GLOBAL AIDS RESPONSE PROGRESS - COUNTRY REPORT, LAO PDR

2012

Foreword

Lao People's Democratic Republic (Lao PDR) has HIV prevalence of 0.2% in adult population. Lao PDR is surrounded by countries with higher HIV prevalence, and as the country's commitment to economic expansion transitions the country from "a landlocked to a land-linked country", the risk to HIV vulnerabilities is growing. Increased mobility across borders coupled with the existing commercial sex vulnerabilities and the emergence of high-risk groups, places Lao PDR on a continuous alert of a new HIV threat.

In response to the HIV epidemic situation, the Government of Lao PDR has provided strong political commitment to support a multi-sectoral response. The role of key international and national partners has been invaluable, coordination and collaboration have strengthened greatly since the country's first endorsed the Declaration of Commitment at United Nation General Assembly Special Session on AIDS in 2001 and this is further emphasized as the country endorsed the 2011 Political Commitment Declaration in June 2011.

As the National Strategy and Action Plan for HIV/AIDS/STI Prevention and Control 2011-2015 has just passed the first year of its implementation, the preparation process of this report is an opportunity for the National AIDS Authority and its partners to review the progress made in the last two years, as well as to consider the efforts needed to reach the new and ambitious targets set in the National Strategy. Recognizing its important status, all partners have been invited to take part in an open and participatory process for the report.

There has been much progress as this report will describe, from improved political commitment and enabling environment, and stronger civil society involvement, to scale up quality and coverage of HIV prevention and treatment services. The evidence points to the improved outputs, outcomes and due to these efforts.

Despite the aforementioned accomplishments, Lao PDR still has many challenges to address. Increasing capacity to monitor and evaluate the current response as well as identifying potential challenges that can accelerate the spread of the epidemic is much needed, since there is still much that is not understood, particularly in newly emerging vulnerable groups. Prevention activities will need to continue to target existing and emerging high-risk groups. With the changing of global development assistance due to the down turn of global economy, it is ever more important for Lao PDR to mobilize more sustainable resources to support the increasing needs on treatment, as well as on the expansion of other components of the National AIDS Response.

Maintaining a proactive multi-stakeholder response is a challenge, and obtaining support and resources through both internal and external commitments will require the Government of Lao PDR to continuously stay one step ahead of the epidemic. These concerns will guide the multi-sectoral force as it works to obtain universal access, to achieve the 2015 Millennium Development Goal and to reach the Three Zeros strategy – Zero new HIV infections; Zero discrimination and Zero AIDS related deaths.

Vientiane 30 MAR 2012
Chair, National Committee for the Control of AIDS

Assoc.Prof. Bounkong SYHAVONG

Acknowledgement

The Global AIDS Response Progress – Country Report for Lao PDR in 2012 was prepared through an inclusive and consultative process, under the leadership of the Centre for HIV/AIDS/STI (CHAS), on behalf of the National Committee for the Control of AIDS (NCCA). The reporting team includes members from CHAS, UNAIDS, WHO, UNICEF and an international consultant.

We would like to express our thanks to all the national partners both governmental and civil society who have contributed and participated in the national response and provided important input throughout the reporting process. These include Ministry of Health/CHAS; Ministry of Education and Sport; Ministry of Information, Culture and Tourism; Ministry of Labour and Social Welfare; Ministry of National Defence; Ministry of Public Security; and Ministry of Public Work and Transportation; Lao Red Cross, Lao Youth Organization, Lao Women's Union, Lao Trade Union, and Lao Font for National Construction. We would also like to thank the national civil society organizations, including PEDA, LaoPHA and LNP+.

Our gratitude also goes to international partners UNICEF, UNFPA, UNDP, WHO, UNODC, UNWOMEN, WB, IOM, WFP, AFD, ESTHER ARC, BI, PSI, NCA, FHI, World Vision and others for their continued collaboration and technical expertise, and invaluable input towards this report. A special thanks to UNAIDS for their technical and financial support throughout the process of this report and to the international consultant for all the technical assistance during the development of this report.

Contents

List of Abbreviations

ADB	Asian Development Bank
AEM	Asian Epidemic Model
AFAO	Australian Federation of AIDS Organizations
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APCASO	Asia Pacific Council of AIDS Service Organizations
ART	Antiretroviral Therapy
ARV	Antiretroviral
ATS	Amphetamine-type Stimulants
AusAID	Australia Agency for International Development
BCC	Behaviour Change Communication
CAI	Community Advocacy Initiative
CHAS	Centre for HIV/AIDS/STI
CUP	Condom Use Programme
DCCA	District Committee for the Control of AIDS
DIC	Drop – in – Centre
EPP	Estimation and Projection Programme
FDI	Foreign Direct Investment
FHI	Family Health International
FSW	Female Sex Workers
GARP	Global AIDS Response Progress
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HSS	Health System Strengthening
IBBS	Integrated Biological and Behavioural Survey
IPT	Izoniazid Preventive Therapy
ILO	International Labour Organization
INGO	International Nongovernmental Organization
IPT	Izonazid Preventive Therapy

KAP	Key Affected Population
LaoPHA	Lao Positive Health Association
LCDC	Lao National Commission for Drugs Control and Supervision
LNP+	Lao Network of People Living with HIV
LRC	Lao Red Cross
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MNCH	Maternal Neonatal and Child Health
MOH	Ministry of Health
MSM	Men who Have Sex with Men
N/A	Not available
NA	National Assembly
NAR	National AIDS Response
NASA	National AIDS Spending Assessment
NCA	Norwegian Church Aid
NCCA	National Committee for the Control of AIDS
NCPI	National Commitment and Policy Instrument
NGO	Nongovernmental Organization
NSAP	National Strategy and Action Plan on HIV/AIDS/STI Control and Prevention
NSEDP	National Socioeconomic Development Plan
NTC	National Centre for TB Control
ODA	Official Development Assistance
OVC	Orphan and Vulnerable Children
PCCA	Provincial Committee for the Control of AIDS
PEDA	Promotion for Education and Development Association
PICT	Provider Initiated Counselling and Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PPT	Periodic Presumptive Treatment
PSI	Population Service International
PUD	People who Use Drugs

PWID	People Who Inject Drugs
RAR	Rapid Assessment Report
SELNA	Support for an Effective Lao National Assembly
SIS	Stigma Index Survey
STI	Sexually Transmitted Infection
SW	Sex workers
TB	Tuberculosis
TWG	Technical Working Group
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
USCDC	United States Centre for Disease Control
VCT	Voluntary Counselling and Testing
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

Glossary

Definitions of key populations that have been mentioned in this report, as defined in the National Strategy and Action Plan for HIV/AIDS/STI Control and Prevention:

Low-risk Men – refers to men who have a low-risk perception and behaviour, including ex-clients of sex workers. They often become infected through unprotected casual sex.

Low-risk Women – refers to women who have a low-risk perception and behaviour, including married women, ex-sex workers and young girls. Most of these populations are vulnerable because of their partners' at-risk behaviours.

Current clients of SW – includes men who frequent SW. They usually spend an average of five years as clients, after which time they become low-risk men. Successful prevention programmes aimed at SW reduce the number of infections within this group. Clients are often married or in other sexual relationships.

PWID – people who inject drugs comprise of both men and women who inject drugs and share needles. With the current HIV response rate, it is likely that the number of infections within this population will increase dramatically as this population is difficult to reach.

MSM – this population is estimated at around 3% of the entire male population. This particular group of MSM represented in this report refers to men who have sex with men who engage in high-risk behaviours such as selling sex, buying sex and unprotected casual sex. They are many sub-groups within this population including transgendered (katoeys), straight, and married men. With the current HIV response rate, it is likely that the number of infections within this population will increase.

Sex workers (Entertainment based) – this population is defined by the environment in which they work, primarily entertainment venues such as bars, clubs, hotels and guest houses. This group is easy to access as they are often found in the venue and can be monitored. They have more clients leading them to more vulnerable with HIV infection

Sex workers (Non-entertainment based) – are the freelance style, in which they approach clients, usually using mobile phones, not in establishments and majority of them having less clients. This group is difficult to reach and monitor, hence prevention efforts are not currently reaching this group effectively.

Civil Society Organizations (CSO) – in the context of this document, CSO refers to local non-profit associations; informal networks of key affected populations; international NGOs; faith-based organizations and in some extent, mass organizations due to their broad mandate and structure that reach down to community level, despite that they are Government set-up organizations.

I. STATUS AT A GLANCE

1. Inclusiveness of the stakeholders in the report writing process

Ten years after the landmark UN General Assembly Special Session on HIV/AIDS (UNGASS), the progress was reviewed at the 2011 UN General Assembly High Level Meeting on AIDS. A new Political Declaration on HIV/AIDS[1] with new commitments and bold new targets was adopted. This report covers the progress made by the National AIDS Response (NAR) in Lao PDR in the two years period 2010 – 2011, against the commitments and targets of the 2011 Political Declaration.

This report has been formulated through a participative process involved around 40 stakeholders from all sectors that working on the issues of HIV epidemic in the Lao PDR. These include Government agencies, United Nations (UN) and bilateral agencies, international nongovernmental organizations (INGO); local non-profit associations, people living with HIV (PLHIV) and mass organizations (see list of stakeholders in annex 5). The reporting team consists of members from the National Centre for HIV/AIDS/STI (CHAS) of the Ministry of Health (MOH); UNAIDS; WHO; UNICEF; and an international consultant who has provided technical assistance throughout the reporting process.

The preparation process for the report started in February 2012 with an orientation workshop attended by representatives from government and nongovernment sectors, international development partners and mass organizations. The workshop was organised by the CHAS, whose function is the Secretariat of the National Committee for the Control of AIDS (NCCA). Due to the late start, there was not adequate time to organise for involvement of stakeholders at provincial level and representatives of networks of Key Affected Populations (KAP) such as men who have sex with men (MSM) and sex workers (SW).

Stakeholders then were invited to discuss and met for the completion of National Commitment and Policy Instrument (NCPI) part A and B. The consolidation workshop was organised on 23 of March, 2012 to discuss and reach consensus on the key contents of the report, as well as on the final completed NCPI forms.

The CHAS plays the leading role throughout the process of this report writing, with support from UNAIDS and the whole reporting team.

2. The Status of the Epidemic

Lao People's Democratic Republic (Lao PDR) is a landlocked country in the Mekong Region, bordering with China, Myanmar, Thailand, Cambodia and Viet Nam. In the last two years, Lao PDR has been in a period of dynamic change with economic growth at around 8% (2010).[2] In 2011, Lao PDR has entered the category of low middle income country (World Bank).[2] The country's growth is fully driven by foreign direct investment (FDI) on natural resource extraction industries and hydro power. Despite this growth in economy and the national efforts to bring down proportion of population living under poverty line to 27.6% in 2010 (UNDP), the poverty gap is still getting wider, with most of the poor living in the vast rural areas of the country, so are the gaps in access to school, food, health care, especially among women and girls.[3]

Recently, Lao PDR has become land-linked with better road access within the country as well as with neighbouring countries, especially in the development context of regional economic corridors (see picture 1).

[1] Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, A/RES/65/277, 10June 2011
[2] Lao National Statistic centre
[3] UNDP/ UNDAF Lao PDR, country analysis 2011 (draft)

Figure 1:

Source: ADB

There has been an increase in flow of people moving in the country and within the region, as Lao people and their neighbours looking for employment and trade opportunities.[4]

In this context, HIV epidemic in Lao PDR has also witnessed new trends in the last two years. Being neighboured by countries with higher HIV prevalence epidemics, especially among sex workers (SW), Men who have Sex with Men (MSM) and people who inject drugs (PWID), combined with the pace of socio-economic development, Lao PDR is experiencing the spread of HIV due to dynamic movement of people within and crossing the borders, as people take part in many economic development sites throughout the country. The Rapid Assessment on Most-at-Risk Adolescents and Young People to HIV in Lao DPR, 2011 supported by UNICEF confirms this as there are more young people coming to big cities looking for work and for many, especially women whose choices for income generation are limited, are at higher risk for HIV infection.

Lao PDR's HIV epidemic is estimated prevalence of 0.2% among adults aged 15-49 (MOH 2011).[5] Unsafe sexual activity is the main mode of transmission. In the National Strategic and Action Plan for HIV/AIDS/STI Control and Prevention (NSAP) for 2011-2015, the epidemic scenario is stated as "*potential for a concentrated epidemic".* The key populations at higher risk are identified as SW, MSM, People who Use Drugs/ People who Inject Drugs (PUD/ PWID); and clients of SW.

2.1. Sex workers

In 2011, it was estimated that the number of SW was around 14,000 SW in Lao PDR (NSAP). The latest Integrated Biological and Behavioural Survey (IBBS) conducted among this population in 2011 found HIV prevalence at 1% among SW in 6 surveillance provinces, with the highest prevalence in Luang Prabang at 1.8% and lowest at 0.7% (in Vientiane, Champasak and Savannakhet). This is the fourth round of surveillance survey conducted among this population, HIV prevalence has not increased in the last ten years (2% in 2004; 0.43 in 2008 and 1% in 2011).Though commercial sex is illegal in Lao PDR, sex workers normally can be found in entertainment venues e.g. Karaoke, drink bars, restaurants, or in guesthouses. The IBBS 2011 found that half of the surveyed SW had been reached by prevention programme (55.5%) and 87% of them have been given condoms in the last 12 months. Despite this, only one fifth (22%) have had an HIV test and know their results. The reported number of SW that has been reached by peer-led intervention was around 75% of the estimated number of SW in 2011.[6] Recently, more SW, especially young SW, use mobile phone to contact clients or are engaged in opportunistic sex work and they stay only few months in sex work and then move on looking for other work.[7] Little is known about this trend of behaviours, thus the need to

[4] UNICEF. Rapid Assessment: Most-at-Risk Adolescents and Young People to HIV in Lao PDR, 2011
[5] CHAS/UNAIDS Estimation and projection by AEM modeling, 2011
[6] CHAS routine prevention programme report
[7] UNICEF. Rapid Assessment: Most-at-Risk Adolescents and Young People to HIV in Lao PDR, 2011

collect more information about this sub-group in order to design suitable preventive interventions to reach them.

2.2. Men who have sex with men (MSM):

In 2011, MSM were estimated to be around 17,000 (NSAP). The first IBBS survey among MSM was conducted in 2007 in Vientiane Capital, of which prevalence of 5.6% was detected. The other surveys conducted later were IBBS in Luang Prabang; "Mapping of sexual and social networks of men who have sex with both men and women in Vientiane Capital"[8] in 2009; and the "First Round HIV/SIT Prevalence and Behavioural Tracking Survey among transgender (TG) in Vientiane Capital and Savannakhet" in 2010.[9] These surveys found a complex pattern of sexual behaviours in this population (see section 2.2). High prevalence of HIV was also found among MSM/TG: 4.4% in Vientiane Capital and 3.8% in Savannakhet in 2010, but 0% among MSM in Luang Prabang in 2009.

Table 1 shows key indicator data about different behaviours of MSM and MSM/TGs collected by different surveys in the last five years. Due to the ad-hoc nature of the surveys, the data is neither comparable for across the time periods, nor for behaviours across different subgroups.

Table 1: Summary of findings among MSM in the last five years

MSM and transgendered	2007	2009	2010 (Transgender)
Site	VTC	LPB	VTC, SVK
Have been reached by prevention programme (%)*	58.3		84.7
Have been tested for HIV and know results (%)	6	14	73.2
Condom use in the last sex with a male partner (%)			
With male client	n/a	66	57.8
with regular male partner	n/a	67	45.9
with casual male partner	n/a	68	48.0
Have used condom consistently in the last …(%)	3 months	3 months	1 months
with casual male partners	24.2	37	63
with male clients	22	40	n/a
with regular male partner	14.4		55.3
Condom use in the last sex with female client (%)	64	64	
Condom use in the last sex with female sex worker (%)	59	59	
Condom use in the last sex with a female partner (%)	57.6	55	
Have used drug (%)	21.1	39	n/a
Have injected drugs in the last 12 months (%)	12	0.7	n/a
Have sex with women (%)	39.4		n/a
HIV+ (%)	5.6	0	4.2
Received treatment for STI symptoms	42.2		6.2

(VTC – Vientiane Capital; LPB – Luang Prabang; SVK – Savannakhet)

Source: CHAS Surveillance Database

[8] Burnet Institute/CHAS. Sexual networks of MSM who have sex with women in Vientiane Summary. 2010

[9] PSI /CHAS. Report on the First Round HIV/ STI Prevalence & Behavioral Tracking Survey among transgender in Vientiane Capital and Savannakhet (2010)

The recent workshop series on Estimation and Projection for Lao PDR epidemic, supported by WHO and US CDC used the Asia Epidemic Model (AEM) – a modelling software to estimate and project HIV epidemic in Asia – which shows that the epidemic in this population will grow if no further effective prevention interventions are applied. There is the need to collect more trend data and monitor behaviour patterns of this population for effective interventions.

2.3. PUD/PWID:

Northern Lao PDR is in the golden triangle known for high production and trafficking of drugs to other countries. Bordering with Lao to the North is Yunnan, China; and to the North East is Dien Bien, Viet Nam, both of these neighbouring provinces are known to have high prevalence of PWID, as well as high prevalence of HIV (50% in Yunnan, China in 2007, 55% in Dien Bien, Viet Nam in 2009)[10] among PWID. This condition has triggered WHO, AusAID, UNODC, CHAS, and the Lao National Commission on Drugs Control and Supervision (LCDC) to conduct a rapid assessment on drug use and HIV situation in the two provinces of Huaphanh and Phongsaly. The finding was 1.5% of PUD who took unlinked anonymous HIV test found to be HIV – positive. So far, this is the only survey conducted among this key affected population (KAP), which estimated at around total of 17,000 PUD (including injecting and non-injecting), of which estimated 10% are PWID in Lao PDR in 2011. More studies are needed to find out drug taking behaviours as well as other HIV-related vulnerable behaviours among this group, as it is known that the use of contaminated injecting equipment is the highest transmission route of HIV.

2.4. Men with multiple sex partners:

This population refers to clients of sex workers. In the past, the surveillance surveys were conducted among military, truck drivers, and water or electricity workers. In general, the surveys aimed at men whose job requires frequent traveling and who have tendency to frequent SW. In the reported HIV positive case, 50% of PLHIV currently is this category of men with multiple partners.[11] Unfortunately, in the last four years, there has been no surveillance conducted among this population. No current data available to inform behaviours and HIV knowledge and status awareness of this group, although sexual behaviours of this population is the main reason for the HIV prevalence among low-risk women.

2.5. Low- risk women:

Eighteen percent (18%) of current reported PLHIV recorded by CHAS are housewives. It is unknown on the HIV status of this group as well as their behaviours. The estimation and projection show a slight increase in prevalence of this group till 2030.

2.6. Young people:

Lao young population (under 25 years old) makes up 60% of the total population (UNFPA) and it is this population that the recently rapid socio-economic development in Lao PDR has had the most impact on. Lack of opportunity for higher education, coupled with more opportunities to travel and seek employment, has increased vulnerabilities for young people, especially for those coming from poor families in rural areas. There are more adolescents and young people engaged in commercial sex, and use drugs.[12] A study conducted in 2009 on drug use (mainly Amphetamine Type Stimulants – ATS) among young people aged 15-24 in Vientiane, found that 46% of the survey respondent reported current use of drug, of whom, 1.4%

[10] USAID – country profiles
[11] CHAS. Routine report 2011
[12] UNICEF. Rapid Assessment Most-at-Risk Adolescents and Young People to HIV in Lao PDR. 2011

injected.[13] There is evidence suggests that young people have engaged in high-risk behaviours and further information should be collected to support prevention intervention for this group.

3. Policy and Programmatic Response

The National AIDS Response (NAR) in the Lao PDR is led by NCCA. It is a multi-sectoral body chaired by H.E Prof. Dr. Eksavang Vongvichit Minister of Health, who has taken this position since 2011. NCCA brings together expertise and commitment of senior representatives of twelve Line Ministries and Mass Organizations, plus recently proposed Representatives of the National Assembly; the Lao Network of PLHIV; Ministry of Justice; Lao Chamber of Commerce and Industry; Lao National Commission of Drug Control and Supervision; Buddhist Association (see annex 5).

