened in 2007. In mid-2010, GoC announced and allocated \$130 million to a major new program to expand HIV, syphilis, and hepatitis-B virus routine antenatal screening nationwide, with the goal of reaching 80% of pregnant women and 90% of HIV-positive pregnant women by 2014. Together with UNICEF and UNAIDS, USG has played an important advocacy role in the formulation of these national plans. Starting in 2008, USG has also provided direct TA to a large-scale pilot program of PMTCT in Guangxi, making optimal use of the three-tiered county/township/rural village health care system. As 8% of MMT clients are HIV-positive and 25% female nationally, USG TA in Guizhou focuses on strengthening linkage between MMT, PMTCT and ART services through an innovative pilot program. In FY11, USG will continue to assist at the central level with harmonization of PMTCT guidelines, further development of the national PMTCT data management and reporting system, removal of key policy barriers and supervisory visits by senior staff to improve implementation in the provinces.

2. Care and Support: In 2003, in response to the urgent needs of advanced PLHA, GoC issued the Four Frees and One Care policy. This program provided free HIV testing and ART for socioeconomically disadvantaged PLHA, schooling for AIDS orphans, and PMTCT provision for PLHA. USG has shifted from direct implementation support to TA provision for model replication and scale-up. To accomplish this transition, USG has continued to develop and strengthen Continuum of Prevention to Care and Treatment (CoPCT) programs for IDU and FSW at demonstration sites in Yunnan and Guangxi. At these sites, an integrated services package, which other GoC- and GFATM-supported projects are replicating, combines

strengthened GoC institutional care and treatment, community-based organization (CBO)/NGO community- and home-based care and PLHA support group services. As part of the model rollout, USG provides documentation and lessons learned for program replication, funding for study tours and participation in internship courses provided at the model sites. USG successfully leveraged funding from GoC and other donors to support project offices and staff.

USG continued to support GoC and GFATM RCC scale-up of the Essential Care Package (ECP) model, a comprehensive approach for providing care and support services to PLHA that includes ARV adherence, home-based care and support, OI prophylaxis, regular ART follow-up services, clinical monitoring and condom promotion. The ECP package is delivered through the three-tiered county/township/rural village health network system, while including community and PLHA family members.

USG will continue to support ART adherence interventions in Yunnan and Guangxi, including: use of IDU peers to improve adherence among PLHA; enrollment of PLHA into MMT clinics; and the provision of peer psychological support and follow-up services to these IDUs. USG will continue to work to strengthen links between VCT, prevention, care, and treatment to increase follow-up and referral rates and develop CoPCT linkages.

Early results from MARPs and PLHA livelihood development models look promising. In addition to economic strengthening, these models help mobilize communities through formation of self-managed community groups, building these groups' capacity while reducing stigma and discrimination. These factors support improved prevention, care and treatment by supporting HIV risk reduction, reducing IDUs' relapse rates, improving adherence and improving PLHAs' and IDUs' overall quality of life through socioeconomic and psychosocial support, ultimately helping reduce morbidity and mortality.

USG has focused on the Prevention with Positives strategy in early case finding and case management, setting up referral mechanisms that link case finding programs to care and treatment services, and building the capacity of rural health staff in 15 USG-supported provinces to provide support services to serodiscordant couples (where one is positive and one negative) and improve rates of follow-up, CD4 testing and PMTCT, TB and STI service referral. USG also helped GoC strengthen its use of a home- and community-based care and treatment model featuring directly observed therapy (DOT). USG will continue to provide TA support to China Comprehensive AIDS Response and GFATM programs in all 31 provinces for better implementation of comprehensive care and support services.

In China, where the number of TB patients is second highest in the world and multi-drug resistant TB prevalence highest in the world, TB is the most common OI and a major cause of death among PLHA. In FY11, USG will support the national TB program with guidance and implementation TA, piloting INH preventive therapy and assisting with TB/HIV pilot data validation, analysis and utilization. While PLHA account for only about 1% of TB cases nationally, the USG/China team is continuing to work on increasing collaboration with the National Center for TB Prevention and Control. Additionally, the USG Emerging and Reemerging Infectious Disease Program is recruiting a senior TB scientist to assist with TB response in China, and the Gates Foundation provides significant financial and technical support to in-country TB response.

