



LAO PDR COUNTRY PROGRESS REPORT

Global AIDS Response Progress

Country Report, 2014

Foreword

Lao People's Democratic Republic (Lao PDR), known for decades as a "landlocked country", has now become "land-linked", in the recent years. This is due to the upgrading of roads both domestically and with its neighbouring countries such as Cambodia, China, Myanmar, Thailand and Viet Nam, with relatively higher HIV prevalence. As the country is committed to economic expansion, this increased transit routes enabled new opportunities in employment and trade with increased mobility of the people in and out of the country. This dynamic change of increased mobility across borders coupled with the existing commercial sex vulnerabilities and the emergence of groups at high-risk, places Lao PDR on a continuous alert of a new HIV threat due to the growing risk to HIV vulnerabilities.

Lao PDR has an estimated HIV prevalence of 0.29% in 2013 among adults aged 15-49¹ with unsafe sexual activity forming the main mode of transmission². The HIV epidemic in Lao PDR is classified as low prevalence but with the potential of a concentrated epidemic, example of which is the 2007 IBBS conducted in Vientiane Capital which showed 5.6% HIV prevalence. Sex workers (SW), Men who have Sex with Men (MSM) and people who inject drugs (PWID) form the key affected populations (KAP). The epidemic is based predominantly around these groups. Men who have multiple partners, mainly men who travel frequently for work and engage commercial SWs while away make up around 50% of those living with HIV³.

In response to the HIV epidemic situation, the Government of Lao PDR has moved quickly to strengthen its strategy to respond the HIV epidemic situation of the country. It has provided strong political commitment by endorsing the Declaration of Commitment at United Nation General Assembly Special Session on AIDS in 2001 to support a multi-sectoral response. The role of key international and national partners has been invaluable. Coordination and collaboration have been further strengthened as the country endorsed the 2011 Political Declaration on HIV/AIDS.

In addition, there were two other milestones that were passed namely: National Strategic and Action Plan for HIV/AIDS and STI Prevention and Control 2011-2015 (NSAP). These two milestones confirm the commitment of the Government of Lao PDR to reach MDG 6 and the Three Zeros strategy and the Law on HIV/AIDS Control and Prevention (hereafter refers to as the HIV Law) was approved by the National Assembly and then promulgated by the President of Lao PDR in 2010. The Law is progressive in terms of addressing stigma and discrimination and promoting equity.

As the NSAP 2011-2015 is in the penultimate year of implementation, the preparation process of this report is an opportunity for the National AIDS Authority and its partners to review and reflect on the progress made in the last three years, as well as to consider the efforts needed to reach the ambitious targets set in

¹ AEM Projection 2013

² CHAS Routine Report 3013

³ CHAS Routine Report 2011

the National Strategy. Recognising its important status, all partners have been invited to take part in an open and participatory process for the 2014 report.

A major input to this report is mid-term review (MTR) of the 2011 Political Declaration High Level Meeting (HLM) targets carried out in Lao PDR in mid-2013 aligning it with the review of the progress and achievements of NSAP 2011-2015. The achievement of the NSAP 2011-2015 has contributed to the 2011 Political Declaration targets with one achieved and six on track.

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

Despite the aforementioned achievements, Lao PDR continue to face huge challenges in strengthening its HIV/AIDS response. Increasing capacity to monitor and evaluate the current response as well as identifying potential challenges and gaps that can accelerate the spread of the epidemic and recommendations to address these are much needed. Lao as a low-middle income country still continue to benefit from external resources to fund its response on HIV and AIDS. In 2011, HIV expenditure from external development partners in Lao stood at 93%. With the changing of global funding landscape on AIDS due to the down turn of global economy, Lao PDR needs to double up its effort to mobilise domestic resources to scale up and sustain its national response.

Lao PDR has an enabling policy environment with proactive multi-sector commitment supported by strong political will, thus facilitating reaching the goals of the Ten Targets and NSAP targets altogether and obtaining support and resources through both internal and external commitments. However, Lao PDR Government should continuously stay one step ahead of the epidemic to obtain universal access, to achieve the 2015 Millennium Development Goals (MDG) and to reach the Three Zeros Strategy – Zero new HIV infections; Zero discrimination and Zero AIDS related deaths.

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Acknowledgement

The Global AIDS Response Progress – Country Report for Lao PDR in 2014 was prepared through an inclusive and consultative process, under the leadership of the Centre for HIV/AIDS and STI (CHAS), Ministry of Health, on behalf of the National Committee for the Control of AIDS (NCCA). The reporting team includes members from CHAS, UNAIDS, WHO, UNODC and an international consultant.

We would like to express our thanks to all the national partners both governmental and civil society and

provincial partners who have contributed and participated in the national response and provided important input throughout the reporting process. These include Ministry of Health/CHAS; Ministry of Health/FDD; Ministry of Health/MPSC; Ministry of Health/DH; Ministry of Information and Culture; Ministry of Labour and Social Welfare; Ministry of National Defense; Ministry of Public Security; and Ministry of Public Work and Transportation; Lao Red Cross, Lao Youth Organization, Lao Women’s Union, Lao Trade Union, and Lao Front for National Construction and PCCA. We would also like to thank the national civil society organizations, including PEDDA, LaoPHA, NCA and LNP+.

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

List of Abbreviations

ADB	Asian Development Bank
ADR	Adverse Drug Reaction
AEM	Asian Epidemic Model
AFAO	Australian Federation of AIDS Organizations
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APCASO	Asia Pacific Council of AIDS Service Organizations
ART	Antiretroviral Therapy
ARV	Antiretroviral
ATS	Amphetamine-type Stimulants
AusAID	Australia Agency for International Development
AZT	Zidovudine
BCC	Behaviour Change Communication
CAI	Community Advocacy Initiative
CHAS	Centre for HIV/AIDS/STI
CUP	Condom Use Programme
DCCA	District Committee for the Control of AIDS
DHHP	Department of Hygiene and Health Promotion
DIC	Drop – in – Centre
EPP	Estimation and Projection Programme
FDI	Foreign Direct Investment
FDD	Food and Drug Department
FHI	Family Health International
FSW	Female Sex Workers
GARP	Global AIDS Response Progress
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria

HCD	Health Care Department
HIV	Human Immunodeficiency Virus
HLM	High Level Meeting
HSS	Health System Strengthening
IBBS	Integrated Biological and Behavioural Survey
ILO	International Labour Organization
INGO	International Nongovernmental Organization
IPT	Isonazid Preventive Therapy
KAP	Key Affected Population
LaoPHA	Lao Positive Health Association
LCDC	Lao National Commission for Drugs Control and Supervision
LNP+	Lao Network of People Living with HIV
LRC	Lao Red Cross
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MNCH	Maternal Neonatal and Child Health
MOH	Ministry of Health
MSM	Men who Have Sex with Men
MtF TG	Male-to-Female Transgender
N/A	Not available
NA	National Assembly
NAR	National AIDS Response
NASA	National AIDS Spending Assessment
NCA	Norwegian Church Aid
NCCA	National Committee for the Control of AIDS
NCPI	National Commitment and Policy Instrument
NGO	Nongovernmental Organization
NSAP	National Strategy and Action Plan on HIV/AIDS/STI Control and Prevention
NSEDP	National Socioeconomic Development Plan
NTC	National Centre for TB Control
NVP	Nevirapine
ODA	Official Development Assistance
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
PICT	Provider Initiated Counselling and Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PPT	Periodic Presumptive Treatment
PSI	Population Service International
PUD	People who Use Drugs
PWID	People Who Inject Drugs
PV	Pharmacovigilance
RAR	Rapid Assessment Report
SELNA	Support for an Effective Lao National Assembly
SIS	Stigma Index Survey