The Secretariat of the NCCA, the CHAS, is responsible for the implementation of the National HIV Response (NAR) and the coordination of the national and international partners within the framework of the National Strategy and Action Plan 2011-2015 (NSAP). The National Strategy is aligned with the 7th Health Sector Plan and the 7th National Socio Economic Development Plan (NSEDP) 2011-2015.[14]

3.1. Policy environment and Leadership:

Below are highlights of the policy and political environment since 2009 in the context related to the HIV epidemic in Lao PDR:

- In 2011, the Minister of Health, Chair of NCCA together with a high level delegation from Lao PDR attended the UN High Level Meeting on AIDS in New York and in this occasion, the Minister endorsed the 2011 Political Commitment Declaration with its seven targets. The Three Zero Strategy also been endorsed by the country.
- The 7th National Socioeconomic Development Plan 2011-2015 has emphasised the country's commitment to reach the Millennium Development Goals (MDG), of which MDG 6 on HIV, TB and Malaria is on track, though much efforts is still needed to achieve the target on HIV.
- The NSAP 2011-2015 confirms the commitment of the Government of Lao PDR to reach MDG 6 and the Three Zeros strategy. The development of this NSAP has been a new level of multi-stakeholder engagement with inclusive participation and involvement from all international partners working on AIDS as well national associations, PLHIV, of Key Affected Populations (KAP). The detailed costed action plan has earmarked budget for key stakeholders was a progressive step. For this period, the NCCA recognised the need to double the total budget to US$ 54million compared to the previous period, though much of it still needs to be mobilized.
- In 2009, the Prime Minister's Decree on the Association Establishment came into effect providing the legal framework for the establishment of local non-profit associations (NPA). Since then, three associations working on HIV have been registered: LaoPHA, PEDA and LNP+. This Decree formally recognises the work of these organizations, and is advantageous especially in terms of attracting and mobilising funds. The Decree provides the foundation for greater civil society participation in the National AIDS Response.
- The National Policy on HIV/AIDS has been reviewed and updated.
- In 2011, the Law on HIV/AIDS Control and Prevention (hereafter refers to as the HIV Law) was approved by the National Assembly and then promulgated by the President. The Law is progressive in terms of

[13] CHAS/Burnet Institute. Amphetamine Type Substance Use and Sexually Transmitted Infection Risk Among Young People in Vientiane Capital and Vientiane Province, Lao PDR, 2009.

[14] UCO survey, 2011 – Lao PDR

addressing stigma and discrimination and promoting equity. However, the international community is concerned about the clause in Article 52 which prohibits individual from engaging in risky behaviour which influencing the spread of HIV.[15] The section of the Decree relating to enforcement of the law and which will stipulate how the law should be implemented is still under consideration.

- The last two years have witnessed strong and progressive involvement of civil society in the National AIDS Response, especially in the areas of prevention, care and supports. Highlights are the proposal of LNP+ as a member of NCCA; participation and involvement of civil society in the development process of the NSAP and the HIV Law; participation of KAP informal networks in outreach prevention interventions; involvement of civil society, especially in the care and support services provided to PLIHV and those affected by AIDS; surveys and research.

3.2. Programmatic Response:

- **Prevention:**

  The prevention programme consists of peer-led interventions (outreach workers and peer educators); Drop-in Centres (DIC) that provide condoms, HIV and STI testing and counselling as well as referral to antiretroviral therapy (ART). In 2011, there were total of 25 SW outreach workers and 586 SW peer educators and 22 MSM outreach workers and 401 MSM peer educators working in the country. The seven DIC which provide services for SW supported by FHI have now been handed over to the NCCA network. The other three DIC for MSM are operated by PSI in Vientiane Capital and Savannakhet. Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has been the main funders for this programme area with additional support from USAID through PSI.

  - In 2011, there were 10,530 SW (75% of estimated SW) and 3,915 MSM (23% of estimated MSM) have reportedly been reached by the peer-led interventions. The NAR has managed to keep the HIV prevalence among SW lower than it first detected in 2004 which was at 2%. More work is needed to reach out for MSM and the emerging more mobile SW.

  - 100% condom use programme, supported by GFATM, together with other sources of condom (UNFPA) has tried to distribute condom through all different channels: social marketing, free condom at entertainment bases (karaoke bars, restaurants).[16]

  - STI services: Apart from health facilities, STI services for KAP were provided at DIC. 2011 saw a drop in numbers of SW and MSM who came and received STI treatment at DICs because of shortage of STI test kits and drugs due to delayed GFATM procurement procedures. Private clinics also provide STI management services to both general population and KAP but data are not attainable from this sector. There's the need to partner with private sector to monitor the trends of clients at private clinics. Periodic presumptive treatment (PPT) for STI has been provided among SW for many years but due to financial constraints, its coverage has declined during the last few years (WHO).

  - PMTCT: since the start of the pilot programme in 2006 in six provinces, the percentage of estimated HIV-positive pregnant women who received ART prophylaxis has remained low (around 14% - 15%). There are estimated about 180,000 pregnancies per year in the country (WHO) but although antenatal care (ANC) coverage rates are increasing across the country, those most at risk are not accessing ANC services.[17] More efforts are needed to encourage women, especially women at risks

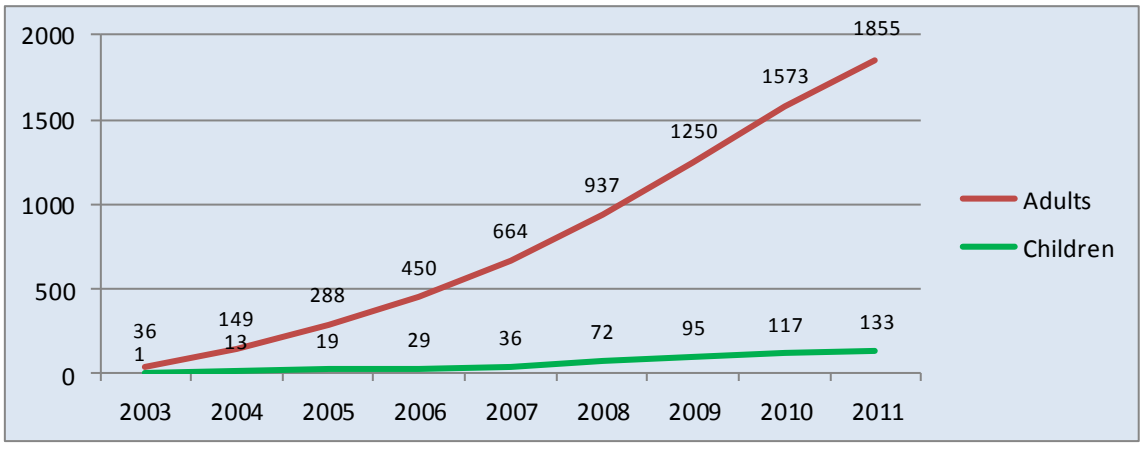
[15] Law on HIV/AIDS Control and Prevention
[16] CHAS, Condom Social marketing Programme assessment, 2010
[17] MOH. National Health Statistic Report 2009/2010

to attend ANC for HIV screening. At the same time with the acceleration of the national maternal neonatal and child health (MNCH) comprehensive package of services, including counselling and screening for HIV for referral, it is crucial to implement this vigorously in areas which are identified in the NSAP as in need of comprehensive intervention.

- Blood safety: Lao PDR has been doing well with 100% of blood units screened for HIV, with external quality assurance as recommended by WHO.
- General population:
  - Life-skills education has been implemented in 74% of secondary schools in the country in 2009. A small rapid assessment done by UNICEF in 2009 found that children attended school with life-skills curriculum had better understanding about HIV and knew more about means of protection. For out of school children, this is still a gap in intervention.[18]
  - HIV in the work place: no further action was taken to follow up on implementation of the 2009 tripartite declaration on HIV at workplace that took place in 15 hotels in Luang Prabang and Vientiane Capital, under support from Ministry of Labour & Social Welfare; Lao Chamber of Commerce and Industry; and Lao Federation of Trade Union.

- **Treatment:**
  - *VCT*: by the end of 2011, there were total of 139 VCT sites nationwide. In 2011, total of around 24,000 HIV tests were conducted. The NSAP is planning to increase the sites to 160 by 2015. So far, all the test kits have been funded through GFATM.
  - *ART treatment*: compared to previous UNGASS report, the percentage of eligible PLHIV who received ART has decreased from 94% in 2009 to 50.8% and 52.3% in 2010 and 2011, although the absolute number is increasing (1,690 in 2010 and 1,988 in 2011) (see figure 2). The reason for that is due to the change in selection criteria for the estimation of number of PLHIV that are eligible for ART treatment, from CD4 counts less than 200 to less than 350 - according to WHO guidelines. All ARV are funded from GFATM and with the decrease in GFATM funds, it's crucial that resources from other donors are mobilised to ensure sustainability of this programme.

Figure 2 - Number of PLHIV received ART 2003 - 2011



Source: CHAS. Routine Report Data

[18] UNICEF – Assessment of Life-skills curriculum Project Lao PDR, 2011

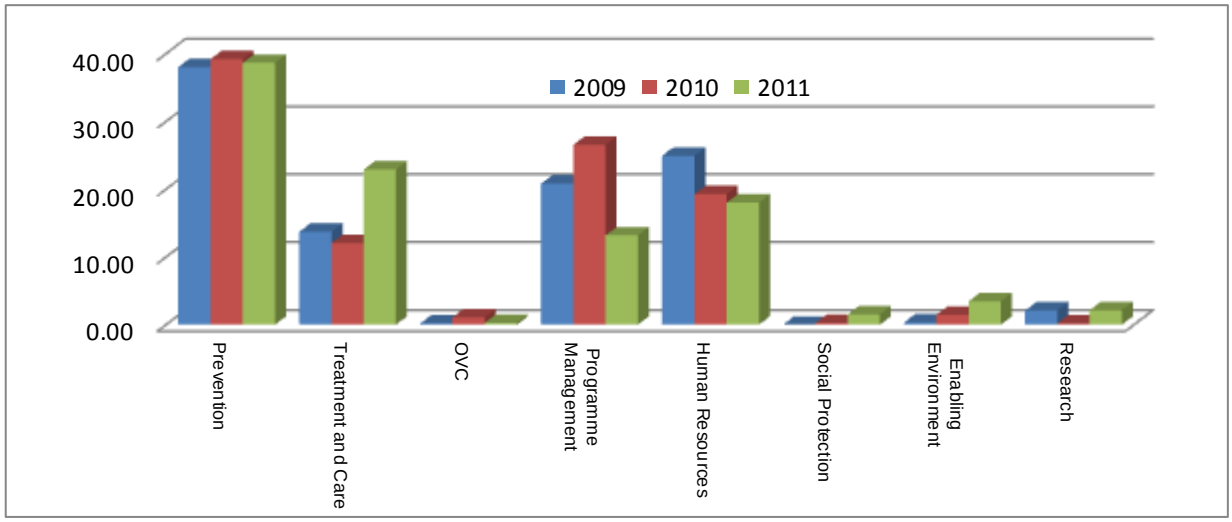
- **Impact mitigation**: there is no available literature on this area. The NCCA network has provided some financial support to children of family of PLHIV at community but in small scale.
- **Care and support**: most of this work is done at community by civil society organisations and informal networks of KAP. UNICEF has been with the Lao Youth Action for AIDS Programme and a range of government and funding partners to put in place what has become the Community-based Care and Support Model for Children and Families Living with HIV. The model is now active in six provinces and Vientiane Capital, operating through a network of self-help groups totaling over a thousand members. A recent evaluation in 2011 found that this model provided an effective continuum of treatment, care and support needed by children and families living with HIV or affected by AIDS.[19] The community-based care and support programme operated by ART centres in ten provinces, including two central level hospitals in Vientiane Capital, mainly provides psychosocial support for PLHIV who received ART, have reached around 50% of the estimated people in needs in 2011. More work is needed to address stigma and discrimination.
- The work with technical support from the USCDC through WHO Lao PDR in the area of **estimation and projection** has been on-going in the last two years, in the course of four workshops. This work has brought in new insights on how the epidemic evolves and recommendations for a more effective response (see chapter 3.5).

3.3. AIDS expenditure

In the two years 2010 and 2011, the expenditure on AIDS has increased compare to 2009, at US$ 7.35 million for 2010 and UD$11 million for 2011 (see annex 1 – NASA for detailed expenditure). Nearly 40% of expenditure on AIDS is spent on prevention programme, followed by management and human resource (see figure 3).

The key feature of budget on AIDS is the predominance of fund from external sources with small contribution of Government (3% in 2011) and the private sector at 0.05% in 2011.

Figure 3 - Total budget by source (%), 2009 - 2011



Source: NASA, 2011

[19] UNICEF. Rapid Assessment of Community-based Care and Support Model for Children living with HIV or affected by AIDS, 2011

Of all external resources, GFATM provides the largest share, at 73% for 2011. This figure was followed by bilateral agencies at 10% and UN at 9% as top three funding sources for the NAR in Lao PDR (see Chapter VI for more details). The funds from external sources will be going down in the near future, hence the need to mobilise more resources and increase domestic investment. The national response relating to the policies and programmes of prevention, treatment, care and support are analysed in chapter III of the report. The details of key reported indicators are presented in Annex 4, and summarised in Chapter 4 of this report.

Summary

In the last two years, progress on NAR has been on many fronts: policy and leadership commitment as the HIV law and the NSAP 2011-2015 have come to effect, combined with the government's commitment to achieve the MDG targets. More PLHIV in needs of ARV have received treatment, care and support. The coordination among different partners, including local associations and informal networks, private sector has got stronger, results in partnerships in prevention, care and supports. Comprehensive prevention has resulted in keeping the HIV prevalence among SW stable and reaching out to other harder to reach populations of MSM, PWID. The NAR has received increasing funds from external sources for its implementation. For the NASP 2011-2015, the costed budget also doubled to approximately 54 million USD, in order to achieve its ambitious national targets.

In 2010, the NSAP 2011-2015 was developed and approved with a set of core indicators; costing and targets set for each of the main components of the plan. These targets was set based on the analysis of information collected through M&E system and activities of the NCCA, as well as on the outcome of an on-going estimation and modelling project with CHAS, supported by WHO and US CDC. The NSAP presents clearly the goals of the National HIV/AIDS/STI Control and Prevention programme as mentioned above. To achieve the goals, three components were set:

1. Prevention: Increase coverage and quality of HIV prevention services
2. Increase coverage and quality of HIV treatment, care and support services – with target for ARV and OI and home and community -based care
3. Improve national programme management to support service delivery.

2015 will be an important milestone as three important global strategies all set targets for this year: MDGs; 2011 Political Commitment Declaration with seven targets on HIV, of which this report is monitoring against; and the UNAIDS Global strategy of Reaching Three Zeros.

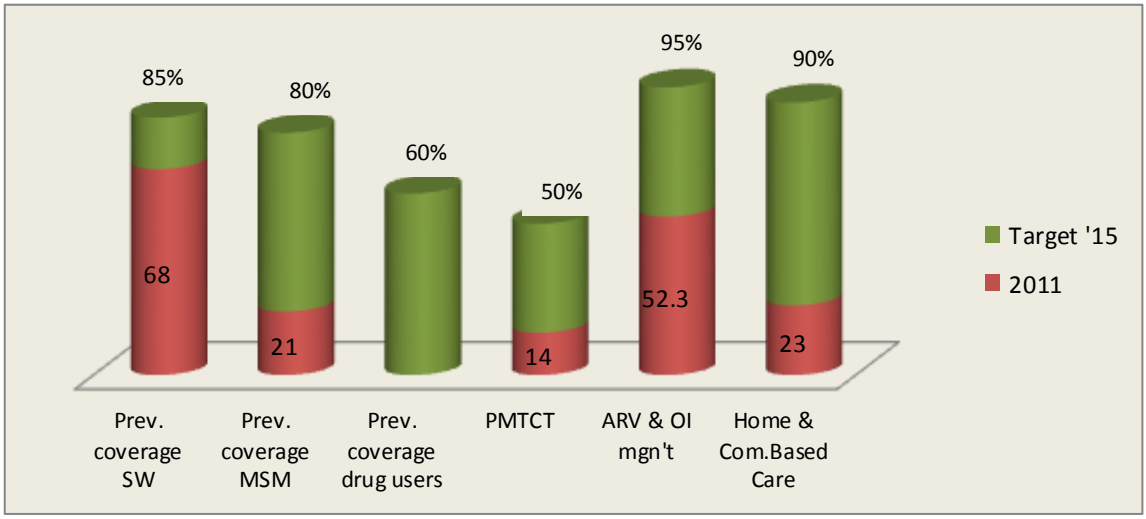
At national level, the National Socio-economic Development Plan, the National Health Sector Development Plan, the NSAP, and the United Nations Assistance Framework (UNDAF) also end its cycle in 2015.

For the National AIDS Response, the NSAP 2011-2015 has set targets for six areas covering prevention, treatment, and care and support. The figure 4 below shows the set targets and the gaps to be covered if the National AIDS Programme is to meet its targets set in the NSAP for 2015. Calculation of coverage reached in 2011 was based on the estimation of population target in 2015.

There is lack of baseline data for prevention coverage for PUD/PWID due to the late initiation of the pilot harm reduction on PWID, so no results are published yet.

There is a need to have a unified and functioning data collecting system to monitor progress in all of these areas. The implementation of NSAP has passed its first year and there is time to identify priorities, as well as develop the effective approaches to record the progress and to reach the national and global targets.

Figure 4 - Reaching NSAP targets: current status, 2011



Source: CHAS/MOH - NSAP 2011-2015 and M&E system reports 2011.

The following recommendations, based on the outcomes of the National Commitment and Policy Instrument (NCPI) recorded in annex 2 should be considered for the National AIDS Response from now until 2015:

- ***Institutional structure**:* Stronger involvement and coordination from NCCA members. NCCA should meet more often.
- ***Policy and Legal environment***: Enhance the new HIV Law enforcement, including dissemination of the law and development of the under law decree for implementation; improving the registration process for national associations, especially a legal aid system to support HIV casework.
- ***Leadership***: Stronger leadership from NCCA and affiliated ministries; more involvement from the Government and Party leaders; further engagement from National Assembly at all administrative levels.
- ***National Strategic Planning*:** strengthen monitoring implementation process of the current NSAP, especially activities that are carried out by civil society organizations;
- ***Civil Society Involvement*:** the momentum created in 2009-2010 during the development processes of the HIV Law and the NSAP should be kept and continued with more involvement of CS at community level as well as at policy making level through their membership in NCCA. Promote capacity building among CSO, especially local associations and networks as a means to empowerment and stronger involvement.
- ***Prevention*:** More effort is needed to access the hard-to-reach KAP (non-entertainment based SW; sub-populations of MSM; PWID and clients of SW). Strengthen prevention programme monitoring in order to have effective interventions.
- ***Treatment, care and support*:** There is a need to encourage PLHIV in advanced stage to come to treatment early as well as strengthen follow-up system, in order to maintain a high survival rate among ART patients. Scale-up of care and support at home and community levels

and palliative care. Improve monitoring and reporting of care and supports in order to measure this against the national target.

- ***Resources***: More domestic investment on AIDS as an essential part of sustainable AIDS response. Fund-raising and resource mobilisation strategy to be developed in order to attract funds from other sources outside GFATM. Building infrastructure, and human capacity for CHAS/ NCCA system as well as local associations and networks working on AIDS.
- ***Strategic Information*****:** The national M&E plan needs to be finalised, in line with NSAP. Improving the Monitoring (M) of the M&E through strengthening the system, capacity building and completion of the national indicators.
- ***Impact Mitigation***: Currently, there is no baseline information on this aspect of the NAR in Lao PDR though the Government of Lao PDR has programmes to support the poor and vulnerable. There is the need to link poverty reduction with impact mitigation due to the heavy socioeconomic burden that the HIV epidemic can cause at household level.

