LAO PDR COUNTRY PROGRESS REPORT

Global AIDS Response Progress

Country Report, 2016

Foreword

Lao People's Democratic Republic showed significant economic improvements from the past years having moved up from its income categorization from a low income economy to a lower-middle income economy.[1] With this progress come improvements on the provision of health services throughout the country. Health outcomes were closely monitored and reported as part of the Millennium Development Goals (MDGs).

The year 2015 marked the conclusion of the MDG's goals with time-bound targets, which center on the principles of human dignity, equality and equity, and freedom from extreme poverty. Remarkable gains were achieved in most development indicators. These indicators are being tracked to inform decision-making in identifying gaps and in implementing actions that are responsive to the needs of the people.

The Government of Lao PDR continues its political commitment towards improved health outcomes. It supports, promotes and carries out its roles under the Declaration of Commitment at United Nation General Assembly Special Session on AIDS in 2001 to support a multi-sectoral response, the MDG 6 (combat HIVand AIDS, malaria and other diseases) and Three Zero Strategy (Zero new HIV infections, Zero discrimination and Zero AIDS related deaths), the 2010 Law on HIV and AIDS Control and Prevention (hereafter refers to as the HIV Law), and the 2011 Political Declaration on HIVandAIDS. We have developed the National Strategic and Action Plan for HIVandAIDS and STI Prevention and Control 2016-2020 (NSAP), which will further lay out a more focused and result-driven response in combating HIVandAIDS. Moving forward, the country supports the global movement to embark on a fast-track strategy to end AIDS epidemic by 2030. Through rapid scale up of HIV programmes, it will enable to outpace the epidemic by 2030. The strategy is to achieve a target of 90-90-90 for treatment (90% of PLHIV knowing their status, 90% who know their status are receiving treatment, and 90% of those on treatment having a suppressed viral load) by 2020 and further increase these to 95-95-95 by 2030.

With the policy framework in place, the country will continuously support the post-MDG initiatives led by development partners by building on what we already started under MDG and contribute in the Sustainable Development Goals (SDG), which serve as the core of development agenda beyond 2015. The key is to have a sustained effort in responding to the health gaps by focusing on efficient and effective programme implementation at the national and local levels.

Through the Global AIDS Response Progress Report (GARPR) 2016, we will be able to track health trends and assess our achievements over targets set for MDG 6 related to HIV. This report also begins to track new indicators that are crucial in sustaining the gains in health outcomes that will transition to achieving the SDG. Apart from the national level data, GARPR 2016 also marks a greater focus on health trends in key locations that may spur concentrated HIV epidemics, specifically the capital areas and key cities. By bringing more understanding on how these areas behave, we can locally respond and act on the gaps and centrally support and design ways to sustain and expand efforts throughout the country. We are looking forward to a more aggressive effort in programme implementation and sustained cooperation with all partners.

HIS EXCELLENCY KHAMPHONE PHOUTTHAVONG
Minister of Health and Chair of the National Committee for the Control of AIDS

[1] Lao PDR and UN. *The Millennium Development Goals and Lessons Learnt for the Post 2015 Period: A Summary Review*, 2015.

Acknowledgment

The development and preparation of the Lao PDR 2016 GARPR was conducted through an inclusive and consultative process, under the direction of the Centre for HIV/AIDS and STI (CHAS), Ministry of Health (MOH), on behalf of the National Committee for the Control of AIDS (NCCA) with technical assistance from UNAIDS Country Office and Regional Support Team and funding support from UNAIDS through the Technical Support Facility (TSF).

The 2016 GARP reporting has been formally endorsed by the Ministry of Health through a Decree to Organise the 2016 GARP Report Committee that includes the following: I) Guiding Team, Prof. Dr. Eksavang Vongvichit, Minister of Health; Dr. Bounlay Phommasack, Director General of the Department of Communicable Disease Control; Dr. Bounpheng Philavong, Director of CHAS; II) Over-all Responsible Team: Dr. Sisavath Soutthanirasay, Deputy Director General of the Department of Communicable Disease Control; Dr. Phouthone Southalack, CHAS Deputy Director; Dr.Khanthanouvieng Sayabounthavong, CHAS Deputy Director; III) Technical Team: Dr. Keophouvanh Doungphachanh, CHAS Head of M&E and Surveillance Unit; Dr. Beuang Vang Van, CHAS Head of Planning and Cooperation Unit; Dr. Bounleuth Vilayhong, CHAS Head of Administration Unit; Dr. Phengpet Phetvixay, CHAS Head of Information Education Communication (IEC) Unit; Dr. Ketmala Banchongphanith, CHAS Deputy Head of HIV/AIDS and STI Management Unit; Dr. Bouathong Simanovong, CHAS Deputy Head, Monitoring and Evaluation (M&E) and Surveillance Unit; and, Dr. Khanti Thongkam, Technical Staff of M&E and Surveillance Unit.

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List of Abbreviations

ADB	Asian Development Bank
AEM	Asian Epidemic Model
AIDS	Acquired Immune Deficiency Syndrome
ADB	Asian Development Bank
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
AusAID	Australia Agency for International Development
BCC	Behaviour Change Communication
CCM	Country Coordinating Mechanism
CHAS	Centre for HIV/AIDS and STI
CPS	Champasak
CSO	Civil Society Organisation
DCCA	District Committee for the Control of AIDS
DIC	Drop in Centre
EQA	External Quality Assurance
EU	European Union
FHI	Family Health International
FSW	Female Sex Workers
GARP	Global AIDS Response Progress
GARPR	Global AIDS Response Progress Report
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMS	Greater Mekong Subregion
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
HRG	High-risk Group
IBBS	Integrated Biological and Behavioural Survey
IEC	Information Education Communication
INGO	International Non-government Organization
KAP	Key Affected Population
LaoPHA	Lao Positive Health Association
LNP+	Lao Network of People Living with HIV
LYU	Lao People's Revolutionary Youth Union
M&E	Monitoring and Evaluation
MCHC	Maternal and Child Health Centre
MCHN	Maternal and Child Health and Nutrition
MDG	Millennium Development Goals
MOH	Ministry of Health
MSM	Men who Have Sex with Men
MSW	Male Sex Worker
MtF TG	Male-to-Female Transgender
NASA	National AIDS Spending Assessment
NCA	Norwegian Church Aid
NCCA	National Committee for the Control of AIDS
NCLE	National Center of Laboratory and Epidemiology
NCPI	National Commitment and Policy Instrument
NGO	Nongovernmental Organization
NSAP	National Strategy and Action Plan
OVC	Orphan and Vulnerable Children
PCCA	Provincial Committee for the Control of AIDS
PDR	People's Democratic Republic
PEDA	Promotion for Education and Development Association
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
POC	Point of Care
PR	Principal Recipient
PSI	Population Service International
PWID	People Who Inject Drugs
QI	Quality Improvement
SDG	Sustainable Development Goals
STI	Sexually Transmitted Infection
SW	Sex Workers
TA	Technical Assistance
TB	Tuberculosis
TG	Transgender
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint 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
USD	United States Dollar
VCT	Voluntary Counselling and Testing
VTC	Vientiane Capital
WHO	World Health Organization

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I. Status at a Glance

A. The inclusiveness of the stakeholders in the report writing

The 2016 Global AIDS Response Progress Reporting was conducted through an inclusive consultative process among the HIV stakeholders and partners. Inputs and contributions came from a wide range of stakeholders in Lao PDR including government agencies, CSOs, network of people living with HIV (PLHIV), mass organizations, international and local nongovernmental organizations (INGO), UN, bilateral and multilateral agencies. The report was developed and consolidated under the leadership of the MOH – CHAS, on behalf of the NCCA. The UNAIDS Country Office and the Regional Support Team-Asia Pacific provided technical guidance and supported an international consultant who worked closely with the national team of experts in developing the Lao PDR GARPR 2016.

The data gathered in this report were taken from the review of literature of various sources such as the 2016 GARPR Guidelines; Lao PDR GARPR 2015, Global Fund Concept Note, NSAP 2011-2015 and 2016-2020; Lao PDR National HIV Monitoring and Evaluation Strategy and Action Plan 2016-2020 (Draft), Global Fund reports such as the Progress Update Disbursement Request, HIV surveillance reports such as the Integrated Biological and Behavioural Survey (IBBS) 2014, HIV behavioural studies, programme and project reports of various stakeholders involved in HIV and AIDS programmes in Lao PDR. Some data also came from key informant interviews (KII) and focus groups discussion (FGD) with the stakeholders.

Consultations with key agencies were conducted throughout the report preparation process from briefing of the UNAIDS Lao Country and Regional Offices of the 2016 GARP Reporting guidelines, the design of data collection, drafting of research instruments and validation of data and narrative report presented herein. Introductory meetings on 2016 GARP Report process were conducted among the CHAS Team on 10 March 2016, chaired by CHAS Director participated by heads and deputy heads of CHAS Units namely: M&E and Surveillance; Management of HIV, AIDS and STI; IEC; Planning and Cooperation; and Administration among stakeholders on 11 March 2016 by CHAS Deputy Director. Participants on this meeting were: PSI, LaoPHA, APN Plus, PEDA, Lao Red Cross, UNAIDS, FHI360, UNFPA, WHO, UNICEF, USCDC, Global Fund's Country Coordinating Mechanism (CCM) and Principal Recipient (PR), and CHAS.

This report contains the narrative report which details the progress on the data indicators for each of the Ten Targets in the 2011 UN Political Declaration on HIV and AIDS and the National Funding Matrix. The City Indicators and the national core indicators were directly encoded on-line to the AIDSreportingtool@unaids.org The National Composite Policy Index (NCPI) is not part of this report.

A validation meeting at the technical level was conducted on 23 March 2016, chaired by CHAS Director. Participants were: WHO, UNICEF, AusAID, USCDC, ADB, LPN+, French Red Cross, Lao Red Cross LaoPHA, NCA, PEDA, Department of CDC, Department of Planning and international Cooperation, APL+, National TB Centre, National Centre for Laboratory and Epidemiology, CIEH, Medical Product Supply Center, Mahosot Hospital, CHAS M&E and Surveillance Unit Head and staff, CHAS HIV/AIDS and STI Management Unit and staff, CHAS Planning Unit head and staff and CHAS IEC Unit Head and staff. The validation meeting was a venue to verify the veracity of the data and discuss further the recommendations and future actions.

Further revisions were made taking into consideration the comments and recommendations from the different stakeholders.

A validation meeting at the policy level was conducted on 5 April 2016, chaired by the Acting Minister of Education and Sports, Vice-Chair of NCCA and attended by 50 participants, who were members of NCCA, focal points of NCCA, Regional Director of UNAIDS for Asia and the Pacific, and representatives of Departments of MOH.

B. Status of the epidemic

The overall HIV prevalence in the general population aged 15-49 years old of Lao PDR remains low at 0.3% in 2015 but showed an increasing trend from 0.16% in 2003 to 0.3% in 2015, based on the Asian Epidemic Modelling and Spectrum data.[2] The number of PLHIV was estimated at 11,958 in 2015. HIV incidence is estimated to be between 800 and 1000 cases per year.[3]

The 2014 IBBS revealed that the highest prevalence of HIV was found in key affected population (KAP) namely: men who have sex with men (MSM), 1.6% and sex workers (SW) 1.4%.[4] People who inject drug (PWID) was not part of this survey due to limited funding. Cross-border migration in nearby countries in the Greater Mekong Sub-region (GMS) may have contributed to this trend.

The potential threat for concentrated epidemic exists even with the current low rate of HIV prevalence due to the increased cross-border mobility of people contributed by increased trading across countries, especially among the ASEAN Economic Community, better transport system and work-related migration.[5]

Sexual activity was the primary mode of HIV transmission. Heterosexual contact accounted for the majority of HIV transmission at 88% from 1990-2013followed by homosexual contact at 8% and mother to child at 4%.[6] By the end of December 2015, there were 8,168 reported cases of HIV based on AIDS registry. Of which, 3,807 (46.60%) were women and 4,361 (53.39%) were men. Of the 8,168 reported cases, 408 PLHIV were below 15 years of age while 7,760 were above 15 years of age. The total number of the new reported cases in 2015 was 1,096 with 588 (53.64%) males and 508 (46.35%) females. The number of adults under ARV treatment was 3,657 while the number of children under ARV treatment was 222 with a national coverage of 33.91%.[7]

The majority of HIV cumulative cases (83.4%) were identified in border provinces along the Mekong River with Vientiane Capital (40.5 %), Vientiane Province (3%), Savannakhet (21.1%), Champasack (13%), Luangprabang (4.8%) and Khammouane (3.9%).[8] These areas are the most populated where large urban areas are located along the Mekong River. Population of SW and MSM and TGs are highest in these areas. These provinces experience much cross border migration, both for Lao citizen and external migrants. The high amount of

[2] MOH, *Projection Results AEM and Spectrum*, 2015.
[3] MOH, *NSAP 2016-2020*.
[4] MOH, *Integrated Biological and Behavioural Survey (IBBS),* 2014.
[5] MoH, *GARPR, 2015*.
[6] MOH, *Routine Report* 2015.
[7] CHAS, M&E Surveillance Unit, *AIDS Registry*, 2015.
[8] MOH and WHO, *HIV Epidemiologic Review and Impact Analysis,* Lao PDR, October 2014.

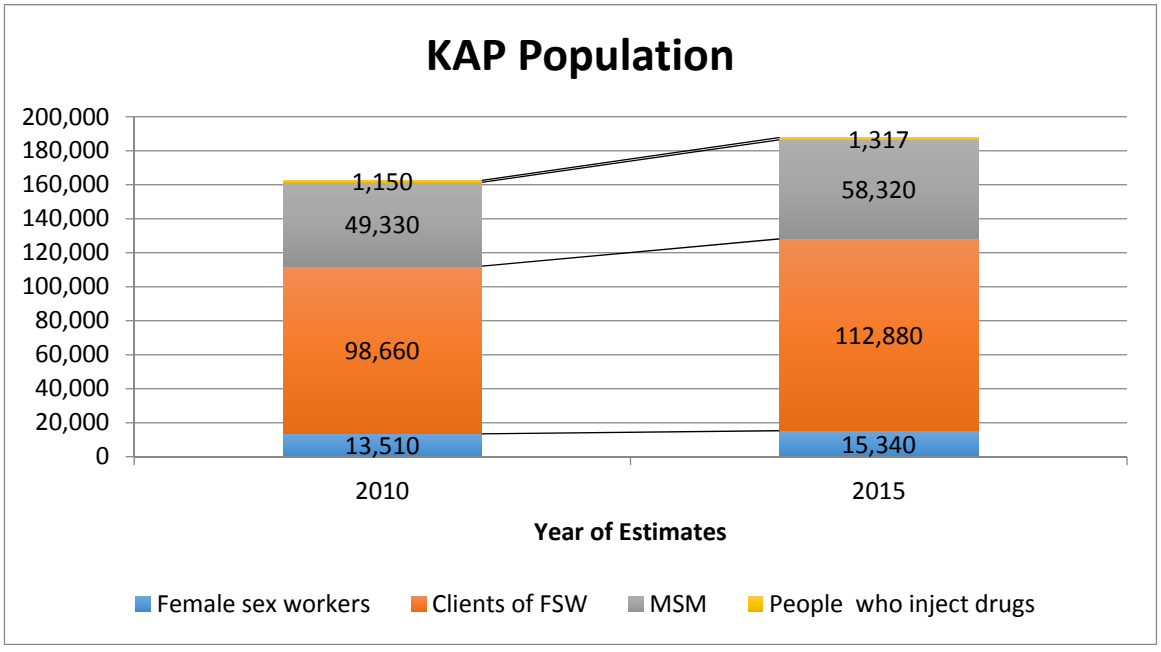
movement across the neighbouring countries with high HIV prevalence highlights the role migration has played and may continue to play in Lao's epidemic.

The number of KAP increased by 15 percent from an estimated number 162,650 to 187,857. This has programmatic implications as it will further stretch the limited budget in providing HIV-related services.

Table 1. Estimated number of key affected population 2010-2015

	Previous[9]		Current[10]	
KAP	**Estimated population size**	**Year of estimate**	**Estimated population size**	**Year of estimate**
Female sex workers	13,510	2010	15,340	2015
Clients of FSW	98,660	2010	112,880	2015
Men who have sex with men (MSM)	49,330	2010	58,320	2015
Includes: High risk MSM	*17,000*	*2011*	*18,810*	*2015*
People who inject drugs	1,150	2010	1,317	2015
Total	162,650		187,857	

Figure 1. Estimated KAP population[11]



[9] *Lao PDR Investment Framework 2013*.
[10] MOH, *Projection Results AEM and Spectrum*, 2015.
[11] Ibid.,

C. Policy and programmatic response

The Government of Lao PDR continued its political commitment supporting the MDGs, which concluded in 2015, wherein HIV is one of the targets for MDG 6 –'to halt and reverse the spread of HIV in the country. It carried out its roles under the Declaration of Commitment at United Nation General Assembly Special Session on AIDS in 2001 to support a multi-sectoral response and Three Zero Strategy (Zero new HIV infections, Zero discrimination and Zero AIDS related deaths), the 2010 Law on HIV andAIDS Control and Prevention (hereafter refers to as the HIV Law), and the 2011 Political Declaration on HIV andAIDS. It developed the NSAP geared towards a focused and result-driven response in combating HIV andAIDS. Both NSAPs 2011-2015 and 2016-2020 are aligned with the National Socioeconomic Development Plan (NSEDP) 2011-2015, the 7th Health Sector Plan and integrate global commitments such as the MDG in its framework.

The country supports the global movement to embark on a fast-track strategy to end AIDS epidemic by 2030. Through rapid scale up of HIV programmes, it will enable to outpace the epidemic by 2030. The strategy is to achieve a target of 90-90-90 for treatment (90% of PLHIV knowing their status, 90% who know their status are receiving treatment, and 90% of those on treatment having a suppressed viral load) by 2020 and further increase these to 95-95-95 by 2030.

The implementation of the NSAP 2011-2015 and the Law on HIV and AIDS Control and Prevention, together with the development of the new NSAP 2016-2020, showed the Lao Government political commitment and support in responding to the HIV epidemic.

The goals identified in the NSAP 2011-2015 have been achieved. First is to maintain the present low level of HIV prevalence in the general population (15-49) below 1%. Estimated data based on AEM on HIV prevalence among the genral population aged 15-49 years of age was a low 0.3%. The second goal is to ensure HIV seroprevalence among KAP is lower than 5%. Actual data pointed to a prevalence rate of less than 3%. These goals were maintained in the new NSAP 2016-2020. Lao PDR aims to further reduce the HIV prevalence among KAP to below 3% while maintaining HIV prevalence among general population below 1%. This is proposed to be achieved by scaling up the national response in order to minimise the impact of HIV and AIDS on socioeconomic development and improving the quality of life of people infected with and affected by HIV. The national response will include increased coverage and quality of HIV prevention services, resulting in 60-85% coverage of most-at-risk populations, increase coverage and quality of HIV treatment, care and support services, resulting in 95% coverage of people in need of ART, and a treatment dropout rate of less than 10%, and, improved national programme.