STI	Sexually Transmitted Infection
SW	Sex workers
TB	Tuberculosis
TWG	Technical Working Group
UN	United Nations
UNAIDS	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
VCT	Voluntary Counselling and Testing
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

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I. Status at a Glance

A. The Inclusiveness of the Stakeholders in the Report Writing Process

The preparation of this report was guided by the “Global AIDS Response Progress Reporting 2014: Construction of Indicators for monitoring the 2011 United Nations Political Declaration on HIV and AIDS” and had fully benefited from the valuable inputs and contributions from a wide range of stakeholders in Lao PDR including government agencies, civil society organizations (CSO), network of people living with HIV (PLHIV), mass organizations or unions, international and local nongovernmental organizations (INGO), United Nations (UN), bilateral and multilateral agencies. The report was developed and consolidated under the leadership of the National Centre for HIV/AIDS and STI (CHAS) of the Ministry of Health (MOH) and the strategic guidance of the National Committee for the Control of AIDS (NCCA). The UNAIDS Regional Support Team, Asia Pacific supported an international consultant who worked closely with the national team of experts in developing the Lao PDR GARP 2014.

The data presented in this report were taken from various sources such as the country reports, annual reports, mid-term report, Global Fund reports such as the Progress Update Disbursement Request (PUDR), HIV surveillance reports, HIV behavioural studies, programme and project reports of various stakeholders involved in HIV and AIDS programmes in Lao PDR.

The data were contributed by the following agencies CHAS, MOH; Food and Drug Department (FDD); Medical Product Supply Center (MPSC); Department of Hygiene and Health Promotion (DHHP); Provincial Committees for the Control of AIDS (PCCA) of 17 provinces; Promotion for Education and Development Association (PEDA); Population Service International (PSI); Lao Network of People Living with HIV (LPN+); Lao Positive Health Association (LaoPHA); Norwegian Church Aid (NCA); Lao Red Cross (LRC); United Nations Programme on HIV/AIDS (UNAIDS); United Nations Population Fund (UNFPA); United Nations Children’s Fund (UNICEF); United Nations Office on Drugs and Crime (UNODC); United States Agency for International Development (USAID); United States Centre for Disease Control (USCDC); World Health Organization (WHO); World Food Programme (WFP); Asian Development Bank (ADB); Australia Agency for International Development (AusAID); Australian Federation of AIDS Organizations (AFAO); and Asia Pacific Council of AIDS Service Organizations (APCASO).

Consultations with key agencies were conducted throughout the report preparation process from the

design of data collection, drafting of research instruments and validation of data and narrative report presented herein.

This report is composed of three parts containing 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, the National Funding Matrix and the National Composite Policy Index (NCPI).

The data were consolidated from various national and local reports including Lao PDR HIV response: progress against 2011 Political Declaration Mid-Term Review 2013, Lao Social Indicator Survey (LSIS) 2011-2012, Rapid Assessment and Response (RAR) to Drug Use and HIV-related Risk Behaviours at Hotspot Areas in Lao PDR, HIV/AIDS Asia Regional Program (HAARP) Reports, Integrated Biological, Behavioral Surveillance (IBBS) Survey Among Service Women, People Living with HIV Stigma Index 2012, Gender Assessment of the National HIV Response in Lao PDR 2013, First Round HIV and STI Prevalence and Behavioural Tracking Survey among Male-to-Female Transgender in Lao PDR 2010, Second Round HIV and STI Prevalence and Behavioural Tracking Survey among Male-to-Female Transgender in Lao PDR 2012.

The CHAS, Ministry of Health assisted in providing data on AIDS Spending based on the National AIDS Spending Assessments (NASA). Information on the NCPI was consolidated through the conduct of interviews with key stakeholders in the government, for Part A of the prescribed questionnaire, and representatives from the civil society organization (CSO), multilateral organizations, UN family, mass organizations and non-government organizations, for Part B.

After the consolidation of indicator data and narrative report, a validation meeting was conducted and participated by CHAS Director who chaired the meeting, WHO, UNODC, AusAID, ADB, LPN+, LaoPHA, NCA, PEDDA, 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 CGAS 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.

B. Status of the Epidemic

A Mid-Term Review on the 2011 Political Declaration was conducted in 2013. The result of the review framed the foundation of this Global AIDS Response Progress Reporting 2013 (GARPR) which focused on reporting specific targets and accomplishments based on the Ten Targets. The Centre for HIV/AIDS and STIs (CHAS) combined the conduct of the MTR of the National Strategic and Action Plan (NSAP) on HIV/AIDS/STI Control and Prevention 2011-2015, the GARPR and the MTR of the Political Declaration Targets.

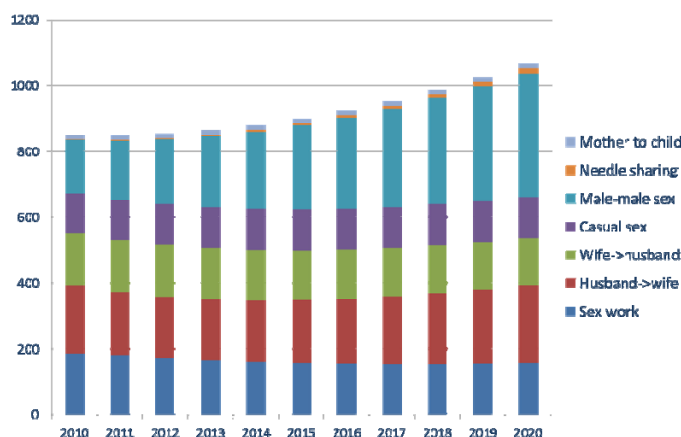
Lao PDR has a low prevalence HIV epidemic, with the potential for a concentrated epidemic transmitted via heterosexual transmission amongst key populations groups. Sexual activity is the primary mode of transmission. The national adult HIV prevalence is at 0.29% among 15-49 years old in 2013 based on the

Asian Epidemic Model (AEM). This figure is relatively lower compared with countries in the Greater Mekong Sub-region (GMS). The highest prevalence of HIV can be found in key affected populations (KAP) primarily among men who have sex with men at 3.1%⁴, followed by drug users at 1.5%⁵ and sex workers at 1%⁶, and 1.2% using AEM. Other at-risk population groups identified in the National HIV/AIDS/STI Strategy and Action Plan (NSAP) include men with multiple partners such as migrants and mobile populations, which make up around half of those living with HIV.⁷ Some 18% of current reported PLHIV recorded by the CHAS are married women who are presumably infected by husbands who became infected through unprotected sex with SWs or other casual partners⁸.

By the end of December 2013, there were 6,230 reported cases of HIV (AIDS Registry) and by 2015 it is estimated there will be 12,291 people living with HIV (PLHIV).⁹ At the end of 2013, a total of 2,787 adults and children PLHIV had received ART, the equivalent to 58.26% of estimated PLHIV.¹⁰ In 2012, ART coverage was at 55.4%.¹¹

The status of HIV in Lao PDR is considered as “potential for concentrated epidemic” based on the NSAP on HIV, AIDS, STI Control and Prevention 2011-2015. The country’s economic landscape shifts from lower to lower-middle income economy and with cross-border migration and employment opportunities opening up with improved transport system, HIV situation is rapidly evolving and beginning to reflect the trends of the neighbouring countries with higher HIV prevalence rate categorised to have generalised or concentrated HIV epidemic.