Currently, The Lao Social Indicatory Survey (LSIS) and the GFATM programme review are undergoing. Their results and findings will bring invaluable insights and recommendations to formulate a more effective national response to AIDS in reaching the national and global targets.

4. Overview of indicator data

Table below presents summary of available indicators for Lao PDR that are reported to the global target indicators. Out of 30 indicators, Lao PDR NAR is able to report on 11 indicators. See annex 4 for details description of the reported indicators for Lao PDR.

	GARP Reporting Indicator	Source	Value	Remarks
Target 1 - Reduce sexual transmission of HIV by 50% by 2015				
	General population			
1.1	Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission		N/A	Population-based survey on health and HIV related issues is not available.
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15		N/A	
1.3	Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months		N/A	
1.4	Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used condom during their last sexual intercourse		N/A	
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past		N/A	

	12 months and know their results			
1.6	Percentage of young people aged 15-24 who are living with HIV		Not applicable	This indicator is for generalized epidemic

	Sex workers			
1.7	Percentage of sex workers reached with HIV prevention programmes	IBBS 2011	FSW: 55 <25 yr: 53.6 >25 yr: 64.1	This survey was conducted among female sex workers in 6 provinces, the sample size was 1,434
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	IBBS 2011	92.5 <25 yr: 92.5 >25 yr: 91.9	
1.9	Percentage of sex workers who received an HIV test in the past 12 months and know their results	IBBS 2011	22.2 <25 yr: 21.3 >25 yr: 28.1	
1.10	Percentage of sex workers who are living with HIV	IBSS 2011	1.0 <25 yr: 2.8 >25 yr: 0.1	
	Men who have sex with men			
1.11	Percentage of men who have sex with men reached with HIV prevention programmes		N/A	
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner		N/A	Data from one survey on transgendered in Vientiane was not representable for the country.
1.13	Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results		N/A	
1.14	Percentage of men who have sex with men who are living with HIV		N/A	
Target 2 - Reduce transmission of HIV among people who inject drugs by 50% by 2015				
2.1	Number of syringes distributed per person who injects drugs per year by Needle and Syringe Programmes		N/A	Assessment survey among drug users and people who inject drug was not representable to the country situation
2.2	Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse	N/A	N/A	
2.3	Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	N/A		
2.4	Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results	N/A		

2.5	Percentage of people who inject drugs who are living with HIV	N/A		

Target 3 - Eliminate mother to child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths				
3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	Routine reports; AEM estimation	2010: 8.5 2011: 14.0	
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Routine PMTCT report, CHAS	2010: 1.1 2011: 9.1	There were 3 tests in 2010 and 29 tests done in 2011, use of PCR technique.
3.3	Mother to child transmission of HIV (Modelled)		N/A	
Target 4 - Have 15 million PLHIV on antiretroviral treatment by 2015				
4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	Routine report	2010:Total: 50.8 Children: 21.2 Adults: 53.3 2011:Total: 52.3 Children:32.1 Adults: 54.7	Change in calculation of the denominator: Since 2010, criteria for eligible for ART is CD4 count 350 and less as WHO guideline
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Routine report 2011	Total: 86.4 Children: 86.4 Adults: 87.3	This data is for those who initiated in 2010 and still alive 12 months later
Target 5 - Reduce TB deaths in PLHIV by 50% by 2015				
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Routine report 2010;	2010: 49.2	Estimate of TB cases among HIV + for 2011 is not available
Target 6 - Reach a significant level of annual global expenditure (US$22-24billion) in low and middle income countries				
6.1	International AIDS spending by categories and financing sources	NASA	Annex 1	
Target 7 - Critical enablers and synergies with development sectors				
7.1	National Commitments and Policy Instruments (NCPI)	NCPI	Annex 2	
7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male		N/A	No population based survey has been conducted on these

	intimate partner in the past 12 months			topics
7.3	Current school attendance among orphans and non-orphans aged 19-14		N/A	

7.4	Proportion of the poorest households who received external economic support in the past 3 months		N/A	

Data sources for the above mentioned indicators come from: different programme reports (VCT, GF); HIV/AIDS estimates and projections conducted in 2010, 2011 & 2012; the HIV/STI integrated biological and behavioural surveillance (IBBS) among SW conducted in 2011. In most cases, data disaggregated by gender and age group is not available, and due to the sampling methodology (only selected provinces were included in the studies) the results do not always reflect the nationwide situation.

Since there has been no population based survey on health and HIV related issues since 2006, data for target 1 indicators on general population; for target 2 indicators on PWID were not available and neither were data on indicators 7.2; 7.3; 7.4.

II. OVERVIEW OF THE HIV EPIDEMIC

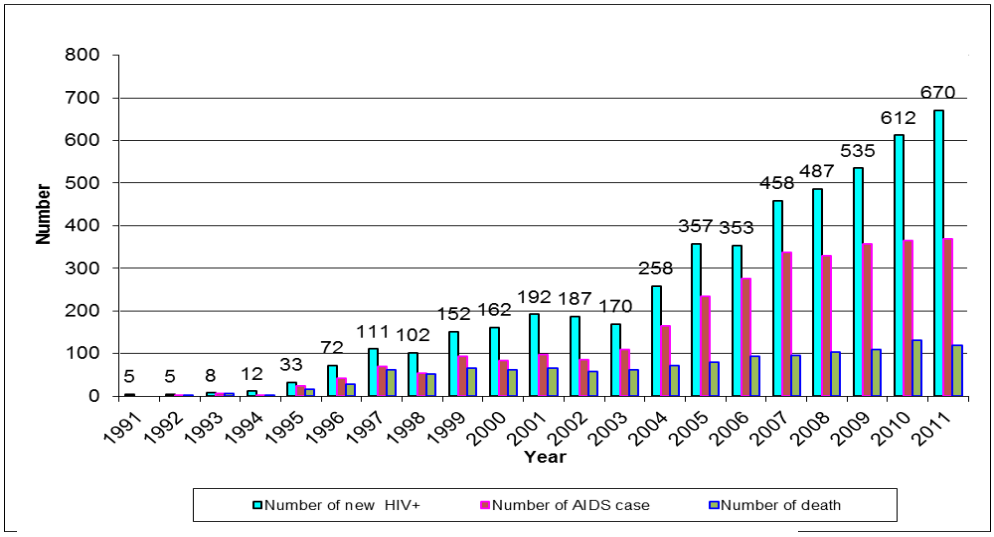
1. Status of the epidemic

In Lao PDR, the HIV prevalence among adult aged 15 - 49 is 0.2%, with estimated 9,600 PLHIV in 2011 (EPP, MOH/CHAS 2011). The main mode of transmission is sexual contact (both hetero sexual and homo/bisexual). Eighty-seven percent (87%) of transmission is through heterosexual contact, with mother-to-child transmission (PMTCT) following at 4.6%, and transmission through anal sex in MSM emerging at 1.3%.[20]

The current HIV epidemic in Lao PDR is in the second wave with the first wave coming in 1990 mainly among migrant workers who returned home from neighbouring countries. The first wave stayed mainly in rural areas, with secondary infection affecting mainly housewives and children but did not spread further. This wave is now fading out.[21]

The current epidemic mainly spread among some key populations at higher risks, identified SW, MSM, and clients of SW. Recent studies on PUD conducted in 2009 and 2010 in bordering provinces and Vientiane Capital have detected HIV presence among people who use drugs (PUD) (1.5%)[22] in the two Northern provinces; all of the HIV-positive detected in the survey are injecting drug users.

Figure 5 - Overview HIV epidemic in Lao PDR



Source: CHAS. Routine Report. 2011

By December 2011, there were reported total case-reports of 4,942 people living with HIV (PLHIV) with the male:female ratio at 1:1.2. The reported HIV-positive cases include those who have died of AIDS related causes in the same period. The actual PLHIV was around 3,500 which is one third of the estimated 9,600 PLHIV for 2011. This indicates a low detection rate among current PLHIV in Lao PDR in the case reporting system.

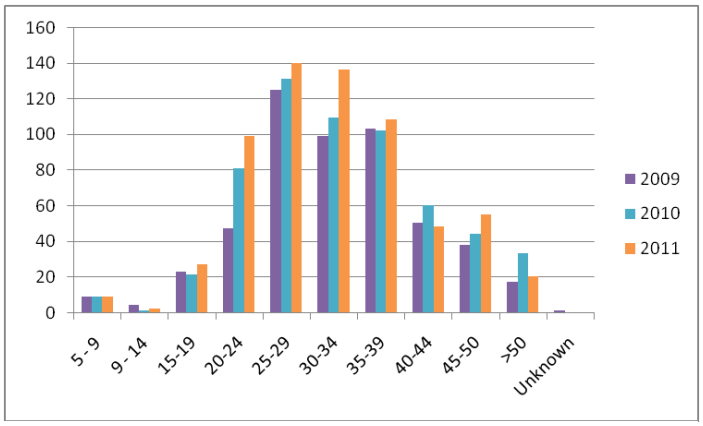
[20] CHAS/MOH routine report, 2011
[21] NSAP, 2011-2015
[22] HAARP/ ADB. Rapid Assessment and Response to Drug Use and Injecting Drug Use in Huaphanh and Phongsaly in Lao PDR . 2010

For the same period, there have been reported total of 1,290 people died of AIDS related causes and number of PLHIV developed to AIDS is still increasing (see chart 5). The number of reported new HIV infection is increasing by year and estimated to reach accumulated 14,000 PLHIV by 2015.[23]

As case reports for 2010 and 2011 show, there are 612 and 670 new HIV infections detected respectively. The most affected age group is 25 to 35 years old (figure 6). Nearly one fifth of PLHIV (18%) is housewives, followed by other occupations (e.g. labourers, migrant workers, business persons).

Among the 670 new infections reported in 2011 through case reporting, the highest proportion of them falls in the age group of 20 to 40 (see chart 5 for details). These are cases collected through case-reporting system which currently is the only source that can provide trend data, although quality of data is not always reliable.

Figure 6 - Age structure of reported new HIV infections, 09-11



Source: CHAS/MOH, programme routine reporting, 2011

Geographically, most of reported PLHIV live in the two big cities Vientiane Capital (33%) and Savannakhet (34%), other provinces have significantly lower number of PLHIV (9% in Champasak and 4% or less in all other provinces) (CHAS, 2011). The latest NSAP provided a map with prioritised focus provinces and districts (NSAP 2011 – 2015, Page 22).

2. Characteristics and trends of the HIV Epidemic in Lao PDR

Based on number of surveillance surveys and behavioural surveys that have conducted in the last ten years, the key-affected-population (KAP) with the highest prevalence is SW with prevalence of 1% (IBBS 2011), an increase from 0.43% in 2008 (IBBS). Other populations that have been under surveillance, though found in small number of vulnerable provinces, are MSM – HIV prevalence detected in Vientiane Capital was 5.6 in 2008 and among the specific group who identify as transgendered – prevalence was 4.2% in Vientiane Capital and Savannakhet; PUD/ PWID – HIV prevalence was detected 1.5% among unlinked anonymous blood test of 549 PUD in Huanphanh and Phongsaly.[24]

2.1. Female sex workers

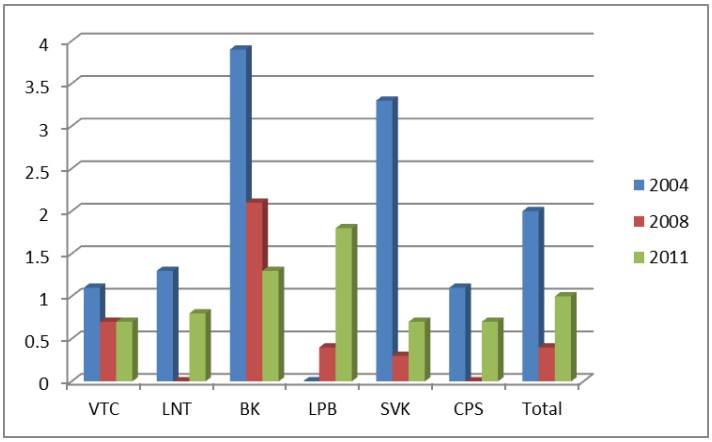
Sex work is illegal in Lao PDR, which makes identifying women who give sex in exchange for money has a significant challenge. There are estimated around 14,000 SW in Lao PDR in 2011. Most of them can be found in entertainment venues (Karaoke, drink bars), restaurants and guesthouses... and an increasing number of sex workers now to operate by mobile phone.[25] In this report, the term SW is referred to female sex workers only, who can be entertainment based or non-entertainment based.

HIV surveillance of the sex worker populations began in 2001 and has been tracked periodically through the last ten years. Despite being the group most surveyed, there still is not enough knowledge to understand the contextual factors, especially among those operating outside the usual karaoke, beer-shops.

[23] CHAS/UNAIDS/WHO Estimation and Projection, AEM modeling workshop outcomes
[24] UNODC/AusAID HAARP Programme - Rapid Assessment and Response to Drug use and injecting drug use in Huaphanh and Phongsali Provincie, Lao PDR. 2010
[25] UNICEF. Rapid Assessment of Most-at-Risk Adolescent and Young People to HIV in Lao PDR

The IBSS 2011 found that HIV prevalence in this population was 1% with the highest prevalence in Luang Prabang at 1.8% and lowest at 0.7% in Vientiane, Savannakhet and Champasak (see figure 7). Condom use during sex with the most recent client was found lowest in Luang Prabang at 86%, compared to total average of 92.5%. Findings also show that HIV prevalence was higher among SW older than 25 years old (2.1%) compare to SW younger than 25 years old (0.8%). This feature occurs in four out of six surveillance provinces, the two provinces where HIV was not detected among SW >25 are Vientiane Capital and Bokeo. The number of SW>25 that entered the survey was also very small 34/304 in Vientiane and 10/150 in Bokeo. Accept for Luang Prabang that HIV prevalence found in IBBS 2011 increased compared to findings of previous surveys, the prevalence in other provinces has gone down or stable. This indicates a success in the prevention programme targeting this population.

Figure 7 - HIV Prevalence in SW found in IBBS 2004 - 2011



Source: CHAS. IBBS 008, 2011

Table 3: Characteristics of SW found in surveys, 2008 – 2011.

Sex workers	IBBS 2008	BBS 2009	IBBS 2011
Sites	6 provinces	6 provinces	6 provinces
Sample size	1,425	912	1,434
Have been reached by prevention programme (%)	45	70	55.5
Have been tested for HIV and know results (%)	15	14	22.2
Used condom with most recent client (%)	95	97	93.9
Used condom consistently with clients in the last 3month (%)	60	n/a	69.4
HIV+ (%)	0.4	n/a	1
Have injected drug in the last 12 months (%)	1	1	n/a

In another independent study on HIV/STI among migrant workers and population living along the border of Lao PDR and Viet Nam, that SW reported less consistent use of condoms with regular partners than with clients. Another noteworthy finding was that many of SW in this survey have reported the use of drugs - mainly synthetic drug; with a few of them have started injecting drugs. [26,27]

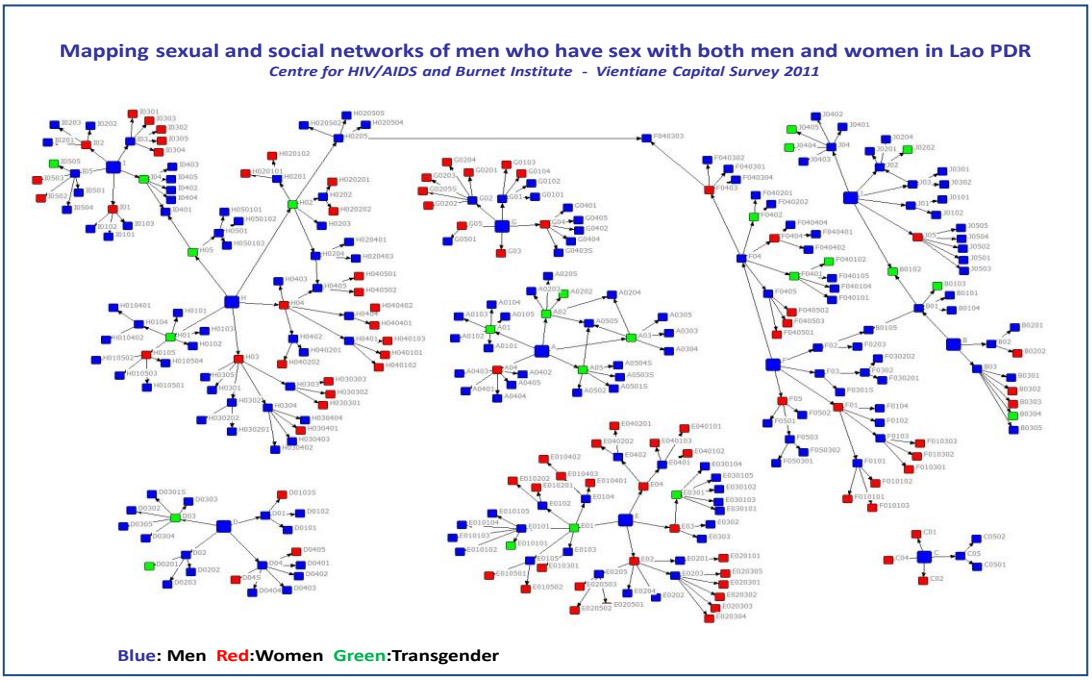
The projection trends show a stable epidemic for the period 2010-2020, with current efforts of preventive intervention (figure 10). However, with new emerging of young, mobile, more vulnerable and hard-to-reach sex workers, it is important to keep tracking their behaviours and open for new approaches reaching to these sub-populations – as it is mentioned in the UNICEF assessment. [28] However, it should be noted that the study was conducted among a small number of adolescent and young people (sample size was 49).

[26] In Lao: Phongsaly, Bolikhamxay, Attapeur; in Vietnam: Sonla, Hatinh and Gialai
[27] HSPI/CHAS. HIV Transmission at the Vietnam - Lao Border Area Current Status and Solutions - HSPI Report, 2009
[28] UNICEF. Rapid Assessment Most-at-Risk Adolescent and Young People to HIV in Lao PDR. 2011

2.2. Men who have sex with men

The population of MSM is estimated to be much larger - at 17,000 in 2011 (NSAP) and risk behaviours are more prevalent than anticipated earlier. The IBBS survey conducted among MSM in Vientiane Capital 2007 showed an alarming HIV prevalence rate of 5.6% highlighted the need to understand and access this hidden population whose behaviours and complexity would be a real concern if HIV prevention interventions do not reach them. Since then, three more studies were conducted, one among MSM in Luang Prabang in 2009 which found prevalence was 0%; one was conducted among men who have sex with both men and women in Vientiane Province, in 2009.[29] The latest survey was conducted among transgender (MSM/TG) in Vientiane Capital (HIV prevalence was 4.4%) and Savannakhet (3.8%)[30] in 2010. Though all the surveys were conducted in small geographical areas, with the use of different methodologies, they found similar patterns of the sexual behaviours and context that is complex (see figure 8)[31]. These patterns of behaviours and social context are reflection of the social and sexual behaviours reported in the other study on this specific population.[32]

Figure 8:



Source: PSI/CHAS. The first round HIV/STI prevalence and behavioural tracking survey (2010)

The IBBS 2008 on MSM and the tracking survey on MSM/TG in 2010 have collected and analysed information on the scope of their sexual network and condom use behaviours. The common behaviours identified were that MSM and MSM/TGs have regular and casual partners of both male and female; at the same time, they also both sell and buy sex from and to male and female commercial partners. Condom use was at the highest level when having sex with most recent male commercial partners involved (78%)[33] and lowest with regular transgender partner (13%).[34] The survey among transgender in Vientiane Capital showed

[29] Burnet Institute/CHAS. Social Mapping among men who have sex with men and with women in Vientiane. 2009
[30] CHAS/PSI. First Round HIV/STI Prevalence and Behavioural Tracking Survey among Transgendered in Vientiane Capital and Savannakhet, Lao PDR (2010)
[31] Aidsdatahub.com/lao-pdr_all-indicators
[32] Lyttleton, Chris. Mekong Erotics: Men Loving/Pleasuring/Using Men in Lao PDR. Bangkok: UNESCO Bangkok, 2008.
[33] CHAS/MOH IBBS 2008

low condom use with both clients and regular partners (57.8% and 45.9%), these figures were similar with consistent use of condoms in the last month among MSM/TG in Vientiane Capital (despite that 58.6% of them have been reached by prevention services).[27,34] Due to the survey being conducted among a specific sub-group of MSM/TG in two cities of Vientiane Capital and Savannakhet in 2010, the data are not considered sufficiently representative and therefore cannot be generalised as national data on MSM. Therefore, no data is reported for indicators 1.11 – 1.14 in this report.