3. Treatment: By the end of June 2010, a cumulative 90,234 patients in China had received ART, of whom approximately 72,000 were currently on ART, 62% of them men. 1,930 children have cumulatively received ART, including 1,673 current recipients. USG and CHAI have provided TA for rollout of second-line ART, currently offered in 26 of China's 31 provinces. In recent years, the national ART program has expanded service provision to MARPs including IDUs, sex workers, and MSM. In conjunction with GFATM, GoC has developed national targets of 117,200 adults and 3,000 children currently on ART by 2012, with GoC supporting 80% of treatment costs and GFATM and other international partners



supporting the remainder. While these targets represent an expansion of current enrollment levels, they are more conservative than the UNAIDS/WHO estimate of 190,000 patients in need of treatment.

In addition to its treatment pilot sites at Pingxiang and Ningming, USG has piloted PITC programs in hospital, TB and STD clinics in seven provinces for early case detection and referral services. In FY11, USG will continue to assist GoC in revising its National Free ART Program manual to include a greater emphasis on TB/HIV service integration and hepatitis B and hepatitis C co-infection.

82.3% of PLHA who started treatment in 2008 continued treatment for at least 12 months. Family members and PLHA serve as DOT volunteers to improve first- and second-line ART adherence. They also support follow-up services, including quarterly CD4 and annual VL monitoring. In FY11, USG will assist the RCC scale-up of a community- and home-based treatment model in 76 of the most heavily HIV-affected counties. In addition, USG supports monitoring of ARV drug resistance (DR).

USG will cooperate with the University of Washington's International Training and Education Center on HIV to revise the national training curriculum on ART and to develop an evaluation tool for China's National AIDS Clinical Training Program. There are 13 HIV/AIDS clinical training centers which provide two- to three-month residencies for physicians across China. Training materials to be developed will meet international standards for pediatric and adult HIV/AIDS care and treatment and be culturally sensitive to China, where more than 70% of HIV patients live in rural areas. Training will include a comprehensive care and treatment package for infants and children, including EID, pediatric ART formulations, regular clinic and CD4 monitoring, monitoring of growth and development, cotrimoxazole prophylaxis and treatment adherence support, as well as TB and other OI screening and treatment.

4. Other Programs:

A. Laboratory infrastructure: USG works primarily through China's NARL to strengthen laboratory capacity and to improve the quality of diagnostic services. USG assists in the writing of national laboratory testing guidelines, including drug-resistance testing, EID, incidence testing, and proficiency-testing programs. Nationally, 17.9% of patients receiving ARV in 2010 were shown to have experienced virologic suppression failure, probably due to the emergence of resistance.. USG will assist the establishment of a network that will collect and transport blood specimens from rural areas to centralized facilities for determination and obtain timely data to inform treatment regimen decisions and broader public health decisions. To decrease the gaps in patient CD4 and VL coverage, USG will assist in the evaluation of point-of-care technologies in Yunnan and Guangxi provinces.

B. Strategic information (SI): USG SI activities follow a TA-based model complementing GoC's Five Year Action Plan for HIV/AIDS (2011-2016), and in keeping with the GHI core principle of improving metrics. Activities focus on strengthening governmental and NGO SI capacity at national and sub-national levels, piloting innovative methods that GoC scales up, and ensuring local capacity to collect, analyze, and use HIV/AIDS data via TA and specialized trainings. USG will continue to provide TA to support the development, implementation and documentation of innovative SI methods and models, with an emphasis on measuring outcomes.

USG will assist GoC with annual HIV estimation and projection, including exploring new methods for MARPs size estimation. USG will assist the State Council AIDS Working Committee Office M&E Unit and NCAIDS in developing an evaluation plan and indicators for the national HIV/ AIDS program, including an evaluation of the sentinel surveillance system after its 2010 expansion from about 1,300 to nearly 2,000 sites. USG transitioned 200 sites in FY10 to GoC, but continues to provide TA, and directly supports 38 sites targeting populations not otherwise covered by national surveillance. USG is providing TA to the NCAIDS in developing a 2010 National HIV/AIDS Surveillance Report, a first for China, which will be unveiled on World AIDS Day and is modeled after the US' biannual surveillance report. Additionally, USG

will provide TA to the National Center for Women's and Children's Health to analyze its PMTCT data, and integrate the data with the national AIDS reporting system.