Figure 1. Number of New Infections by Route of transmission (2010-2020),
Source of Information: CHAS 2013, AEM Model



⁴ IBBS 2011, (Vientiane Capital)

⁵ Rapid Assessment 2009 (Houaphan, Phonsaly)

⁶ Ibid 4

⁷ Lao PDR HIV Response Progress against 2011 Political Declaration: Background Document for 2013 Mid-Term Review.

⁸ CHAS Routine Report 2011

⁹ Ibid 8; CHAS/UNAIDS Estimation and projection by AEM modeling 2011

¹⁰ CHAS/MOH routine report 2013

¹¹ Dr. Bounpheng. ICAAP Presentation. 2013.

The estimated number of population among KAP is presented in the table below:¹²

Table. 1 Estimated Number of Key Affected Population

	Estimated population size	Year of estimate
Female sex workers (FSW)	13,510	2010
Clients of FSW	98,660	2010
Men who have sex with men* (MSM)	49,330	2010
High risk MSM	17,000	2011
People who use drugs (injecting and non-injecting)	17,000	2011
People who inject drugs	1,150	2010

*including transgender

C. Policy and Programmatic Response

Government support in responding to the HIV epidemic is evident with the strong commitment in implementing two major milestones which are National Strategy and Action Plan for HIV/AIDS and STI Prevention and Control 2011-2015 and the implementation of the Law on HIV/AIDS Control and Prevention (hereafter refers to as the HIV Law).

“The National Strategy and Action Plan 2011-2015 (NSAP) is the guiding document for Lao PDR’s national response to HIV/AIDS and outlines key goals and objectives to be achieved to reduce the impact of HIV/AIDS in Lao PDR. The NSAP is aligned with the National Socioeconomic Development Plan (NSED) 2011-2015, the 7th Health Sector Plan and integrates global commitments such as the Millennium Development Goals (MDG) in its framework. The NSAP outlines two goals to be achieved by 2015; maintain the present low level of HIV prevalence in the general population (15-49) below 1% and ensure HIV seroprevalence among KAP is lower than 5%. To achieve these goals, Lao PDR aims to scale up the national response in order to minimise the impact of HIV and AIDS on socioeconomic development, and improve 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, improve national programme

¹² Lao PDR Investment Framework. 2013.

management resulting in annual work plans, annual progress reports, two surveillance rounds, quality service delivery, and more effective performance on current donor grants.^{13 14}

“The Law on HIV/AIDS Control and Prevention 2011 addresses stigma, discrimination and promotes equity; legislates for state provision of VCT and HIV services targeting high risk populations; mandates the right of migrants (“aliens or foreigners”) to information on HIV control and prevention; and prevents discrimination and termination of employment for people with HIV.”

In addition to these milestones, Lao PDR has endorsed the UN initiated Millennium Development Goals (MDGs) of which HIV is one of the targets for MDG 6 –‘to halt and reverse the spread of HIV in the country’. The Government of Lao PDR also endorsed the UNAIDS principle of Three Zeros – Zero new infection; Zero Discrimination and Zero AIDS related deaths.¹⁵

D. Overview of GARP Indicator Data¹⁶

The status of the GARP indicator data are summarized in the in the table below:

Indicators with no available data are 1.3, 1.4, 1.6, 1.7, 1.8, 1.11, 1.12, 1.13, 1.14, 2.3, 2.4, 2.5, 3.4, 3.5, 3.10, 6.1, 7.1, 10.1, and 10.2.

Table 2. Summary of GARP Reporting Indicator Values

	GARP Reporting Indicator	Source	Value	Remarks
Target 1 – Reduce sexual transmission of HIV by 50% by 2015				
General Population				
1.1	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%	Gave correct answers to all 5 questions
1.2	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%	
1.3	Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the	N/A	N/A	

¹³ National Strategic and Action Plan on HIV/AIDS/STI Control and Prevention 2011-2015

¹⁴ Lao PDR HIV Response Progress against 2011 Political Declaration: Background Document for 2013 Mid-Term Review.

¹⁵ MOH/CHAS. National HIV Monitoring and Evaluation Strategy and Action Plan, 2012-2015.

¹⁶ Lao PDR HIV Response Progress against 2011 Political Declaration: Background Document for 2013 Mid-Term Review

	past 12 months			
1.4	Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	N/A	N/A	
1.5	Percentage of women and men aged 15-49 who received a HIV test in the past 12 months and know their results	LSIS 2011-2012	All: 2.53% Males: 2.54% Females: 2.53%	
1.6	Percentage of young people aged 15-24 who are living with HIV	N/A	N/A	
Sex Workers				
1.7	Percentage of sex workers reached with HIV prevention programmes	N/A	N/A	No updated data available since previous reporting
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	IBBS 2011	Female: 92%	No updated data available since previous reporting
1.9	Percentage of sex workers who have received a HIV test in the past 12 months and know their results	N/A	N/A	No updated data available since previous reporting
1.10	Percentage of sex workers who are living with HIV	IBBS 2011	Female: 1%	
Men who have sex with men				
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	Second Round HIV and STI Prevalence Trucking Survey among Male-to-Female Transgender in Lao PDR 2012	3.4%	
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	N/A	N/A	No data available data. This will be included in IBBS 2014
1.13	Percentage of men who have sex with men that have received a HIV test in the past 12 months and know their results	N/A	N/A	No data available data. This will be included in IBBS 2014
1.14	Percentage of men who have sex with men who are living with HIV	N/A	N/A	No data available data. This will be included in IBBS 2014
Target 2 – Reduce transmission of HIV among people who inject drugs by 50% by 2015				
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	HAARP 2013 Annual Progress Report	Syringes per IDU/year: 246 Number of IDUs: 152 REF: Section 2.1.1, p9, 2013	People who inject drugs (PWID) are clients of the pilot NSP in 4 districts of Houaphanh and Phongsaly province

			HAARP annual report In comparison, the UNODC and UNAIDS report that in Asia, high-level NSP programs distribute an average of 200 syringes to each PWID (UNODC, 2012)	
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	Rapid Assessment Report on HIV and Drug Use in Houaphanh and Phongsaly Province 2010	N/A	No data representing national situation
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	Rapid Assessment Report on HIV and Drug Use in Houaphanh and Phongsaly Province 2010	N/A	No data representing national situation
2.4	Percentage of people who inject drugs that have received a HIV test in the past 12 months and know their results	Rapid Assessment Report on HIV and Drug Use in Houaphanh and Phongsaly Province 2010	N/A	No data representing national situation
2.5	Percentage of people who inject drugs who are living with HIV	Rapid Assessment Report on HIV and Drug Use in Houaphanh and Phongsaly Province 2010	N/A	No data representing national situation
Target 3 – Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths				
3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	Programme record/spectrum 2012	16.44%	
3.1a	Percentage of women living with HIV receiving antiretroviral medicines for themselves or their			New