STI prevalence also has been reported high in the MSM/TG group, with prevalence of anal Gonorrhoea and Chlamydia in Vientiane Capital and Savannakhet at 8.1 and 6.2% respectively. Though a high proportion of respondents reported knowledge of STI screening sites, only 29% of them reported having been screened for STI in the last 12 months.

There is urgent need to get more information about location, population size, sexual networking and contextual factors of vulnerability among this group. The on-going estimation and projection of trends of the epidemic predicts that the number of MSM/TG will continue to rise and reach 18,810 in 2015, in the same period HIV prevalence will continue to grow, unless effective prevention interventions are scaled up.

2.3. People who use drugs and people who inject drugs (PUD/PWID)

To date, there have been very few studies looking at drug use situation conducted among population of PUD and PWID. Of the studies taken recently, one was looking into the behaviours of drug users, mainly ATS users in Vientiane Capital. The other was conducted in Huaphanh and Phongsaly, the two provinces that bordering with China and Viet Nam where prevalence of PUD and PWID is suspected to be high. Results of the latter study were disseminated in 2010 but not considered as generalizable across the country, in particular, the sample size for PWID was very small (N=46). Hence no data can be reported for target 2 indicators. Findings show that the majority respondents smoked opium (>60%), with small proportion (37 in Huaphanh and 9 in Phongsaly) injecting drugs. However, the use of sterile needle and syringes and condom was low. None of the correspondents have ever been tested for HIV, although the unlinked anonymous HIV testing within the context of this study detected HIV prevalence at 1.5% (8/549) among PUD in 2009.[35] It should be noted that all eight people with HIV positive detected were PWID.

Table 4: Summary of key findings among PUD in the rapid assessment study in Huaphanh and Phongsaly

Province	Number of correspond-ents	No. (%) of PWID	No (%) have heard of HIV	No (%) of condom use at last sex	Have used sterile needles and syringes	No (%) have ever been tested for HIV
Huaphanh	300	37 (12%)	69 (23%)	11 (4%)	20/37 (54%)	0
Phongsaly	250	9 (3.6%)	59 (24%)	45 (18%)	5/9 (56%)	0

Source: CHAS/UNODC/AusAID. Rapid Assessment and Response to Drug Use and Injecting Drug Use in Huaphanh and Phongsaly Provinces, Lao PDR. 2010

Even though the overall situation of PUD and PWID in these two provinces was not so significant in the national context, it is important to take in account the fact that these two locations border provinces with high

[34] PSI/CHAS. Report on Transgender HIV, STI & Behavioral Survey (2010)

[35] *HAARP. Rapid Assessment and Response to Drug Use and Injecting Drug Use in Huaphanh and Phongsaly Provinces, Lao PDR. 2010*

HIV prevalence among PWID, which are Yunnan, China and Dien Bien, Viet Nam have prevalence up to 50% and 55% respectively.[36] With the amount of development, movement and trading activities crossing the borders, it is becoming essential to monitor the situation closely due to the very high risk of HIV infection among PWID. Moreover, it seems that injecting drugs is more likely to be prevalent among actual or former users of opium which traditionally exists in remote villages in the mountainous areas along the borders.

2.4. Among **clients of sex workers**, mobile men (migrants, construction workers, business, and traders) are those likely to buy sex.[37] Unfortunately, surveillance survey has stopped tracking behavioural patterns of these groups after 2004. The data from the cross border survey shows that awareness about HIV and how HIV is transmitted among these groups is high although there are clients who stated they refuse to use condoms.[38] The government of Lao PDR is now seeking to develop a major regional transit hub and economic corridors for overland trade and travel between the Greater Mekong Sub-region and the Chinese and East Asian economies, within the framework of the Asian Highway network.[39] With this scale of construction, in parallel with cross-border socio-economic development, namely cross-border trade, investment, labour movements in and out of Lao PDR, especially among the economic corridors along China, Vietnam and Thailand border, this creates a vulnerable environment for HIV to spread.[40] This makes monitoring and surveillance all the more essential to track on this population.

2.5. Young People

This age group of 15-24 makes up around 60% of the total population of Lao PDR (UNFPA). They are the group that is affected most by the recent development scenario in the country. Poverty; lack of study opportunities in combination with availability of information and opportunities to travel; to find alternative livelihoods, have made this group more vulnerable to more risky behaviours. Although not sufficient, evidence of more young people engaging in commercial sex and drug use have been found. More studies are needed to explore more on behaviours, knowledge, and practices among this population.

2.6. Low-risk-men and women

This group accounts for majority of number of PLHIV in Lao PDR (in both reported cases and in projection). However, there has been no recent population based study to look into this group so far.

As the estimation shows, in the next ten years, if the prevention efforts remain effective, HIV epidemics in key population like SW, mother- to- child, non-commercial sex will all be stable. The two populations that need further attentions are MSM whose prevalence will continue to increase; and PUD/PWID whose information that have been collected so far is not sufficient enough to forecast the trend of this population in the future. Considering the location of Lao PDR which is bordering with high HIV prevalence countries: Myanmar at 0.6%; Viet Nam at 0.4% (55% among IDU in border province of Dien Bien; Cambodia at 0.5%; and Thailand at 0.3 in 2009),[41] more information should be collected in order to understand more of their contextual behaviours, sub-groups and patterns of the key populations in Lao PDR.

[36] USAID - HIV/AIDS Country Profile. *http://www.usaid.gov/locations/asia/countries/vietnam/; cited Mar12, 2012*
[37] NSAP, 2011-2015
[38] HSPI/CHAS. HIV Transmission at the Vietnam - Lao Border Area Current Status and Solutions. 2009
[39] http://www.iom.int/jahia/Jahia/lao-pdr
[40] http://beta.adb.org/publications/greater-mekong-subregion-economic-cooperation-programme-overview?ref=countries/lao-pdr/publications
[41] http://www.avert.org/aids-hiv-south-east-asia.htm

III. THE NATIONAL RESPONSE

The period of 2010 – 2011 was a period of ending and reviewing the implementation of the NSAP 2006-2010, as well as developing and beginning the implementation of the NSAP 2011-2015. With the outcomes of the UN High Level Meeting on AIDS in 2011 in New York, the response to AIDS has been reshaped with the new aim to reach the Three Zeros in a context of global economic downturn, which affects the funding for all interventions worldwide and Lao PDR is not an exception.

The new NSAP has shed a clear view on how the country responses to the HIV epidemic in the five years period 2011-2015. It clearly states that the country "has responded to the HIV epidemic with relatively high (reported) coverage of HIV prevention services for sex workers, men have sex with men, and high levels of ART coverage for PLHIV with advanced disease"[42]. The Strategy also raises the possibility of concentrated epidemics through sexual networks or network of injecting drug users.

1. Policy and Political Environment

The National Committee on the Control of AIDS (NCCA), an inter-sectoral coordinating body, was established in 2003, chaired by the Minister of Health (MOH). The key role of the NCCA is guiding the national policy, endorsing new AIDS programme initiatives, national strategies and plans. Currently NCCA has 14 members representing line ministries, mass organizations and Civil Society (e.g. faith-based organizations; PLHIV; local NGO) (see annex for list of members of the NCCA and their line agencies). The Centre for HIV/AIDS/STIs (CHAS), under the MOH functions as the secretariat for the NCCA. CHAS also serves as the National AIDS Response (NAR), including the National HIV Monitoring and Evaluation (M&E). The NCCA has network structured from central level to provincial and district committees with similar roles and functions as of at their administrative levels and report to NCCA. The NCCA members meet twice annually.

In 2011, the Lao Government Delegation led by the Minister of Health who was also the Chair of NCCA attended the UN High Level Meeting on AIDS. In this occasion, Lao PDR endorsed the 2011 Political Declaration to reach the seven targets and the Three Zeros Strategy – Zero new infection; Zero discrimination; and Zero AIDS related death.

The year 2011 marks the beginning of implementation of the National Socioeconomic Development Plan (NSEDP) for 2011-2015, in which Lao PDR stressed determination to achieve the Millennium Development Goals (MDGs). This year, NCCA also have a new Chair - Prof. Dr. Eksavang Vongvichit who became the new Minister of Health of Lao PDR. The new leadership has emphasised on reaching MDG goals, together with getting the Three Zeros in his recent trip to attend the *Asia-Pacific High-level Intergovernmental Meeting On Assessment of Progress Against Commitments in the Declaration on HIV/AIDS And the Millennium Development Goals Efforts* organised in Bangkok in February 2012.

HIV/AIDS is in the MDG 6 and despite recent reports show that the country is on the right track, more efforts needed to strengthen the existing organizational structure of the HIV response, improved coordination mechanisms at all levels and harmonized interventions across sectors and institutions (see table 2).

The first achievement in the policy for AIDS in Lao PDR in this period is the NSAP 2011-2015 which was developed in an inclusive, participative approach, with involvement from PLHIV and CSO. The second achievement is the establishment of the Law on HIV/AIDS Control and Prevention (hereafter refers to as

[42] The National Strategy and Action Plan for HIV/AIDS/STI Control and Prevention 2011-2015

the HIV Law) which was approved by the National Assembly (NA) and promulgated by the President in 2010. Article 5 in the HIV Law states that the government is committed to the response to AIDS in its role of developing policies, laws and setting up organizational structures, providing staffing and necessary budget, medicine and other essential equipment. It also addresses issues related to stigma and discrimination.

Table 5: Status of reaching to MDG 6 – HIV component

MDG 6: HIV indicators	Targets	Status, 2011	Comments
1. HIV prevalence among general population	< 1%	0.2	On track
2. MSM who are HIV infected	< 3%	n/a	A survey among MSM is needed to determine the HIV prevalence among this population
3. HIV prevalence among service women	<2%	1%	On track
4. Condom use among SW with the most recent client	95%	92.5%	On track
5. Adults and children with advanced HIV infection receiving ART	>90%	52.3%	More work is needed to bring PLHIV in need of ART to treatment earlier.

The NA has been active in bringing the HIV Law to the community and addressing stigma and discrimination. The cooperation between UN, NA, INGOs and PLHIV has strengthened involvement of PLHIV in the work of NA at community level. It also realises the role of parliamentarians in the National AIDS Response. NCPI rating for this component in part A is 9/10, the same as in previous report.

2. Civil Society involvement

During the development process of this report, Civil Society Organisations (CS) includes national non-profit associations; networks or self-help groups of KAP at community (i.e. PLHIV, SW, MSM); international nongovernmental organizations (INGO), faith-based organizations and mass organizations (i.e. Lao Women Union, Youth Union, Trade Union). Since the issuance of the Prime Minister's Decree on Association Establishment in November 2009, the two formally informal networks that had involved and worked with PLHIV and affected population namely LaoPHA and LNP+, have been officially registered as non-profit associations. This is a big progress towards greater involvement of CSO in the National AIDS Response.

The roles of CSO in the NAR implementation have been increasingly significant and recognised by all stakeholders and the Government of Lao PDR. More and more INGOs, associations, community and PLHIV have taken part in the NAR. The NCPI part B rates this component 7/10 with recognition of stronger involvement of CS compared to the previous report (8/10), but put under the new context of more enabling environment after the issuance of the Decree on Association Establishment and the HIV Law (see NCPI part B for more details).

- **Policy and planning development process**: members of CSO were invited to take part and contribute in consultative meetings for GFATM proposals Round 10 and 11. They also took part in the development of the NSAP, as well as the HIV Law. The proposal to include LNP+ and other local

organization to join the NCCA was a strong sign of recognition of their work by the Government sector. CSO now are sub-recipients of GFATM and have been included and earmarked budget for their activities in the NSAP 2011-2015. LNP+ has been a strong advocator for NAR and for PLHIV and has been playing an active role in bringing the experiences from community to the policy making and planning arena.

- **Community Involvement**: In the last two years, community has played an essential part in the NAR, especially in care and supports for PLHIV and affected populations. The work that has been managed and implemented at community are nutrition pilot project in Savannakhet and Champasak; LaoPHA Community based Advocacy Partnership project with collaboration from community, government and private partners to deliver a comprehensive package of care, support, behaviour change communication (BCC) and referral service for HIV testing, ARV and STI treatment. The drama group, supported by LaoPHA and UNICEF in bringing advocacy message on stigma and discrimination through performances played by the children living with or affected by HIV. The pilot harm reduction project for PWID in four districts in Huaphanh and Phongsaly has used the supports from community authorities (head of villages, police, youth union) to create an enable environment for peer educators and outreach workers to provide information, condoms and clean needles and syringes to PWID, who otherwise will be very hard to identify and reach.

  Major part of community involvement is about care and support for PLHIV, especially during the advanced stage. The NSAP has included the activities and responsibilities with budget allocation to LNP+ and LaoPHA for 2011-2015.

- **Researches and surveys**: participation of members of key populations at higher risk (SW, MSM, and PWID) has helped researchers reach the target population. In the IBBS survey conducted among transgendered in Vientiane Capital in 2010 and among female SW in 2011, peer educator participated as interviewers as well as help reach to the right populations. The latest stigma index survey (supported by the French Red Cross and funded by ILO) was conducted by PLHIV and members of key affected populations.

3. Prevention

3.1. Comprehensive prevention programme:

This programme consists of condom distribution; BCC by outreach workers and peer educators; STI management; and DIC where applicable. The prevention services are delivered by Government agencies (DCCA/PCCA) and INGOS such as FHI and PSI, Burnet Institute, Norwegian Church Agency (NCA); and national associations like LaoPHA, LNP+, and PEDA. The overall prevention is rated 9/10 in part A and 8/10 in part B of the NCPI, similar results to the last report.

3.1.1. Peer-led intervention includes outreach workers and peer educators of SW or former SW, MSM, transgender (MSM/TG) and recently, in the pilot project on harm reduction in Huaphanh and Phongsaly for PWID. By the end of 2011, there were 25 outreach workers; 586 peer educators working with SW and 22

Drop-in centrer *(DICs) were set-up through grants from donors and operate as "one-stop shops"*
where target groups can avail of services. A DIC is client-specific facility for either for sex workers or for MSM. They have in-house doctors, outreach workers and peer educators. Drop-in centers are part of larger grant-funded HIV projects focused on BCC. These are staffed by medical personnel, outreach workers and peer educators. Peer educators are the main contact points for clients. Condoms are made available as part of existing prevention programmes funded by donors, primarily GFATM, USAID and UNFPA. Condoms are displayed at the front counter and anyone can get them.
Source: Social Marketing Assessment 2010.

outreach workers; 401 peer educators working with MSM. They provide BCC, condoms and referral service to VCT and ART when needed. Currently, the network of peer and outreach workers are supported and managed by and PCCA, INGOS and national associations with majority of funding coming from GFATM. In Phongsaly and Huaphanh, there is a team of twelve PWID peer educators working in a pilot project on harm reduction in four districts. They have been trained, with supports from local and community authorities, to reach out to PWID, providing sterile needles and syringes and condom, as well as BCC. This pilot project is supported by AusAID through UNODC and WHO.

3.1.2. Drop-in-Centres (DIC) provides counseling, STI management, and referral to HIV testing and ARV treatment. There are two types of DIC, one to provide prevention services to SW and supported by FHI, the other to MSM/TGs supported by PSI. Rapid testing for HIV is provided for free at the three PSI DIC. Recently FHI is ending this activities and the DIC for SW has been handed over to PCCA. Currently there are seven DIC for SW in Vientiane Capital, Savannakhet, Champasak, Bokeo and Luang Prabang. For MSM, there are three DIC in Luang Prabang, Vientiane and Savannakhet. Other areas, MSM will be reached by peer educator. GFATM and USAID support these centres.

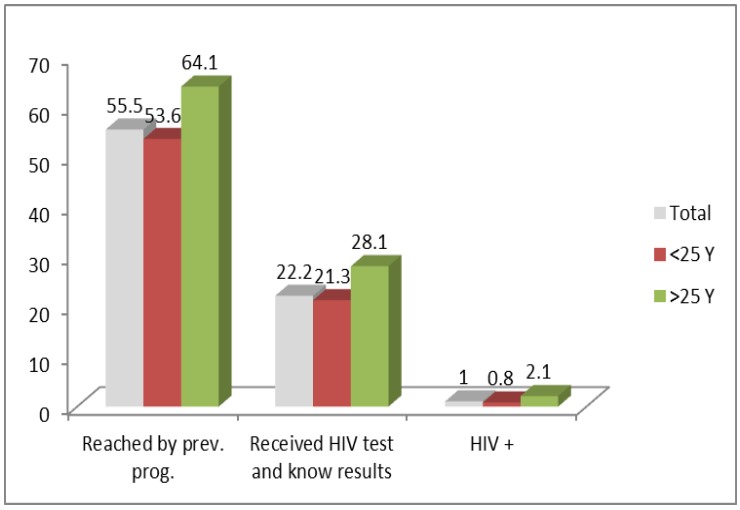
3.1.3. Outcomes:

Sex workers and clients

The latest estimation of number of SW was around 14,000 in 2011 and this number will reach around 15,500 in 2015. CHAS reported that by June 2011, there were about 10,500 SW (75% of total estimate) have been reached by peer-led interventions.

The IBBS 2011 shows that 55.5% of SW in the six surveillance provinces has been reached by prevention services. Among respondents who answered to two questions i) do you know where you can go if you wish to receive an HIV test? ii) in the last 12 months, have you been given condoms? 58.3% and 93.8% of SW answered "Yes" to the questions, respectively.

Figure 9 - Percentage of SW as of results of key prevention interventions



Source: CHAS/PSI, IBBS among SW, 2011

For outcome on BCC, this survey also found that 22.2% (21.3% for <25 years old and 28.1% among 25 and older) of SW who participated in the survey have received an HIV test and know their results. More work is needed to increase the proportion of female SW who received HIV tests and know their HIV status (see table 9).

95.2% of SW interviewed in IBBS 2011 survey reported **condom use** with the most recent client; compared to 69.4% of them reported consistent condom use in the last three months. There is no significant difference in condom use between SW younger or older than 25 years old. The presence of SW use telephone to operate instead of having a base, also more young people selling sex,[43] have made the SW behaviours more multi-dimensional and complex. This poses a new challenge to the prevention programme for SW. This requires innovative prevention approaches that should be suitable and sensitive enough to reach and provide prevention services to as many as possible. Hence, more evidence is

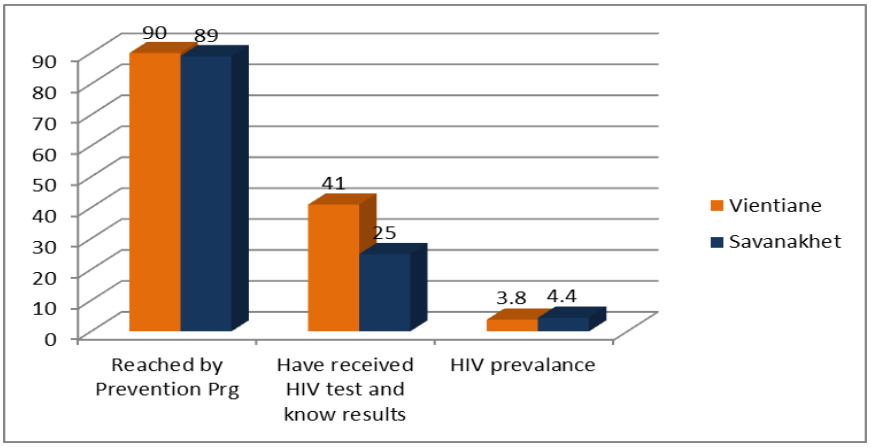
[43] UNICEF. Rapid Assessment of Most-at-Risk Adolescents and Young People to HIV in Lao PDR, 2011

needed to understand behavioural patterns and to identify possible ways to reach this sub-population. It's hoped that with stronger participation of CSO, they can be the bridge to reach out to this group.