Health authorities in Guangxi and Yunnan have used the analysis methodology of the Integrated Analysis and Advocacy (A²) project to strengthen MSM intervention resources and programs, and advocate for more government funding and human resources to control HIV. USG will provide additional TA and training on using A²-generated data and A² tools at national and sub-national levels for strategic planning and advocacy, and will pilot a resources estimation tool with local CBOs in Yunnan for identifying resources needed for HIV prevention, care and treatment among MSM, with the goal of translating this experience to GFATM implementation. USG will document and disseminate findings and lessons learned from the routine behavioral tracking survey for FSWs and MSM (with IDUs to be surveyed in 2011) and an outcome evaluation of the CPP model for IDUs, and organize a national forum to discuss outcome evaluation results among key stakeholders to guide future IDU risk reduction interventions.

C. Policy: China has been proactive in developing a robust HIV legal and policy framework, and USG works with GoC to advocate for replication of successful HIV policy approaches. In recent years, with USG support, this policy framework has evolved in China, particularly in Yunnan, to become more consistent with international laws and best practices. Key outstanding policy challenges relate to consistent policy implementation at all levels, operational policy blockages and conflicts between public health and law enforcement policy approaches. The areas where USG has been able to add most value is TA and advocacy on strengthening weaknesses in current policies and/or their execution, facilitation of feedback loops through provincial-level policy assessment and local CBO advocacy.

USG will focus on improving operational policies to support access to services, protection of rights, and harmonization of HIV legal frameworks and policies that support community participation, including NGO registration. Importantly, USG will reposition MARPs and PLHA to enable them to meaningfully participate in the policy process by strengthening their advocacy capacity, supporting community mobilization, and consolidating community structures. A commitment to ensure the best-quality data is driving decision making, and that this data is used for policy analysis, advocacy, and public consumption underpins all activities.

D. Stigma and discrimination: USG program addresses stigma and discrimination within the comprehensive prevention package, which includes specific focus on reducing stigma and discrimination, as well as other supportive interventions, such as policy development and work with livelihoods, that directly or indirectly address stigma and discrimination. USG tailors its work to the unique needs and circumstances of PLHA and each MARP group, and focuses upon measuring the extent to which national policies are known and understood, and promoting better implementation of existing policies and laws to protect rights of PLHA and their family members. USG also supports trainings for physicians and Red Cross workers on stigma reduction.

E. Community mobilization and organizational capacity building: Community mobilization is an approach that recognizes the power of communities in initiating activities to support HIV-related prevention, treatment and care. Dimensions of community mobilization are community leadership, self-governance, community ownership of interventions and commitment to quality and impact, and a sense of belonging to a community. Community groups' organizational capacity has increased in areas of management, planning, finance and administration, fundraising, cohesion among groups and service delivery, often as a result of USG support. In turn, many of these CBOs with increased capacity have been able to develop constructive collaborations with government partners and take on a greater role in service delivery through peer education and counseling and other community-based psychosocial support. USG also involves these CBOs during provision of TA to government and GFATM partners, with the goal of improving services and uptake rates. A need remains for greater focus on documenting, monitoring and



evaluating these approaches and USG-supported TA in order to support advocacy efforts for model replication and scale-up.

The USG will continue to focus upon building capacity of local CBOs. Adaptation of CBO capacity tools to China is ongoing, and includes assessment of group development needs and group capacity, and assisting groups in devising capacity building work plans. Given that CBOs and NGOs in China must often partner with government bodies to officially register, USG will simultaneously build these government partners' capacity to enable them to effectively support these local groups, while continuing to support individual NGO registration.