	infants during breastfeeding			
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	EID testing laboratories/spectrum 2012	7.38%	
3.3	Estimated percentage of child HIV infection from HIV-positive women delivering in the past 12 months	Spectrum 2011	39.60%	
Target 4 – Have 15 million people living with HIV on antiretroviral treatment by 2015				
4.1	Percentage of adults and children currently receiving antiretroviral therapy	ART patient registers/spectrum 2013	All: 58.26%	No disaggregate data available among children
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy 4.2B 24 months retention 4.2C 60 months retention	ART Patient Registers Jan-Dec 2013	12 months: 83.73%	Only 12 months retention data available. No disaggregate data by sex and age groups. Some ART sites cannot provide complete data.
Target 5 – Reduce tuberculosis deaths in people living with HIV by 50% by 2015				
5.1	Percentage of estimated HIV positive incident TB cases that received treatment for both TB and HIV	ARV Patient Registers and Estimates from WHO Stop TB Database 2013	All: 61%	No disaggregate data by sex available. 183/300
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				
6.1	Domestic and international AIDS spending by categories and financing sources	N/A	N/A	
Target 7 – Eliminating gender inequalities				
7.1	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	N/A	N/A	
Target 8 – Eliminating stigma and discrimination				
8.1	Percentage of women and men aged 15-49 who report discriminatory attitudes towards PLHIV			LSIS/SIS 2011 conducted. One in 2 questions asked on stigma corresponds to GARP definition. (“Will you buy fresh vegetables”)
Target 9 – Eliminate travel restrictions				
	<i>Travel restrictions data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed</i>			
Target 10 – Strengthening HIV integration				
10.1	Current school attendance among orphans and non-orphans aged 10-14	N/A	N/A	
10.2	Proportion of the poorest	N/A	N/A	

	households who received external economic support in the last 3 months			
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II. Overview of the AIDS Epidemic

This section covers the detailed status of the HIV prevalence in the country during the period January 2012-December 2013 on the latest studies and projections. The sources of information for all data provided are included in this section.

A. HIV Prevalence in the General Population

The national adult HIV prevalence is at 0.29% (AEM Projection 2013) among 15-49 years old. Unsafe sexual activity is the primary mode of transmission for HIV¹⁷. Needle sharing among injecting people who inject drugs (PWID) comes as a second major mode of transmission.

By the end of December 2013, there were 6,239 reported cases of HIV and by 2015 it is estimated (AEM Projection 2013) there be 11,826 people living with HIV (PLHIV).¹⁸ At the end of 2013, a total of 2,787 adults and children PLHIV had received ART, the equivalent to 58.26% of estimated PLHIV.¹⁹ The population of men who have multiple partners make up around 50% of those living with HIV (mainly men who travel frequently for work and engage commercial SWs while away)²⁰. Further, 18% of current reported PLHIV recorded by the CHAS are married women who are presumably infected by husbands who became infected through unprotected sex with SWs or other casual partners. The Integrated Biological and Behavioral Surveillance (IBBS) in 2011 estimated HIV prevalence in SWs to be 1.0% and 1.2% using Asian Epidemic Model (AEM). However sex work is evolving and increasingly SWs are using mobile phones to contact clients or engage in opportunistic work, making them harder to reach with traditional drop in centres (DIC) and outreach HIV prevention programmes.²¹

The first IBBS survey among MSM was conducted in 2007 in Vientiane Capital and reported an estimated prevalence of 5.6%.²² In 2012 among MSM and Transgender (TG) population prevalence rates were

¹⁷ Global AIDS Progress Reporting, Country Report – Lao PDR, 2012

¹⁸ CHAS/MOH routine report 2013, CHAS/UNAIDS Estimation and projection by AEM modeling 2011

¹⁹ CHAS/MOH routine report 2013

²⁰ CHAS/Routine report 2011

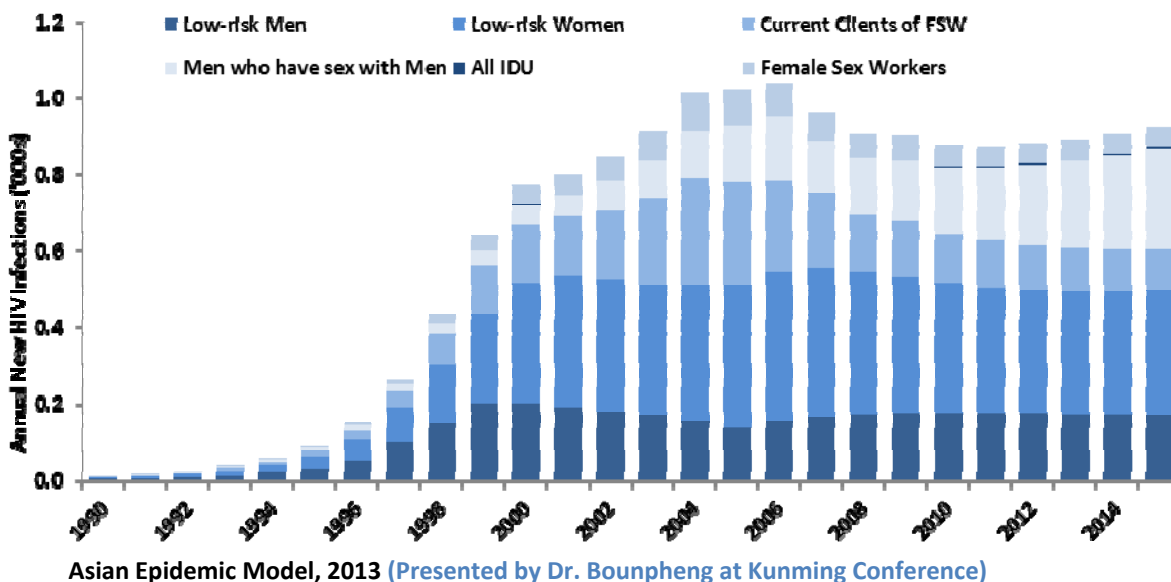
²¹ UNICEF. Rapid Assessment: Most-at-risk Adolescents and Young People to HIV in Lao PDR, 2011

²² IBBS, CHAS, 2011

reported at 3.34% in Vientiane Capital and 2.54% in Savannakhet province.²³ Condom use rates among MSM are low and rates of reported sexually transmitted infection (STI) high. The number of MSM reached by prevention interventions is low, with an estimated 27% reached in 2012.

HIV incidence in the general population has slowly been declining in the past years but estimated figures for 2014 shows that this trend may be shifting with slightly increasing figure. Reported new HIV infections are increasing annually rising from 612 to 670 cases in 2010 and 2011, respectively. Figure 2 depicts HIV incidence among high risk groups and the general population. HIV incidence among SW has consistently been decreasing over the past years whilst MSM has been increasing.

Figure 2. HIV incidence amongst KAP and general population, 1990 – 2014 (est.)



Lao PDR's is now considered a low-middle income country due to its geographical location and improving economic stature which contributed in the rising HIV incidence. Rapid development spurred transit and migration, bringing along heightened sexual risk infections. The government is closely monitoring the increased HIV transmission in three transit communities of Savannakhet, Champasak and Vientiane region. These provinces are access points to the neighboring Thailand, Viet Nam and Cambodia. Employment is also one of the reasons for the people to travel to these neighboring countries. "Mobile men including migrants, construction workers, business and traders have a higher level of vulnerability due to their likelihood to buy sex. Lao PDR has limited employment opportunities available within the country, especially in rural areas, and many Lao workers migrate to Thailand due to its low unemployment rate, higher wages and a demand for low-skilled workers."²⁴ Due to their mobility, they are exposed to sexual risk especially in these areas with higher prevalence of HIV than Lao PDR.