D. Indicator data in an overview table

Table 2. Summary of indicators

GARP 2015 #	GARP 2016 #	GARP Reporting Indicator	Source	Value	Remarks
Target 1 – Reduce sexual transmission of HIV by 50% by 2015					
		HIV prevention among general population			
1.1	1.1	Young people: knowledge about HIV prevention *Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	LSIS 2011-2012	All: 25.13% Males: 27.64% Females: 23.98%	No updated data available since previous reporting
1.2	1.2	Young people: sex before the age of 15 *Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15*	LSIS 2011-2012	All: 5.24% Males: 2.72% Females: 6.40%	No updated data available since previous reporting
1.3	1.3	Multiple sexual partnerships *Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months*	N/A	N/A	N/A
1.4	1.4	Condom use at last sex among people with multiple sexual partnerships *Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse*	N/A	N/A	N/A

1.5	1.5	People living with HIV who know their status* *Percentage of people living with HIV who know their status (including data from case-based reporting)*	VCT Routine Report 1990-2015	All: 56.1% Males: 53.2% Females: 59.5% City-level data: VTC: 54.1% CPS: 52.2% SVK: 80.0%	
1.6	1.6	HIV prevalence from antenatal clinics, by age group* *HIV prevalence among women attending antenatal clinics in the general population **	MCH ANC, CHAS	0.24% City-level data: VTC: 0.29% CPS: 0.19% SVK: 0.18%	
1.20	1.20	HIV incidence rate* *Number of new HIV infections in the reporting period per 1000 uninfected population*	AEM/Spectrum 2015	0.13% City-level data: NA VTC: CPS: SVK:	
		Key populations			
2.9	**2.1**	Size estimations for key populations	AEM/Spectrum 2011-2015	SW: 15,340 MSM: 58,320 PWID: 1,317 Client SW: 112,880 High risk MSM: 18,810 Total: 187,857	
		Sex workers			
2.10	2.2	Sex workers: condom use *Percentage of sex workers reporting the use of a condom with their most recent client*	IBBS 2014	Female: 92.7% <25: 93.1% 25+: 90.8% City-level data: VTC: 92.6% CPS: 96.3% SVK: 93%	

2.11	2.3	HIV testing in sex workers *Percentage of sex workers who have received an HIV test in the past 12 months and know their results*	IBBS 2014	Female: 38.0% <25: 36.6% 25+: 44.3% City-level data: VTC: 60.3% CPS: 39.3% SVK: 52.2%	
2.12	2.4	HIV prevalence in sex workers *Percentage of sex workers who are living with HIV*	IBBS 2014	All: 1.40% <25: 1.3% 25+: 1.9% City-level data: VTC: 1.7% CPS: 1.0% SVK: 1.7%	
		Men who have sex with men			
2.13	2.5	Men who have sex with men: condom use *Percentage of men reporting the use of a condom the last time they had anal sex with a male partner*	IBBS 2014	All: 44.4% <25: 43.7% 25+:47.8% City-level data: VTC: 41.7% CPS: 52.0% SVK: 51.2%	
2.14	2.6	HIV testing in men who have sex with men *Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results*	IBBS 2014	All: 18.1% <25: 16.2% 25+: 27.7% City-level data: VTC: 28.8% CPS: 11.9% SVK: 6.3%	
2.15	2.7	HIV prevalence in men who have sex with men *Percentage of men who have sex with men who are living with HIV*	IBBS 2014	All: 1.6% <25: 0.9% 25+: 4.7% City-level data: VTC: 3.9% CPS: 1.1% SVK: 1.0%	
Target 2 – Reduce transmission of HIV among people who inject drugs by 50% by 2015					
		People who inject drugs			

2.16	2.8	Needles and syringes per person who inject drugs *Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programmes*			Programme intervention on PWID not in place
2.17	2.9	People who inject drugs: condom use *Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse*			Programme intervention on PWID not in place
2.18		People who inject drugs: safe injecting practices *Percentage of people who inject drugs reporting the use of sterile injecting*			Programme intervention on PWID not in place
2.19	2.11	HIV testing in people who inject drugs *Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results*			Programme intervention on PWID not in place
2.20	2.12	HIV prevalence in people who inject drugs *Percentage of people who inject drugs who are living with HIV*			Programme intervention on PWID not in place
2.21	2.13	Opioid substitution therapy coverage *Percentage of people who inject drugs receiving opioid substitution therapy (OST)*			Programme intervention on PWID not in place
		Prisoners			
2.22	2.14	HIV prevalence in inmates/detainees* *Percentage of inmates/detainees who are living with HIV*			Programme intervention on PWID not in place
		Transgender people			
2.22		HIV prevalence in transgender people* *Percentage of transgender people who are living with HIV*			TG was included as part of MSM
Target 3 – Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths					
		Prevention of mother-to-child transmission (PMTCT)			

3.12	3.1	Prevention of mother-to-child transmission *Percentage of HIV-positive pregnant women who received antiretroviral medicine (ARV) to reduce the risk of mother-to-child transmission*	MCH ANC ART Site	11.2%	Services are integrated to other health programmes and data are still being processed and verified
3.3	3.2	Early infant diagnosis *Percentage of infants born to HIV-positive women receiving a virological test for HIV two months of birth*	MCH ANC ART Site, Meriux	26.2%	Services are integrated to other health programmes and data are still being processed and verified
3.3	3.3	Mother-to-child transmission of HIV *Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months*	MCH ANC ART Site	34.4%	Services are integrated to other health programmes and data are still
3.3a	3.3a	Programme-level mother-to-child transmission of HIV *Registered percentage of child HIV infections from HIV-positive women delivering in the past 12 months*			Services are integrated to other health programmes and data are still being processed and verified
3.4	3.4	PMTCT testing coverage *Percentage of pregnant women with known HIV status*			Services are integrated to other health programmes and data are still being processed and verified
3.5	3.5	Testing coverage of pregnant women's partners *Percentage of pregnant women attending antenatal clinics whose male partners were tested for HIV during pregnancy*			Services are integrated to other health programmes and data are still being processed and verified
3.7	3.7	Coverage of infant ARV prophylaxis *Percentage of HIV-exposed infants who initiated ARV prophylaxis*	ANC ART Sites, CHAS	0.5%	
3.9	3.8	Co-trimoxazole (CTX) prophylaxis coverage *Percentage of HIV-exposed infants started on CTX prophylaxis within two months of birth*	ANC ART Sites, CHAS	0.5%	
Target 4 – Have 15 million people living with HIV on antiretroviral treatment by 2015					

		Treatment			
4.1	4.1	HIV treatment: antiretroviral therapy *Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV*	ART Site, CHAS	All: 33.9% <15: 24.1 % >15: 34.8% City-level data: VTC: CPS: SVK:	
4.2	4.2	Twelve-month retention on antiretroviral therapy *Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy*	ART Site, CHAS	All: 83.6% <15: 92.3 % >15: 83% City-level data: VTC: 88.2% CPS: 93.2% SVK: 71.8%	
4.2a	4.2a	Twenty-four-month retention on antiretroviral therapy *Percentage of adults and children with HIV known to be on treatment 24 months after initiation of antiretroviral therapy in 2013*	ART Site, CHAS	81.1%	
4.2b	4.2b	Sixty-month retention on antiretroviral therapy *Percentage of adults and children with HIV known to be on treatment 60 months after initiation of antiretroviral therapy in 2010*			No data yet
4.3	4.3	HIV care coverage* *Percentage of people currently receiving HIV care*	ART Site, CHAS	38.4%	
4.4	4.4	Antiretroviral medicines (ARV) stock-outs *Percentage of facilities with stock-outs of antiretroviral medicines*	ART Site, CHAS	100%	
4.5	4.5	Late HIV diagnoses *Percentage of HIV-positive persons with first CD4 cell count < 200 cells/µL in 2015*	ART Sites, CHAS	All: 53.2% <15: 25.9% >15: 54.3%	

4.6	4.6	Viral load suppression* *Percentage of adults and children receiving antiretroviral therapy who were virally suppressed in the reporting period (2015)*	ART Sites, CHAS	74.1% City-level data: VTC: 84.0% CPS: 83.7% SVK: 83.8%	
4.7	4.7	AIDS-related deaths* *Total number who have died of AIDS-related illness in 2015*	ART Sites, CHAS	All: 128 <5: 0 5-14: 1 15+: 127 City-level data: VTC: 26 CPS: 39 SVK: 37	
Target 6 – Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22-24 billion in low- and middle-income countries					
		AIDS Spending			
6.1	6.1	AIDS Spending *Domestic and international AIDS spending by categories and financing sources*		Domestic: US$ 2,511,495 International US$ 5,471,931	
Target 7 – Eliminating gender inequalities					
		Gender			
7.1	7.1	Prevalence of recent intimate partner violence *Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months*	National Study on Women's Health and Life Experiences 2014	4.0% 3.1% 6.0%	Physical Violence Sexual Violence Physical and/or sexual violence
Target 8 – Eliminating stigma and discrimination					
		Stigma and discrimination			
8.1	8.1	Discriminatory attitudes towards people living with HIV *Percentage of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV*			

Target 9 – Eliminate travel restrictions					
		Travel restrictions			
		Travel restrictions data are collected directly by the Human Rights and Law Division at UNAIDS headquarters and, therefore, no reporting is needed.		ACHIEVED	No travel restrictions
Target 10 – Strengthening HIV integration					
		Health systems integration			
10.2	10.2	External economic support to the poorest households *Proportion of the poorest households who received external economic support in the past three*			Proportions undetermined but support is provided by self-help groups, LaoPHA
Target 5 – Reduce tuberculosis deaths in people living with HIV by 50% by 2015					
		HIV and other diseases			
		Tuberculosis			
11.4	11.1	Co-management of tuberculosis and HIV treatment *Percentage of estimated HIV positive incident TB cases that received treatment for both TB and HIV*	WHO estimation TB incidence estimate 2014	55.2%	
11.5	11.2	Proportion of people living with HIV newly enrolled in HIV care with active tuberculosis (TB) disease *Total number of people living with HIV having active TB expressed as a percentage of those who are newly enrolled in HIV care (pre-antiretroviral therapy or antiretroviral therapy) during the reporting period*	ART Sites, CHAS	20.5% City-level data: VTC: 22.3% CPS: 20.9% SVK: 20.1%	
11.6	11.3	Proportion of people living with HIV newly enrolled in HIV care started on tuberculosis (TB) preventive therapy *Number of patients started on treatment for latent TB infection, expressed as a percentage of the total number newly enrolled in HIV care during the reporting period*	TB Center	12.7% City-level data: VTC: 0.2% CPS: 38.6% SVK: 40.3%	

		Hepatitis			
11.7		Hepatitis B testing *Proportion of persons in HIV care who were tested for hepatitis B virus (HBV)*			there are no data on compolsary testing since there is no funds allocated for reagents
11.8		Proportion of HIV-HBV coinfected persons currently on combined treatment			there are no data on compolsary testing since there is no funds allocated for reagents
11.9		Hepatitis C testing *Proportion of people in HIV care who were tested for hepatitis C virus (HCV)*			there are no data on compolsary testing since there is no funds allocated for reagents
11.10		Proportion of persons diagnosed with HIV-HCV infection started on HCV treatment during a specified time frame (e.g. 12 months)			there are no data on compolsary testing since there is no funds allocated for reagents
		Sexually transmitted infections			
11.11		Syphilis testing in pregnant women *Percentage of pregnant women accessing antenatal care services who were tested for syphilis*			
11.12		Syphilis rates among antenatal care attendees *Percentage of antenatal care attendees who were positive for syphilis*			National level data are not available. Data are collected and reported in select programme sites only.
11.13		Syphilis treatment coverage among syphilis-positive antenatal care attendees *Percentage of antenatal care attendees positive for syphilis who received treatment*			National level data are not available. Data are collected and reported in select programme
11.14		Congenital syphilis rate (live births and stillbirth) *Percentage of reported congenital syphilis cases (live births and stillbirths)*			National level data are not available. Data are collected and reported in select programme

11.15		Men with urethral discharge *Number of men reporting urethral discharge in the past 12 months*			National level data are not available. Data are collected and reported in select programme
11.16		Genital ulcer disease in adults *Number of adults reported with genital ulcer disease in the past 12 months*			National level data are not available. Data are collected and reported in select programme

* New GARPR indicators for 2016

**Male circumcision indicators not included

Items in the Summary of Indicators table with N/A notations represent missing data that can be any of the following reasons:

- National level data are not available. Data are collected and reported in select programme sites only.
- No specific programme tracking is in place, e.g. indicator on 60-month retention for ART
- No programme being implemented related to the indicator, e.g. Hepatitis indicators wherein there are no data on mandatory testing since there is no funds allocated for reagents
- Services are integrated to other health programmes and data are still being processed and verified, e.g. PMTCT data that will be provided by MCHC ANC clinics.

It is of utmost concern that all fields be completed by the MESU. Hence, the following recommendations were submitted by the Consultant to improve GARP Reporting:

- *MoH and M&E need to have ownership on the indicators being collected for GARP reporting. It is important that the indicators are readily available come reporting time. This can only happen if they see the value of the indicators that they collect. They should also see how each of the indicators is used in their programme planning, decision-making and assessments. While there are a lot of GARP indicators that are tracked, there are also a number of indicators that are not reported due to limited data sources or data are not available nationally. There are missed opportunities if data collection and reporting is not standardized because there may be programme needs that are not identified or good practices in one area that is not scaled up.*

- *Disseminate result and translate the knowledge into actions. The most important thing in making the GARP indicators compiled in a report, validated by programme implementers and other stakeholders and disseminated locally and globally is if that knowledge is translated into advocacy and action towards improving service delivery. Disseminating the result of this exercise is important to gain attention to further discuss issues faced by the country as a whole or for specific provinces or KAPs. Further analyzing indicators that raise red flags are needed to immediately craft stopgap solutions and*

address the problems in the long-term. This is also particularly critical in prioritizing projects for funding allocation. For the rest of the indicators that do not require immediate actions, integrating improved services into the health system is more sustainable to ensure the services are available.

Intimate partner violence as related to indicator 7.1

National Study on Women's Health and Life Experiences 2014 was conducted to collect much needed evidence to develop an effective policy-making response to the issue. This study, adopting the methodology of the WHO Multi-country Study on Women's Health and Domestic Violence against Women, was led by the NCAW and LSB with support from UNFPA and UN Women. Results showed the following: Among ever-partnered women, 11.6% experienced physical violence in their lifetime and 4.0% in the past 12 months (current violence); Among ever-partnered women, 7.2% experienced sexual violence in their lifetime and 3.1% in the past 12 months; and physical and/or sexual violence was experienced by 15.3% of ever-partnered women in their lifetime and 6.0% in the past 12 months.[12]

[12] NCAW, *Lao National Survey on Women's Health and Life Experiences Study on Women's Health and Life Experiences 2014, A Study on Violence Against Women*, 2015.

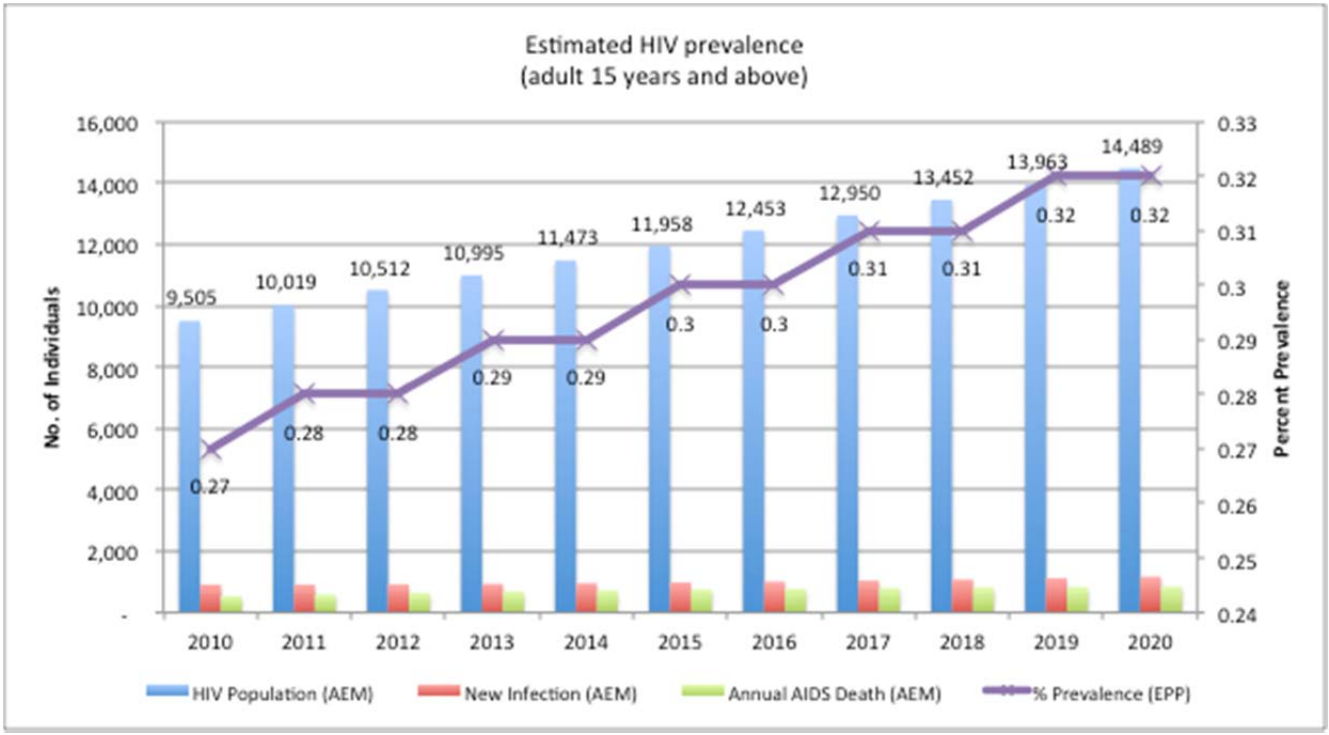
II. Overview of the AIDS Epidemic

This section presents the status of the HIV prevalence in the country during the period January - December 2015 based on the latest studies and projections.

A. HIV prevalence in the general population

The national adult HIV prevalence is at 0.3% among 15-49 years old based on the projections using the AEM Projection Model. Figure 2 presents the estimated number of PLHIV from the general population in 2015 at 11,958 adults.

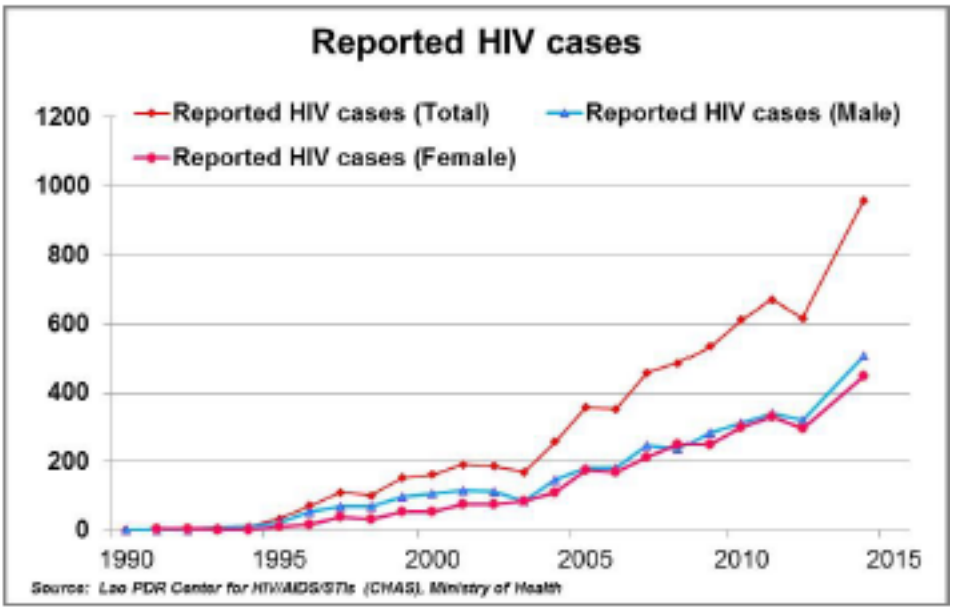
Figure 2. Estimated HIV prevalence[13]



The new HIV cases reported increased significantly in the past three years from 679 in 2013 to 834 in 2014 to 1,096 in 2015 based on AIDS Registry. However, the AEM projection showed a diminishing estimated number of new HIV infection from 1,057 in 2014 to 957 cases in 2015.

[13] MOH, *Projection Results AEM and Spectrum*, 2010-2020.

Figure 3. Reported HIV cases[14]



The total number of deaths reported from 107 in 2014 increased to 133 in 2015 as reported in the AIDS Registry. The AEM estimates showed a significantly higher projection reaching as much as 725 annual AIDS death in 2014 and taper to 481 in 2015. The number of deaths may be due to increasing number of PLHIV coming late for the diagnosis (53.20%), either stage 3 or 4 under WHO Clinical Classification or CD4 count less than 200.[15]

There was an increasing number of PLHIV receiving ART for the period of 2013-2015. In 2013, there were 2,787 both children and adults receiving ART; in 2014 there were 3,336 (children and adults) while in 2015 there were 3,879 receiving ART both children (222) and adults (3657).

B. HIV prevalence among key affected populations

The estimated number of most-at-risk population in 2015 was 187,857, according to the AEM and Spectrum software models. The individuals most-at-risk for HIV infection were FSW, MSM, PWID, and clients of SW. Their population is gradually increasing with males engaging in casual sex as the biggest cohort.