Men who have sex with men

Community based and community led interventions have been implemented in 11 provinces and appear to be effective in all sub-groups of MSM.[44] According to CHAS, around 4,000 MSM have been reached by peer-led interventions in 2011, equal to 23% of the estimated 17,000 MSM in the country in 2011.The tracking survey among MSM/TG conducted in 2010 found that 84.7% of 450 respondent reported to have been provided information on HIV testing and condoms. These findings were similar between MSM/TG <25 and >25 at 85.8% and 81.1%. 98.8% of respondents knew where to go for HIV testing and 92.2% of them have been given condoms (table 10). Table 1 in section 2.2, chapter 1 shows rates of condom use in all categories among MSM of all sub-groups, were low. More efforts needed to increase the condom use rate with all partners, especially the consistent condom use among MSM.

Figure 10 - Percentage of MSM/TG in relation to key prevention results



Source: CHAS/PSI – first round HIV/STI prevalence and behavioural tracking survey, 2010

Up to date, all three surveys among MSM have done in small scale, which makes it difficult to generalise information to the national scale. More information is needed on the size, distribution (geographically and behaviourally) of MSM/TGs and its sub-populations in order to tailor suitable and effective prevention strategies and interventions.

People who use drugs/ People who inject drugs (PUD/PWID)

Since September 2011, a pilot harm reduction project under CHAS and LCDC, funded by AusAID through UNODC, with support from WHO, has started the first ever harm reduction programme in four districts of two provinces Huaphanh and Phongsaly in northern Lao PDR. The project trains nurses at health centres, and peer outreach workers to reach to the target population and have distributed three thousands clean needles and syringes in 2011. It is still early to say how effective this pilot project has been. However, it's clear that this type of intervention can only happens with participation and support from local authorities, communities and PUD/PWID themselves.

Lao PDR has recognised the need to reach this population with effective preventive interventions and have earmarked $3.6 Million and targets national HIV prevention services to reach 60% of estimated

[44] National Strategy and Action Plan for HIV/AIDS/STI Control and Prevention 2011-2015

1150 people who inject drugs, to use safe injecting equipment and condoms, as stated in the NSAP 2011-2015.

3.2. Condom programme

The 100% condom use programme (CUP) was initiated in 2003 with support from WHO, then ADB/JPFP/ CDC and GFATM later. The idea of the 100% CUP is to enlist the aid of provincial administrative and health authorities, governors, the police, sex workers, and the owners and managers of sex establishments to make it impossible for clients to purchase sexual services without using a condom.[45] The programme aims at prevention of sexual transmission of HIV/STI in the general population by ensuring a high level of condom use among sex workers and their clients. The fund from GFATM round 4 grants has been approved and now the programme has reached all 17 provinces of Lao PDR.

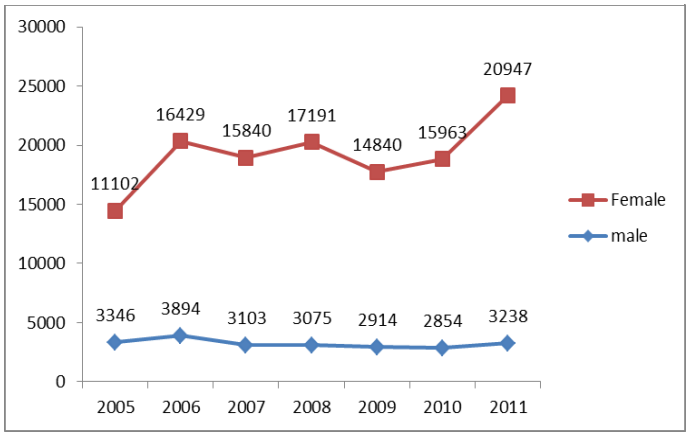
There are two centres under MOH responsible for condom programming: CHAS and the Maternal and Child Health Centre (MCHC). CHAS distributes free condoms through the various Provincial Committees for the Control of AIDS (PCCA) as part of its HIV and STI prevention programme condom promotion activities.[46] It currently procures condom using GFATM funds, which in turn delivers the condoms to the 17 Provincial Committees for the Control of AIDS (PCCA). MCHC gets its condom supply from UNFPA, which directly procures its condoms through the UNFPA procurement system. UNFPA condom supply is available for reproductive health and family planning programme in the country.

Condoms are currently made available through the DIC, health centres and peer educators, managed by either INGOs or PCCAs; and through the social marketing system of PSI where condoms are sold at subsidised prices at private sector pharmacies, minimarts, drink shops, hotels and guesthouses.[47]

Findings from IBBS surveys conducted in 2009, 2010 and 2011 show that most-at-risk-population (SW, MSM) do have access to condom. However, more work is needed to promote condom use among MSM.

3.3. STI management

Figure 11 - Number of STI treatments among target populations



Source: CHAS/MOH. Routine STI Report, 2011

By the end of 2011, there were total of nearly 21,000 STI treatments for females and 3,000 for male of targeted populations, according to CHAS report. This makes the total treatments that have been provided to the target population to around 24,000 in 2011 (see figure 11). This number is likely much bigger considering that more people would go to private clinics and pharmacies for treatment and presently data is not attainable from private sector.

DIC also provides STI treatments for MSM, SW and their partners. For 2011, the total numbers of sex workers who seek STI treatments at DIC are 884. The number for MSM came to DIC for STI treatment were 140 in 2010 and 37 in 2011. The reason for less MSM came to

[45] CHAS/MOH. Condom Social Marketing Assessment Final Report, 2010
[46] CHAS. Condom Social Marketing assessment 2010
[47] CHAS. Condom Social Marketing assessment 2011

DIC for STI treatment in 2011 was the shortage of STI test kits and drugs due to delay in GFATM procurement procedure.

3.4. Prevention of Mother to Child Transmission (PMTCT)

Despite improvements in ANC rates across the country with an average figure of 71%[48] the number of pregnant women being tested has not increased since 2009. Monitoring of PMTCT pilots in five target provinces between 2007 and 2008 showed that as VCT was not provided at the point of ANC service, there were high rates of loss to follow up. Identification by ANC staff of high risk pregnant women has shown to be problematic without sufficient training in counselling and addressing stigma and discrimination. Women who received ARV treatment during pregnancy to reduce the risk of PMTCT represent between 8.5% (27) and 14% (49) of the total estimated number of HIV positive women who are pregnant in 2010 and 2011 respectively (see figure 13). This shows that most pregnant women at high risk of HIV infection are not accessing ANC services and reinforces the need for stronger programmatic linkages between interventions for high-risk women and ANC promotion especially for sex workers women already living with HIV.

In 2009, the National Framework of MNCH Services 2009-2015 was launched, in combination with provision of the free MNCH package of services to nationwide, the coverage of ANC for one visit, has increased to 71% in 2010,[49] form to 35% in 2006[50].

Figure 12- Number of pregnant women received HIV test and number of HIV+, 2008-2011

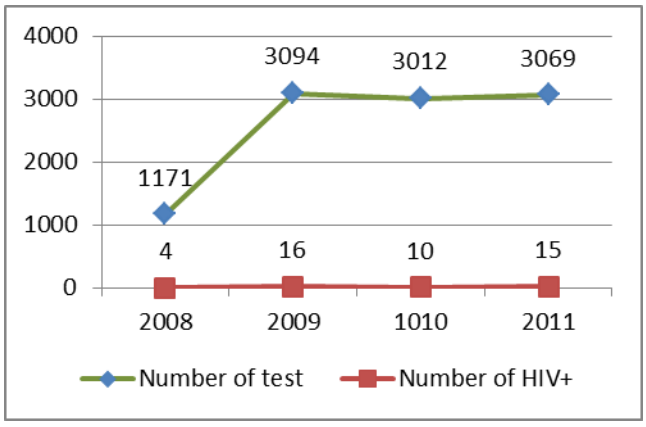
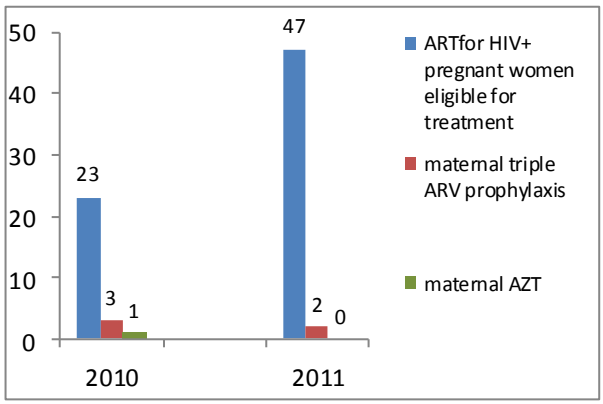


Figure 13 - Number of pregnant women HIV positive received ART by regimen



Source: CHAS/MOH. ART Routine Report, 2011

The National MNCH Framework introduces a comprehensive package of MNCH services, including i) STI/HIV risk assessment, counselling and referral; ii) Syphilis testing for all pregnant women attending ANC, among other elements. After two years of implementation, the practice of these two specific HIV related services are limited to where resources are available and it is not always where it needed most, such as districts with high prevalence of KAP. There was also question of cost-effectiveness if PMTCT (including counselling and testing) should be available as part of ANC nationwide, due to the low HIV prevalence in general. On the positive side, once a pregnant woman was confirmed HIV-positive, she will be registered and will receive ARV for PMTMC and follow-up care and support as needed.

[48] Rates for at least one ANC visit ranged from 169% in Vientiane Capital to 27% in Oudomxay Province
[49] National Health Statistic Report 2009/2010. MOH, 2010.
[50] WHO. Lao country data

The number of pregnant women who received HIV test and know their results for 2010 and 2011 were 3,012 and 3,069 respectively. The number of HIV-positive cases among pregnant women were ten (0.33%) for 2010 and 15 (0.48%) in 2011. Figure 12 presents the trend of number of pregnant women who got HIV test and the number of HIV positive detected in this group in the last four years.

3.5. Others

3.5.1. Blood Safety

The Lao Red Cross (LRC) is the Government Organization that is responsible for blood supply and safety nationwide and manages the national blood banks. With technical and financial support from the GFATM 100% blood unit have been screened for HIV with quality assurance.

3.5.2. General population

School-based life skills education – The programme has been implemented in Lao PDR since 2003 in selected schools, by 2010, 74% secondary school in the country have included life-skills curriculum in their teaching programme. An assessment of the programme conducted by UNICEF in 2009 found that children attending schools with the life-skills curriculum are more aware of HIV/AIDS/STI as well as way to protect themselves from getting infection (95% compare to 77%). However, it is still unknown about how much out-of-school children know about HIV and its transmission. Given the low attendance rate for secondary school in Lao PDR (39% for boys; 33% for girls, 2010),[51] it is essential to have the information and prevention interventions reached this group.

HIV in the Workplace - In 2009, with support from UNAIDS through ILO, a tripartite declaration to address HIV/AIDS issues was signed among three key sectors working with and for worker and migrant workers: Ministry of Labour and Social Welfare; The Lao Federation of Trade Unions and the Lao National Chamber of Commerce and Industry. The declaration adopts the ILO Code of Practices for HIV at work place and was implemented in 15 hotels in the two cities of Vientiane Capital and Luang Prabang. The outcome of this work has yet to be measured.

Recently, the Ministry of Public Security has launched a strategy on AIDS prevention at work place. Ministry of Public Work and Transport, the Lao Women Union, Lao Red Cross also have developed similar plan.

Consumption of commercial sex is known to happen among mobile men such as government officials and businessmen, truck drivers, electricity workers, police and military. Many mobile men are potential clients of sex workers, but do not consider them being at risk of HIV/AIDS/STI. However, there has been very little information on knowledge, behaviours about this group that have been collected in order to tailor a suitable and effective preventive measure for this group. With the fast pace of development and movement of people in the region, it is essential to coordinate with relevant sectors to monitor this population together with preventive interventions.

3.6. Health system strengthening

Health System Strengthening (HSS) was one component of GFATM proposal for round 8. This component is essential to assure smooth delivery of NAR and has been implemented since 2010. The areas covered include:

- Improve drug supply chain management system to assure good quality, safe and effective drugs for HIV, TB and Malaria.

[51] UNICEF database. http://www.unicef.org/infobycountry/laopdr_statistics.html. Cited 22.06 hr, 12 Mar 2012

- Improve health system
- Improved efficiencies of drug quality assurance (registration, inspection, sampling and testing, good manufacturing practices, storage, distribution and pharmacy practices, and regulatory processes).

This component is under management of three different Departments under the MOH: Curative; Food and Drug; and Medical Product Supply Centres. The progress has been slowed, especially on drug quality and supply management (see table 5 below).

Table 6: Result of the implementation of HSS by June 2011. Data for 2010 was not available.

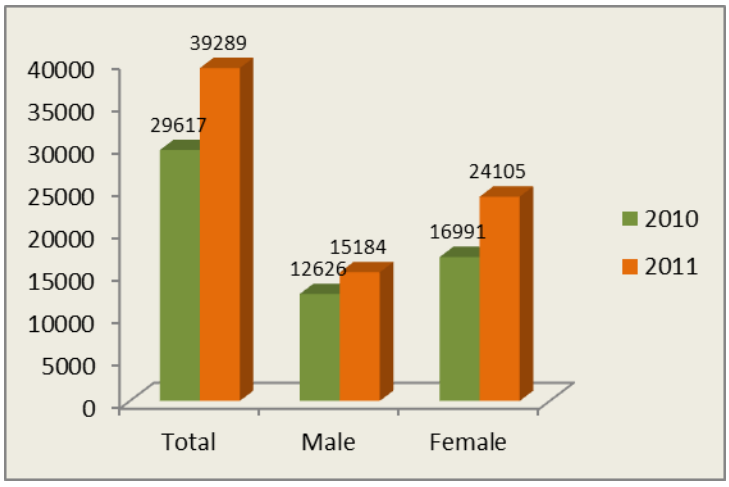
	GFATM indicators	Target	Result
1	Number and percentage of inspectors trained in GMP and passed post-training test among those trained.	National: 9 District: 10 P: 90 %	National : 0 District: 0 P: 0 %
2	Number of health facilities renovated (district hospitals and health centers)	20	14
3	Number of hospitals currently using a functional dispensing database	5	5
4	Number of applications for drug registrations processed	863	944
5	Number and percentage of provincial hospital pharmacies with no reported stock-out of essential medicines (as defined by MPSC) lasting more than one week any time during the past three months)	National: 14 District: 19 P: 73.7 %	National: 2 District: 19 P: 10.5 %

Source: Periodic review performance profile - PUDR, GFTAM CCM Lao PDR – HIV/AIDS. 12/2011.

4. Treatment, Care and Support

4.1. Voluntary Counselling and Testing

Figure 14 - Number of people who have received HIV tests and know results, 2010 - 2011



Source: CHAS/MOH, 2011.

In the period 1990 - 2011, there were total of 318,659 HIV tests provided, of which 43,918 and 46,839 tests were conducted in 2010 and 2011. The numbers of people who have received HIV test and know their results in the last two years continued to increase (see figure 14). Among SW, compare to 2009 IBBS, the percentage of FSW who have received HIV test and know their results also increased from 14% (2009) to 22.2% (2011). The same indicator for MSM was 14% of MSM in Luang Prabang (2009); 73% among MSM/TG in Vientiane Capital and Savannakhet (2011).

To date, VCT are available in all provincial hospitals, ART sites as well as in district hospitals in Vientiane Capital and Savannakhet. In total there

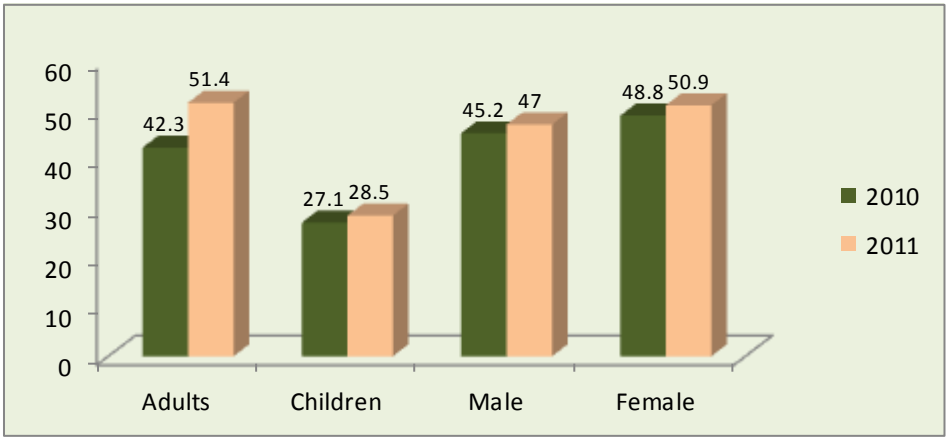
were seven sites at central level; 40 VCT sites at provincial level; 89 VCT sites at district level and three sites at health centres and 10 DIC provide VCT in 2011.

GFATM grant has provided fund for VCT and provided HIV test kits. There is the need to improve supply management, including coordination as stock out of test kits has occurred in the past due to procurement process. With increasing involvement of local networks and associations as their role has been recognised, the national plan to expand VCT, including TB/HIV, and with the currently low rate of HIV detection (estimate at less than 2% - CHAS), it is even more crucial that the VCT sites function effectively.

4.3. Treatment:

Treatment has been one of the success stories of the NAR in Lao PDR in 2008-2009 periods.[52] By the end of 2011, total of 1,988 adults and children PLHIV who in need have received ART. This is equivalent to 52.3% of estimated PLHIV eligible for ARV have received ART, a small increase compare to 50.8% in 2010 (figure 15). For 2010 and 2011, despite continuous increase in the absolute number of PLHIV who received ART, the percentage rates dropped due to change in calculation for estimate eligible PLHIV for ART as mentioned in chapter I, section 3.3 (see figure 1).

Figure 15 - Percentage of eligible PLHIV have received ART, 2010-2011



Source: CHAS/MOH. Routine ART report 2011and AEM Estimation.

It is commonly known that most of the PLHIV came for ART late, when their CD4 counts were already low (less than 200). This new estimation based on CD4 count of 350 and less, combined with a low detection rate, has revealed a big gap of potential ART patients that have not been captured.

For survival rate 12 months after ART initiation, Lao PDR has done well. Compare to last report, the rate is lower: 95% for adults in 2009 compare to 87.3% in 2011; and 100% compare to 88.4% (see table 6).

Table 7: Percentage of PLHIV known to be on treatment 12 months after initiation of ART.