²³ CHAS/PSI. First Round HIV/STI Prevalence and Behavioural Tracking Survey among Transgendered in Vientiane Capital and Savannakhet Lao PDR (2010)

B. HIV Prevalence among Key Affected Populations

1. Sex workers

HIV prevalence among sex workers was registered at 1.0% based on the Integrated Biological and Behavioural Survey in 2011. This figure was earlier reported in the GARPR 2012 submitted by the country. The IBBS 2011 data was based on the surveillance of sex workers in six provinces with highest prevalence in Luang Prabang. The HIV prevalence among sex workers is at 1.2% using the AEM projection for 2013.

2. Men who have sex with men (MSM)

IBBS data in 2011 showed HIV prevalence among MSM at 3.1%²⁵. The data was based only from a sample in Vientiane capital only and therefore not nationally representative. This figure is slightly lower than what was reported in 2007 IBBS among MSM in Vientiane Capital with an estimated prevalence of 5.6%.²⁶ Using these limited data, the prevalence of HIV among MSM presented a higher prevalence than the female SW surveyed at 1%. In 2009, an Ad hoc survey was done among MSMs in Luang Prabang which revealed 0%. In 2010, the first round of the HIV/STI Prevalence and Behavioural Tracking Survey among Male to Female Transgender (TG) in Lao PDR was conducted in Vientiane Capital and Savannakhet. This study revealed 4.1% HIV prevalence among TG (4.4% VTC), (3.8% SVK). In 2012, the second round of the HIV/STI Prevalence and Behavioural Tracking Survey among Male-to-Female Transgender (TG) in Lao PDR was again conducted in Vientiane Capital and Savannakhet which revealed 3.4% HIV prevalence among TG. There was no significant change in HIV prevalence between 2010 and 2012. 4.1% of respondents tested positive for HIV in 2010 and 3.4% in 2012²⁷.

3. Persons who inject drugs (PWID)

HIV prevalence amongst people who inject drug in two provinces surveyed is under 5%. However, this data from a rapid assessment and response study conducted in 2010 that reported a 17% prevalence rate among 46 heroin injectors (from a sample of 549 drug users) is not representative of the national situation. There is limited information on the prevalence for PWID.

4. Persons with multiple sex partners

²⁴ MTR 2013.

²⁵ IBBS, CHAS 2011

²⁶ IBBS, CHAS, 2011.

²⁷ Second Round HIV/STI Prevalence and Behavioral Tracking Survey among male-to-Female Transgender in Lao PDR 2012, PSI, The Global Fund, USAID

This group is referred to as clients of sex whose jobs require frequent travelling, such as military, truck drivers, and water or electricity workers with a tendency to seek services of sex workers. In the reported HIV positive case, 50% of PLHIV currently is this category of men with multiple partners. Report on consistent condom use with casual partners among targeted mobile men (including civil servants, migrants, transport workers, business men, others) is around 70%. Chlamydia and Gonorrhoea prevalence amongst men with multiple partners is under 10%.

5. Young people

The Adolescent and Youth Situation Analysis provide a comprehensive discussion on youth behaviour. HIV incidence among the youth covering the period 2010, 2011 and 2012, based on the CHAS reports 15 to 24 year olds was 98, 126 and 102, respectively. These account to 16.7%, 18.8% and 15.9% of all new cases in each respective year. The number of new cases in 10-14 year olds was small, ranging from one to two each year.²⁸

III. National Response to the AIDS Epidemic

The year 2013 provided a benchmark in identifying progress against targets on a number of key indicators. The Centre for HIV/AIDS and STIs (CHAS) decided to combine the MTR of the National Strategic and Action Plan (NSAP) on HIV/AIDS/STI Control and Prevention 2011-2015, the Global AIDS Response Progress Reporting 2013 (GARPR) and the MTR of the 2011 Political Declaration on HIV and AIDS. The progress made and the initiatives initiated by the government and other stakeholders are presented in this section.

A. Prevention, care, treatment and support

Lao PDR may have a low HIV prevalence but it is surrounded by high prevalence countries making it vulnerable to the risk of transmission. The government continuously provides prevention, care, treatment and support programmes to the general and key affected population (KAP).

1. Prevention programmes

1.1 HIV education and condom use programme

General population. The government, with funding support from ADB and AusAID (now DFAT), has implemented an HIV prevention programme in anticipation of the increased HIV risk of rural villages in

²⁸ Centre for HIV/AIDS/STI, Lao PDR – HIV/AIDS Case Report 2012.

Houaphanh Province during and after a road construction project. The project ran from July 2011 to June 2013.²⁹

The 100% condom use programme (CUP) is implemented in nine out of 17 provinces in the country.³⁰

PSI Laos has implemented a Condoms Social Marketing Programme in Lao PDR since 1999 up to the present. It also started to implement an HIV/AIDS Prevention Projects among FSW and MSM since year 2000.

Sex Workers (SW). Lao PDR has a comprehensive prevention programme targeting FSW. The prevention programme consists of peer-led interventions, Drop in Centres (DIC), HIV and Sexually Transmitted Infections (STI) testing and counselling as well as referral to antiretroviral treatment (ART). By the end of 2012, there were 28 female sex workers (FSW) outreach workers, 632 peer educators working with FSW³¹. By the end of 2013, there were 27 female sex workers (FSW) outreach workers and 296 peer educators working with FSW³². The reduction of number of peer educators working with FSW was due to the reduction of budget, the FSW were highly mobile which was difficult to manage and supervise and to improve the quality of services, whereas before one outreach FSW targeted sixteen FSW but now it has been reduced to ten per outreach worker. The 9 DICs for FSW are located in Vientiane Capital (4), Bokeo, Luang Prabang, Xiengkhouang, Savannakhet and Champasack.

In 2012, the number and percentage of FSW reached by peer educators with HIV and AIDS prevention education was 6285/11394 (55%, CHAS Report, 2012) based on the Global Fund targets while in 2013, it was 8,907/11686 (76.2%, CHAS Report 2013).

Men who have sex with men (MSM). The government ensures that MSM, the KAP with the highest prevalence of HIV, is reached with prevention programmes namely peer-led interventions, Drop in Centres (DIC), HIV and Sexually Transmitted Infections (STI) testing and counselling as well as referral to antiretroviral treatment (ART). The number of and percentage of MSM reached by peer educators with HIV and AIDS prevention education is at 27.2% or 4,832 out of 17,862.³³ The denominator is 1/3 of the estimated 3% of men aged 15-49 years old, considered as high-risk. Accordingly there is a need to review the estimated number for MSM in Lao PDR. By the end of 2013, there were 20 MSM outreach workers 302 peer educators working with MSM³⁴. In 2012, the Second Round /HIV Prevalence and Behavioural Trucking Survey among Male-to-Female Transgender (MtF TG) in Lao PDR revealed that the majority of respondents possessed accurate knowledge of HIV/STI transmission. Most agreed with the statement that an HIV-infected pregnant woman could transmit HIV to her baby (97%). A strong majority of respondents also know a healthy-looking person can still be infected with HIV/STIs (95%) and that monogamous couples can help prevent HIV transmission (85%). Around two thirds of respondents were aware of the falsehood of some HIV-related myths, namely mosquitoes do not transmit HIV (69%) and sharing food or meals with an

²⁹ HIV Prevention and Infrastructure: Mitigating Risk in the Greater Mekong Subregion. Sub-Project 10: Pre-construction HIV prevention in Lao PDR and Viet Nam. Project Brief.