[14] UNDP, *Country Analysis Report: Lao PDR,* 2015. Available from http://www.la.undp.org/content/dam/laopdr/docs/Reports%20and%20publications/2015/Country%20Analysis%20Report%20Lao%20PDR%202015.pdf.

[15] CHAS M&E and Surveillance Unit, *HIVCAM Record*, 2015.

1. Female sex workers (FSW)

The number of FSW slightly increased from 14,814 in 2014 to 15,340 in 2015 in Lao PDR.[16] The latest IBBS report showed an increasing prevalence among FSW at 0.4% in 2008, 1 % in 2011 to 1.4 % in 2014.[17]

2. Men who have sex with men (MSM)

MSM contributes the largest group among the most-at-risk population with an estimated 58,320 men in 2015, up from 56,200 in 2014.[18] A sub-group of these MSM is the high-risk MSM which is estimated to be 18,810 men. The government aims to maintain HIV prevalence among this group to be under 3%. This is achievable as the current IBBS 2014 data showed a prevalence of 1.6%. IBBS 2014 did not disaggregate MSM, TG was part of the MSM

3. Persons who inject drugs (PWID)

The number of PWID can be seen as negligible compared with other most-at risk groups with an estimated number of 1,317 injecting drug users in the country in 2015 based on the AEM model. In 2011, HIV prevalence of PWID was 0.1%. (2011)[19]. Two bordering provinces with Viet Nam, Houaphanh and Phongsaly, were monitored for possible concentrated epidemic among PWID. The prevalence of HIV in these provinces is relatively low, being less than 1%. No data is available on prevalence except for the 17% prevalence rate registered from among a sample of PWID identified in 2010 rapid assessment. In VTC, FSW who reported injecting drugs had an HIV prevalence of 12.5%.[20]

4. Persons with multiple sex partners

Certain sub-groups of the general population are more vulnerable to engaging in multiple sexual partnerships, which increase their chance to get HIV infection. Such risk behaviours can be observed among those whose jobs require frequent travelling, such as military, truck drivers, and water or electricity workers, and have a tendency to seek services of sex workers. Migrants and mobile population are at higher risk for HIV infection and engage in sex work either as providers or consumers of sex. A high proportion of new HIV cases were reported in border provinces along the Mekong River.

[16] MOH, *Projection Results AEM and Spectrum*, 2014.
[17] MOH, *IBBS FSW* - 2014, slide 51.
[18] MOH, *Projection Results AEM and Spectrum*, 2015.
[19] MOH, *IBBS – PWID,* 2011
[20] MOH, *IBBS FSW* - 2014, slide 51.

5. Young people

Lao PDR has a young population with a majority (60%) of its six million inhabitants belonging to the under 25 years age bracket. A third (30%) of the population are between 10 and 24 years indicating that young people constitute a large proportion of the country's population.[21]

Youth are faced with rapid economic growth, which also influences cultural and societal norms. These play a role on the risk behaviours among the youth, especially those which relate to health. Work migration is becoming a trend and youth are predispose to migrate to look for job or education opportunities elsewhere. With increased mobility, there is a higher chance of exposure to infectious diseases and other health risks, such drug, such as yabba, and alcohol abuse. These risk behaviours are associated with higher likelihood of overall health risks and getting infected with HIV.

Lao PDR has the highest adolescent pregnancy rates in the region, as early child bearing is a common scene. Early exposure to sex coupled with risk-taking sexual behaviours such as non-use of condom and having multiple sexual partners increase the risk to contract HIV.

Knowledge on HIV is high with 80% of young people aged 15-19 years reported having heard about HIV/AIDS, although levels of comprehensive knowledge about HIV-transmission are low. Two studies pointed that less than one quarter of young people aged 15-19 years had a comprehensive knowledge about HIV/AIDS.[22, 23]

According to the study, reported rates of HIV are low but the prevalence of sexually transmitted infections (STIs) is high, including chlamydia and gonorrhoea.[24] It is important to track incidence of STI as this may increase the transmission and susceptibility to HIV infection. Getting the information out and providing access to services and products remain a challenge. There is a lack of or limited access to adolescent and youth-friendly sexual and reproductive health counselling and information, high cost of services, negative attitudes of health workers, stigma and discrimination, and lack of confidentiality discourage youth to seek health services and information.

[21] LYU and UNFPA, *Adolescent and Youth Situation Analysis Report*.
[22] UNICEF and MOE. *Assessment Life-Skills Based Curriculum Project in Lao PDR. Scaling up the response for Children*, 2009. As cited in LYU and UNFPA, *AYSA Report*, 2014, p.IX.
[23] Thanavanh B, Harun-Or-Rashid M, Kasuya H, Sakamoto J., *Knowledge, attitudes and practices regarding HIV/AIDS among male high school students in Lao People's Democratic Republic*: J Int AIDS Soc.,16: p.17387, 2013. As cited in LYU and UNFPA, *AYSA Report*, 2014, p. IX.
[24] Ibid.

III. National Response to the AIDS Epidemic

The 2016 Global AIDS Response Progress Reporting is the last reporting round for the 2011 Political Declaration. It is the transition reporting round for AIDS-related targets in the MDGs and the SDGs._This provides an opportunity for the National AIDS Authority and its partners to review the achievements and challenges that capped the past five years of the HIV programme implementation set under the NSAP 2011-2015 targets. As the NSAP 2016-2020 had been developed, this Report will provide the baseline for monitoring the UN declaration targets for HIV envisaged to be set in June 2016. The identified challenges and constraints, and recommended actions in this Report will be used to accelerate achievement of the targets for the SDG.

The NCCA leads the HIV programme while the CHAS in the Department of Communicable Disease Control, MoH is responsible to manage and coordinate the national response. At the provincial and district level, multi-sectoral Provincial Committee for the Control of AIDS (PCCA) and District Committee for the Control of AIDS (DCCA) are responsible for the implementation and coordination of activities at the local level.

The CSOs were involved in revising the National Policy on HIV or the HIV Law. The Law has been widely disseminated at the provincial and district levels reaching mostly the officials of the PCCA, DCCA, mass organisations, ministries, and community leaders, but not the community in general. The Lao PDR Parliament has been active in the dissemination of the Law.[25]

Some of the revisions noted in the HIV Law were reaching more population groups such as people who use drugs (PWUD), PWID, and transgender (TG). These will be in addition to the current efforts of reaching out to high-risk groups such as SW and MSM. Other provision in the revision of the Law is to increase access to health care services at all levels, national, provincial, district in order to serve of those who need it most. This means increasing number of facilities providing antiretroviral therapy (ART) thus responding to the growing need of PLHIV who need the antiretroviral (ARV) drugs as well as drugs for opportunistic infections.

A. Prevention

The prevention, care, treatment and support services are embedded in the national HIV response. The NSAP 2016-2020 aims to ensure the response to HIV is sustainable. The government strives to provide an enabling environment to PLHIV to live normal lives making available services in all levels of the health system at the national, provincial, district, and village-level health facilities.

HIV testing and counseling (HTC) services have been scaled up to 170 sites in 17 provinces and ART services are now available in 10 sites in seven provinces. Despite the fact that more PLHIV are receiving ART, monitoring data suggests that achieving 90-90-90 targets by 2030 will be a challenge. The ability to achieve epidemic control in Lao PDR is constrained by an HIV health system that does not provide an integrated continuum of prevention, HTC, care, treatment, and support services that respond to the needs of priority populations, such as MSM and TG and their partners. Despite the substantial investment for providing HTC

[25] Civil Society Organizations, focus group discussion, March 2016. Vientiane, Lao PDR.

services in Lao PDR , there has been little effort to systematically evaluate the quality of HTC services provided by various types of health providers.

1. Prevention programmes

HTC services had been scaled up to 170 sites in 17 provinces. Prevention programme spans an extensive network of governmental mass organizations, namely, LYU, Lao Women's Union, Lao Trade Union, that supports planning and implementation of HIV/AIDS activities from the central to the village level.

CSOs expanded their coverage among the KAP to include TG and PWID in addition to the SW and MSM. Outreach activities were conducted among KAP to create awareness and understanding on HIV and AIDS, STI, condom use (including condom distribution), the provision of HTC and ARV drugs, and where to access these services. CSOs working with KAP are FHI 360 and LaoPHA for MSM, PEDA for FSW and PSI for MSM/TG, and FSW.

The CSOs, including the self-help groups, encourage PLHIV not to infect others in order to help reduce the transmission of new HIV infections through prevention programmes and caring for PLHIV without stigma and discrimination. *(The HIV Law, under Article 69: Criminal Measures, provides that it is a criminal offence for a person to deliberately spread HIV infection to others.)*

In 2015, the number of HIV test performed in VCT sites increased to 85,703 with 84,154 receiving their results (98.14%) while in 2014, the number of HIV test performed was 58,745 with 56,853 received their results (96.77%).

HTC had been expanded during the past six years with the current number of testing sites totalling to 165 in 2013 to 170 in 2015. Provider-initiated treatment and counseling (PITC) was given to patients with HIV-suspected symptoms, TB and STIs patients, and pregnant women. The three rapid HIV tests were approved with the algorithm developed and the validation study conducted. This will be included in the national testing guidelines as part of quality assurance to improve services of these facilities.

The National Center of Laboratory and Epidemiology (NCLE), with assistance from WHO, is validating WHO recommendation changing from two to three HIV testing algorithm, due to low HIV prevalence < 5%. The new 3-test algorithm is estimated to be rolled out in 2017, tapping Global Fund resources to procure the test kits. Capacity building for lab technicians are needed to ensure the quality of the 3-test algorithm.[26]

a. General population

Integration of HIV-related services into the existing health system was done to ensure access of the general population to important services. Training of health care staff was an ongoing initiative. Due to funding limitation, extensive prevention initiatives were concentrated in reaching KAP. Special programmes for vulnerable groups such as migrant workers were implemented in key locations such as cross-border provinces. Other activities were done targeting the young people.

[26] President's Emergency Plan For Aids Relief, *2016 Sustainability Index and Dashboard Summary: Lao PDR*.

Condom programming. Population Services International (PSI) Laos played a major role in condom distribution in Lao PDR. The social marketing program implemented by PSI Laos distributed a total of 19,498,726 pieces of condoms for the period of 2011-2015. Of the total number distributed during that period, 3,188,008 pieces were distributed for free to key affected populations (SW, MSMs, TGs, PWID) at the worksite like entertainment establishments, drink shops, karaoke bars, hotel and motels, etc., while for the general population, the distribution was done during special events such as World AIDS Day Celebration, Thatluang Festival and other special events.[27] In 2015, 8.5 million pieces of condoms were procured and arrived the country in mid-June 2015. PSI contracted out 3.2 million pieces to DKHS, a local distribution company, for CSM. Out of this number only 2 million was sold out and 1.2 million pieces was returned to PSI by the end of December 2015. The free condom distribution was conducted by PCCA (300,000 pieces) while the 700,000 pieces was distributed by by the peer-led outreach through the CSOs, The remaining 5 million of the 8.5 million pieces of condoms is currently with CHAS and planned to be distributed in the next years.[28]

HIV testing and counseling. There were 170 VCT sites with 85,703 tested and 84,154 knew their results (98.19%) in 2015.[29] External quality assurance (EQA) for HIV testing in VCT sites in three priority provinces were scaled up. More than 40 VCT sites were covered in the first round of EQA for HIV testing with results sent back to the national laboratory this year. However, nearly half of the participating VCT sites, mostly Savannakhet and Champasak, were not able to send back the results to NCLE. The low turnout of results being returned to NCLE was due to the lack of contact person for the EQA performance in the designated sites. The next round of EQA will cover provincial and district hospitals, mainly from Vientiane capital, Savannakhet and Champasak by March 2016. A training workshop on the SOP for EQA will conducted on May 2016.[30]

b. Female sex workers

HIV prevalence among FSW was at 1.4%.[31] within the target of under 3%. Data from IBBS 2011 showed a coverage of 55%. IBBS 2014 showed a decline with 37.9% coverage. Programme reports, which include government and development partners-initiated programmes, showed a higher percentage coverage in 2015 with a total of 11,154 SW reached or 85% coverage against the target of 13,039 (representing 85% of all estimated SW).

Condom programming. The government targets to reach 80% of SW to practice consistent condom use with their clients. IBBS data showed that percentage of SW reporting consistent condom use was 92% in 2011 IBBS and 92.7 % in IBBS 2014.

HIV testing and counseling. In 2015, there were 3,794 SW tested for HIV and 3,793 (99.97%) received their results. All those found positive were referred to ART sites.

Diagnosis and treatment of STI. NSAP2016-2020 aims to provide access to quality assured STI services to at least 80% of SW. A new strategy has been adopted in 2016 under the Global Fund New Funding Model to address the decreasing number of SW reached by prevention programme wherein permanent peer educators

[27] Interview with Mr. Sihamano, PSI Laos, Communications Manager, 24 March 2016.
[28] Interview with Dr. Khanthanouvieng Sayabounthaboung, CHAS Deputy Director, 10 March 2016.
[29] Ibid.
[30] WHO, *Lao PDR Progress Report*, March 2016.
[31] MOH, *IBBS,* 2014. As cited in MOH, *NSAP 2016-2020*,

has been employed at the DIC and mobile peer educator to prevent rapid staff turnover and ensure continuity of services and follow-ups.

c. Men who have sex with men (MSM)

MSMs were reached with prevention programmes through peer-led interventions, DIC, HIV and STI testing and counselling as well as referral to ART. Prevention services for MSM were implemented in 10 priority provinces. NSAP 2011-2015 targets to reach 80% of estimated MSM or 46,656 MSMs of the total 58,320 MSMs. Programme reports showed coverage of 6,046 MSM, which is 13% achievement against target (representing 10.4% of all MSM). IBBS 2014 data showed a lower distribution of coverage at only 4.1%.

USAID, through Family Health International 360 (FHI 360), supports programmes for MSM/TG, transgender women, male sex workers (MSW), and transgender sex workers. It implements the Linkages across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) Project in the three provinces of the country with the highest HIV burden, Vientiane, Savannakhet, and Champasak, offering targeted interventions to strengthen the ability of partner governments, civil society, and private-sector providers to deliver comprehensive, high-quality HIV prevention, treatment, and care services to these populations. It aims to strengthen the enhanced peer mobilizer model (EPM) and the Social Network Strategy (SNS); strengthen the test for triage approach, which is embedded in the EPM model, using rapid oral HIV testing; strengthen care and support activities at the community level to provide support services on retention to clinical service, adherence to treatment, and prevention for HIV-positive people; continue to support and reinforce a cloud-based system using a CommCare system to strengthen linkages in the HIV cascade through real-time communication; establish an M&E system for LaoPHA and LINKAGES Laos, which will be linked to the national system; continue to support quarterly meeting to update partners on HIV cascade data usage in the three priority provinces; and, instill gender-related activities to improve quality of care from a gender perspective.

To date, the KP reached expended and the uptake of KPs into the continuum of care increased due to the EPM. This model engages community-based supporters. In the last quarter of 2015, the test for triage approach using HIV oral fluid (OraQuick) screening was introduced at community level. This facilitates a fast and effective strategy to recruit KPs on HTC. In addition, data report from LINKAGES was successfully merged with the data from the national database (HIVCAM) with the support of U.S. CDC. They also conducted community consultations on PrEP among MSM and TG women in Champasak and Savannakhet in collaboration with LaoPHA and CHAS.

Condom programming. Free condoms were continuously being provided with the Global Fund support. In 2015, around 619,120 pieces of condoms was targeted to be distributed to MSM at an average of 109 condoms per MSM per year. The actual number of condom distributed was 338,579, with 54.7% achievement. Despite this low turnout, the figure was higher than the previous year.[32] Consistent condom use with non-regular partners had fallen substantially from 37% to 11% based on IBBS results in 2009 and 2014.

HIV testing and counseling. In 2015, there were 1,294 MSM tested for HIV and 1,294 (100%) received their results. All those found positive were referred to ART sites. IBBS 2014 data showed that only 18.1% of MSM

[32] Global Fund/CHAS, Progress Update Disbursement Request, 2015.

received HIV test and know the result in the last 12 months. This is far from the target coverage of 80% for HTC.[33]

Facility-based interventions were tapped to provide counselling, testing and referral services aimed to capacitate counsellors on HIV counselling and testing for MSM. Skills included learning to identify MSM, encouraging them to undergo HIV testing, and recording of client profiles, especially STI patients. More than 20 counsellors from central and districts hospitals were trained in Vientiane Capital. Increasing HTC among MSMs was a challenge because HTC health providers were mostly from ANC clinics; thus, they were not exposed to MSM cases. Similarly, it would be unlikely for MSM to visit ANC clinics such that it was very rare that MSMs were reported to the national HIV/AIDS programme of receiving HIV testing from districts. Innovative solutions were needed to promote HTC among MSMs like engaging communities in VCT site to increase HTC among KAPs. It was also learned that health providers, having limited exposure in handling MSM, would benefit most from having small group trainings to have more practice in providing HTC. The upcoming training will be held on September in Savannakhet and Champasak.

Diagnosis and treatment of STI. Referral system was strengthened with focus on capacitating local health facilities and drop-in centres to screen and manage STI cases. Peers were tapped to refer clients for STI screening and treatment. NSAP2016-2020 aims to provide access to quality assured STI services to at least 80% of SW. A new strategy has been adopted in 2016 under the Global Fund New Funding Model to address the decreasing number of SW reached by prevention programme wherein permanent peer educators has been employed at the DIC and mobile peer educator to prevent rapid staff turnover and ensure continuity of services and follow-ups.

Those peers with signs and symptoms are referred and accompanied by peer educators to health care facility either a district or provincial hospital or a drop-in-centre if available for further diagnosis and treatment. Information about HTC is provided by the mobile peer. The peer educators also accompanies and refers the peer to the nearby VCT site with the use of the referral form. Condom activity includes the need to use condom consistently and correctly, in every sexual act to prevent HIV or STI transmission, condom demonstration and provision of condoms for the peers.

d. People who inject drugs

PWID remains a subgroup that should be closely monitored. In 2011[34], the HIV prevalence was 0.1%. There were no new data on PWID in 2015.

Harm reduction. The harm reduction pilot programmes in the provinces of Houaphanh and Phongsaly initially supported by the Australian Government (DFAT) was continued by the ADB. In 2011, the Needle and Syringe Assistance Programme (NSAP) commenced to address the HIV burden from sharing of unsterile injecting equipment. It is the only community-based health outreach in the country that is managed by former and current drug users at village level catering to both Lao and Vietnamese clients. It assists vulnerable groups and their families living in 24 villages, including five health centers and 152 PWID clients, in four target districts in Houaphanh and Phongsaly provinces. [35]

[33] MOH, *NSAP 2016-2020*, p. 32.
[34] IBBS 2011.
[35] ADB, *Technical Assistance Consultant's Report - Regional: Greater Mekong Subregion Capacity Building for HIV/AIDS*

The government is currently negotiating for the continuation of the PWID Project under the ADB funding. A more comprehensive study on IDU situation in Lao PDR is planned to be conducted before expanding the project to other provinces to start a new project.

A point-of-care referral system (POC) was put in place in 2014 to link the needle and syringe programme (NSP) with HIV counseling and testing, and AIDS treatment services at secondary and tertiary health facilities. This project is under the technical assistance (TA) on Regional Capacity Development for Strengthened HIV Response, a 20-month project that closed last December 2014.[36] The Houaphanh and Phongsaly was the only harm reduction program with PWID and was implemented under CHAS, rather than the Lao Committee for Drug Control. This technical assistance (TA) supplements the "Greater Mekong Subregion Capacity Building for HIV/AIDS Prevention Project,"[37] a 5-year grant from ADB which will be running from 2013 to 2018. [38]

e. Prevention of mother-to-child transmission

Expected outcomes by 2015, which are maintained in the NSAP 2016-2020, for the prevention of mother-to-child transmission (PMTCT) outcomes include 50% of ANC attendants receiving PICT, 90% of identified HIV positive pregnant women receiving ARV to reduce the risk of mother-to-child transmission and 100% of infants born to identified HIV-infected mothers receiving ARV drugs. To achieve this, the government aims to integrate PMTCT in the existing health services such as family planning, reproductive health and tuberculosis treatment. The national policy and guidelines on PMTCT is being finalized for endorsement by the MoH. With this available, it will provide a framework to effectively integrate PMTCT into the current health system.