Total	Male	Female	< 15 years old			15 years old +		
2007	2009	2011	2007	2009	2011	2007	2009	2011
87.5%	85.4%	89.6%	93%	100%	88.4	90%	95%	87.3%

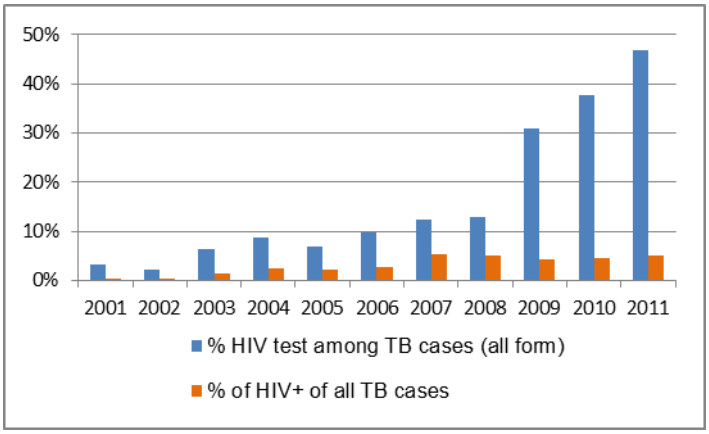
Source: CHAS/MOH. Routine reporting 2011

Management of TB-HIV has been improved significantly since the establishment of the National Committee for TB–HIV coordination in 2008 and with the support from GFATM. At the end of 2011, all

[52] NCCA. UNGASS Country Progress Report 2010

HIV patients have access to ART sites have been screened for TB and vice versa with TB patients registered to the National TB centres. HIV – TB linkage has been initially implemented and scaled up nationally. In 2010, 49% of adults received ART also have started on TB treatment, in 2011, this number is 146, compare to 118 in 2010. [53]

Figure 16 - HIV screening among TB cases 2001 - 2011



Source: WHO, TB Programme Mission Report, 2011

47% of the TB patients all forms had an HIV test result in 2011 in spite of lack of rapid tests in some provinces. Total 218 TB-HIV patients (10.6% of tested TB patients and 5.6% of all notified TB cases) were notified in 2011 including 125 PLHIV and 93 newly tested for HIV after the diagnosis of TB. The National Centre for TB Control (NTC) and CHAS have finalised jointly TB-HIV guidelines and monitoring and reporting system.[54] Figure 16 shows the trends of HIV screening and detection among TB cases in the last ten years.

All provincial TB staffs were trained on provider initiated HIV counselling testing (PICT) for all TB patients.

Setthathirath Hospital in Vientiane Capital started Isoniazid preventive therapy (IPT) in 2011. NTC has planned to scale-up IPT for 10% of the newly diagnosed PLHIV in 2011, 20% in 2012, 30% in 2013, 40% in 2014 and 50% in 2015 (in the National TB Strategic Plan 2011-2016, based on CHAS estimates of the number of new PLHIV/year). However implementation of IPT has remained very low until now.[54]

4.4. Care and Support

Most of the care and support are provided at community with operational supports from CSO (NCA, LaoPHA, LNP+ and INGO) and financial support from GFATM and UNICEF. Another government agency that takes part in the implementation of care and support is Lao Red Cross.

NCCA, through network of ART sites in ten provinces (including Vientiane Capital) operates network of community-based peer workers who provide psychosocial support for PLHIV who are on ART and their family. The service consists of counselling; moral support; treatment adherence; referral when needed; and financial support for family members of PLHIV. In 2011, there were total of 472 PLHIV and 1,269 people who are affected by AIDS (48.7% of estimated total of people in needs of care and support for 2011) have been reached by the community-based psychosocial support teams. The ART centres also have mobile teams that go to the community addressing stigma and discrimination.

UNICEF has taken the main share in supporting Orphaned and Vulnerable Children (OVC) and their families by variety of approaches at community level, through social protection in money and in-kind; home supports; Enabling environment and Community Development. The total budget has been contributed to community based care for OVC by UNICEF was US$ 233,466 for 2011.

[53] CHAS. Routine report 2010 and 2010
[54] WHO. TB programme mission report, 2011

Other CSO and informal network of peer KAP and PLHIV are other providers of care and support at community level. LaoPHA has been supporting a Community Based Comprehensive Package in seven provinces in partnership with CHAS, hospital and private clinics (see section 4.2, Chapter IV). With UNICEF support, in 2010 -2011LaoPHA has provided assistance to 589 HIV positive and affected children access to essentials services including education material; nutrition; life skills; leadership; reproductive health; adherence; and support for access to ARV treatment. 113 children living with HIV now have access to ARV treatment and regular health check-up. In 2011, LaoPHA supported 98 pregnant women living with HIV to have access to ART and treatment for opportunistic infections in Vientiane Capital, Savanakhet and Champasak provinces. In the same year, 156 HIV positive women have received grant support for positive income generation in 7 provinces, Salavanh, Champasak, Savanakhet, Khammuoun, Bolikhamxay, Vientiane Capital and Vientiane province.

A WFP-supported **nutrition** project to provide better HIV treatment and care in Lao PDR has recently received an award in recognition of excellent South-South Cooperation as an effective example of alliance of government, non-profit and private sector actors to improve the nutrition and treatment of people living with HIV. It brought together the experience of WFP, the Thai Red Cross, the Albion Street Centre (Australia), Mahidol University (Bangkok), the Australian Agency for International Development, the Lao Ministry of Health and the World Health Organization. With technical support from WFP and The Lao-Thai-Australia Collaboration in HIV Nutrition (Lao-TACHIN) successfully reached its goal to improve the health and quality of life of people living with HIV in Champasak Province, Lao PDR, including by training health care staff and providing nutrition education for people living with HIV. From July 2009 to June 2011, 184 people living with HIV benefited from nutritional assessments and counselling in Champasak Province; in 2012, with the expansion of the project into Savannakhet Province, Lao-TACHIN aims to provide these services for another 150 people. (See story at http://www.wfp.org/stories/hiv-project-lao-pdr-wins-award-south-south-cooperation). [55]

Based on experience from this project, the Standard Operational Procedure on Nutrition for PLHIV will be disseminated nationwide. The challenge of this type of programme is that adherence of recommended food intake is low due to poverty status of most of PLHIV. However, this project has raised the requirement to include PLHIV into the target of National Nutrition Programme of MOH, to scale up and assure sustainability of this component. The project evaluation will be conducted and results will be disseminated nationwide.

5. Future trends of HIV epidemic in Lao PDR and recommended actions – results of the estimation and modelling working group 2010-2011:

In the course of two years 2010-2011, with support from Bangkok based USCDC through WHO Lao, four workshops on the estimation and projection of HIV epidemic in Lao PDR were organised. Participants were from CHAS, WHO and UNAIDS. USCDC sent two technical experts to conduct the workshops with the Lao team.

In March 2012, the final session was conducted, adding 2011 data for accuracy. This session presents projection of trends of HIV epidemic in the assumption of current prevention efforts, as results of these workshops.

[55] HIV project in Lao PDR wins award for South-South Cooperation. http://www.wfp.org/stories/hiv-project-lao-pdr-wins-award-south-south-cooperation

5.1. HIV prevalence and incidence:

It is estimated around 9,600 PLHIV in Lao PDR in 2011 and this number will reach 16,000 in 2030. The groups with the highest number of PLHIV are 'low-risk' which refers to ex-clients of SW, former SW, men with multiple partners (see the Glossary section). However, this number will remain stable throughout the period. The other population whose HIV prevalence will be stable are the male clients of SW and the SW. The population that will need more attention is MSM as their number continue to increase and will contribute to increase on total number of PLHIV. As the chart in figure 17 indicates, the prevalence of PLHIV among MSM clearly increases with time. For PWID, though seems to continue to increase, takes a very small proportion of PLHIV. This is because of a very small population that have been detected in ad-hoc survey, and more information is needed in order to have a close estimation of PWID and of PUD and their behaviours in the future.

As indicated in figure 17 and 18 below, the new infection is still increasing, mainly among male-to-male sex; husband to wife transmission as the husbands are likely in the population of men with multiple partners which are more vulnerable to HIV as mentioned above; and among those who share needles (PWID) although this number is not significant. The HIV incidence will stay almost stable for the population for sex workers, who engage in casual sex and among low-risk females.

Figure 17:

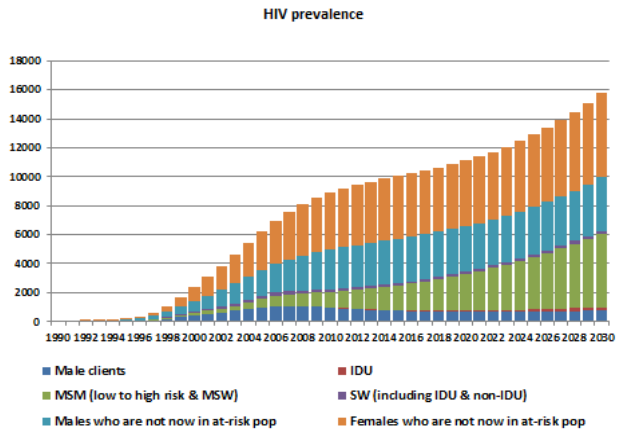
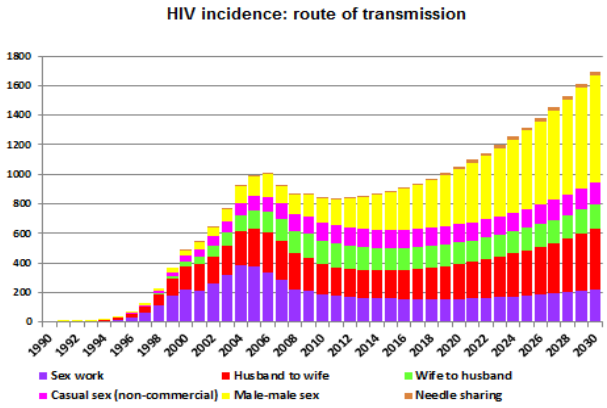


Figure 18:



Source: Estimation and Projection workshop, 2012

5.2. Policy analysis:

Projections of the epidemic with different intervention scenarios were applied. These intervention scenarios comprises of 1) intervention for SW to reach target of 95% prevention coverage; 2) intervention for MSM to reach 80% coverage; 3) combine intervention for both SW and MSM; 4) combine intervention for both SW, MSM and Spousal of Condom use with 30% target.

Figures 19 and 20 below show the results of new infections in adults with different scenarios. As it indicates, combine preventive intervention 4 is the most effective as it results in the least new number of infection among adults, including ART effect. However, it should be noted again that attention should be given SW, MSM and men with multiple partners, since they are likely to transmit HIV infection to their spouse. It is important to promote use of condom among high-risk groups to reduce transmission of husband to wife.

Figure 20:

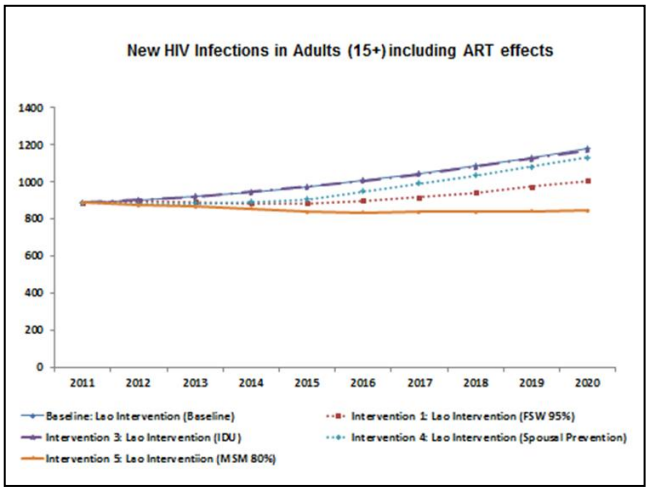
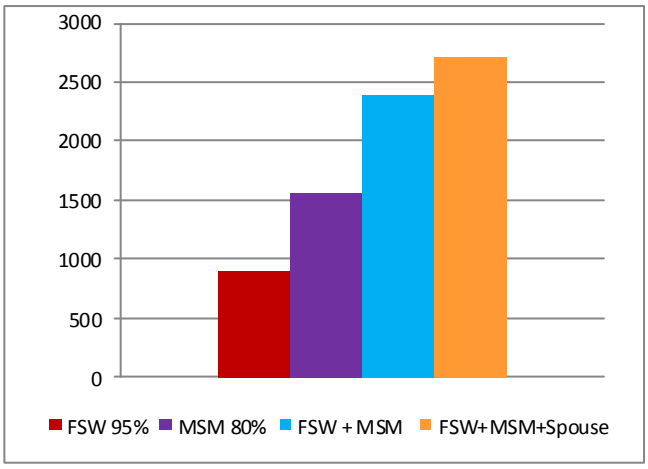


Figure 19 - Total HIV infections averted in the next 10 years



Source: Estimation and Projection workshop, 2012

In **conclusion,** with current efforts to prevention and treatment, the HIV epidemic will continue to increase in the next ten years, with the main mode of transmissions are husband to wife; male-male sex; and sharing of infected needles. The new infection in the next ten years will increase among MSM, men with multiple partners, and PWID though still in limited number.

As to improve the overall national response, in addition to the general recommendations mentioned in chapter 1 – Status at a Glance, focus on prevention is the key to halt the spread of HIV infection. Based on the outcome of the estimation and projection workshop, for prevention efforts, the combined model of preventive interventions targeting FSW, MSM and condom use among men with multiple partners would be crucial for an effective national response to AIDS.

It is aligned with the NSAP that has emphasises the prevention efforts to SW and MSM. More work will need to focus on the promotion of condom use, as well as general BCC for the low-risk men and women population.

IV. BEST PRACTICES

In the last two years, paralleled with the major progress made by the NCCA and CHAS network, the NAR has seen increasingly strong participation and involvement from nongovernmental and non-profit organizations working mainly in the areas of prevention, care and support to PLHIV and those affected by AIDS at community level. The proposed addition of LNP+ as the new member of the NCCA) has initiated an active and strong participation and contribution from community based organizations in the development of the NSAP 2011-2015 and the HIV Law. The Prime Minister's Decree on Association Establishment, has encouraged the work of local networks of PLHIV and KAP to take part in the NAR.

In 2010-2011, there have been a number of pilots and new projects, funded by international donors, supported by the Government or international technical assistance agencies (UN, bilateral organisations) but managed and implemented by community based organizations, in partnership with local authority and private sector. This chapter describe some examples of their work that has been implemented in Lao PDR for the first time in the spirit of 'State Agencies in partnership with network and community based organization to increase coverage and quality of service – progress toward Universal Access by 2015'. These examples though have mostly been implemented in small scales and have demonstrated some limited effects, but they are initiatives that are in a good direction and can be inspirational for those who involve in the NAR.

1. First ever pilot project on Harm Reduction to People who Inject Drugs in the Northern Provinces:

Figure 21 - Training of PWID peer educators and health workers in Huaphanh (*Source: UNODC, Lao PDR*)

Lao PDR is on the strategic location of drug trafficking of opiates and stimulants in the golden triangle when its northern mountainous areas in poverty stand for 10% of global opium production. By bordering Mekong countries, ethnic minorities in border Provinces have adopted the behaviour of injecting of illegal drugs in northern Viet Nam and Yunnan while using opium as part of culture. Rapid assessments in early 2010 identified one in six infected with HIV in a small sample of heroin injectors in two Northern Provinces. An AusAID funded UNODC project in Lao PDR, in collaboration with UNAIDS and WHO, made the response to launch the first ever needle syringe programme in four remote health centre of four border districts of Phongsaly and Houaphanh Provinces. Twelve nurses and twenty PWID peer educators have been assigned for outreach and other support services to hidden clients in the remote setting, distributed some three thousand clean needles in 2011. It denotes strong commitment and prompt response of MOH and Lao PDR Commission on Drug Control and Supervision reporting to National Task Force on HIV and Drugs following the successful study tour to Viet Nam in 2011. Lao National Strategic Plan 2011-15 earmarks $3.6 Million and targets national HIV prevention services to reach 60% of estimated 1 150 people who inject drugs, to use safe injecting equipment and condoms.

Two Provincial and four District Project Management Committees take the overall responsibility of advocacy and liaising with law enforcement and drug control authorities, and work directly with village community heads

and what is used to exist as village health committees. While services from health centres reaching to villages, messages from project peer educators and increased communication from nurses are bringing some hidden clients into picture. Since it is the first remote outreach programme ever in the South East Asia context, challenges exist to reach out to drug users who are shifting to drug injecting after several years of smoking opium and Vietnamese and Chinese migrants in the construction business.

Reference: *National Strategic Plan, Lao PDR 2011-15; Stakeholders' meeting 2011 December 16; Feedback from refresher peer educators training in Samnuea, CHAS 2012 February 1-8; UNODC HAARP Project Progress Report 2010; UNODC Mission Reports 2011*

(Submitted by Harm Reduction Project team, UNODC)

2. Community Advocacy Initiative – an example of multi-sector partnership that works at community level.

The Community Advocacy Initiative (CAI) is a partnership programme that aims to strengthen country and regional level community sector advocacy capacity towards improved responses to HIV and AIDS. CAI is implemented in Indonesia, Lao PDR and Vietnam from mid-2008 to present. CAI is funded by AusAID through the HIV Consortium for Partnerships in Asia and the Pacific (The Australian Federation of AIDS Organizations (AFAO) is APCASO's project partner.[56]

Since 2010, in the context of GFATM funded project, LaoPHA has been supporting networks of key affected populations (KAP), specifically MSM, SW and recently reaching to OVC that have been affected by AIDS in seven provinces in central and southern Lao PDR. The aim of the project is to empower key affected communities by helping them establish partnership networks and developing their capacity to advocate for improved AIDS response in the country.

Key partners involved: LaoPHA, network of KAP (both positive and non-positive with HIV), community authority, district hospitals, PCCA and private clinics at community and district levels and the Lao Buddhist Metthadama.

Under the theme *"Key Affected Community as Partners, not Target Groups*", LaoPHA has managed to involve the KAP to take part in the project as equal partners. All partners were enabled to contribute in each step of project's planning, implementation and monitoring processes. LaoPHA, with support from AFAO and APCASO conducted trainings to build capacity for key members of the KAP networks to manage and operate the project, as well have the essential skills to do their work with communities, to advocate and to reach out further to people in need. The project with AFAO and APCASO has strengthened LaoPHA's own capacity to implement the GFATM project and deliver a comprehensive package of services for prevention, care and support, and treatment in partnership with other involved partners. The partnership with private clinic helps those who wish not to have STI check-up at government's facilities. The agreement with private clinic uses GTATM grant to cover the cost for those who come to their clinic for STI check-up and treatments. At treatment facilities, there are peers to provide support and comfort during treatment, thus enhancing patient adherence. The network also works at community to support those who come back from hospital.

Key achievement of the project so far has been the formulation of a strong network of people who are affected by HIV, their involvement and commitment to their work at community. Through the partnership with Government sector, slowly the work of the network members has been recognised by local authority and health authority. Highlight of it was the inclusion of involvement of PLHIV in the current NSAP 2011-2015. The collaboration between LaoPHA and LNP+ has created a flow of information between the works of the two organizations. LaoPHA provided the information of the work of different networks at community to LNP+ who then used this information for advocacy at national level.

[56] http://www.apcaso.org/v2/?p=702

To implement this initiative successfully, the people working at communities, as well as Lao PHA and donors have overcome challenges to win the recognition of their work from key government agencies as well as to fight stigma and discrimination within communities. This first example of strong partnership and collaboration between civil society organizations, private and government sectors that actually works for the benefit of the community as well as of KAP and PLHIV. It *is "Building capacity for a good partnership"* as a member of LaoPHA emphasised.

3. Stigma Index Survey - French Red Cross / ILO and LNP+

Capacity Building:

- The Stigma Index Survey (SIS) was carried out by PLHIV, who were trained and mentored in data collection and interviewing skills by the French Cross Technical Team. Twelve people in total (gender balanced group) were trained.
- GIPA Principle: PLHIV have been involved in all aspects of the proposal development, project design, implementation, data entry and analysis and as such have offered perspective that the technical team from the French Red Cross had not considered, rendering the project more comprehensive and dynamic.
- In lieu of hiring an expatriate to manage the quantitative aspect of the study, a Lao national took responsibility for these aspects of the project, including adopting the IPPF SIS methodology to the Lao context, training PLHIV to conduct the surveys and collect data, entering the data, creating the data analysis plan and conducting the analysis. This process lead to further capacity building and sustainability within the Lao PDR.
- This project lead to capacity building on the national level of LNP+ as the Secretariat worked directly with the French Red Cross to coordinate all aspects of the project. Specifically, activity coordination skills and communication with provincial level branches of LNP+ were strengthened and teamwork within the Secretariat elevated to implement the SIS.

Empowerment

- The SIS created a safe environment where PLHIV could share their experiences in confidence with other PLHIV (those conducting the interviews), and created an opportunity through which PLHIV could transition from being victims of the epidemic to actors actively engaging in the fight against the epidemic by advocating for their rights.