³⁰ GF SSF PUDR 2013.

³¹ FHI Report. "HIV Prevention among Female Sex Workers (FSW) : The Lao Model Drop in Centre (DIC)

³² GF SSF PUDR 2013

³³ SSF Annual Report 2012.

³⁴ GF SSF PUDR 2013

infected individual does not transmit HIV (67%)³⁵.

People who inject drugs (PWID). In 2011, a pilot needle syringe programme (NSP) commenced in Houaphanh and Phongsaly province to address the HIV burden from sharing of unsterile injecting equipment. The NSP is the only community-based health outreach in the country that is led by former drug users at village level and reaches both Lao and Vietnamese (20-30%) clients. The outreach strategy of the NSP includes:

- 24 peer educators (PE) who distribute sterile needles and syringes, condoms and IEC materials to 152 PWID clients who receive an average of three needles weekly
- brief interventions for behaviour change by PE using various IEC materials on safer sex and safe injection (i.e., safer drug use, such as vein care, overdose management) in Lao, H'mong and Vietnamese languages³⁶.
- awareness events at villages and the provincial/district capital (e.g., World AIDS Day) organised by narcotics and AIDS control staff health centre staff, PEs and their village heads.
- referral to VCT, STI or ART at various sites within the province or nearby (but locals often use health facilities in Viet Nam, e.g., Dien Bien Provincial Hospital).

Injecting drug use appears to be widespread at the four districts bordering to Viet Nam where the NSP reaches 60 PWID in Mai District (Phongsaly) and 80 PWID in Xiengkhor, Sopbao and Viengxay districts (Houaphanh). The RAR identified 9 and 37 PWID in Phongsaly Province and Houaphanh Province respectively, among the 549 PWUD sampled.

There is no OST (opiate substitution treatment) for HIV prevention among heroin injectors in Laos Tincture of opium (TO) capsules are used for drug dependence detoxification and treatment among opium users, who are generally opium smokers and eaters. The Lao PDR TO treatment protocol do not conform with the UN definition and guidelines for using substitution maintenance therapy for HIV prevention among opium dependents (primarily heroin injectors); current evidence for OST (including for prisons) are only with the use of methadone and buprenorphine,

In 2013, 152 PWID received 37,334 syringes in four project districts thus, on the average, each PWID received 246 syringes in a year, equaling to 20 syringes monthly, or 5 syringes weekly. In comparison, the UNODC and UNAIDS report that in Asia, high-level NSP programmes distribute an average of 200 syringes to each PWID yearly.³⁷ Also, 19,200 used syringes were returned through the PE. Notably in Phongsaly, return rate was over 50%. Ensuring a higher return rate is difficult as syringes are often discarded in rice fields far away from the villages, yet HAARP's syringe return rate is considerably higher compared to most NSP, and needs to be explored. PWID and their families/network also received 6,227 condoms.

³⁵ Second Round HIV/STI Prevalence and Behavioural Tracking Survey among Male-to-Female Transgender in Lao PDR 2012

³⁶ IEC materials are brochures, A4/poster-size flipcharts and posters

³⁷ GARP 2012

A point-of-care referral system (POC) has been planned from 2014 to link the NSP with HIV counseling and testing, and AIDS treatment services at secondary and tertiary health facilities. It is a decentralised approach planned for Houaphanh Province and will refer clients through a cycle of services designated as the '4 points of care' offering a minimum package of HIV and AIDS services:

- HIV prevention – needle and syringe programme (NSP), voluntary counselling and testing (VCT), screening for sexually-transmitted infections (STI) and tuberculosis (TB)
- AIDS treatment – screening and treatment for AIDS opportunistic infections, anti-retroviral therapy (ART)
- Care for people with AIDS – peer counselling, self-help groups, home-based care

By delivering services at or closest to the location of clients, results are obtained immediately and loss to follow-up is reduced. The POC services will complement VCT and ART centres in Luang Prabang and Vientiane Capital that are frequented by clients from Houaphanh Province, and will build on peer education services provided by the NSP and by past ADB HIV mitigation projects³⁸. Finally, the POC envisions a mobile service that could be integrated with existing primary health care outreach later on.

A baseline survey that assessed service delivery services at provincial and district hospitals, and village-level services also recommend the following capacity building priorities for enabling the POC:³⁹

- Supervised mentoring post-training by central-level HIV/AIDS Centres at Setthathirat and Mahosot hospitals.
- Improving inter-ward coordination and incorporation of HIV/AIDS services into systems for TB, STI, MCH and reproductive health at provincial and district facilities.
- Supporting the provincial and district health offices, health centres, and peer educators to increase demand for VCT (and the consequent support for people infected and affected by HIV) through awareness and sensitization activities.

Discussion on this survey is on progress with CHAS and in conjunction with the ADB GMS HIV Prevention Capacity Building Programme and the associated Technical Assistance Project.

The Lao National Commission for Drug Control and Supervision (LCDC) with the support of the Centre for HIV/AIDS and STI (CHAS)⁴⁰ are the primary implementers of the NSP and the POC under the HIV/AIDS Asia Regional Programme (HAARP) for Lao PDR. The project has also begun developing a national advocacy strategy on harm reduction.

HAARP is implemented through UNODC, with an allocated budget of Aus\$ 4 million for 2009 to 2015. The UNODC and the DFAT (formerly AusAID) post in Vientiane Capital jointly provide technical supervision and capacity building. Activities are monitored by provincial and district counterparts of LCDC and CHAS. HAARP is currently exploring new funding following early closure in April 2014 when Australian government support ceases.

³⁸ TA-6467 (REG): HIV Prevention and Infrastructure; Mitigating Risk in the Great Mekong Subregion; Sub-Project 10: Pre-Construction HIV Prevention Associated with the Second Northern GMS Transport Network Improvement Project

³⁹ 'Point-of-Care Referral System Baseline Survey Report'. HAARP. January 2014.

⁴⁰ CHAS is delegated to work with HAARP by the Ministry of Health Department of Communicable Diseases Control and Health Care

There is still a limited data to establish the HIV status of PWID in Lao PDR. This was partly driven by the fact that injecting drug use and drug possession are criminal offenses based on the Law on Drugs (No. 10/NA) and the Penal code (Articles 55 and 146). Penalties include imprisonment up to five years or compulsory drug treatment, and families are fined if they do not report individuals who use drugs in the family or if they relapse after treatment. These regulations work against principles in the NSAP that call for harm reduction approaches.⁴¹ Also, the NSP is currently unable to report HIV prevalence among the PWID due to lack of linkage with VCT services.

1.2 Prevention of Mother-to-Child Transmission

The need for interventions on the PMTCT was addressed in the NSAP 2011-2015, National Policy and Law. Lao PDR has made provision for a comprehensive package of Maternal, Neonatal and Child Health (MNCH) services under the National MNCH Framework Services 2009-2015 including HIV and STI risk assessment, counselling and referral and syphilis testing for all pregnant women attending ANC.⁴²

The NSAP 2011-2015 outlines strategies for PMTCT including the maternal and child health centre to further implement the PMTCT guidelines as part of the essential antenatal care package including rapid HIV testing at antenatal service sites, HIV prevention interventions for SW and other most-at-risk women to incorporate family planning, reproductive health and PMTCT services, and the MCH centre to increase male involvement in PMTCT and in antenatal care in general. Expected outcomes by 2015 include 50% of ANC attendants receive Provider Initiated Counselling and Testing (PICT), 90% of identified HIV positive pregnant women receive ARV to reduce the risk of mother-to-child transmission and 100% of infants born to identified HIV-infected mothers receive ARV drugs.⁴³ PMTCT programme was initiated in two districts of the province and ten dispensaries with support from Medecins du Monde. Training for health care provider for PMTCT and HIV testing among pregnant women was conducted.