HIV testing and counseling. PMTCT HIV testing is offered at ANC to pregnant women including their partners. The proportion of testing in ANC had risen dramatically from 4% in 2008 to 55% in 2013 of all PICT. In 2015, there were 44,676 women tested for HIV at antenatal clinics including those who already know their[39] HIV positive status. Of this number, 106 women were found to be HIV positive with a prevalence rate of 0.24%. NSAP 2011-2015 review revealed that the coverage for provider-initiated counselling and testing (PICT) was over 50% of ANC attendees and 90% ARV prophylaxis was provided to those women identified to be HIV positive. PMTCT was expanded through integration with antenatal care services, led by Maternal and Child Health Centre (MCHC) with CHAS.

Prevention of vertical transmission. Part of the PMTCT programme was the provision of ART for infants. The government aimed to provide ARV to all infants born to mothers with HIV.

Prevention Project, 2015, p.2. Available from http://www.adb.org/sites/default/files/project-document/172859/42179-013-tacr.pdf.

[36] The purpose of the TA is to support HIV service delivery for migrants and mobile populations in high-risk settings at cross-border areas in Lao PDR and Viet Nam. The TA has three outputs: i) Capacity building for regional planning and management of HIV programs; ii) Pilot-testing of service delivery models for improved access to and quality of HIV services for migrants and mobile populations at border areas; and, iii) Shared knowledge on regional cooperation on HIV prevention and management.

[37] Project outputs are: (i) strengthened planning and management capacity, (ii) enhanced capacity to provide quality and accessible services, (iii) improved access to HIV prevention outreach among target populations, and (iv) effective and sustainable regional collaboration to strengthen HIV response.

[38] ADB, Technical Assistance Consultant's Report - Regional: Greater Mekong Subregion Capacity Building for HIV/AIDS Prevention Project, 2015. Available from http://www.adb.org/sites/default/files/project-document/172859/42179-013-tacr.pdf.

[39] MOH, *ANC MCH and CHAS Report*, 2015.

The estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months was 34.4%. This was derived by dividing the estimated number of children newly infected with HIV (114) due to mother-to- child transmission among children born in the previous 12 months to HIV- positive women (numerator) with the estimated number of HIV-positive women (331) who delivered in the previous 12 months (denominator).

To increase uptake of HIV testing among pregnant women, early referral to care and M&E system improvement were conducted. In addition, PMTCT wokplan included the conduct of a 5-day training on PMTCT and couple counselling, site monitoring and a national workshop on PMTCT in Vientiane Capital, Savannakhet and Chamapasak provinces. Training of ANC staffs and counsellors at labour room of provincial and district hospitals will be held on April to August 2016. One of the problems encountered in PMTCT monitoring since its launch in 2015 was the incomplete surveillance data due to a lack of fulltime staff in charge of data entry, forms were not fully filled up, and surveillance software was not yet in its final version. National and provincial team will conduct the software data analysis on April 2016 with assistance from IT experts.[40]

f. Management of TB-HIV co-infection

TB/HIV collaboration is an important strategy to increase coverage and improve quality of HIV intervention programme. The government aims to reach 100% of estimated HIV-positive incident TB cases that received treatment for both TB and HIV. Actual coverage was still a low 25.3% and a lot still needed to be done to achieve full coverage.[41] In accordance to the TB/HIV guidelines, the government trained health staff of provinces and districts on the "3 Is" (Intensified case detection, Infection control and Isoniazid preventive therapy) among PLHIV. TB patients were screened for HIV and PLHIV were screened for TB. There was still a need to improve coordination between the national HIV and TB programmes and in the implementation of these programmes at the health services level in the field. Managing TB was challenging in itself as only a third of all estimated TB cases were detected and that TB prevalence was higher than estimated.[42]

The estimated number of incident TB cases in people living with HIV is 500. There are 276 adults and children with HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines) within the reporting year. The percentage of estimated HIV-positive incident tuberculosis (TB) cases that received treatment for both TB and HIV was 55.20%. The percentage of those who are newly enrolled in HIV care (pre-antiretroviral therapy or antiretroviral therapy) during the reporting period was 20.45%.

[40] KII, Dr. Chintana Somkhane, National Programme Officer, WHO, 18 March 2016
[41] MOH, *NSAP 2016-2020*, p.32.
[42] Lao PDR and UN. *The Millennium Development Goals and Lessons Learnt for the Post 2015 Period: A Summary Review*, 2015, p.11-12.

2. Care, treatment and support programmes

Providing a holistic and sustainable care, treatment and support programmes for PLHIV requires a long-term solution of integrating HIV treatment into health services and integrating care for PLHIV into social welfare services. This would entail strengthening of the health system and social system. The government developed a social system with professional social workers, but this was not yet fully operational.[43] The government was in the process of reviewing standardised package for community-based care and support services.

The Treatment, care and support programme interventions centered on ARV management and care and support for PLHIV. ART Guidelines were revised for implementation. It stipulated that all PLHIV can start the use of ART regardless of their CD4 count. CD4 was still taken and recorded for baseline purposes and to monitor effectiveness of ARV annually. The guidelines also promoted WHO recommendation of adopting the Option B+ for PMTCT which means that all HIV-positive pregnant and breastfeeding women on ART for the rest of their lives. Previous treatment guidelines provided varying treatment regimens depending on the viral load.

Pre-exposure prophylaxis (PrEP) was also adopted for treatment as prevention, primarily for MSMs and TGs. Training were already conducted in VTC, SVK and CPS. Through PrEP, high risk individuals can use ARV medications to prevent acquisition of HIV infection by uninfected partners.

Apart from providing a wider menu of HIV services, it was also important to improve on quality of HIV care and treatment services. One strategy was to increase early recruitment to ART and improve the complete cascade of HIV treatment services. Since 2013, WHO started quality improvement (QI) programme in ART sites by training clinicians, counsellors and peers who provide ART services. Assessment meetings on the QI project at site levels were held in 2015. QI coaching will be rolled out on September 2016 using a coaching tool to improve the QI programming. Assessment from the last training workshop showed that health providers from nine out of 10 ART sites had clear understanding on QI project in terms of patient database management using the HIVCAM software and working as a team to improve quality of services.

Common issues encountered related to QI were the lost to follow-up in pre-ART and on ART patients, low viral load testing in ART patients and missing patient data files. Thus, it was important to collect and analyse cumulative data generated over a long period of time to establish trends. Monthly, quarterly and yearly reports provided useful evidence on uptake of HIV services and identifying significant changes over time. Root cause analysis was recommended to identify the issues encountered for the QI project.[44]

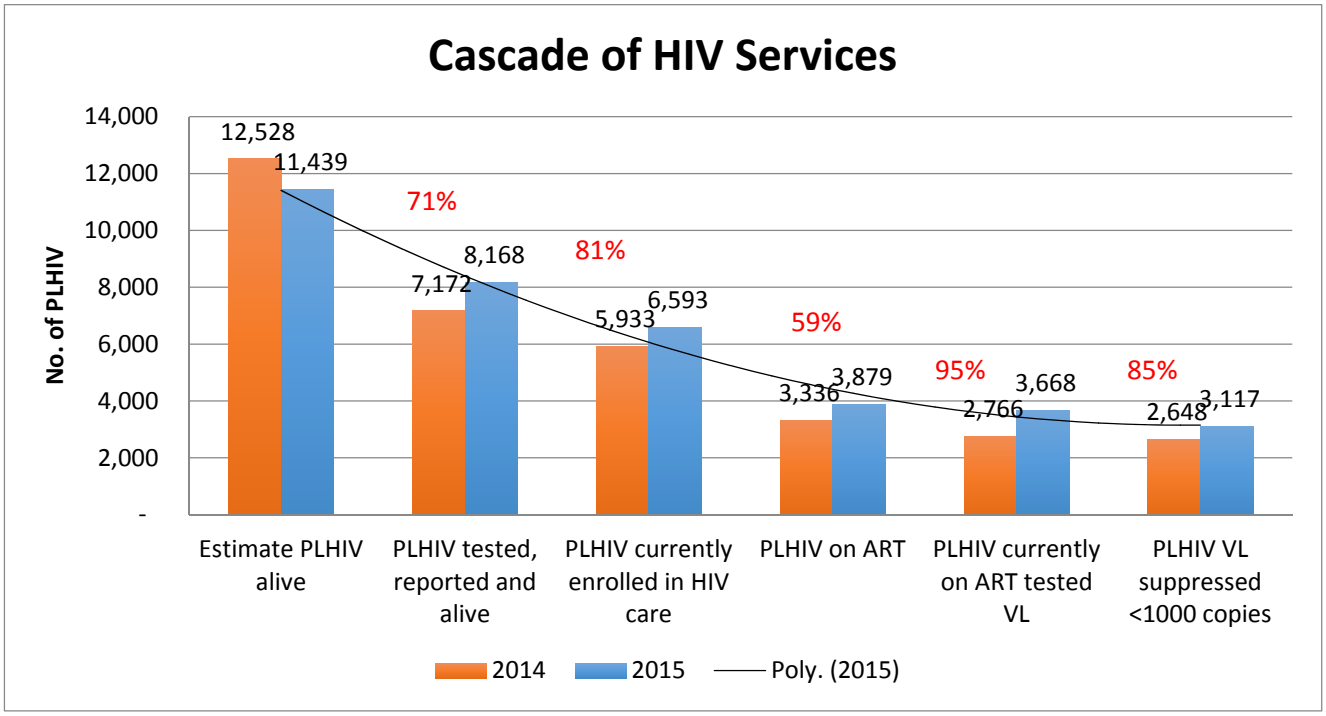
Quality improvement activities have been initiated in all sites where antiretroviral therapy is available to improve the quality of services for care and treatment of HIV/AIDS. Technical assistance on QI was provided by Thai US CDC and financial support through WHO-CDC Cooperative Agreement.

[43] Ibid., p.11.
[44] KII, Dr. Chintana Somkhane, National Programme Officer, WHO, 18 March 2016

a. Care and treatment cascade

The care and treatment cascade showed that only 71% of estimated number of PLHIV was identified, of whom 81% were enrolled in care and 19% failed to access care and treatment. The proportion of PLHIV who have accessed care and eventually undergo ART was only 59%. Of those in ART, 95% were tested on viral load, and 96% of those tested have had VL suppression. The biggest challenge is in initiating HCT and starting with ART. This scenario will eventually change as the new treatment protocol on starting ART will make all PLHIV eligible to start with the treatment. Reducing lost to follow-up will greatly impact in managing the epidemic.

Figure 4. Cascade of HIV services45



Fast-Track Initiative: 90-90-90 Target

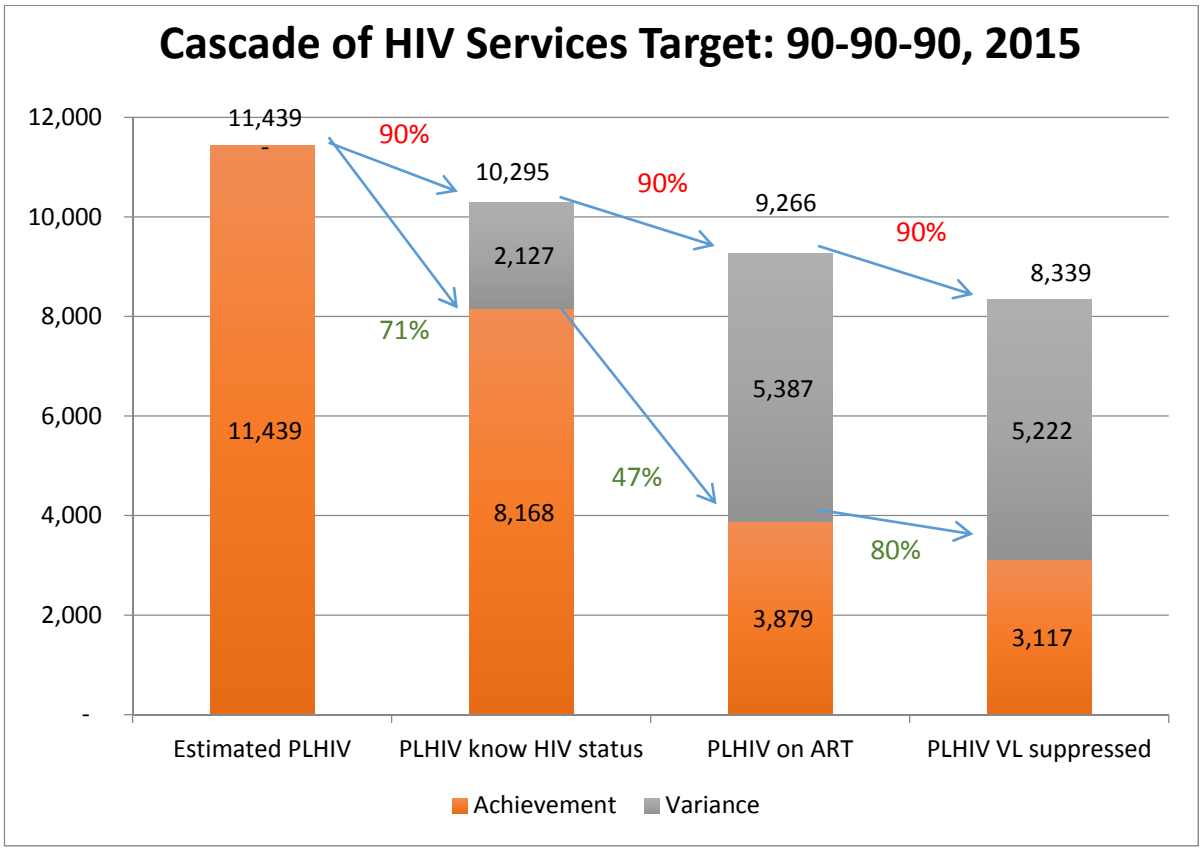
The HIV national response supports the Fast-Tack Initiative[46] which increased the target of HIV coverage of 90-90-90 in the cascade of services to create significant impact in ending the HIV epidemic as a global health threat by 2030. The strategy is to quicken the pace for essential HIV prevention and treatment approaches to limit the epidemic to more manageable levels and enable countries to move towards the elimination phase. If the progress is too slow, the financial and social cost of increasing HIV burden will be much bring higher toll on resources to respond to treatment and prevention programme needs.

[45] MOH, *Patient Record*, 2014.
[46] UNAIDS, *Fast-Track Ending the AIDS Epidemic by 2030,* 2014, p.6.

The new target for the HIV treatment scale-up beyond 2015 is summarised as 90-90-90. This means that by 2020, 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression. By 2030, these targets will be increased to 95% for all the three components.

Based on these three targets, 2015 data showed that only 71% of PLHIV know their status, 47% of the PLHIV who know their status are on ART and 80% of those on ART have viral suppression.

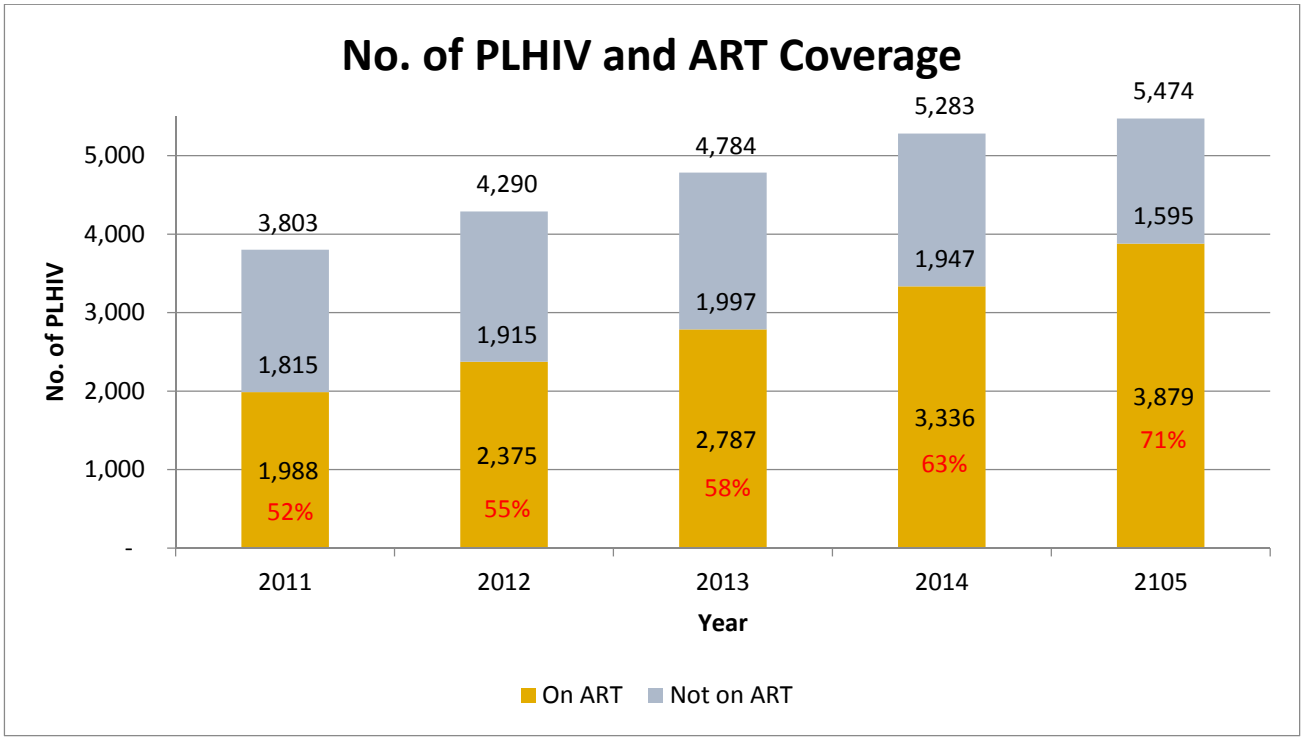
Figure 5. Recommended cascade of HIV services: 90-90-90 target, 2015



b. Provision of antiretroviral therapy (ART)

New national guidelines for antiretroviral therapy have been updated according to the WHO 2013 guideline for the use of antiretroviral drugs. The implementation of the new guidelines will start in 2016 based on the results from stock analysis for country readiness.

Figure 6. No. of PLHIV and ART coverage, 2011-2015



The 2015 patient record revealed that the percentage of adults and children currently receiving antiretroviral 3,879 or 33.9% among all adults and childre living with HIV. There were 5,474 adults and children in need of ART in 2015, representing 100% of all reported HIV cases as per new WHO guideline on ART.

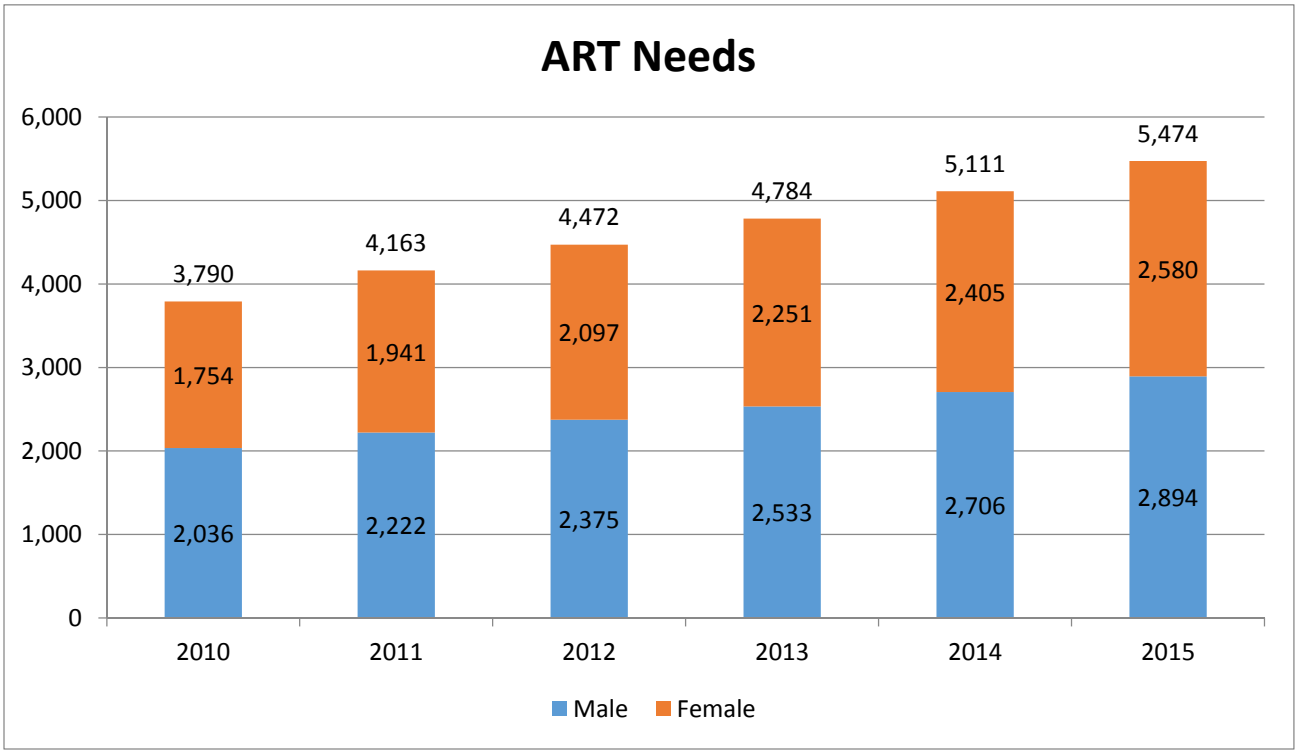
ART coverage decreased from 58.2% in 2013[47] to 33.9% in 2015. One reason for the decline is the shift in indicator definition. For the 2016 GARP reporting, this indicator is computed with the denominator as the estimated number of adults and children living with HIV while 2015 GARP used the denominator as the number of PLHIV eligible for ART (The 2014 ART eligibility criteria specifies less than 350 CD4 count to access treatment).

The percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy was 83.6% based on ART Patient Registry in Jan-Dec 2015 and 24 months after initiation of ART was 81.1%.

For PMTCT, ART was given to 100% of eligible pregnant women.

[47] NCCA. *GARP Report 2015.*

Figure 7. ART needs (100% of PLHIV), 2010-2015



Note: ART needs is computed to cover 100% of registered PLHIV following new recommendations from WHO treatment protocol to start ART to all PLHIV regardless of CD4 count.

B. Knowledge and behaviour change

The national response it to conduct specialized prevention programmes for specfic KAP and health education programmes that are integrated in the existing health services for the low risk groups.

1. Knowledge about HIV prevention and sexual behavior

One of the most important to reduce the rate of HIV infection is having correct knowledge of how HIV is transmitted and strategies for preventing transmission. Correct information is the first step towards raising awareness and giving people the tools to protect themselves from infection. The LSIS 2011-2012 data points to the low level of knowledge about HIV prevention and transmission among the poor and with lower levels of education. Overall, knowledge of HIV transmission and prevention is very low in Lao households making them vulnerable to HIV infection. [48]

[48] Lao Statistics Bureau, *Lao Social Indicator Survey (LSIS) 2011-2012*, p.246.

a. Young people

Young people is a segment of the general and vulnerable population. The NSAP 2016-2020 targets 80% of young women and men aged 15-24 to both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. Much needs to be done as only 28% of men and 24% of women correctly gave responses about HIV prevention and transmission.[49] Continued effort to reduce disparities in access to health services by different groups of young people is needed. Not only the health sector but all sectors have important roles to play to increase advocacy and awareness for health education programmes for young people at all levels for example by incorporating 'life skills' education into national core curricula in schools. UNPFA's progress report for 2015 showed that young people who are vulnerable and most at risk in priority urban areas have increased participation in and access to youth-friendly, gender-sensitive and socially inclusive sexual reproductive health information and services.[50]

b. Female sex workers

Sex work remained illegal in Lao PDR and hence FSW were typically hidden. This had implications in fully understanding their behaviour and implementing effective programmes. It is estimated that there were 15,340 FSW in 2015 in Lao PDR. There was difficulty in identifying who the sex workers were. One factor was that venues for engaging in sex work can take place in a lot of places including local bar or "drink shops," nightclubs, guest houses, restaurants, and karaoke. [51]

The percentage of FSW reached by prevention programme decreased to 38% in 2014 from 55% in 2011[52] while the NSAP 2011-2015 target was set at 85%. HIV outcomes in knowledge, prevention coverage and condom use had decreased while HIV prevalence had increased from 0.5% to 1.3%[53]. While the percentage of sex workers who report consistent condom use with most recent clients was relatively high (92% in 2011, which slightly increased to 92.7% in 2014), Chlamydia increased from 19% to 35% in 2008 and 2011 respectively.

c. MSM

The work on MSM mobile peer outreach was continued this year which aimed at providing information and awareness on the four basic areas, behaviour change communication (BCC), HIV/AIDS and STI, condoms, and HTC.

d. PWID

A more comprehensive study on PWID situation in Lao PDR has been planned since its pilot studies in Houaphan and Phongsaly in 2012 before expanding the project to other provinces to start a new project. Baseline survey on the knowledge, attitudes, practices, and behavior is planned under the ADB Project.

[49] Ibid. p.VI.
[50] UNFPA, *Standard Progess Report,* January-December 2015, p.1.
[51] NCCA, *Global Fund Concept Note*, 2014.
[52] Ibid.
[53] Ibid.

2. Gender equality

The government is committed in promoting gender equality as identified in one of the guiding principles of the national response as stipulated in NSAP 2016-2020. Human rights are advanced, stigma and discrimination are reduced and gender equality is fostered in AIDS response. In addition, another principle is the move towards universal access to HIV service and eliminating HIV-related marginalisation. Promoting gender equality empowers men and women to access the needed health information and services.

UNFPA supports the promotion of gender equality. They reach out to young people who are vulnerable and most at risk in priority urban areas have increased participation in and access to youth-friendly, gender-sensitive and socially inclusive sexual reproductive health information and services. Specific assistance include supporting the national capacity to design and implement community and school based Comprehensive Sexuality Education (CSE) programmes that promote human rights and gender equality.[54]

Much needs to be done to improve gender awareness and sensitivity. Women access to health care remains a big challenge in Lao PDR. Women access is constrained by several factors including mobility limitations based on social norms and heavy domestics duties, language barriers and not wanting to go alone. However, the most significant barrier is financial.[55]

3. Stigma and discrimination

Lao PDR has made progress in addressing stigma and discrimination. The Provisions of the Penal Code revisions and recommendations were submitted to the Parliament. This was submitted by Dr. Bounpheng Philavong, CHAS Director and Chair of the Task Force in November 2015.

According to the Task Force, criminalization of HIV transmission and exposure is generally unjust and ineffective public policy; intentional and reckless transmission of HIV can be addressed through conventional criminal laws; and efforts should be directed toward HIV prevention and treatment activities and reducing vulnerability and harm to high-risk populations.[56] This is aligned with recommendation of the Global Commission on HIV and the Law, specific criminalization of HIV transmission can potentially have stigmatizing effect, be misused to target vulnerable populations and deter people from undertaking HIV testing.

The issue on criminalization of act of selling sex (Article 236) among SW can lead to stigmatisation, increasing their vulnerability and making it difficult to ensure access to health services. The Task Force recommends the removal of the article in the Law and if not acceptable, an alternative solution was proposed to reduce penalties and provide sentencing options other than fine and imprisonment.

As to injecting drug users or PWID, another at-risk population for HIV, crminalising low threshold of narcotic possession inhibits access to health services. In this aspect, the Task Force recommends to amend Chapter 8 offences by increasing threshold quantities for illicit drug possession and providing increased range of sentencing options including community-based treatment programmes.

[54] Ibid. p.1-2.

[55] MOH, *Lao PDR HIV Response Against 2011 Political Declaration, Background Document for 2013 Mid-Term Review*, 2013.

[56] Dr. Bounpheng Philavong, *Review Provisions of the Penal Code*, November 2015.

C. Impact alleviation

The Health System Reform Strategic Plan 2013-2025 aims at strengthening primary health care to ensure access to quality health services to the poor and/or vulnerable populations in remote areas with the objective of Social Health Protection for100% of all poor and 50% of those in the informal sector by 2015. The first phase (2013-2015) of the HSR focus on Primary Health Care which is the first level for the community to health services. The entry point is delivery of the maternal, neonatal and child health (MNCH) service package which will allow an opportunity to strengthen the health system as a whole[57]

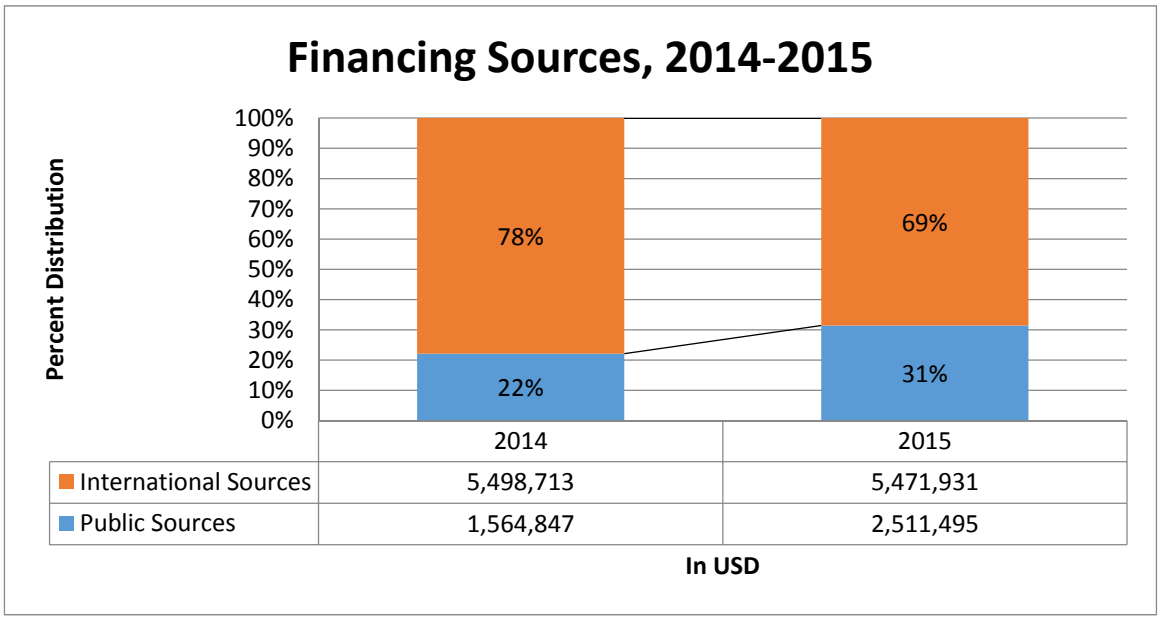
The health sector is governed by a series of laws, decrees, regulations and policies that provide seemless provision of services across sectors to achieve Universal Access. The MOH's Seventh 5-Year National Health Sector Development Plan (2011-2015) (NHSDP) provides direction on technological health infrastructure, including sustainable health financing, expansion and strengthening the health system, and eradicating poverty to improve the Lao people's quality of life.

Accompanying this overall plan, a series of sub-sectoral plans and strategies have been developed, which include the Health Information Systems; Human Resources for Health; Health Financing Strategy; Reproductive Health Strategy. The main areas of linkage to the national health strategy centers on the goal to reach the universal access by 2020. To achieve this, the government ensures targets are reached not just in quantity but also the quality of care provided. Compliance to quality assurance standards directs how the government does business. Moving from decentralized to recentralized health system, Lao PDR puts value to efficiencies and regulations to strengthen the health system.

Apart from the government's investments in health, international sources support the achievement of improved health outcomes. The current GF programme supports the majority of the HIV programme being implemented. These provided linkages with the three diseases in terms of joint planning processes, coordination structures, procurement standards and protocols and reporting mechanisms. The public sources accounted to 22% in 2014 and increased to 31% in 2015. The share of international sources were maintained at USD 5.5 million for both years but the proportion of its share to total budget decreased by nine percentage points.

[57] NCCA, *Global Fund Concept Note*, 2014.

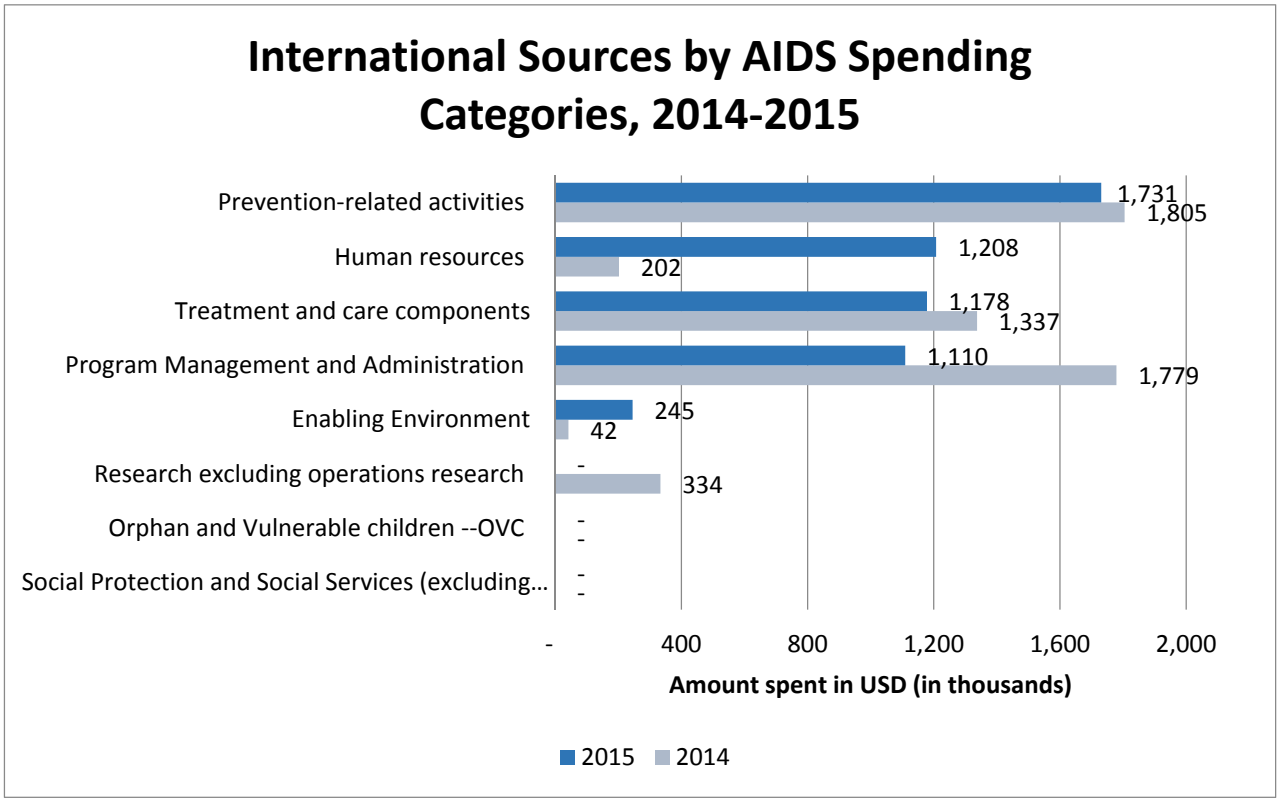
Figure 8. Total expenditure on AIDS by source, 2014-2015



Similar to 2014 AIDS spending from international sources, the component heavily financed in 2015 was prevention-related activities (32%). Other components's funding allocation varied in 2015. Funding went to treatment and care components (22%) and human resources (22%), program management and administration (20%) and enabling environment (4%). No funds were allocated for research, and OVC and social protection/services.

The data was provided by CHAS reflecting the counterpart financing of the government in implementing the HIV programme. Aggregated provincial data reflect the administrative costs such as salaries. The increase in percentage can be due to increased quantity of staff or increased salaries. The Global Fund grant requires at least 20% counterpart fund provided by the receiving country.

Figure 9. International sources by AIDS spending categories, 2014-2015



AIDS spending in 2015 is largest on prevention-related activities at USD 1.7 million, which decreased slightly from 2014 figure at USD 1.8 million. This was followed by human resources and treatment and care components at USD 1.2 million. No funds were allocated for orphan and vulnerable children and social protection and social services.

IV. Best Practices

A. Political leadership

The Lao government is in the forefront in planning and coordination of HIV programme implementation. Lao PDR deserves praise for its strong leadership and oversight roles leading diverse stakeholders to actively engage in planning and implementing of national programme response to HIV/AIDS epidemics in a more concerted and innovative manner.[58]

B. Supportive policy environment

The Lao Government improved public access to information through the dissemination of M&E and programme performance and implementation reports. Despite having limited Information Education Communication / Behavioral Change Communication publications to educate general public on HIV/AIDS prevention and availability of treatment drugs, the government has made significant strides in building its capacity to improve programme implementation and ensure transparency to make HIV/AIDS program performance data including surveillance, routine service delivery and financial reports available and accessible to stakeholders and the public.[59]

C. Scale-up of care, treatment and/or support programmes

Lao – Thai Collaboration on the Development of Referral System

The Lao-Thai collaboration project developed a referral system that is considered as one of the best practices proving that through installing proper mechanisms, care, treatment and support programmes can be scaled up. The objective of this Project is to develop standard operating procedures (SOP) for referral on continuing care and treatment on Lao migrants working in Thailand and vice versa. This Project is an extension of the National Access to ARV Programme for PLHIV and AIDS (NAPHA).

One of the many challenges in achieving the 90-90-90 target is the high rate of lost-to-follow up cases. With the referral system, lost-to-follow up is reduced and tracking of PLHIV and uptake of treatment are increased even across countries which is what the Lao-Thai collaboration project has achieved. The referral system provides collaboration between the hospitals in Lao PDR and Thailand with a referral form that includes patient description, laboratory and treatment results with feedback mechanism included in the referral form duly signed by the hospital directors and hospital attending physicians of both countries.

If a Lao migrant worker with working permit in Thailand has Thai Health Insurance, he/she can avail of free ARV and other laboratory examination in the Thai hospital. If the Lao Migrant has no working permit, he/she

[58] *2016 Sustainability Index Dashboard: Lao People's Democratic Repu*blic.
[59] Ibid.

will be referred back to Lao PDR Hospital for ARV and other laboratory procedures to be also provided for free in Lao PDR. If opportunistic infections occur, both Lao PDR and Thai hospitals will provide the necessary medications first and provide the referral for ARV from the hospitals where they were getting their ARVs.

This project developed and made available the manual of operations and referral forms in both Lao and Thai languages. This a collaborative project of the Lao PDR Ministry of Health, Thailand Ministry of Health, US-CDC Bangkok, and the Global Fund. In 2015 both countries conducted a Joint Cross-border Technical Meeting to develop a framework of Collaboration on HIV/AIDS and STI and a Joint Cross-borber was conducted separately at the beginning of 2016.

WHO-CDC Collaboration Agreement project on HIV and AIDS programme.

The GAP/ARO in collaboration with WHO in Lao PDR with support from the US President's Emergency Plan for AIDS Relief program (PEPFAR) has initiated a technical cooperation between Thailand and Lao PDR to enhance an effective implementation and sustainable HIV responses under the national strategy and action plan (NSAP). This programme has been designed to support the gap of the Global Fund workplan and be flexible in terms of technical and financial support based on the Global Fund workplan. This project has started since 2009-2013 for the first period and continuing in the second period 2014-2018. This project is mainly focusing in quality improvement and development of guidelinesfor care and treatment including HIV counselling, strengthening and improving the quality of laboratory system to promote the effectiveness of national HIV/AIDS Program, strengthen the utilization of strategic information, PMTCT demonstration intervention and surveillance data, and strengthening the effective HIV prevention , counselling and testing program among MSM, and monitoring the accessibility of HIV/AIDS intervention. Many standardized guidelines on the use of ART, opportunistic infection, training manuals on HIV basic and pre-post test counselling, SOP, flipcharts for MSM clients, and national HIV testing guidelines have been released for the implementation in the nationwide. All 10 ART sites have been trained on quality improvement for ART, more than 30% of VCT sites have covered for EQA run by the National Center for Laboratory and Epidemiology. Number of pregnant women and their husbands have been tested for HIV was increasing in 2015. Mapping has been done in Vientiane capital and Vientiane province for MSM. Electronic database of HIV care has been set in all ART sites. It will be used to link to the national health information. system (DHIS2). Behavior change communication (BCC) approach have been used among MSM peer outreach workers to reduce risky behaviors among MSM.[60]

Peer supporting programme in clinical services for ART

Two PLHIV peers are stationed in all ART sites. They conduct adherence counselling and help identify any issues that may hinder their regular follow-up visits. They provide a linkage between clinical and community care and encourage those with new HIV infection to become members of self-help groups with a good network in 14 provinces. They also support health providers on data management in some sites. They may need more regular training on pre-post test counselling, adherence counselling, ART counselling that would support for lost-follow cases when they conduct home visit.[61]

[60] KII with Dr. Chintana Somkhane, National Programme officer, WHO, 6 April 2016.
[61] Ibid.