Coordination with National Level Stakeholders

- LNP+ also gained experience engaging with various different stakeholders on the national level, including government entities (MOH and CHAS) whilst adopting the survey methodology and coordinating with ARV centers to conduct interviews.
- In particular, in order to conduct a study on HIV and AIDS in Laos, an organization must receive approval from CHAS and the Ethical Committee of CHAS. As this is the first survey assessing issues of stigma and discrimination, to receive approval indicates a change in the political environment of the Lao PDR. Even more impressive is that CHAS provided technical assistance to the survey teams carrying out the interviews.
- The SIS is meant to serve as a baseline survey regarding issues related to PLHIV in the Lao PDR – and one that will guide future research and feed into an observatory on stigma and discrimination. This observatory is in the nascent stages of development but has the overall goal to act as a monitoring

mechanism for stigma and discrimination and feed into the National Assembly, which is responsible for monitoring the implementation and effectiveness of the HIV/AIDS Law, recently adopted in 2010.

(Submitted by: La Croix-Rouge Française and the Lao National Network of People Living with HIV)

4. HIV Law – a legal framework for reducing stigma and increase access to service

Support to an Effective Lao National Assembly Joint Programme (SELNA) is a UN joint Programme to enhance the effectiveness and efficiency of the National Assembly of the Lao PDR. The programme supports the National Assembly to further strengthen its legislative, oversight and representational capacity through initiatives targeted for assembly members, the committees, their support staff, and the assembly secretariat for the period 2009 – 2012.[57]

During the drafting and development process of the Law on HIV/AIDS Control and Prevention, SELNA supported the participation of civil society, especially PLHIV via network of LNP+. Through this work, many of the parliamentarians have found the needs to address the law and the issues of stigma and discrimination to community and villages throughout the countries. These are champions that have been trained on their roles as: *1) Sensitise other NA members about HIV epidemic; 2) Advocate for the HIV law; 3) Addressing stigma discrimination at local level.*

These trained members are to travel to community and talk to village and community leaders about the issues of HIV/AIDS/STI and the needs to be vigilant to the epidemic. Due to the characteristic of the national assembly – a legislative institution and the parliamentarians, who are elected by the Lao people, it is their role to support and supervise implementation of the laws in Lao PDR, which put them in an unique position to talk about the law and the rights of PLHIV and communities. Most of the travelling and materials are funded by WHO and UNAIDS. Specially attention are paid to visiting vulnerable areas to HIV as development zones, villages and communities near the border with high level of border crossing traffic and migrants (e.g. Savannakhet, Champasak).

The cooperation between NA, SELNA, CHAS, LNP+ formulate a team who travel to communities and address issues of law, stigma and discrimination and discuss with local community about issues that occurred locally or answer their questions. Condoms are also distributed as mean to family planning and HIV/STI prevention.

In 2011, a new parliament was elected of which 60% are new members. The senior parliamentarians has helped raise awareness about HIV and the law to the new members and involved them in this task. To date, there has been a strong network in partnership of NA, NCCA/CHAS, UN, international NGO and PLHIV to carry on this work. GFARM has recognised this and awarded grant for Round 11. Unfortunately, funding for this round has been cancelled. This has affected the sustainable planning of this project as the work will need to continue, considering the development context of the country in relation with the HIV epidemic. SELNA is developing a comic book as hand-out materials to address HIV related issues to community, and young people.

The parliamentarians have reached three hundreds communities and they have received positive feedback on this type of work. In the future, there is prospective of working with countries in the region like Cambodia and Vietnam who has done similar work for regional partnership and capacity building.

5. Population Services International (PSI) *New Friends* (Pheuan Mai) - Peer-led Transgender HIV and STI Prevention Project in Lao PDR

[57] http://www.undplao.org/whatwedo/factsheets/democratic/2010/2010-06_SELNA%20Fact%20Sheet_final.pdf

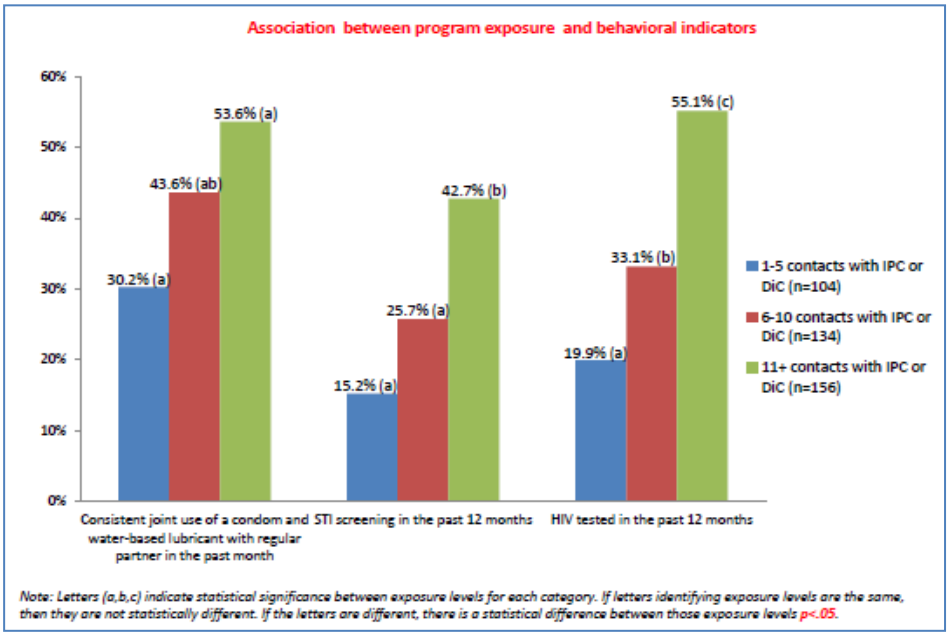
In Lao PDR, MSM face the highest burden of HIV. In Vientiane Capital, approximately 5.6% of MSM are HIV positive (2008), compared with 30.7% in Bangkok (2008) and 8.7% in Phnom Penh (2007). This high prevalence of HIV, coupled with high levels of and unprotected anal sex, multiple sexual partnerships, high rates of STIs and low condom use, threaten to expand and accelerate the HIV epidemic in Laos.

With support from USAID and GFATM, and working in close collaboration with the Lao PDR Centre for HIV/AIDS/STI (CHAS) and other partners, PSI Laos implements the peer-led *New Friends (Pheuan Mai)* program. The project is active in three provinces of Laos where there is a high concentration of MSM and TGs – Vientiane Capital, Luang Prabang, and Savanakhet. Through the *New Friends* program, PSI delivers a comprehensive package of services (CPS) which includes intensive inter-personal communication (IPC) activities to promote behaviour change, Drop-in Centres in 3 provinces offering VCT services with free HIV rapid testing, referrals to fully-subsidized STI treatment (for Gonorrhea & Chlamydia) at private sector clinics, referrals to HIV care and treatment, ensured accessibility to pre-packaged STI treatment, male condoms, and lubricant at 90% of pharmacies and 80% of guesthouses, and a cell phone SMS health messaging system. Many of the core services on the *New Friends* project are operated largely by transgender, themselves.

The campaign aims to measurably reduce HIV/STIs and promote healthy sexual behaviours among MSM, especially Male to Female (MtF) transgender (TG) and partners. As shown in the chart below, the project has achieved significant and measurable improvements in key HIV/STI prevention behaviours among TGs. Behavioural data collected during a joint CHAS/PSI behavioural survey in 2010 shows that TGs with more exposure to PSI program activities have higher rates of desired behaviours, including higher rates of consistent condom and lubricant use with regular partners, higher reported STI screening, and higher rates of HIV testing (See Graph).

The project shows how an effective HIV and STI intervention can be built through close collaboration between government, civil society, and private sector partners, with a strong element of peer leadership in delivery of products and services to the target group.

Figure 22



(Submitted by PSI Lao PDR)

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

1. Progression on previous challenges

Recommendations to overcome identified challenges were suggested to be included in the NSAP for 2011-2015 (see table 8 on the opposite page).

2. Challenges for the National AIDS Response

The National AIDS Authority has promoted a meaningful involvement of the Lao Networks of People living with HIV which is today recognized as Associations. More of those networks of key affected population together with community based organizations are urgently needed to reduce the number of people newly infected with HIV and avoid a concentrated epidemic among SW, MSM and PWID. Efficient partnerships between states agencies, networks and community based organizations will allow for a substantial increase in coverage of services of the HIV Response.

The HIV Response must **be better equipped to monitor risk behaviours**, understand the predisposing factors these behaviours, and identify those sub-groups with the highest risk and vulnerability, and those hardest-to-reach (for example due to young age, gender or location). This requires further involvement of networks and communities in the design and implementation of the national research agenda.

For **the existing services to reach out to key affected populations**, many of whom are known not to access public sector health services due to stigma and criminalisation of their behaviours, networks and community based organizations need to be in a better position to reach out to them, provided they receive organizational, technical and financial support.

The scale up HIV related health services will require a paradigm shift **towards integrating HIV management into the public health system**. It is estimated in 2015, Lao may have 14,000 people living with HIV, and 5,780 in need of ART. Scaling up and maintaining quality will rely on developing a continuum of care framework, decentralization of HIV management to provinces and district health services, and strong public-private partnerships with network and community for home based care.

In the context of the global economic crisis, and shifting donor priorities away from disease specific funding towards global health funding, a major challenge is **to sustain the current financial resource for the response**. In practice, this will require a strategic approach to resource mobilisation, combined with strategies to increase domestic funding and cost-effectiveness of HIV interventions. *(Source: 2. Issues and challenges to be considered, UCO survey's 2011, Lao PDR)*

3. Remedial Actions

The NSAP 2011-2015 sets two goals:

1. Maintain the present low level of HIV prevalence in the general population below 1%
2. Ensure HIV seroprevalence among most at risk populations is lower than 5%

The UN High Level Meeting on HIV/AIDS in 2011 resulted in the 2011 Political Declaration that sets 7 targets Lao PDR has endorsed and promotes the Three Zeros principles.

With that in the background, for the implementation of NSAP, it has been costed for a total of US$54,226,653 to achieve three main objectives: i) Increase coverage and quality of HIV prevention services; ii) Increase coverage and quality of HIV treatment, care and support services; iii) Improve national programme management

Table 8: Status of progression in relation to the recommendations made in the UNGASS report 2010 for Lao PDR.

Recommended Remedial Actions	Status of implementation	Rational
1. More intensified gender-sensitive and gender-responsive strategy	Section 6.4 under Guiding Principles for the National Response is about gender consideration. Thus gender analysis framework must be applied to all planning, service delivery and research process.	Evidence indicates that there is no discrepancy in access to HIV-related services for male and female. Hence the NSAP expresses **equal access to HIV –related services** for both men and women.
2. Prioritizing strategic response to emerging vulnerable groups	SW and their clients; MSM and PUD/PWID are prioritized groups for targeting prevention intervention	Sexual interaction remains the main HIV transmission route and as the KAP evolve, more SW working outside established environment, they are younger, more vulnerable and harder to reach. As more studies and work have been done with MSM, it has revealed the complexity of social and sexual behaviours of this group with many subgroups. More work also needed against stigma and discrimination against MSM, especially transgendered PUD/PWID has recently emerging as a potential most-at-risk group. Evidences are that HIV is prevalent in this group, even though detected in small, bordering areas in the North of Lao PDR, and signs of SW use and injecting drugs also have been reported. Additionally, Lao PDR locates in the central of a very dynamic and active drug trafficking region, with high level of drug use in neighbouring countries.
3. Increased M&E, surveillance and research		

Suggested priorities: - Situational analysis IDU - Update study on migrants, with focus on young female - Study on general population and youth Include global indicators (UNGASS) in data collection efforts	- RAR conducted in Huaphanh and Phongsaly - Not yet - A national population based survey on social, health and economic issues in Lao PDR has been conducted in 2011. Results are expected to be available early 2013. - UNGASS indicators have been integrated into the National Core indicators presented in the NSAP Questions to answer these indicators have been included in the previously mentioned population based survey	2010 – 2011 was the planning period for the first ever nationwide population based survey on social, health and economic situation in the Lao PDR. Results of this survey will serve as baseline data for many key indicators related to all sectors in Lao, including HIV. The survey also requires participation and contribution (technically and financially) from all development partners in the country.
4. Mobilizing resources for neglected/deficient priority areas: Development of a resource mobilization plan	The NSAP 2011-2015: all components with key activities have been costed and budget earmarked for implementers. However all the cost and budget still rely heavily on external funds.	This exercise is becoming more urgent with the global budget cut and: GFATM has been the biggest funder for AIDS related activities in Lao PDR. The restructure of the organization justifies for the need to mobilize more resources According to the WB, Lao PDR has moved in the Low middle income country category, which means the Government will have to increase the domestic expenditure on health, as well as the country will not be entitle to receive grant but soft loan.

In order to reach these targets and objectives, with the challenges identified above, more attention needed in the following areas:

1. **Strengthen data collection among key populations at higher risks** (SW, MSM, PUD/PWID) for strategic preventive intervention as well as for monitoring programme progress – currently, there's lack of trend information on the newly emerging most-at-risk population such as mobile phone sex workers, MSM/TG, PWID. Having continuous information, especially behavioural information of emerging most-at-risk populations is essential for setting suitable and effective intervention approaches for this population.

2. **Enhance involvement and participation of community based networks and organizations –** this is particularly important to reach hidden population such as MSM, PWID and mobile phone sex workers. The roles and importance of peer networks (networks of PLHIV, MSM) and community based organization (LaoPHA, PEDA, NGOs) have been recognised by the government of Lao PDR and all partners involved in the NAR, especially in the area of care and supports to PLHIV, OVC and those affected by AIDS. In the future, the needs to involve these partners will be greater as HIV related services move further towards the population in needs. These include:
   - **a.** Participation in surveys and monitoring data collection, especially information about community based activities that are not included in the national routine reporting system.
   - **b.** Planning and M&E
   - **c.** Provision of preventive, care and support services, in partnership with other CSO, government and private sectors
   - **d.** Fight against stigma and discrimination at community level
   - **e.** Positive health - advocacy for self-aware and self –protection from further transmission among PLHIV and their sexual partners.

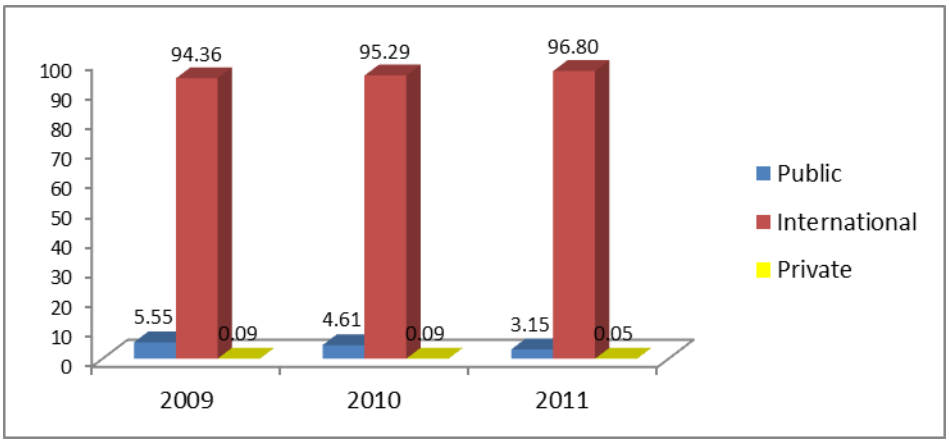
3. **Resource mobilization –** The main source of fund for NAR in Lao PDR is from external partners, of whom GFATM plays the biggest role. With the current situation of global economic down turn where all donor countries are facing budget cuts. GFATM also is facing shortage of funds and in the process of restructuring their support and funding mechanism. In that context, it is crucial for Lao PDR to enhance resource mobilization from other donors, private sector as well as advocating for increase of domestic fund, especially as Lao has now is a lower – middle – income country, according to the World Bank.

VI. SUPPORT FROM THE COUNTRY DEVELOPMENT PARTNERS

1. Key support received from development partners

Lao PDR relies heavily on external support, both technically and financially, for the implementation of the National AIDS Response. Figure 23 shows the proportion of external fund in the reporting period, in comparison to the other sources of fund.

Figure 23 - Structure of AIDS budget by sources 2009 - 2011

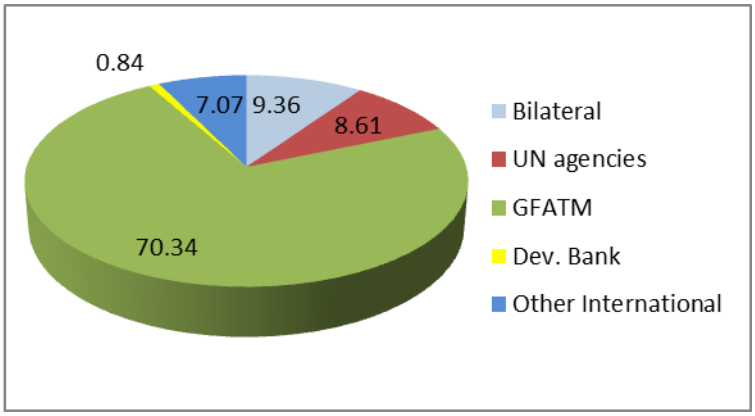


Source: NASA report, 2011.

Compare to the previous UNGASS reporting period, this structure has not changed. GFATM still is the biggest donor for the AIDS Response in Lao PDR at 70%, followed by Bilateral Agencies (10%) and UN agencies (9%) (figure 24). The trend has been increase among bilateral and UN funding and GFATM now has started restructuring its funding mechanism to cope with strongly funding cut from its donors.

Lao PDR has won grants for total of four rounds form GFATM: round 1, 4, 6, 8 and RCC round 4. Implementation of round 4 grants has completed. GFATM grants have been the main source of funding for all programme areas, including health system strengthening to support a smooth operation of the NAR. GFATM also is the main source of funds for ARV drugs.

Figure 24 - Structure of external funds in Lao PDR

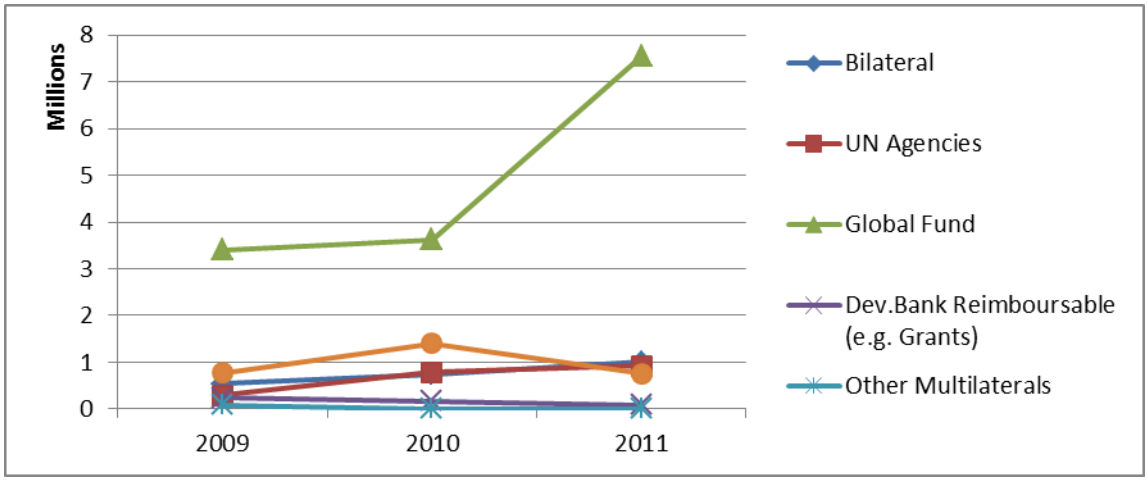


Source: NASA 2009 - 2011

UN Agencies: UNAIDS, as the UN programme coordinates its co-sponsor in the UN system, has been the key partner in supporting for multi-sectoral response. WHO has been supporting the care and treatment and PMTCT programme (in partnership with UNICEF), in term of technical assistance and guidance. WHO has been the main partner in building capacity for health care workers within the government system and provides small financial funding for care and support initiatives at local level. UNICEF has provided strong supports for care of OVC and community based initiatives for children and young people. Life-skills education prorgamme joint supported by UNICEF and

UNFPA has reached to school children. The support from UN, both technical and financial, have been reported in different aspects of programme: capacity building for CHAS and its structure; M&E; coordination; HIV in the work place; advocacy; nutrition; community based care and support…

Figure 25 - Trend of funding by external partners (Mil. USD)



Source: NASA 2009 - 2011.