Around 16.44% of HIV-positive pregnant women received antiretroviral drugs (ARV) to reduce the risk of mother-to-child transmission. In addition, 7.38% received a virological test for HIV within 2 months of birth among infants born to HIV-positive women. (Refer to Graph 3).⁴⁴ In 2012, it was estimated that out of HIV-positive women delivering in the last 12 months, 39.6% of children were infected. The lack of access to ARV may have contributed to this increased infection among children. Furthermore, only 10.74% of infants born to HIV-infected women received ARV prophylaxis.⁴⁵ These figures demonstrate that a large number of women are failing to access ANC services, and of those that do only a small proportion of HIV positive

⁴¹ HIV/AIDS Asia Regional Program (HAARP) Law and Policy Review July 2009, United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific. As cited in Policy Brief.

⁴² MTR 2013.

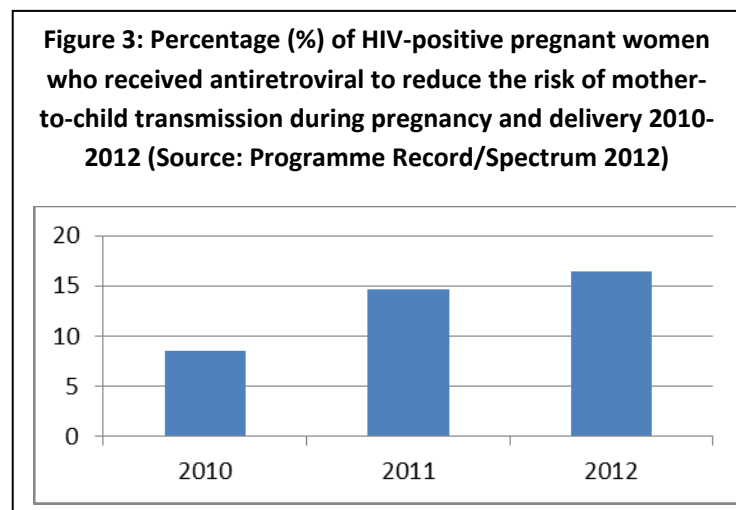
⁴³ National Strategic and Action Plan on HIV/AIDS/STI Control and Prevention 2011-2015

⁴⁴ Program Records/Spectrum Estimates 2011-2012

⁴⁵ Ibid

women have access to treatment.⁴⁶ Access to ARVs may be more challenging in the future since the country is primarily dependent on donors to procure these drugs.

Another factor contributing to this problem is that there is no specific national target for elimination of HIV infections among children. The NSAP 2011-2015 focuses predominantly in targeting pregnant women reached by ANC. The number of women attending ANC at least once during the pregnancy remains low at approximately 54% in 2011.⁴⁷



The proposed PMTCT framework has been designed to accelerate the implementation of PMTCT program. It is aimed to reduce the risk of transmission of HIV infection from parent to child. It highlights a results-oriented plan to facilitate systematic and synergised implementation of the PMTCT programme integrated with MCH services in the country.

Phased planning and implementation: PMTCT programme in Lao-PDR will be implemented in clear phases with timelines. This will enable re-planning for better results. Strengthening of PMTCT programme in high burden provinces will be a priority. The rationale will be to make the most of PMTCT in Lao-PDR setting.

The Phase I (2013-2015,) PMTCT programme will be Implemented in geographically prioritised 4 provinces with 80% PICT coverage for all pregnant women who have access to ANC in VTC, SVK, LPB and CPS. The other remaining provinces, 80% of PICT for all pregnant women will have access to ANC in Provincial hospital. At the District Hospitals (in all 13 remaining provinces), PICT at ANC sites will focus on high risk pregnant women at all functional VCCT sites at district hospitals and

⁴⁶ MTR 2013.

⁴⁷ MTR 2013

will improve referral system (linkages). For Phase II (2015-2018) PMTCT will be scaled up involving more provinces, and for Phase III (2018-2020), all provinces will implement PMTCT programme integrated with MCH services.

The underlying fundamental principles of the framework to enable the PMTCT targets to be achieved are: ensuring quality in implementation; using evidence based actions; using innovation for achieving results; and strengthening community ownership and social mobilisation.

There are **five key strategic areas** in the proposed PMTCT framework. These are crucial for scaling up quality integrated PMTCT services in the country, and will provide the basis for provinces and districts to identify their main issues and determine their subsequent activities in order to achieve the goals set out in the plan. These strategic areas are:

1. **Scaling up PMTCT coverage and improving the quality of PMTCT integrated with MCH to reduce MTCT.** The activities under this strategic area focus on increasing access and availability of PMTCT services as part of comprehensive MCH services in geographically prioritized provinces. Activities to increase male partner participation in MCH services including PMTCT services with a family centred approach are included.
2. **Health System strengthening to accelerate PMTCT integration with MCH.** The first key strategic area aims to improve leadership, management and coordination activities for smooth functioning of the PMTCT programme as an integral component of MCH services. The activities include strengthening coordination activities at the national and sub national levels, and building evidence and linking data to ensure the best quality guidelines and policies are available for all facets of the PMTCT programme. There is also emphasis on increasing visibility and advocacy for PMTCT integrated with MCH services.
3. **Employment of effective interventions for PMTCT programme.** This strategic area aims to enhance activities under each prong of PMTCT in order to raise awareness on services offered, improve utilization and increase demand for PMTCT services. Activities to enhance uptake of family planning services by HIV infected women in reproductive age will be implemented. Measures to improve early booking for ANC services and increase HIV testing rate during Pregnancy will be implemented. Issues related to stigma and discrimination and disclosure will be addressed at all level.
4. **Linkages of services between HIV, STI & MCH programme and Increasing awareness and community involvement in the PMTCT programme integrated with MCH.** The activities under this strategic objective aim to build capacities and integrate PMTCT services at all levels, to ensure that different programmes do not operate in parallel. It is critical to ensure synergy and coordination at the health care level to maximize impact. Special efforts will be made to strengthen linkages within the health care facility, as well as between the facility and community, and reaching women and families in hard to reach and vulnerable communities. Activities to increase male partner participation in MCH services including PMTCT services with a family centred approach are included. Gender based violence; sexual assault and rape are some of the critical issues that need

to be addressed by strengthening the quality of counselling, ensuring linkages with social support services and including male participation in the program, as well as maintaining confidentiality and supporting the woman and her family. Issues related to stigma and discrimination and disclosure will be addressed at community level.

5. **Improve measurement of PMTCT programme performance and impact.** The importance of streamlining monitoring and reporting systems and ensuring good data quality at source for ANC and PMTCT programmes cannot be overemphasized. This strategic objective includes activities to strengthen the monitoring system with clarity in data collection, flow, analysis and feedback. The aim of this thematic area is to improve the overall quality of data and decrease the risk of double counting. In addition, it will allow the capture of missing data points, be able to track loss to follow ups, and promote a common understanding of the definition of indicators across all health care workers and other stakeholders delivering PMTCT services.