D. Capacity-building

Greater Mekong Subregion Capacity Building for HIV/AIDS Prevention Project, Attapeu Province, Supported by ADB/TA 8204

A successful model of capacity building on HIV prevention is exemplified by the Greater Mekong Subregion Capacity Building for HIV/AIDS Prevention Project supported by ADB which is now in its second phase (January 2015 – December 2017) of implementation. It builds upon the successes of the first phase (November 2013 – December 2014) of the project. Its objective is to increase knowledge and build capacity of Lao-Vietnamese migrant workers who are at risk to get cross border HIV/AIDS infection. The need for a more rigorous HIV prevention programme has become more crucial with the increased cross border migration and its positive impact cannot be underscored.

The project is being implemented in the five districts (Sanxay, Phuvong, Samakysay, Saysettha and Samamxay) in Attapeu province with focus on Lao-Vietnamese entertainment places, international check-point between Laos-Vietnam, and migrant worker camps in the area of hydropower construction. Project beneficiaries include Lao-Vietnamese migrant workers, private sector and community in Attapeu, company managers, owners of entertainment places, truck drivers at Km 37-53, and health personnel. Project implementers are the PMU-MOH with overall management for the project by CHAS-MOH and with technical assistance from Attapeu PCCA and DCCA in the five districts.

The project has achieved increased prevention programme coverage of migrant workers through close coordination with all the partners including PMU, CHAS, PCCA and DCCA. Senior leaders at all levels were supportive and there were cooperation from concerned sectors, local authorities, and business sector. The pilot activities were fully funded and carried out as planned.

To date, key activities implemented by the project include the conduct of advocacy meetings for key stakeholders at provincial and district levels with Lao-Vietnamese owners of entertainment places and HIV outreach activities for the following: migrant workers at Huang Anh, truck drivers at Km 37-52, Lao-Vietnamese owners of entertainment places at Ban Phaosamphanvixay, Lao-Vietnamese migrant workers in the area of Xekaman hydro power; sex workers and owners of entertainment places in the area of Xekaman hydropower, and sex workers at the International check point.

Training on HIV workplan development by non-health sector

CHAS-MOH, through the IEC and Planning Management Units, led the development of HIV workplans by providing training to various line ministries and mass organisations. After the training, the participants were able to develop their own HIV workplans for 2016-2017 and identify their own funding source to implement their plans. Participants to the training were focal points from: Lao Women Union; Lao Front Union; LYU Union; and the Ministries of Education, Public Transportation, Social Welfare, and Information and Culture. This activity received funding support from the Asian Development Bank (ADB).

V. Major challenges and remedial actions

A. Progress made on key challenges reported in the 2013 Country Progress Report;

In the 2013 Country Progress Report, one of the challenges identified was the stigma and criminalisation attached to HIV which inhibits PLHIV and other key affected populations to access health services.

To determine the extent of this problem and how to address this, an assessment was conducted on the policy and protection framework to better understand how to increase access to HIV services for key populations (SW, MSM, TG, PLHIV and PWID). Findings were shared with government partners to discuss on structural, laws and policy barriers that need to be removed in order to scale up access to HIV services for key populations.[62]

Through the Ministry of Health CHAS has submitted a proposed amendments for some of the offence related to HIV and AIDS to the National Task Force on Penal Code under the Ministry of Justice. The principal advice to the Task Force were the following: criminalization of HIV transmission and exposure is generally unjust and ineffective public policy; intentional and reckless transmission of HIV can be addressed through conventional criminal laws; and efforts should be directed toward HIV prevention and treatment activities and reducing vulnerability and harm to high-risk populations.[63]

As recommended by the Global Commission on HIV and the Law, specific criminalization of HIV transmission can potentially have stigmatizing effect, be misused to target vulnerable populations and deter people from undertaking HIV testing and accessing health services.

CHAS recommended the following: replace offence under Article 183 with offence of intentional or reckless transmission of disease to other person(s); include a defense to proposed offence on the grounds of person taking reasonable precautions to prevent infection; and reduce penalties and provide sentencing options other than fines and imprisonment.

The issue on criminalization of act of selling sex (Article 236) among SW was discussed. This can lead to stigmatisation, increasing their vulnerability and making it difficult to ensure access to health services. CHAS also recommended the removal of the article in the Law and if not acceptable, an alternative solution was proposed to reduce penalties and provide sentencing options other than fine and imprisonment.

Another issue was on injecting drug users or PWID. PWIDs are the most at-risk population for HIV in the context of using unsterilised needles. Criminalising low threshold of narcotic possession inhibits access to health services. In this aspect, CHAS recommended to amend Chapter 8 offences by increasing threshold quantities for illicit drug possession and providing increased range of sentencing options including community-based treatment programmes.

[62] UNAIDS, *Enterprise Resource Planning (ERP) Report*, 2015.
[63] Dr. Bounpheng Philavong, *Review Provisions of the Penal Code*, November 2015.

- Integrating HIV-related health services

Another challenge reported was the the issue on integrating HIV-related health services. The ability to achieve epidemic control in Lao PDR was constrained by an HIV health system that lacked an integrated continuum of prevention, HTC, care, treatment, and support services that respond to the needs of priority populations (MSM and TG women) and their partners. Overcoming this required implementation of standards for same-day, high-quality, patient-friendly HTC, with immediate referral of PLHIV to care and ART, targeting priority populations in priority provinces. A more effective integration of services was established and continuous training of health providers were done such as PMTCT integration into the Maternal and Child Health and Nutrition (MCHN) ANC services and strengthening of TB-HIV collaboration. Prevention and HCT services were integrated in local health facilities and community-based programmes.

B. Challenges faced throughout the reporting period (–2015) that hindered the national response and the progress towards achieving targets;

One of the challenges that hindered the national response on HIV was the limited private sector engagement. The Government of Laos recognizes the importance of private health care providers and private business as active partners providing quality health care to its citizens. This resulted in emerging number of private hospitals and private health insurance companies throughout the country. Private health institutions were not yet fully utilized to provide HIV-related services and become part of the overall framework of the national response. National health financing schemes have not yet included HIV/AIDS related services. CHAS, UNAIDS, and USCDC are underway of discussing health financing scheme.

C. Remedial action plans to achieve agreed targets.

Universal Health Coverage. The government is committed to achieve universal health coverage as part of the health sector reform, which aims to provide good health services effectively delivered to the population. Part of the reform agenda is increased social protection to cover the people's health risks. To support increased service delivery, health facilities will be rationally distributed and adequately equipped, and information systems will be established.[64] Aiming for universal health coverage will not only need improving health services at point-of-care but will also require health systems strengthening (HSS).

Health System Strengthening. Components of health systems strengthening will require having improved service delivery at point-of-care, skilled health workforce, functional health information system, adequate health care financing, and leadership and governance. The government also adopts the strategy on HSS to improve collaboration across its different health programmes, primarily HIV, TB and Malaria. [65]

Health Financing. To improve health financing, the Sector Reform outlines that at least 9% of the general government expenditure is allocated to the health sector. Further, it mandates that social health protection coverage of the total population is 50% and of the poor is not less than 70%. The out --of-pocket payment is

[64] *Sector Reform Framework Lao PDR to 2025*, Vientiane 2013.
[65] NCCA, *Global Fund Concept Note*, 2014.

less than 40% of total health expenditure. [66] This level is still high and remains restrictive to the poor population's access to health services. The government is committed increasing health expenditure and guided by the National Health Financing Strategy 2011-2015. In addition, public private partnerships will be encouraged to increase investments in health financing.

The Integrated Maternal, Neonatal and Child Health Services Package (IMNCI). It is being implemented in a phased approach by the MOH in close collaboration with several development partners. The aim is to reach coverage of the entire country, district by district, through a uniform approach. The MNCH package includes an essential set of services and an additional optional set. IMNCI is the primary delivery strategy for providing preventive and curative interventions for childhood illness and was adopted in 2002. An outreach package of interventions has also been developed that responds to the needs of remote communities and increases coverage. The core package provides a framework for all levels of the health system: central, provincial, district, and household and community levels. This has helped ensure the development of systems to support maternal and child health activities along the continuum of care, from the preconception period through pregnancy, delivery, the postnatal period and childhood[67].

Implementing new service delivery model. This new initiative for peer educators and outreach workers interventions will address the full and more comprehensive package of interventions which ensures that the full cycle or cascade of treatment, care and support and continuum of care are addressed and followed. This needs more motivating and high qualify peer educators and outreach workers not just to provide knowledge on HIV/AIDS and STI to their peers, but to provide condoms, channel them to HTC and /or STI sites and then to ART sites if found HIV infected[68].

They will also follow-up them to ensure that they comply with treatment adherence and prevent lost to follow-up, including home visit and provision of psychological support. Each peer educator has to reach at least 70 peers per year instead of 16 earlier practiced. Thus, a better and more reasonable incentive is proposed to be provided to them. This new initiative is different from the earlier interventions by peers which focus mainly on providing knowledge on HIV/AIDS and STI to their peers with little referral or follow-up through treatment, care and support cascade. On the other hand, in the past there were too many peer educators with limited capacity and skills which caused difficulties to monitor them as they were more often changed because of their mobility

People who inject drugs (PWID) are at increased HIV transmission risk because of unsafe injecting practices and a host of other individual, network, and structural factors. Thus, PWID have a great need for services within the Cascade of HIV prevention, diagnosis, care, and treatment (HIV Cascade). Yet the systems that monitor their progress through the Cascade are often lacking. As in Lao PDR. Subsequently, fewer reliable data are available to guide programs targeting this key population (KP).

[66] Ibid.
[67] WHO, *Success Factors for Women's and Children's Health*, Lao PDR, 2015.
[68] NCCA, *Global Fund Concept Note*, 2014.

Adolescent and Youth. Lack of or limited access to adolescent and youth-friendly sexual and reproductive health counselling and limited information and services for both, married and unmarried young people, cost of services, the attitudes of health workers, self-censorship, fear of social stigma and the perceived lack of confidentiality discourage youth to seek health services and information they need.[69]

Improving access to health services by different groups of young people is needed. Not only the health sector but all sectors have important roles to play to increase advocacy and awareness for health education programmes for young people at all levels for example by incorporating 'life skills' education into national core curricula in schools. Point of care such as Youth Centers should be known by the youth to facilitate access to the services needed.

Ethnic groups. Ethnic groups have less access to education and information in their own languages especially those living in remote areas. As a result, many youth drop out of the school system and start moving to look for employment in the cities or abroad. They could become targets for exploitation and abuse, as many cannot read and write properly and have limited knowledge about their rights. Ethnic minority populations require prevention packages suited to their cultural and linguistic specificities.[70]

Effective Collaboration. The government is committed to a more effective collaboration with development partners and the formal signing and launching of the Vientiane Declaration on Partnership for Effective Development Cooperation (2016-2025) is a testament of the shift from aid effectiveness to effective development cooperation.

The government had outlined its strategic directions and planned actions in the NSAP 2016-2020. This provided concrete actions to achieve targets and its commitment under SDG. Policy environment will need to be assessed and revised with regards to the punitive provisions of the HIV Law and a stricter implementation and adherence to quality standards for HCT, ART and treatment protocols. Expanding reach to key populations would require innovative solutions using community-based mechanisms and integration of services into the existing health system will be needed in the context of limited funding to sustain impact.

Resource mobilization. Most of the HIV interventions are funded from external sources. Therefore, resources will need to be mobilized from private investors in large infrastructure development projects such as mining, dam and road construction that employ thousands of mobile workers.[71] Resource mobilization, both local and international, advocacy and mechanism to initiate financing schemes both public and private covering HIV/AIDS service delivery will be carried out to ensure future sustained response to the HIV/AIDS epidemic in Lao PDR.[72]

Strategic Information. There is a need to strengthen strategic information system capacity, implementing new service delivery models with more efficient tracking of the cascade for key populations, institutionalizing pre-

[69] LYU, UNFPA, *Adolescent and Youth Situation Analysis*, Lao PDR, 2014.
[70] MOH, NSAP 2016-2020.
[71] Lao PDR and UN. *The Millennium Development Goals and Lessons Learnt for the Post 2015 Period: A Summary Review*.
[72] KII with Dr. Douangchanh Xaymounvong, Public Health Specialist, USCDC, Lao PDR.

service training of the health workforce, and addressing stigma and discrimination will be integral to sustainably control the epidemic. Other proposed actions include making services available and accessible, improving technical and organizational capacity, creating demand among most-at-risk groups, and promoting compliance to treatment are remedial actions to help resolve the constraints of the National HIV Programme.

VI. Support from the Country's development partners

A. Key support received from development partners to ensure achievement of GARP targets

The Global Fund is the largest donor of the HIV response in 2015 contributing 59.73% of the total international cost at USD 5,471,931 of the country's HIV response. Other important development partners include the United States Agency for International Development (USAID), the European Union (EU), the ADB, WHO and UNICEF. All these donors other than the GFcontributed roughly 40.27%%. The government provided USD 2,511,495 to the HIV response in 2015.

The Global Fund's Single Stream of Funding (SSF) supported the prevention, treatment, care and support among key population groups including PLHIV. It supported the procurement of HIV diagnostic kits in VCT sites and ART sites including those of Lao Red Cross. It also supported almost all aspects of the national programme from total condom marketing, outreach interventions, drop-in centres, package of services, accessing KAPs, M&E activities, commodities procurement from ARV, OI drugs, laboratory equipment including vehicles. It supported sub-recipients, namely CHAS, PSI, PEDA, LaoPHA to run their programmes through the support of PR and CCM

UNAIDS provided financial and technical assistance to the national HIV programme. It assisted the government in crafting its country response supportive of the Fast-track Initiative of 90-90-90 targets to scale up HIV detection, treatment and viral load suppression. It led the coordination meeting with donors to stress the need to mainstream into the current programme response supported by Global Fund, PEFPAR, ADB and other development partners. It also promoted the Three Zeros key principle, Zero new infection, Zero discrimination and Zero deaths related to HIV; expanded comprehensive HIV prevention to key population at higher risk, MSM, sex workers, clients of sex workers and young mobile population; and UNAIDS Country Office's leadership profile and coordination functions were raised with the Joint UN. UNAIDS assisted in conducting assessments for the MDG review and policy and protection framework to better understand how to increase access to HIV services for key populations (SW, MSM, TG, PLHIV and PWID). It carried out several discussions and consultations with service providers and key affected populations to identify service delivery issues and recommend strategies to address them. Findings were shared with government partners to discuss on structural, laws and policy barriers that need to be removed in order to scale up access to HIV services for key populations. Additionally, UNAIDS and its co-sponsors also carried out a country analysis on the HIV and AIDS situation which contributed to the setting up of priorities for the UN support to the HIV and AIDS programming under the United Nations Partnership Framework 2017-2021. UNAIDS also participated in the joint effort with WHO and other development partners to support CHAS, MOH, in conducting series of activities as part of the World AIDS Day Campaign aimed at creating awareness, spur discussions on HIV issues, and promote call to action on HIV.

UNICEF provided technical assistance in the following areas: MCHN, supporting the PMTCT Task Force; preparation of the GF New Funding Model proposal on PMTCT; conduct of CHAS's costing exercise of the PMTCT – at the ANC and the routine HIV testing for pregnant women; assisted WHO in the preparation of the PMTCT Curriculum by updating the old guidelines; assisted in the development of the Maternal, Nutrition Child Health Services Strategy 2016-2020; and participated in the development of the Joint UNAIDS Work-plan on PMTCT.

WHO and USCDC provided technical assistance in the following areas: Epidemiological Review of the HIV epidemic in Lao PDR; M&E; quality assurance; care and treatment; PMTCT; and TB/HIV. They assisted in the improvements done in HIVCAM, MERS (including PMTCT surveillance data) and IBBS. WHO collaborated with the NCLE on the EQA among VCT sites, with 30% of them having completed the evaluation, and on all 10 ART sites on HIV laboratory examinations following the three HIV test algorithm. WHO, in collaboration with CHAS, disseminated the Consolidated Treatment Guideline on ART following the new recommendation of starting the ARV drugs regardless of CD4 count. WHO supported the capacity building of the health care workers at the ANC and delivery rooms in health facilities in VTC, CPS, and SVK to increase uptake of HIV test among pregnant women and their husbands. The training included couple counseling and provider initiated counseling and testing (PICT). WHO collaborated with MCHC on other tests needed to ensure that the pregnant women are provided HIV and STI treatment as part of the strategic plan of the MCHC. WHO contracted out a TA from Thailand to facilitate training on TB/HIV on Isoniazid Prevention therapy (IPT) in all ART sites. This initially done in Mahosot and Setthathiranth Hospitals.[73]

UNFPA focused and worked on the following areas: supported government partners to disseminate and make use of results from AYSA; supported Ministry of Education and Sports (MoES) to implement Sexual Reproductive Health curricula across departments and strengthen monitoring tool; supported Department of External Relation (DER) to effectively coordinate work plan implementation; and supported partners to provide access to SRH information to adolescents and young people. UNFPA worked with Ministry of Education and Sports on SRH and published a Teacher Guide Book in 2013 that contains STI, HIV and AIDS, Drug Issues, SRH and Gender Issues. Line agencies were trained on the Guide Book including Department of Teacher Training (DTT), Department of Secondary Education (DSE), Department of Technical and Vocational Training (DTVT), and Department of Non-Formal Education (DNFE). Through the Guide Book, UNFPA was able to advocate for comprehensive sexuality education (CSE) in primary school setting. CSE is now included in the 5-year Education Sector Plan and part of the revised primary education curriculum, which will be implemented beginning 2016.[74] UNFPA also coordinated with the DER, LYU and Vientiane Youth Centre for Health and Development (VYC) on the conduct of age appropriate training on SRH, Family planning, STI, HIV, Drugs in four provinces such as Oudomxay (ODX), Phongsaly (PSL), Luang Namtha (LNT) and SVK. UNFPA collaborated with MoH in establishing Youth Friendly Services in 4 districts in SVK and Teacher Training Institute (TTI). The TTI has counselling room for students used for peer-education, counselling on violence against young people and referral to district hospitals.[75]

USAID, through Family Health International 360 (FHI 360), supports programmes for MSM/TG, transgender women, male sex workers (MSW), and transgender sex workers.

B. Actions that need to be taken to ensure achievement of GARP targets

CHAS needs to continue implementing several projects to ensure achieving of the GARP targets utilizing local budget and funding support from development partners.

For the GF new funding model (NFM) for 2016 and 2017, the total amount of fund received is USD 8.3 million

[73] KII with Dr. Chintana Somkhane, National Programme Officer, WHO, 18 December 2016.
[74] Ibid.
[75] KII with Mr. Oloth Sene-Asa, National Programme Analyst, UNFPA Lao PDR.

allocated for KAP prevention and treatment, care and support interventions in eight priority provinces.

ADB is supporting capacity building for central, provincial and local level to improve quality of access prevention, treatment, care and support and cross-border collaboration with Viet Nam. The project is USD 5 million USD implemented in 8 priority provinces for the period from 2013 to 2017.

CHAS has also undertaken some HIV/AIDS activities funded by USCDC through WHO focusing on surveillance, reporting system, and laboratory quality. The project supported by USAID through Family Health International 360 (FHI 360) implemented in three main provinces (VTC, SVK and CPS provinces) focusing on MWS/TG. The activities include oral fluid testing (Oraquick), social network strategy and Comcare. In addition, there are some small projects supported by French Red Cross and French 5% to build capacity of CSOs.