F. Management and operations (M&O): M&O funds will support personnel in Beijing and Bangkok needed to support USAID and US-CDC activities. M&O funding is critical to the success of USG TA, and ensures that staff with necessary technical expertise are available to support the development of host country capacity, oversee and coordinate innovative research, and engage with policy makers. REDACTED For this reason, and because it is appropriate within the current TA model, US-CDC proposes to reprogram the existing Associate Director for Science position to serve as an Associate Director for Program. US-CDC will seek to hire an FTE with strong behavioral science skills in MSM risk reduction interventions to assist our work in this area. Support for logistical and administrative costs is also essential, but significant efforts to minimize these costs while ensuring quality service were made in FY10 and will continue in FY11.

New Procurements

REDACTED

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Time Frame: October 2011 to September 2012

**Acronyms**

AIDS – acquired immunodeficiency syndrome
ART – antiretroviral therapy
ARV – antiretroviral
A² – Integrated Analysis and Advocacy
CBO – community-based organization
CD4 – cluster of differentiation 4 (a protein on the surface of T helper cells)
CHAI – Clinton HIV/AIDS Initiative
China-CDC – China Centers for Disease Control
CoPCT – Continuum of Prevention to Care and Treatment
CPP – Comprehensive Prevention Package
DOT – directly observed therapy
ECP – Essential Care Package
EID – early infant diagnosis
ELISA – enzyme-linked immunosorbent assay
FPD – former plasma donor
FSW – female sex worker
GFATM – Global Fund to Fight AIDS, TB and Malaria
GHI – Global Health Initiative
GoC – Government of China
HCW – health care worker
HIV – human immunodeficiency virus
IDU – injecting drug user
INH – isonicotinyhydrazine (TB treatment)
MARP – most-at-risk population (e.g. FSW, IDU, MSM)
MMT – methadone maintenance therapy
MOH – Ministry of Health
MSM – men who have sex with men
M&O – management and operations
NARL – China's National AIDS Reference Laboratory
NCAIDS – China's National Center for AIDS/STD Control and Prevention
NGO – non-governmental organization
OI – opportunistic infection
PCR – polymerase chain reaction
PITC – provider-initiated testing and counseling
PLHA – people living with HIV/AIDS
PMTCT – prevention of mother-to-child transmission
QA – quality assurance
RCC - Rolling Continuation Channel, GFATM funding provision
SI – strategic information
STI – sexually transmitted infection
TA – technical assistance
TB – tuberculosis
USAID – United States Agency for International Development
US-CDC – US Centers for Disease Control and Prevention
USG – United States Government
VCT – voluntary counseling and testing
VL – viral load
WHO – World Health Organization

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	730,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Adults 15-49 HIV Prevalence Rate	00	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Children 0-14 living with HIV						
Deaths due to HIV/AIDS	26,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Estimated new HIV infections among adults						
Estimated new HIV infections among adults and children						
Estimated number of pregnant women in the last 12 months	17,374,000	2007	UNICEF State of the World's Children 2009. Used "Annual number of births (thousands) as a proxy for number of pregnant women.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	6,800	2009	Towards Universal Access. Scaling up priority HIV/AIDS			



			Intervention in the health sector. Progress Report, 2010. This mid-point estimate is calculated based on the range provided in the report.			
Number of people living with HIV/AIDS	740,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Orphans 0-17 due to HIV/AIDS						
The estimated number of adults and children with advanced HIV infection (in need of ART)	260,000	2009	Towards Universal Access. Scaling up priority HIV/AIDS Intervention in the health sector. Progress Report, 2010. This mid-point estimate is calculated based on the range provided in the report.			
Women 15+ living with HIV	230,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

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

Redacted

Public-Private Partnership(s)

(No data provided.)