Bilateral agencies – AusAID in support to the Lao Red Cross and Burnet Institute has supported strategic information, nutrition (in partnership with WFP and Thai Red Cross); USAID has supported FHI and PSI on the prevention work with MSM and social marketing programme.

International NGOs have taken the key part in the work at community, supporting network of PLHIV and of other most-at-risk populations to provide preventive, care and supports. PSI has conducted a first round HIV/STI prevalence and behavioural tracking survey among transgendered in Vientiane Capital and Savannakhet. FHI supported CHAS in surveillance survey and also managed 14 drop-in centres for SW in four provinces. FHI just ended the project and handed over the centres to PCCA. PSI operates 63 DIC for MSM in ten provinces and manages the condom social marketing programme in the country since 2003.
Development Banks – ADB has supported HIV prevention activities in ADB funded road construction projects inside the country and throughout the region.
Figure 25 shows trends of external funds to the NAR in the last three years.

2. Actions that need to be taken by development partners

From the costed action plan for NSAP 2011 - 2015, NCCA will need around US$ 54millions for the NAR and the funding gaps are estimated between 35% to 40% for 2011 and 2012 respectively (estimates based on the cost from the NSAP and the pledged funds). This gap is expected to rise for the period 2013-2015. Considering the economic situation of many donor countries, which has already affected the GFATM funding, fund raising from emerging, new donors who have already invested and supported the health sectors and other sectors in the country is essential. The importance of integrating HIV prevention component as an essential element of infrastructure project should be promoted by international partners.

In 2011, Lao PDR became 'lower middle income country', this could affect the flow of official development assistance (ODA) to the country. The development partners should promote and support the Government of Lao PDR to increase domestic investment and HIV should be one of the priorities due to the socio-economic impacts that HIV can have at household level and that can bring those affected to poverty. International

partners should advocate for promotion of income generation by supporting better access to education, vocational training and financial supports for poor people, especially those affected by AIDS

International partners were a strong force behind the development of evidence-based NSAP 2011-2015. It is important to continue this support for strengthening and supporting data collection, analysis and use for stronger M&E system to support programmatic planning, especially to reach out to the hard-to-reach (informal SW, MSM, migrant, PWID); policy dialogues and advocacy.

The implementation of the HIV Law needs supports from international partners in the development of the decree on implementation of HIV law, and promoting law enforcement nationwide (SELNA project).

For the UN, the development of the UN Development Assistant Framework (UNDAF) and action plan for 2012-2015 is in process. The effective implementation of this plan, once it is approved by the UN and the Government of Lao PDR, will create a common environment to address the multi-façade of AIDS response in Lao PDR: i.e. education; social and economic development; health care; child protection; M&E; policy… to support the getting to Three Zeros strategy.

As the role of civil society, especially those work with and at community level, has been increasingly important and beneficial to the NAR. Therefore, the need to be supported technically and financially so that they are better equipped for more active and meaningful involvement and participation in all different areas of the national response: prevention, care and support, reduction of stigma and discrimination, M&E and policy dialogues. Capacity building is essential and international partner have contributed and should continue to support in this aspect.

VII- MONITORING AND EVALUATION ENVIRONMENT

1. Overview of the current monitoring and evaluation (M&E) system

It is stated in the NSAP that CHAS is responsible for the M&E of the NAR through the M&E strategy and annual work plans. 3.5% (US$ 1.9mil.) of the costed NAR budget has been allocated to M&E for the period 2011-2015.

Since 2007, a functioning M&E unit has been established and housed at CHAS. The unit currently has three full-time staff and local M&E consultant supported by GFATM, all have been trained on M&E. The Unit is responsible for smooth operation of routine data collection from all implementing partners and facilities as well as disseminating information to concerned partners periodically. The Annual Programme Review also under responsibility of M&E unit. Additionally, M&E unit is a leading partner and responsible for all the HIV surveillance surveys and reports.

Currently, the Unit has used two soft-wares: HIVCAM for ART management, care and treatment; The National M&E software (MERS) is used for prevention programme. However, the two software work paralleled and need to be updated regularly. At the moment, the task of collecting surveillance data is with the surveillance, care and support. This makes M&E unit depend on other unit when they need the data and prevent M&E unit function as one of the Three Ones. The CHAS is planning to restructure to make M&E responsible for strategic information of the NAR in Lao DPR.

Table 9: Lao PDR M&E system based on the UNAIDS recommended 12 Components M&E system

M&E components	Status at 2011 and Remarks
1. Organizational structure with HIV M&E functions	- There is a structure of M&E with information flow (mainly upward to higher administrative level). - Budget for M&E still low - Lack of M&E staff at provincial and district levels - Surveillance, and treatment is under another Unit within CHAS which hinder the data collection process
2. Human Capacity for HIV M&E	- All staff at M&E Unit in CHAS have been trained but further training is needed in specific area such size estimation, data analysis; evaluation; design M&E plan; use of M&E tools…. - Inadequate training for staff at provincial and lower levels, especially at service delivery facilities. This affects the quality of data collected. - Staff at district and community level has multiple tasks, one of them is collecting data for M&E, and therefore they cannot perform sufficiently due to work overload.
3. Partnership to plan, coordinate and manage the HIV M&E system	- The national M&E TWG has been established but has not met regularly. - Data from other ministries and CSO are not always reported routinely but available when requested
4. National multi-sectoral HIV M&E plan	- Drafted but not yet finalised
5. Annual cost M&E work plan	- None. Plan to develop in the future
6. Advocacy, communication and culture for HIV M&E	- TWG has not met hence advocacy for data use and the role of M&E in programmatic planning and strategy development. - There's plan for M&E TWG to meet in the near future.

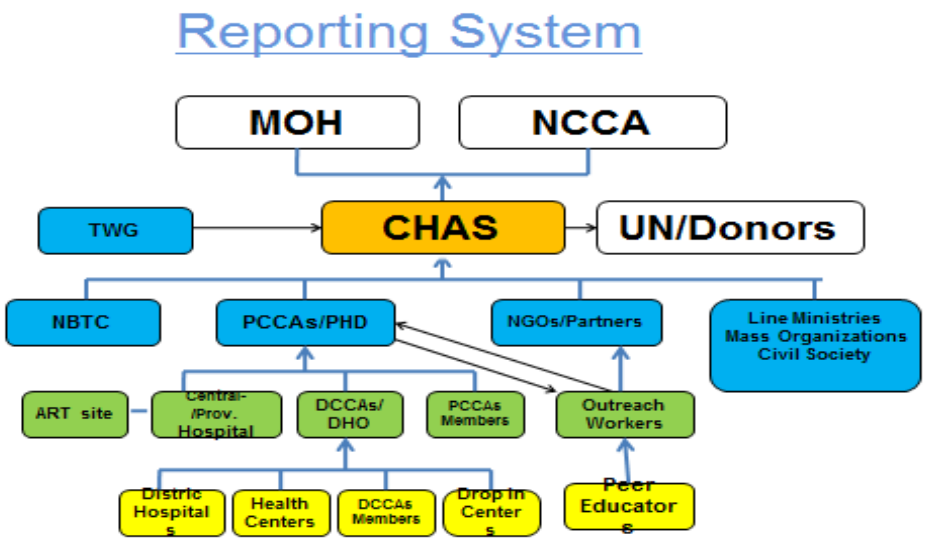
7.	Routine HIV programme Monitoring	- National guidelines and data collection forms to be developed - Monthly reports are collected from service delivery sites to district and provincial level then to CHAS - No available reports from line ministries
8.	Survey and surveillance	- IBBS/BBS has been conducted most regularly though surveyed populations is not always consistent, as well as methods and questionnaires. - 2010: tracked IBBS conducted among MSM/TGs in Vientiane Capital and Savannakhet. - 2011: IBBS conducted among female SW in six provinces - Lao Social Indicator Survey (LSIS) is in process. Data will be available around 2013.
9.	National and Sub-national data base	- M&E unit in CHAS currently hosts HIV national data base but not sub-national data base - Care and treatment monitoring software is applied
10.	Supportive supervision and data auditing	- Regular supervision visits to provinces and data checking on sites.
11.	HIV evaluation and research	- Condom Social Marketing Programme Evaluation conducted in 2010.
12.	Data dissemination and use	- Data mainly used for global reporting, and for the formulation of the NSAP. - Data is used for planning and policy making at national and sub-national levels - Estimation and projection of key affected populations, epidemics and estimate ARV needs, policy analysis to support enable policy timely and accurately.

Routine Reporting – the primary data is collected and compiled at community based service providers such as VCT sites, DIC, peer educators and outreach workers, as well as health centres, district hospital, DCCA members. This data, together with reports from ART sites, is reported monthly to relevant provincial level, of which will compile and report as provincial data to relevant vertical line central level, who then report to M&E Unit at CHAS (see figure 26 below).

However, there has been very little use of the routine data for monitoring purposes. At the same time, many indicators are missing for monitoring the implementation of the work plan as well as monitoring the development of the epidemic. Due to the lack of monitoring data, the country tends to have many reviews and evaluation in order to collect programmatic information. This is expensive and time consuming.

Surveillance Survey and other surveys: BBS/IBBS have been conducted regularly every two years though target populations are not consistent, except the continuous surveillance among female sex workers. Most of the surveys are conducted on ad-hoc base, depending on available resources and which population is considered in need of more information (see table 11 below). Due to this practice, it is very difficult to monitor behavioural patterns and trends of any key affected population as well as the monitoring of the epidemics within each of the population. Lao PDR also lacks periodic population based survey such as the Demographic and Health survey, or the AIDS Indicator survey. 2010-2011 has been focused for the first national population-based survey on social, economic and health sector, the first ever done in Lao PDR. This survey has been supported (technically and financially) by all development partners in the country and its results will serve as baseline for many of the key development indicators that are still missing for the time being.

Figure 26 - Data flow in routine HIV programme monitoring system



Source: CHAS/MOH

Estimation and Projection: In the last two years (2010, 2011) CHAS, in supports from Bangkok based US CDC through WHO, has organized a series of workshops to determine trend of the HIV epidemic in Lao PDR. This work serves two purposes: *1) provided estimate number of PLHIV, new infections, deaths due to AIDS related cause as well as number of children born to HIV positive pregnant women, HIV prevalence and estimated ARV needs for the country; 2) building capacity for CHAS on Estimate and Projection*. Results of this work are presented in Chapter III section 5.

2. Challenges faced in the implementation of a comprehensive M&E system

In the UNGASS country progress report 2010, a list of remedial actions was listed. Table 11below show status of actions:

Table 10: Progress made based on the Remedial Actions recommended in UNGASS Country Report 2010

	Recommended remedial actions	Status	Relevant for the next period
1	Conducting formal M&E assessment including multi-stake holder system	- None. Only done on small scale assessment	Yes
2	Providing standardized M&E training at all level and to CSOs	- Training module is ready - Training have been conducted to central and provincial staff	Revise training and develop training plan, based on the outcome of the M&E system assessment
3	Involving CSO's more in the M&E process, from data collection, to quality assurance and use	None. TWG has not started. Reports sent from CSO have been checked and validated	Yes, with the establishment of a functioning M&E TWG, including CSO membes

		by PCCA.	
4	Expanding capacity building of staff through knowledge and skills transfer with on the job training, mentorship and hands on training forums	Feedback on reported data from provinces and central hospital	Feedback loops on the reports sent from district and provincial levels to be strengthened
5	Resource generation for much needed studies through clear priority on needed strategic information	None	Need to promote the use of information
6	Incorporating regular operational research and evaluations in NSAP work plan to determine programme effectiveness	None	Need to develop a M&E work plan based on the NASP
7	Encouraging evidence based decision making and policy through multi-stakeholder forums and review of annual reports	Very little use of M&E information, mainly for reporting purpose.	Continue advocate and promote use of M&E information, especially the formulation, dissemination and use of an Annual AIDS Response Report.
8	Providing sustainable analytical skills through: - Training staff who will then train others in data analysis, estimations and projections - Continued use of strategic information in annual reports and semi-annual reports	Estimation and Projection training is on- going to CHAS staff	

Regarding the current stage of M&E system, the following challenges should be addressed for a functioning M&E system within the framework of the current NSAP:

- Overall, the HIV M&E data collecting system is fragmented. With the exception of IBBS/BBS for SW, the small number of studies and surveys related to HIV conducted in the last ten years in Lao PDR were ad-hoc, in small scale (both geographically and sample size) with the use of different methods. This makes it difficult to draw conclusion from the survey findings for programmatic data analysis, planning and management purpose.
- *Poor data quality*: skills of those who collect and compile data at all level is weak; the installment of hardware to support this process is also lacking, such as computer to avoid calculation mistakes and other human errors.
- *Delayed reporting time*: Due to the structure of the data collection within CHAS, information first sent to the Office of CHAS, then distributed to M&E unit and other relevant unit within. Additionally, the overload working condition in district and health centre levels also causes reports often delayed.
- *Coordination*: There is no multi-stakeholder coordinating mechanism regarding M&E related activities which can be strengthened with a functioning TWG, it is very difficult for M&E Unit in CHAS to call for data collection and reporting, especially report from other line ministries and partners as it's not been acknowledge formally as CHAS mandate.
- District level data collecting *staff is overload with multi-tasks and have not been trained adequately*. At the same time, they have not had a full perspective of their work and where it fits in the

M&E and planning loop. This normally leads to the lack of interest in data collecting, thus affects data quality.

- Data use for programmatic approach: so far, apart from data use for reporting, very little of the HIV related data has been used on programming, planning and decision making process by leaders and local partners. Only effective use of M&E data would drive the data needs, thus help strengthen the M&E system and promote quality information.
- The NSAP recommended 3.5% of its total budget for M&E, still lower than the UNAIDS recommended seven to ten prevent of the total NAR budget if to have a sustainable and functioning national HIV M&E system.

3. Remedial actions planned to overcome the challenges

- There is the need to develop M&E framework including a set of national indicators (with consideration of NSAP core indicators, programme management indicators and other global reporting indicators); tools and means of data collections. This framework also provides guidance on data collection, analysis, dissemination and use. This should be followed by M&E action plan with details activities and responsibilities. This M&E framework will also serve as the monitoring framework for the implementation of the NASP.
- The M&E framework will guide the development of a unified monitoring system for both, the programme implementation and the HIV epidemic.
- Set up and initiate the M&E TWG with agreed upon TOR. This group should consist of Government line ministries representative, other international partners and local NGOs. The M&E TWG would be an effective coordinating mechanism for HIV M&E.
- Develop capacity building plan for M&E at all level. This should be supported by information from M&E system assessment which informs the development process of M&E framework and action plan.
- Annual NAR report to be formulated and disseminated widely.
- Establish monitoring and supportive supervision of the M&E routine reporting, through feedback loop as a simple approach to data quality assurance and capacity building.
- Update data needs and data gaps for more effective planning and use, especially for prevention purposes.
- Develop routine reporting forms based on the NSAP for monitoring purpose.

4. The need for M&E technical assistance and capacity-building

M&E technical assistance has proved invaluable in the past, resulting in the development of the draft M&E plan. CHAS seeks technical assistance particularly in areas needing expanded expertise, but to data has limited support. Much of the above mentioned recommendations will require technical assistance, especially at the stage of building structure and framework for One National HIV M&E system.

Training curriculum, knowledge and skills transfer, improved strategic information analysis and use, will benefit from technical assistance. It is important that technical assistance and capacity building are both included in the M&E framework and M&E plan to ensure continuous funding stream.

Table 11: Summary of available surveys and surveillance survey for target populations 2001 - 20011

Survey Populations	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Sex workers	IBSS			IBBS				IBBS	BBS		IBBS
MSM							IBBS (Vientiane)		BBS (Luang Prabang)	HIV/STI prevalence and behavioural tracking survey for TGs in 2 provinces	
PUD/PWID									BBS + Urine	IBBS (2 prov.)	
Electricity workers				IBBS				IBBS			
Factory workers	IBBS										
Migrants	IBSS					IBBS in 8 border provinces with Thailand			Study: HIV transmission in Vietnam – Lao Border areas		
Militaries	IBBS			IBBS							
Police	IBBS			IBBS							
Truck drivers	IBBS			IBBS							
Young people aged 15-24										ATS use and STI risk among young people in Vientiane	
Water workers				IBBS							

Source: CHAS/ MOH

Table 10 shows that there is lack of continuity of information for most of the target populations, except sex workers.

The surveys among MSM, PUD/PWID have been scatted and in small sites, hence did not reflect well the situation of MSM and PWID in the country. Lao PDR's HIV epidemic is low prevalence hence the need to do sentinel surveillance and behavior surveillance rigorously is small. However, with the prospective that SW, MSM, PUD/PWID are those populations should receive prevention interventions, it's recommended to collect more systematic information to support the development of prevention intervention approaches.

ANNEX

Annex 1: NASA

Annex 2: NCPI

Annex 3: List of NCCA Members

	Organisations	Tittle
Current Members		
1	Ministry of Health	Minister of Health; Chair of NCCA
2	Ministry of Education and Sport	Vice – Minister; Deputy Chair of NCCA
3	Ministry of Information, Culture and Tourism	Vice – Minister; Deputy Chair of NCCA
4	Lao Red Cross	President
5	Ministry of Public Work and Transportation	Director General of the Cabinet
6	Ministry of National Defense	Director of Disease Prevention Division, Health Department
7	Ministry of Labour and Social Welfare	Director General of the Cabinet
8	Ministry of Public Security	Director General of the Cabinet
12	Lao Front for National Construction	Director the Cabinet
11	Lao Trade Union	Director of the Cabinet
9	Lao Youth Union	Director of the Cabinet
10	Lao Women Union	Director of the Cabinet
13	Ministry of Health	Director General – Department of Hygiene and Prevention
14	Ministry of Health	Director of Centre for HIV/AIDS/STI
Director of the Cabinet		
1	Ministry of Justice	
2	Lao National Assembly	
3	Lao Chamber of Commerce and Industry	
4	Lao National Commission of Drug Control and Supervision	
5	Lao Network of PLHIV (LNP+)	
6	Buddhist Association	

Annex 4: Description of reporting indicator data

Annex 5: Roadmap for GARP – Country Reporting Process, Lao PDR

Timeframe	Process
13 – 17/ 02/ 2012	Desk review of reporting guidelines and related documents to prepare for the orientation workshops
17/ 02/ 2012	Orientation workshop on GARP preparation with the key partners involved in reporting
21 /02/ 2012	Meeting of Civil Society organisations for NCPI part B
22 /02/ 2012	Meeting of Government Sector for NCPI Part A
23 – 27/ 02/ 2012	Collect and Validate data for reporting indicators
23 - 27 / 02/ 2012	Collect data and information from all existing sources
1 & 2/ 03/ 2012	Meeting of UN agencies for NCPI Part B
5 – 10/ 03/ 2012	Data Analysis Draft Report
10 – 15/ 03/ 2012	Interview partners and collect related information
15 – 20/ 03/ 2012	Completion of draft report Sumarise NCPI part A and Part B for consensus
23/ 03/ 2012	Validation workshop to comment and endorse the draft report with national and international partners
27/ 03/ 2012	Meeting with partners to finalise NCPI part A and B
23 – 28 / 03/ 2012	Finalise narrative report and NCPI
28/ 03/ 2012	Submission to the Chair of NCCA for approval
By 31/ 03/ 2012	Deadline for submission to UNAIDS HQ
April 2012	Follow up and respond if any recommendation from the reporting team of UNAIDS HQ
April 2012	Disseminate the report to the NCCA members, partners and interested parties

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