The following are pipeline proposals and corresponding key activities anticipated to contribute to the achievement of targets:

PEPFAR Project (in collaboration with CHAS, DCDC (MOH), and USCDC/USAID)

- Improve quality of HIV Testing and Counselling (HTC) programs using a comprehensive prevention package, particularly for KAP addressing continuum of care cascade and linked with evidence-based behavioral change
- Improve the quality of care, treatment and support for PLHIV
- Enhance the quality of laboratory diagnostic capacity
- Strengthen the capacity of countries to collect and use surveillance data and manage national HIV/AIDS programs
- Develop, validate and/or evaluate public health programs to inform, improve and target appropriate interventions on prevention, care and treatment of HIV/AIDS, TB/HIV co-infection and opportunistic infections

FRENCH 5 %: The initiative will support the following:

- Conduct assessment on MSM mapping and analysis of existing data
- Conduct analysis on gap in epidemiologic information
- Conduct full estimation of the technical and financial resources needed in community strengthening
- Provide secondary support

USCDC-WHO

- Continue cooperation projects focused on Surveillance and Reporting (HIVCAM and MERS)
- Integrate software to DHIS 2, CHAS M&E Unit to collaborate with MOH Statistical Division to incorporate HIV indicators to DHIS. HSS will support the initiative from the HSS component of the NFM
- Continue the quality assurance through laboratory assessment with CLE as the agency to monitor the laboratory sites

USAID FHI 360

- Implement a comprehensive package of services to MSMs in VCT, SVK and CPS, on the cascade of services
- Piloted "Oral quick" for HIV test, positive results are sent for confirmation at VCT sites

Continuum of Care- SNN – social network

- Conduct peer-education strategy
- Conduct ART at VCT sites
- Support community strengthening

Community Care

- Introduce smart phone to enter data on MSM linked with continuous care
- Provide community-based support to CHAS, ART site and VCT site

ADB Project (To run until the end of 2017)

- Focus on strengthening and building management and planning capacities at the central and district level
- Improve access to quality prevention, behaviour change communication, and provision of condoms to specific vulnerable groups of people, ethnic groups, youth, migrant workers, SW, MSMs and TGs
- Improve access to quality treatment care and support
- Develop guidelines and SOP for health care workers

New Proposal for ADB (loan, to start on 2017)

- Focus on health security targeting migrant workers in 10 provinces (plus two more sites ATP and Sekong)

VII. Monitoring and Evaluation Environment

A. An overview of monitoring and evaluation (M&E) system

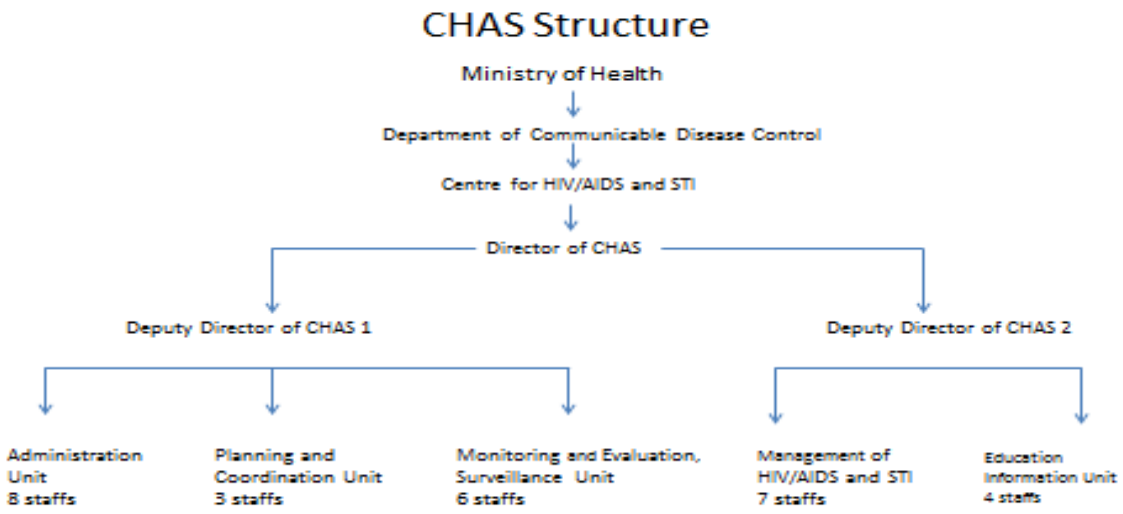
The M&E System can be described on the following components[76]:

1) *Organisational structure:* The organisational structure of the M&E system is composed of the M&E and Surveillance Unit at CHAS as the national AIDS coordinating body. It is composed of 6 full-time M&E posts (epidemiologists, database managers, IT specialists). Other government agencies involved in M&E are Department of Communicable Disease Control, TB Center, MCHC, PR M&E Section, Department of Statistics and CSOs such as PEDA, LaoPHA, PSI, APL+. Local government coordinating authorities are PCCA at the provincial level, DCCA at the district level and health facility staff at the community level. M&E technical support is provided as needed, with assistance from development partners.
2) *Human capacity*: Human Capacity Building (training curriculum) plan is developed by CHAS M&E and Surveillance Unit with support from Technical partners such as UNAIDS, USCDC and WHO. M&E Manual of Operation (draft) is used to streamline reporting and encoding of data in the paper-based and electronic databases.
3) *Partnerships, coordination and management*: The technical working group is headed by NCCA (national M&E TWG) with active participation by line ministries and international development partners and coordinated by MoH. It provides technical leadership on M&E directions and analysis of health data. It follows an inclusive process representation from programme implementers, target population and other stakeholders. The NCCA leads the HIV/AIDS response in Lao PDR, while the MoH is responsible for coordinating and implementing the national response. CHAS is under the Department of Communicable Disease Control of the MoH.
4) *National M&E Plan*: The national multi-sectoral M&E Strategy and Action Plan for 2011-2015 is aligned with the objectives of the National Strategic Action Plan (NSAP) 2011-2015. Both documents are being updated for the next 5-year phase of implementation. The M&E Plan facilitated the development of a unified national M&E system to measure the performance made against targets and establish trends on relevant key health indicators. It defined the data collection methods and
5) *National M&E Workplan*: The costed M&E workplan with specific timeframes exists. Most M&E activities are dependent on GF support. CHAS leads the development of the workplan. The national budget allocates funds for M&E.
6) *Advocacy, communications and culture:* M&E is fully supported by the government having been recently established yet it has accomplished a lot of tasks in the span of four years. Reports are used to inform decision-making and in crafting a more effective response on HIV. M&E unit is progressing as staffing is increased and more systematic trainings to staff are provided.

[76] UNAIDS, *12 Components M&E System Strengthening Tool*. Available from: http://www.unaids.org/sites/default/files/sub_landing/files/2_MERG_Strengthening_Tool_12_Components_ME_System.pdf.

7) *Routine M&E*: Protocols on data collection procedures are being improved for both paper-based and electronic recording and reporting. The draft M&E Manual of Operations Plan details reporting procedures and templates that will facilitate standardized data collection at the field level (e.g. health facilities, community-based organizations, development partners, and private entities) and consolidation of reports and analysis to the next higher level in the health information system. Data quality control to ensure reliability and validity of data will be observed in recording and reporting of service availments, medical records and supply of drugs, including those that go into electronic databases (e.g. MERS, HIVCAM, AEM/Spectrum)
8) *Surveys and surveillance*: The IBBS 2014 data contributed to the completion of the Country Report with the robust data to measure national and province-specific indicators. Specific KAPs were covered in the report. Secondary data, programme monitoring data, facility surveys, condom availability surveys are being used to supplement information not covered in the surveillance data.
9) *National and sub-national databases*: Electronic database to capture and store data at the national level is functional. IT equipment and supplies are being improved at the field level to facilitate timely submission of reports. To ensure quality improvements, IT specialists are contracted to provide training to staff on data quality controls. Focal persons on database management at the facility level are being identified. The database captures integrated reports across health programmes.
10) *Supportive supervision and data auditing*: Supportive supervision on M&E is part of the monitoring visits of health managers to the health facilities. National protocols on supportive supervision exists. Auditing of routine health service delivery data are being done through CHAS M&E and Surveillance Unit.
11) *Evaluation and research:* The TWG on M&E and Surveillance convenes to approve HIV research and evaluation designs. HIV research agenda are outlined in the M&E Strategy and Action Plan. Research findings are being used in policy formulation, planning and implementation. Financial support from the government earmarked on evaluation and research is supplemented by GF and development partners. An inventory of research exists. Joint reviews on HIV response are conducted including mid-term and end-term programme reviews. This is participated by government agencies, local and international development partners and target groups.
12) *Data dissemination and use:* Information products are regularly disseminated through fora, evaluation and planning workshops, annual meetings, etc. participated by programme implementers, recipients and relevant stakeholders. Interested parties can access information products uploaded online from government and development partners' websites.

Figure 10. M&E Unit organizational structure

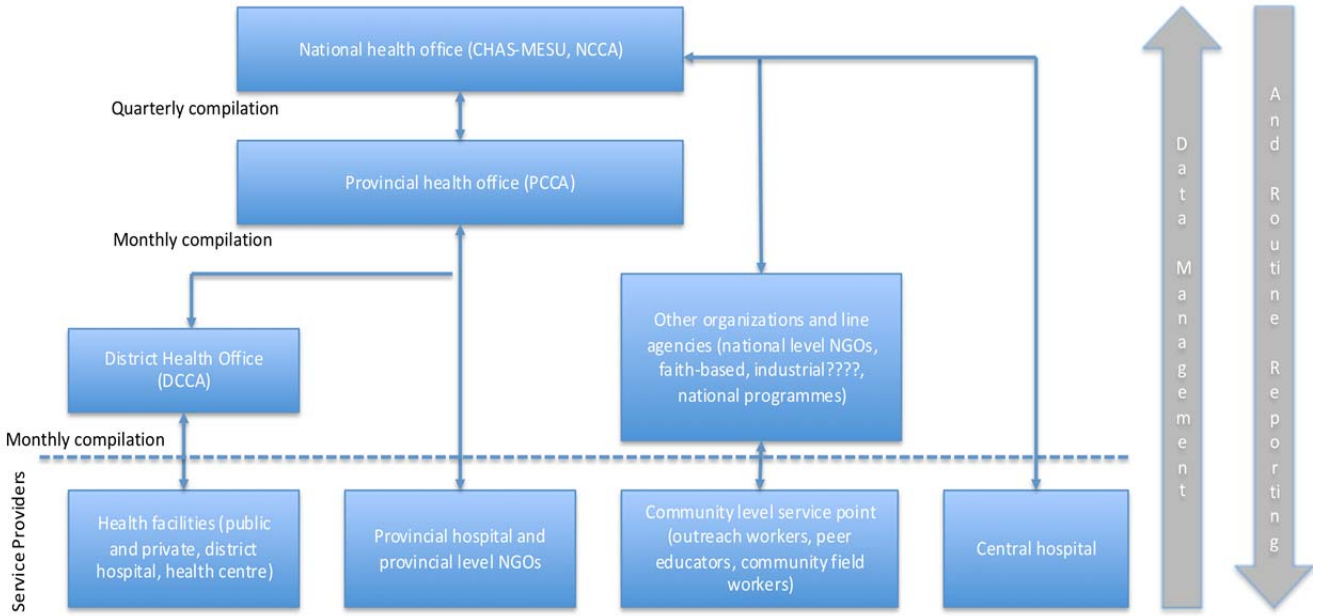


Routine Reporting System

Data management and routine reporting happen in two ways. From bottom up, reports are collated and summarized from community to district to provincial going to the national level. The national data are analysed and inform decision-making on programmes of respective implementing agencies from provincial to the service providers.

Service providers from health facilities, including provincial hospitals and central hospitals, and community level service points such as outreach workers collect epidemiology data and other indicators. Depending on the type of service providers, these reports are collated and submitted to their respective focal agency on a monthly basis. Health facilities submit reports to DCCA; provincial hospital and provincial level NGOs submit data to PCCA; community level service point data are submitted to their respective organizations and line agencies. DCCA generates report and submits to the provincial health office. Other reports submitted to PCCA are those from provincial hospital and provincial level NGOs. PCCA submits reports to the national health office. Other national organizations and line agencies, and central hospital submit reports directly to the national health office. At the national health office level, the MESU from CHAS collates all the data on a quarterly basis for national reporting and submits to NCCA. The national report is generated, analysed and disseminated to all implementing agencies and health facilities. The data are used for programme monitoring and in improving programme implementation at the provincial, district and community levels.

Figure 11. Routine Reporting System Flowchart



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

The M&E and surveillance system has been developed and implemented, the management of the system led under the sole responsibility of CHAS. The hospitals and provinces are only responsible for recording and submitting raw data to the central level mainly due to the lack of decentralized surveillance system/network, shortage of staff and limited capacity, particularly in data analysis and utilization for data quality improvement leading to improvement of program quality management.[77]

Implementing a comprehensive M&E system needs human resources to oversee the system both at the provincial and national level. It needs both the hardware (computers) and the software (programme software such as HIVCAM and MERS) where the data is stored and easily accessed at all levels, the sites that provide reports from the implementation sites up the central level that collate these data. A capacity assessment plan is needed to identify the needs of the human resource. The need to improve collection of data, disaggregation

[77] CHAS, CDC, MOH. *"Strengthening Systems Capacity in Lao PDR to Increase Utilization of High-Quality HIV Diagnosis and Treatment Services by Priority Populations under the President's Emergency Plan for AIDS Relief (PEPFAR)"* (Draft Proposal).

of data, routine report flows and use of strategic information has already been done with the M&E Framework and Action Plan available including the standard operating procedures (SOP). Training new forms is needed.

C. Remedial actions planned to overcome the challenges

There is an on-going strengthening of the Health Information Systems and M&E reporting mechanisms from the field to going to the national level. HMIS strengthening will be done through standardization of routine reporting, improving data analysis through dissemination of results and using them to inform programme decisions at the local level and automation of medical recording and reporting at the facility level. Standard forms will be used from the field and submitted routinely to the district, provincial and national levels.

WHO in collaboration with USCDC is supporting to strengthen the national monitoring system for prevention and care and treatment including utilization the monitoring and surveillance data among KAP and PMTCT for programme planning. They have already scheduled many activities to be implemented in the next few months namely refresher training on HIVCAM plus software for care and treatment data, training on MERS software for prevention and HCT data in VTE capital, SVK and CPS. Many meetings have been done between CHAS, CDC and WHO on DHIS2 integration in this year to clarify on what kinds of indicators to integrate in DHIS. The workplan has been drafted.

D. Highlight, where relevant, the need for M&E technical assistance and capacity-building.

USCDC Bangkok supported training on HIV CAM, critical data management and data entry at the ART sites and at CHAS. There was also the software developed for reporting on prevention activities which needs further TA to further develop its use and the implementation of the system.

Training needs assessment for the M&E unit at the central and provincial level needs to be conducted in order to identify the type of training needed by the M&E staff. There is a need to further strengthen the M&E and Surveillance Unit and maintain second-generation surveillance for impact/outcome monitoring, and continue to engage international technical assistance for design and analysis and strengthen the knowledge, skills, and abilities of the M&E staff through training.

Annexes

Annex 1: Preparation/consultation process for the 2016 GARPR Lao PDR

Preparatory Phase

1 – 28 Feb:

1. Identified Focal Point for the reporting process and submit his/her name and contact details to UNAIDS Geneva through **AIDSreportingtool@unaids.org. Identified** Dr. Bounpheng Philavong, Director of CHAS, MOH, as Focal Point for Reporting Process.
2. Identified TA need for the development of the 2016 GARPR and negotiated with UNAIDS to support through TSF. Discussion was done by Dr. Bounpheng and Dr. Marlyn Borromeo, Regional Investment and Efficiency Adviser, UNAIDS Regional Support Team
3. TA Consultant selected and contract signed. Introduced the consultant to Mr. Thongdeng Silakoune, UNAIDS Country Manager. Mr. Revanta Dharmarajah, TSF Programme Manager (Technical Assistance) prepared contract and introduced Dr Carlos L Calica, TA Consultant to the Lao PDR stakeholders

29 Feb - 1 Mar:

Desk/Literature Review (1)[78]

1. Familiarize with the "Global AIDS Response Progress Reporting 2016" Work with CHAS team to prepare key areas to be reported in the GARP 2016 report and develop GARP reporting roadmap, compile a list of reference reports and documents that will inform the development of the GARPR report.

- Reviewed the following documents: 2016 GARPR Guidelines; 2016 GARPR Frequently Asked Questions; Lao PDR National HIV and AIDS Strategy and Action Plan 2016-2020; Lao PDR national HIV Monitoring and Evaluation Strategy and Action Plan, 2016-2020 (Draft); Global Fund Concept Note, 2014; 2015 GARPR, Lao PDR
- Dr. Bounpheng and Mr Thongdeng met, and a request on the Data requirements for the 2016 GARPR be sent before the Consultant arrives in Vientiane
- Dr. Borromeo met the Consultant in Manila to discuss salient points on the 2016 GARPR Guidelines such as selected city-based reporting on some indicators, etc.

2-4 March

Key Informant Interview and FGD Guide (2)

1. Develop the first outline of the narrative report with the relevant sections on epidemiology, programme interventions, coordination mechanisms, M&E systems, and data summary etc. as per the GARPR 2016 guidelines.

- Based on the 2016 GARPR Guidelines the following has been prepared: Road Map to the development of 2016 GARPR Lao PDR; Outline of Narrative Report 2016 GARPR Lao PDR; Data Requirements for 2016 GARPR; Core indicators for Global AIDS Response Progress Reporting and Health Sector

[78] Technical Assistance Terms of Reference, 2016 GARPR, Lao PDR, TSF/UNAIDS, February 2016

Reporting; Description of core indicators; Summary of the 2016 GARPR Guidelines; and Guide questions for KII and FGD.

7-10 Mar

Facilitate country consultations with Key Stakeholders (3)

1. Consultation with the GARP Writing Committee and Task Force on HIV/AIDS and STI (CHAS, MCH, TB, PR, ART sites,) CSO etc., to consolidate and review data on the GARP indicators set necessary for the report
2. Facilitate in-country consultations on the preparation of the report through meetings with key government officials, civil society and community representatives and other partners (WHO, UNICEF and UNAIDS).

- On 7 March 2016, the TA Consultant met with CHAS GARPR Writing Team. The TA presented his TOR including the timelines which led to the development of the road map for data collection and the scheduling of the activities of the reporting process including the series of meetings and the Teams involved in the process. The road map for Data Collection served as a guide in identifying the processes in the collection and validation of monitoring data, coming up of HIV estimates and drafting and finalizing the narrative report for the Global AIDS Response Progress Report for Lao PDR for 2016. He also summarized the necessary outputs of the 2016 GARPR based on the 2016 GARPR Guidelines. On the other hand, the CHAS Director briefed the TA Consultant on the ongoing and future plans for the National HIV, AIDS, and STI Programme to provide inputs to the 2016 GARPR process. Present during the meeting were: Dr. Bounpheng Philavong, Director of CHAS as Focal Point for the 2016 GARPR; Dr. Khanthanouvieng Sayabounthavong, Deputy Director of CHAS, responsible for Global Fund PUDR Reports as part of data collection; Dr. Bouathong Simmavong, Deputy Head of CHAS M&E Surveillance Unit, focal person to help collect the required data for 2016 GARPR. During the meeting, the 2016 GARP Reporting Team was organized spearheaded by Dr. Bounpheng. This was based on the Decree signed by the Minister of Health on 1 February 2016:

- On 8 March 2016, the TA Consultant met with Mr. Thongdeng Silakoune, Country Manager, UNAIDS, Lao PDR, to discuss points that needs some clarification in the 2016 GARP Reprting Guidelines. This was followed with a “skype” meeting with Mr. Taoufik Bakkali, Strategic Information Adviser, UNAIDS Regional Support Team Asia and the Pacific who clarified matters in collected the data indicators as well as part of the narrative.

- On 9 March 2016, the TA consultant met with the M&E and Surveillance Unit to discuss on the Core Indicators and 3 Cities indicators needed for the 2016 GARP Report. The discussion identified which indicator data were available including sex and age disaggregation. Present during the discussion were: Dr Keophouvanh. Dr. Bouathong, and Dr. Kanti.