Surveillance and Survey Activities

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

		Women, Youth, Other	
HIV drug resistance	HIV Drug Resistance	Other	Implementation
HIV incidence surveillance	Recent HIV Infections	Female Commercial Sex Workers, Injecting Drug Users, Mobile Populations, Men who have Sex with Men, Pregnant Women, Youth, Other	Implementation
HIV-1 molecular epidemiology among MSM	AIDS/HIV Case Surveillance	Men who have Sex with Men	Implementation
Laboratory quality control	Laboratory Support	Other	Implementation
Low-fee sex worker risk behavior survey	Behavioral Surveillance among MARPS	Female Commercial Sex Workers	Development
Methadone Maintenance Treatment (MMT) Outcome Study	Evaluation	Drug Users	Implementation
MSM HIV epidemic and risk behavior qualitative investigation	Qualitative Research	Men who have Sex with Men	Planning
MSM psychiatric examination	Behavioral Surveillance among MARPS	Men who have Sex with Men	Implementation
Needle and syringe program (NSP) evaluation	Evaluation	Injecting Drug Users	Data Review
New incidence assay development	Recent HIV Infections	Other	Implementation
Point-of-care technologies for CD4, VL, and EID	Laboratory Support	Other	Planning
Population size estimation of MARPs	Population size estimates	General Population	Implementation
Survey among wives from high HIV	Population-based	Other	Implementation



prevalence areas	Behavioral Surveys		
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Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHCS (State)	GAP	GHCS (State)	GHCS (USAID)	
HHS/CDC		3,000,000	1,000,000		4,000,000
HHS/HRSA			0		0
USAID			4,000,000		4,000,000
Total	0	3,000,000	5,000,000	0	8,000,000

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency				Total
	HHS/CDC	HHS/HRSA	USAID	AllOther	
HBHC	186,536		239,190		425,726
HLAB	281,316				281,316
HTXS	98,215	0			98,215
HVCT	265,000		197,856		462,856
HVMS	2,256,228		666,000		2,922,228
HVOP	117,030		1,102,984		1,220,014
HVSI	283,120		293,338		576,458
HVTB	22,680				22,680
IDUP	191,920		717,083		909,003
MTCT	54,600				54,600
OHSS	127,640		783,549		911,189
PDCS	63,495				63,495
PDTX	52,220	0			52,220
	4,000,000	0	4,000,000	0	8,000,000

Budgetary Requirements Worksheet

(No data provided.)



National Level Indicators

National Level Indicators and Targets REDACTED



Policy Tracking Table

(No data provided.)



Technical Areas

Technical Area Summary

Technical Area: Adult Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	425,726	
HTXS	98,215	
Total Technical Area Planned Funding:	523,941	0

Summary:
(No data provided.)

Technical Area: Biomedical Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
IDUP	909,003	
Total Technical Area Planned Funding:	909,003	0

Summary:
(No data provided.)

Technical Area: Counseling and Testing

Budget Code	Budget Code Planned Amount	On Hold Amount
HVCT	462,856	
Total Technical Area Planned Funding:	462,856	0

Summary:
(No data provided.)

Technical Area: Health Systems Strengthening

Budget Code	Budget Code Planned Amount	On Hold Amount
OHSS	911,189	
Total Technical Area Planned	911,189	0



Funding:		
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Summary:
(No data provided.)

Technical Area: Laboratory Infrastructure

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	281,316	
Total Technical Area Planned Funding:	281,316	0

Summary:
(No data provided.)

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	2,922,228	
Total Technical Area Planned Funding:	2,922,228	0

Summary:
(No data provided.)

Technical Area: Pediatric Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
PDCS	63,495	
PDTX	52,220	
Total Technical Area Planned Funding:	115,715	0

Summary:
(No data provided.)

Technical Area: PMTCT

Budget Code	Budget Code Planned Amount	On Hold Amount
MTCT	54,600	
Total Technical Area Planned Funding:	54,600	0



Summary:
(No data provided.)

Technical Area: Sexual Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVOP	1,220,014	
Total Technical Area Planned Funding:	1,220,014	0

Summary:
(No data provided.)

Technical Area: Strategic Information

Budget Code	Budget Code Planned Amount	On Hold Amount
HVSI	576,458	
Total Technical Area Planned Funding:	576,458	0

Summary:
(No data provided.)

Technical Area: TB/HIV

Budget Code	Budget Code Planned Amount	On Hold Amount
HVTB	22,680	
Total Technical Area Planned Funding:	22,680	0

Summary:
(No data provided.)



Technical Area Summary Indicators and Targets
REDACTED

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
7411	Family Health International	NGO	U.S. Agency for International Development	GHCS (State)	850,000
7414	Research Triangle International	NGO	U.S. Agency for International Development	GHCS (State)	560,000
10178	Chinese Center for Disease Prevention and Control	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP, GHCS (State)	1,733,772
10196	Management Sciences for Health	NGO	U.S. Agency for International Development	GHCS (State)	0
10197	Pact, Inc.	NGO	U.S. Agency for International Development	GHCS (State)	682,000
10481	International Training and Education Center on HIV	University	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHCS (State)	0
12258	United Nations Joint Programme on HIV/AIDS	Implementing Agency	U.S. Department of Health and Human Services/Centers	GHCS (State)	10,000



			for Disease Control and Prevention		
13186	Population Services International	NGO	U.S. Agency for International Development	GHCS (State)	1,242,000



Implementing Mechanism(s)

Implementing Mechanism Details

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

Total Funding: 850,000	
Funding Source	Funding Amount
GHCS (State)	850,000

Sub Partner Name(s)

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

Overview Narrative

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Impact/End-of-Program Evaluation



Mobile Population

Budget Code Information

Mechanism ID: 7411			
Mechanism Name: TASC3			
Prime Partner Name: Family Health International			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	36,360	
Narrative:			
GHCS (USAID) = \$35,000			
GHCS (State) = \$18,000			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	164,649	
Narrative:			
GHCS (USAID) = \$140,000			
GHCS (State) = \$100,000			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	89,870	
Narrative:			
GHCS (USAID) = \$81,000			
GHCS (State) = \$50,000			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	72,034	
Narrative:			
GHCS (USAID) = \$65,000			
GHCS (State) = \$40,000			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	343,019	



Narrative:			
GHCS (USAID) = \$300,000			
GHCS (State) = \$200,000			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	144,068	
Narrative:			
GHCS (USAID) = \$150,000			
GHCS (State) = \$60,000			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

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

Total Funding: 560,000	
Funding Source	Funding Amount
GHCS (State)	560,000

Sub Partner Name(s)

Kunming Health Institute	Macfarlane Burnet Institute for Medical Research and Public Health	Multiple CBOs for advocacy small grants
Yunnan CDC/VCT work	Yunnan Institute of Drug Abuse (YIDA)	Yunnan Policy Academy

Overview Narrative



Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Increasing gender equity in HIV/AIDS activities and services
 Increasing women's legal rights and protection

Budget Code Information

Mechanism ID: 7414			
Mechanism Name: Health Policy Initiative			
Prime Partner Name: Research Triangle International			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	57,436	
Narrative:			
GHCS (USAID) = \$60,000 GHCS (State) = \$20,000			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	502,564	
Narrative:			
GHCS (USAID) = \$483,500 GHCS (State) = \$216,500			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details



Mechanism ID: 10178	Mechanism Name: China CDC COAG
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Chinese Center for Disease Prevention and Control	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,733,772	
Funding Source	Funding Amount
GAP	743,772
GHCS (State)	990,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,450,000
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Key Issues

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

Budget Code Information

Mechanism ID: 10178



Mechanism Name: China CDC COAG			
Prime Partner Name: Chinese Center for Disease Prevention and Control			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	186,536	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	98,215	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	265,000	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	63,495	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	52,220	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	278,120	
Narrative:			
278120			
Strategic Area	Budget Code	Planned Amount	On Hold Amount



Other	OHSS	122,640	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	117,030	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	191,920	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	54,600	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	281,316	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	22,680	
Narrative:			
22680			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

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

Total Funding: 0	
Funding Source	Funding Amount
GHCS (State)	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: 10196			
Mechanism Name: Strengthening Pharmaceutical Systems			
Prime Partner Name: Management Sciences for Health			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	0	

Narrative:



GHCS (USAID) = \$75,000
GHCS (State) = \$25,000

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

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

Total Funding: 682,000	
Funding Source	Funding Amount
GHCS (State)	682,000

Sub Partner Name(s)

AIDS Care China	Blue Sky Group	International HIV/AIDS Alliance
Sunflower Garden	Sunny Island	Xingcheng Ltd.