- On 10 March 2016, an Introductory meeting on 2016 GARPR Lao PDR between TA and CHAS Units. The presentation includes GARP 2016 report guidelines, 2016 GARP reporting roadmap include Outline of 2016 GARP Report, Indicators, AIDS Spending Matrix that includes domestic and international sources and time frame for data collection and responsible person. Dr. Bounpheng Philavong, CHAS Director, chaired the meeting. Participants were: Dr. Phouthone Soutalack, Deputy

Director; Dr. Khanthanouvieng Sayabounthavong, Deputy Director; Dr. Panina, CHAS Head of HIV/AIDS and STI Management Unit; Dr. Beuan Vang Van, CHAS Head of Planning and Cooperation Unit; Dr. Phengphet, CHAS Head of the IEC Uit; Dr. Bouathong Simmavong, CHAS Deputy Head, M&E and Surveillance Unit; Dr. Ketmala Banchongphanith, CHAS Deputy Head of HIV/AIDS and STI Management Unit; Dr. Phouthaly Keomoukdal, CHAS Deputy Head of EIC Unit; Dr. Khanti Thongkam, Technical Staff of M&E and Surveillance Unit; Dr. Bounleth Vilayhong, CHAS Head of Administration Unit and Dr. Carlos L. Calica, TA supported by UNAIDS through the Technical Support Facility.

- On 11 March 2016, another Introductory meeting on 2016 GARPR Lao PDR between TA and other stakeholders other than CHAS. It includes the CSOs, UN family, donors and other agencies.. The presentation includes GARP 2016 report guidelines, 2016 GARP reporting roadmap include Outline of 2016 GARP Report, Indicators, AIDS Spending Matrix that includes domestic and international sources and time frame for data collection and responsible person. Dr. Khanthanouvieng Sayabounthavong, CHAS Deputy Director, chaired the meeting. Participants were: Dr. Khamlay Manivong, TA CCM; Dr. Khampone Vichittavong, Prgramme Officer, Linkages Project, FHI 360/USAID; Phouthasac Chanpasith, National TB Center; Dr. Thipphasone, TB Programme Officer, WHO; Mr. Sayasitta, Co-chair, APL +; Dr. Phosikeo Bounthong, Project Coordinator, PSI; Dr. Bouathong, CHAS M&E and surveillance Unit; Dr. Dr. Phouthaly Keomoukdal, CHAS IEC Unit; LaoPHA; Mr. Oroth Sene-Asa, Programme Officer, UNFPA; Dr. Douangchanh, USCDC; and Dr. Carlos L. Calica, TA supported by UNAIDS through the Technical Support Facility.

11-22 Mar

Draft Report (4)

1. Review and validate the information to be utilized in the report for quality and accuracy.
2. Develop draft the narrative report with CHAS and GARP writing team based on the findings in the consultative meetings and perform data verification and review with key stakeholders.
3. Develop a compiled sheet of all indicators being reported through the GARPR platform with clear reference tosources of data for verification and validation
4. Finalize the completed matrix for indicator 6.1 on financial expenditures on HIV using compiled information form government, bilateral and multilateral agencies

- Interviewed Dr. Beaung Van Vang—CHAS Head of Planning Unit; got data on the financial expenditures from the bilateral and multilateral agencies; interviewed on the best practice on developing work plan for HIV for non-health sector, 14 March 2016
- Interviewed Dr. Ketmala, CHAS Deputy Head of Management of HIV, AIDS and STI Unit, on Lao – Thai Collaboration on the Development of Referral System as one of the best practices, 14 March 2016
- Sent communication to CSOs on the FGD to be conducted 15 March 2016 at 1:30pm, done by Dr. Bouathong, 11 March 2016
- Communicated through email with Dr. Phengphet- CHAS Head of the IEC Unit on the project: "**Reduce HIV/AIDS for migrant workers, Attapeu Province, Laos",** Supported by: ADB/TA 8204, cited as one of the best practices considered by CHAS
- FGD with CSOs (APN+, PSI, FHI), conducted at CHAS Conference Room, 15 March 2016
- Meeting with Dr. Vilayson, Technical Staff, CHAS M&E and Surveillance Unit, on PUDR 2015

- Interviewed Mr. Thongdeng Silakoune, Country Manager, UNAIDS, Lao PDR, discussed points to be added on the 2016 GARP Report
- Interviewed Mr Oloth Sene-Asa, National Programme Analyst, UNFPA, Lao PDR
- Interviewed Dr. Onevanh Phiahouaphanh, Health Specialist, UNICEF, Lao PDR, 18 March 2016
- Interviewed Dr. Chintana Somkhane, National Programme Officer, WHO Lao PDR, 18 March 2016
- Met with M&E and Surveillance Unit, reviewed indicators together with USCDC, 21-22 March 2016
- Met with Dr. Ketmala Banchongphanith, CHAS Deputy Head of HIV/AIDS and STI Management Unit, and Dr. Chanvilay Thammachah, CHAS Deputy Coordinator of the GF discuss the WHO Programmatic and Policy Questions, responded to the questionnaires, 21 March 2016
- On-going drafting of the 2016 GARP Report

23 March 2016

Validation Meeting- technical Level (5)

1. Validation meeting of the Draft Report with the CSOs, MOH, MCH, Government, UN (WHO, UNAIDS, UNICEF, UNFPA), Donors (partners and Stakeholders). (Dr. Bouathong to send the invites)

- A validation meeting with stakeholders representing the government agencies, international development partners, non-government organizations and civil society organizations was conducted on 23 March 2016. The purpose of which was to have the stakeholders review the compiled indicator data and review the content of the narrative report. The presentation was focused on the core indicators as well as the indicators for three provinces namely: VTC, SCV, and CPS. The best practices were also presented. The meeting was chaired by Dr. Bounpheng Phlavong, CHAS Director. The TA Consultant assisted in the presentation of the findings.

24 March – 4 April

- The CHAS M&E and Surveillance together with UNAIDS Country Office, USCDC and WHO continued to update the indicator data of 2016 GARP Report as it comes, from the sources such as the PCCA, ART sites, MCHC ANC, Meriux.

5 April 2016

Validation Meeting- Policy Level (5)

- A validation meeting at the policy level scheduled on 28 March 2016 was moved and conducted on 5 April 2016, chaired by the Acting Minister of Education and Sports, Vice-Chair of NCCA. Participants were members of NCCA.

6-8 April 2016

- On-line reporting of the 2016 GARP Report by Dr. Bounpheng Philavong, CHAS Director and Focal Point.

For reporting process.

2016 GARP Reporting Guiding Team

1. Prof. Dr. Eksavang Vongvichit, Minister of Health
2. Dr. Bounlay Phommasack, Director General Communicable Disease Control
3. Dr. Bounpheng Philavong, CHAS Director

Over-all Responsible Team

1. Dr. Sisavath Soutthanirasay, Deputy Director General Communicable Disease Control
2. Dr. Phouthone Southalack, CHAS Deputy Director
3. Dr. Khanthanouvieng Sayabounthavong, CHAS Deputy Director

Technical Team

1. Dr. Keophouvanh Doungphachanh, CHAS Head of M&E and Surveillance Unit
2. Dr. Beuang Vang Van, CHAS Head of Planning and Cooperation Unit
3. Dr. Bounleth Vilayhong, CHAS Head of Administration Unit
4. Dr. Phengphet, CHAS Head of IEC Unit
5. Dr. Ketmala Banchongphanith, CHAS Deputy Head of HIV/AIDS and STI Management Unit
6. Dr. Bouathong Simmavong, CHAS Deputy Head, M&E and Surveillance Unit
7. Dr. Khanti Thongkam, Technical Staff of M&E and Surveillance Unit

UN Team Coordination

1. WHO
2. UNAIDS
3. UNICEF
4. UNFPA

CSOs/NGOs/Donors Coordination

1. LaoPHA
2. PEDA
3. PSI
4. APL+
5. LRC
6. French Red Cross
7. FHI 360
8. USAID
9. USCDC
10. ADB
11. WB
12. Metthathadama
13. NCCA Focal Point
14. HIV Task Force

Main Activities

1. Familiarise with 2016 GARP Reporting Guidelines
2. Literature Review:
   a. GARPR 2015
   b. Ten Targets Review

c. Global Fund Concept Note
d. NSAP 2011-2015
e. NSAP 2016-2020

3. Consultations/Interviews/Focus Group Discussion with Key partners
4. Collect Data from PCCA for the NASA
5. Review/Update Core Indicators including Annexes and Appendices of the 2016 GARP Report
6. Series of meetings with Partners
   a. Briefing/Introduction/Orientation on the 2016 GARP Reporting
      - Invite partners
      - Present guidelines, contents of reports
      - Mechanism for gathering data

Teams for Data Gathering and Conduct of Activities:

1. M&E Indicator Core Team
   a. Dr. Keophouvanh Doungphachanh, CHAS Head of M&E and Surveillance Unit
   b. Dr. Bouathong Simmavong, CHAS Deputy Head, M&E and Surveillance Unit
   c. Dr. Khanti Thongkam, Technical Staff of M&E and Surveillance Unit
2. NASA Core Team
   a. Dr. Beuang Vang Van, CHAS Head of Planning and Cooperation Unit
   b. Dr. Chanthasouk Bansalith, CHAS Deputy Head of Planning and Cooperation Unit
   c. Dr. Bouathong Simmavong, CHAS Deputy Head, M&E and Surveillance Unit
3. Logistics and Administration Core Team
   a. Dr. Bounleth Vilayhong, CHAS Head of Administration Unit
   b. Dr. Panina, CHAS Head of Management of HIV, AIDS and STI Unit
   c. Dr. Phouthaly Keomoukdal, CHAS Deputy Head of EIC Unit

Annex 2: National Funding Matrix 2016

Points discussed on the contents of the 2016 GARP Reporting were: “Joint 2016 Global AIDS Response Progress Reporting and Health Sector Reporting Processes”, in close collaboration with WHO and UNICEF including verification of the Health Sector response indicators; revision of the M&E Action Plan as part of the Global Fund requirement; reporting of the 2011 Political Declaration, needs to be carefully written what were achieved, core indicators, results of which can be used for the New Funding Model for the Global Fund and UN Family.

Country: Lao PDR

Reporting cycle (calendar or fiscal year): Calendar

Start of the reporting cycle (mm/yyyy): January 2016

End of the reporting cycle (mm/yyyy): December 2016

Currency of the report (local currency or US dollars): US dollars

Amounts expressed in (units, thousand or million): million

Reporting period average exchange rate (local currency or 1 US dollar): 8,045.96 kip

Annex 3: NASA standard form

Organization: International & NGOs.	YEAR 20-- (1 Jan 2014- 31 Dec 2015)											
	National level											
Functions	Source of funds											
	Govt	ADB	GFATM	AFD/ ESTHER	UNAIDS	WHO	WHO-CDC	USAID	FHI360	PSI	PEFAR	Total
1. Prevention-related activities	**0**	**416,351**	**781,842**	**0**	**14,700**	**81,383**	**0**	**0**	**187,000**	**249,755**	**0**	**1,731,031**
1.01 Communication for social and behavioural change					8,700	59,189						0
1.02 Community mobilization					3,500							0
1.03 Voluntary counselling and testing					2,500	22,194						0
1.04 Risk-reduction for vulnerable and accessible populations												0
1.05. Prevention - Youth in school												0
1.06 Prevention - Youth out-of-school												0
1.07 Prevention of HIV transmission aimed at people living with HIV												0
1.08 Prevention programmes for sex workers and their clients										73,100		0
1.09 Programmes for men who have sex with men									187,000	121,570		0
1.10 Harm-reduction programmes for injecting drug users												0
1.11 Prevention programmes in the workplace												0
1.12 Condom social marketing			781,842							48,685		0
1.13 Public and commercial sector male condom provision												0
1.14 Public and commercial sector female condom provision												0
1.15 Microbicides												0
1.16 Prevention, diagnosis and treatment of sexually transmitted infections										6,400		0
1.17 Prevention of mother-to-child transmission												0
1.18 Male Circumcision												0
1.19 Blood safety												0
1.20 Safe medical injections												0

1.21 Universal precautions												0
1.22 Post-exposure prophylaxis												0
1.98 Prevention activities not disaggregated by intervention												0
1.99 Prevention activities not elsewhere classified												0
2. Treatment and care components	**0**	**420,524**	**667,667**	**0**	**0**	**90,286**	**0**	**0**	**0**	**0**	**0**	**1,178,477**
2.01 Outpatient care	0	0	667,667	0	0	90,286	0	0			0	**757,953**
2.01.01 Provider- initiated testing and counselling						38,896						0
2.01.02 Opportunistic infection outpatient prophylaxis and treatment												0
2.01.03 Antiretroviral therapy			447,525			43,364						0
2.01.04 Nutritional support associated to ARV therapy			220,142									0
2.01.05 Specific HIV-related laboratory monitoring						8,026						0
2.01.06 Dental programmes for people living with HIV												0
2.01.07 Psychological treatment and support services												0
2.01.08 Outpatient palliative care												0
2.01.09 Home-based care												0
2.01.10 Traditional medicine and informal care and treatment												
2.01.98 Outpatient care services not disaggregated by intervention												
2.01.99 Outpatient Care services not elsewhere classified												
2.02 In-patient care	0	0	0	0	0	0	0	0	0	0	0	**0**
2.02.01 Inpatient treatment of opportunistic infections												
2.02.02 Inpatient palliative care												
2.02.98 Inpatient care services not disaggregated by intervention												
2.02.99 In-patient services not elsewhere classified												
2.03 Patient transport and emergency rescue												
2.98 Care and treatment services not disaggregated by intervention												
2.99 Care and treatment services not-elsewhere classified												

3. Orphan and Vulnerable children --OVC	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
3.01 OVC Education												
3.02 OVC Basic health care												
3.03 OVC Family/home support												
3.04 OVC Community support												
3.05 OVC Social services and administrative costs												
3.06 OVC Institutional care												
3.98 OVC services not disaggregated by intervention												
3.99 OVC services not-elsewhere classified												
4. Program Management and Administration	**0**	**226,701**	**747,228**	**0**	**0**	**50,261**	**0**	**0**	**0**	**85,430**	**0**	**1,109,620**
4.01 Planning, coordination and programme management			143,377									
4.02 Administration and transaction costs associated			247,994							40,730		
4.03 Monitoring and evaluation			156,805							44,700		
4.04 Operations research												
4.05 Serological-surveillance (Serosurveillance)												
4.06 HIV drug-resistance surveillance												
4.07 Drug supply systems			22,667									
4.08 Information technology			157,210									
4.09 Patient tracking						50,261						
4.10 Upgrading and construction of infrastructure			975									
4.11 Mandatory HIV testing (not voluntary counselling and testing)												
4.98 Program Management and Administration Strengthening not disaggregated by type			18,200									
4.99 Program Management and Administration Strengthening not-elsewhere classified												
5. Human resources	**0**	**0**	**1,071,644**	**0**	**0**	**0**	**0**	**0**	**0**	**136,020**	**0**	**1,207,664**
5.01 Monetary incentives for human resources			975,104							90,600		
5.02 Formative education to build-up an HIV workforce												
5.03 Training			96,540							45,420		
5.98 Incentives for Human Resources not specified by kind												

5.99 Incentives for Human Resources not elsewhere classified												
6. Social Protection and Social Services excludingOrphans & Vulnerable Children (sub-total)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
6.01 Social protection through monetary benefits												
6.02 Social protection through in-kind benefits												
6.03 Social protection through provision of social services												
6.04 HIV-specific income generation projects												
6.98 Social protection services and social services not disaggregated by type												
6.99 Social protection services and social services not elsewhere classified												
7. Enabling Environment	**0**	**211,713**	**0**	**0**	**33,426**	**0**	**0**	**0**	**0**	**0**	**0**	**245,139**
7.01 Advocacy												
7.02 Human rights programmes												
7.03 AIDS-specific institutional development												
7.04 AIDS-specific programmes focused on women												
7.05 Programmes to reduce Gender Based Violence												
7.98 Enabling Environment and Community Development not disaggregated by type					33,426							
7.99 Enabling Environment and Community Development not elsewhere classified												
8. Research excluding operations research	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
8.01 Biomedical research												
8.02 Clinical research												
8.03 Epidemiological research												
8.04 Social science research												
8.05 Vaccine-related research												
8.98 Research not disaggregated by type												
8.99 Research not elsewhere classified												
Grand Total	**0**	**1,275,289**	**3,268,381**	**0**	**48,126**	**221,930**	**0**	**0**	**187,000**	**471,205**	**0**	**5,471,931**

Remark:

The total budget supported by GF for HIV/AIDS programme year 2015 included:

Excluded PSI which supported by GF the total is:

5,000,726

CHAS and provinces	1,805,623
LaoPHA	209,054
NCA	155,460
PEDA	80,112
PSI	471,605
NBTC	423,961
PR	122,568
Total:	**3,268,383**

ສ ັນຕ ິພາບ ເອກະລາດ ປະຊາທ ິປະໄຕ ເອກະພາບ ວ ັດທະນະຖາວອນ

ພະແນກສາທາລະນະສ ຸ ກແຂວງ:..... ເລກທ ີ:.....

ວ ັນທ ີ:.....

ລາຍລະອຽດ ຂອງ ົບປະມານວ ັດຖະບານ ທ ີ່ ໃຊ ້ ເຂ ົ ້ າໃນວຽກງານ ຕ ້ ານຊ ຶ ້ ອເຮສໄອ ີ ແລະ ພະຍາດເອດ ທ ັ ງ 18 ແຂວງ

No	Institution	Salary (Cat 10)			Running costs other than salaries						Total
		No of staff	monthly Aver	Annual	Cat 11	Cat 12	Cat 13	Cat 16	Cat 17	Sub/Total	
1	2	3	4	5 = 4x12ດ	6	7	8	7	10	11=6+7+8+9+10	12=5+11
1	chas	29	51,721,226	620,654,712	69,773,580	299,399,822	142,920,000			512,093,402	1,132,748,114
2	Setthathirath Hospital	22		488,725,248		56,624,000	23,000,000			79,624,000	568,349,248
3	Mohosoth Hospital	13		309,657,264	892,800	3,965,000		2,300,000	8,764,500	15,922,300	325,579,564
4	NBTC	136	217,600,000	2,611,200,000	33,600,000	864,000,000	15,000,000		100,000,000	1,012,600,000	3,623,800,000
5	Mittaphap Hospital	3	6,586,100	79,033,200	9,233,380					9,233,380	88,266,580
6	Vientiane capital	35	63,283,955	759,407,460	62,044,560	8,750,000	60,000,000			130,794,560	890,202,020
7	Phonsaly	17	24,320,000	291,840,000	3,298,700			13,500,000		16,798,700	308,638,700
8	Bokeo	46	69,453,875	833,446,500	6,351,580					6,351,580	839,798,080
9	Luangnamtha	23	400,005,700	4,800,068,400	10,348,800	47,401,000				57,749,800	4,857,818,200
10	Huaphanh		7,955,028	95,460,336	4,267,200	6,654,000	35,000,000			45,921,200	141,381,536
11	Udomxay	17	46,677,000	560,124,000	54,585,000	3,000,000	20,000,000			77,585,000	637,709,000
12	Luangprabang	21	42,954,170	515,450,040	1,299,480	37,912,500	3,000,000	8,400,000		50,611,980	566,062,020
13	Xiengkhouang	25	41,765,400	501,184,800	7,040,059	20,200,000	36,390,000			63,630,059	564,814,859
14	Sayabury	12	21,499,183	257,990,196	74,021,892					74,021,892	332,012,088

15	saysomboun	13	18,783,758	225,405,096	9,358,320					9,358,320	234,763,416
16	vientiane province	16	28,800,000	345,600,000	5,760,000	3,000,000				8,760,000	354,360,000
17	Bolikhamxay	14	23,157,360	277,888,320	2,009,891		26,762,000			28,771,891	306,660,211
18	Khammouane	24	40,766,000	489,192,000	22,900,080	10,400,000				33,300,080	522,492,080
19	Savannakhet	115	161,537,980	1,938,455,760	12,324,480	24,000,000	38,000,000			74,324,480	2,012,780,240
20	Champassak	30	44,380,000	532,560,000	17,404,800					17,404,800	549,964,800
21	Salavan	33	81,600,000	979,200,000	61,000,000	50,800,000	33,400,000	49,000,000		194,200,000	1,173,400,000
22	Sekong	7	8,534,000	102,408,000	120,500	10,000,000	30,000,000			40,120,500	142,528,500
23	Attapeu	14	18,697,200	224,366,400	894,760	6,000,000				6,894,760	231,261,160
Total		665	1,420,077,935	17,839,317,732	468,529,862	1,452,106,322	463,472,000	73,200,000	108,764,500	2,566,072,684	20,405,390,416

Annex 3: Selected Bibliography

2016 GARPR Frequently Asked Questions

2016 GARPR Guidelines

2016 Sustainability Index Dashboard: Lao People's Democratic Republic.

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