Overview Narrative

Cross-Cutting Budget Attribution(s)

Economic Strengthening	136,400
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Key Issues



Addressing male norms and behaviors
 Impact/End-of-Program Evaluation
 Increasing gender equity in HIV/AIDS activities and services
 Increasing women's access to income and productive resources
 TB
 Family Planning

Budget Code Information

Mechanism ID: 10197			
Mechanism Name: Community REACH Greater Mekong Region Associate Award			
Prime Partner Name: Pact, Inc.			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	202,830	
Narrative:			
GHCS (USAID) = \$324,782			
GHCS (State) = \$170,000			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	13,200	
Narrative:			
GHCS (USAID) = \$30,000			
GHCS (State) = \$15,000			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	208,951	
Narrative:			
208951			
GHCS (State) = \$130,000			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	82,500	
Narrative:			



GHCS (USAID) = \$112,500			
GHCS (State) = \$37,500			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	174,519	
Narrative:			
GHCS (USAID) = \$250,308			
GHCS (State) = \$88,000			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

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

Total Funding: 0	
Funding Source	Funding Amount
GHCS (State)	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Cross-Cutting Budget Attribution(s)

(No data provided.)



Key Issues

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

Budget Code Information

Mechanism ID: 10481			
Mechanism Name: I-TECH COAG			
Prime Partner Name: International Training and Education Center on HIV			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	0	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	0	
Narrative:			
None			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12258	Mechanism Name: UNAIDS COAG
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: United Nations Joint Programme on HIV/AIDS	
Agreement Start Date: Redacted	Agreement End Date: Redacted



TBD: No	Global Fund / Multilateral Engagement: No
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Total Funding: 10,000	
Funding Source	Funding Amount
GHCS (State)	10,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12258		
Mechanism Name:	UNAIDS COAG		
Prime Partner Name:	United Nations Joint Programme on HIV/AIDS		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	5,000	
Narrative:			
None			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	5,000	
Narrative:			



None

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 13186	Mechanism Name: Population Services International
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,242,000	
Funding Source	Funding Amount
GHCS (State)	1,242,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

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

Cross-Cutting Budget Attribution(s)

(No data provided.)



Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: 13186			
Mechanism Name: Population Services International			
Prime Partner Name: Population Services International			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	33,207	
Narrative:			
GHCS (USAID) = \$18,476			
GHCS (State) = \$10,000			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	132,832	
Narrative:			
GHCS (USAID) = \$73,906			
GHCS (State) = \$40,000			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	677,465	
Narrative:			
GHCS (USAID) = \$400,938			
GHCS (State) = \$180,000			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	398,496	
Narrative:			
GHCS (USAID) = \$241,718			
GHCS (State) = \$100,000			



Implementing Mechanism Indicator Information

(No data provided.)



USG Management and Operations

- 1.
Redacted
- 2.
Redacted
- 3.
Redacted
- 4.
Redacted
- 5.
Redacted

Agency Information - Costs of Doing Business U.S. Agency for International Development

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Computers/IT Services				27,400		27,400
ICASS				38,000		38,000
Institutional Contractors				45,000		45,000
Management Meetings/Professional Development				30,000		30,000
Non-ICASS Administrative Costs				10,000		10,000
Staff Program Travel				66,000		66,000
USG Staff Salaries and Benefits				449,600		449,600



Total	0	0	0	666,000	0	666,000
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U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHCS (State)		27,400
ICASS		GHCS (State)		38,000
Management Meetings/Professional Development		GHCS (State)		30,000
Non-ICASS Administrative Costs		GHCS (State)		10,000

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

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Computers/IT Services			50,000			50,000
ICASS			140,000			140,000
Institutional Contractors			67,079			67,079
Management Meetings/Professional Development			47,437			47,437
Non-ICASS Administrative Costs			470,850			470,850
Staff Program Travel			184,000			184,000



USG Staff Salaries and Benefits			1,296,862			1,296,862
Total	0	0	2,256,228	0	0	2,256,228

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

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GAP		50,000
ICASS		GAP		140,000
Management Meetings/Professional Development		GAP		47,437
Non-ICASS Administrative Costs		GAP		470,850