The Costing Tool for Elimination Initiative (CTEI) (*Updated 14 Oct 2012*) developed by the National Center for Global Health and Medicine (NCGM) in Tokyo and the Asia Pacific PPTCT Task Force was used to examine the cost implications of routine HIV testing and PMTCT services for pregnant women in Lao-PDR context.

The objectives of this CTEI are to: support Lao-PDR to estimate the costs of eliminating new paediatric HIV infections and improving the health and survival of mothers and children and estimate the costs of PMTCT, pediatric HIV treatment, and family planning. Cost also includes drugs, laboratory tests and health services cost.

Assumptions to CTEI were:

- Pregnant women were tested for HIV at least once during the antenatal visit.
- ARV prophylaxis was provided based on the National guidelines for the use of Antiretroviral Therapy in adults and children 2011.
- All the pregnant women tested HIV positive received CD4 test.
- Pregnant women with HIV have started ARV prophylaxis from the week 14 and gave birth to a baby (birth weight >2500g) at the week 40.
- There was no still birth and/or infant death.
- In WHO guideline option B, maternal triple ARVs were continued until one week after the exposure to breast milk has ended.
- Exposed infants whose mother has received ARV prophylaxis (i.e. enrolled into PMTCT care) also received NVP or AZT and co-trimoxazole prophylaxis.
- Exposed infants were tested at 6 weeks by virological testing and at 18 months by serological testing.

There were different scenarios selected to look into the cost-effectiveness analysis based on ANC coverage and expenditure to answer the following questions:

- How much are we actually spending with the current service coverage?
- How much do we need for the elimination by achieving full service coverage?

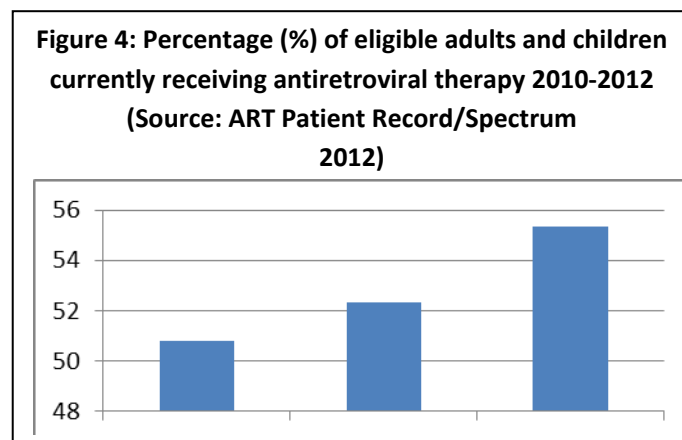
The examples of the different scenarios are:

- *Scenario 1:* Current Lao-PDR.
- *Scenario 2:* Improved access at Lao-PDR
- *Scenario 3:* Best service coverage Lao-PDR
- *Scenario 4:* current Vientiane Capital
- *Scenario 5:* Improved access Vientiane Capital
- *Scenario 6:* current Savannakhet
- *Scenario 7:* Improved access Savannakhet

There are limitations in this CTEI such as: Doesn't include costing for: infrastructure, training, commodity transportation, and M&E. It also doesn't include investment needed for getting increase in ANC coverage and demand side.

2. Care, treatment and support programmes

Care, treatment and support programmes in the country includes the provision of anti-retroviral therapy, hospitalisation and laboratory testing to eligible adults and children



Based on the AIDS Registry and CHAS report 2013, the number of adults and children with advanced HIV infection (currently) receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) is 2787 representing 58.26% coverage⁴⁸.

The results of the study on “WHY Patients Came to ART Sites Late” conducted in 2013, revealed the following: don't think risky (88%); busy (1.23%); fear of HIV status (1.13%); don't want to know result

⁴⁸ AIDS Registry; AEM

(0.51%); VCT site too far (0.51%); don't know VCT site (4.32%); not eager to come for test (2.88%); and too shy (0.82%).

There was a Pharmacovigilance (PV) Pilot Project in Lao PDR on Adverse Drug Reaction (ADR) Monitoring targeting spontaneous reporting for ARV. The aim of the PV system was to monitor and assess ADR of ARV and improve the safeness of ARV with expectation to expand it to other drugs. This was conducted by Food and Drug Department (FDD) and CHAS and Health Care Department (HCD) from Oct 2012 to 31 December 2013 in 5 ART sites. The financial support came from *The Gates Foundation* through WHO. The Targeted Spontaneous Reporting of ADR includes specific toxicities of *Zidovudine (AZT) to monitor Anemia* and *Nevirapine (NVP) to monitor rash of Steven's Johnson syndromes and hepatotoxicity*.

Project outputs resulted into: agreement on an establishment of a management and coordinating committee for Pharmacovigilance for ARV drugs, MOH – Minister decree number 767, 17 May 2012; Targeted Spontaneous Reporting form for ADR of ARV developed; SOP for ADR in five pilot ARV sites developed; and 10 clinicians from five ARV hubs trained on SOP and TSR form reporting.

Project outcomes were: Lao PDR has been accepted as an associated member of UPPSALA monitoring center; PV Unit under FDD is being established to monitor all ADR; and ADR from AZT and NVP are now routinely reported. Project resulted in: From October 2012 until end of September 2013, in 5 ART centers, 421 new patients have been put on ARV; 64 cases of ADR reported among these patients, 33 cases from AZT and 40 cases from NVP.

The strengths of the Project were: first ever project in Lao PDR on PV; support from MOH, FDD, CHAS and relevant key implementers; gaining evidence on ADR of ARV specifically from AZT and NVP; increase on safety on the use of ARV for patients; strong commitment of medical practitioners; adherence was improved; enhance capacity of ARV sites in reporting; experience from this project could be used to institutionalize the PV in MOH; and can be a base and model to expand the project to cover more ARV drugs.

However, there were challenges such as: standardized format to have denominators for data analysis is required for future implementation on PV of ADR of other drugs; timely manner of report submission requires focal point to have close monitoring and follow up; capacity and focal point for data validation and analysis need effective support; immediate responsiveness on ADR site supervision and investigation is required; and funding for sustainability is critical. CHAS now is exploring the possibility of getting financial support in order to continue the pilot project.

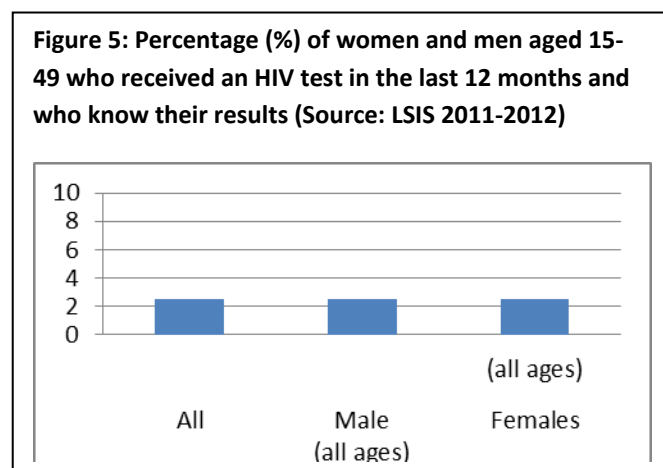
2.1 Voluntary counseling and testing

The government promotes VCT targeting KAP as part of the provisions of the Law on HIV/AIDS Control and Prevention 2011.⁴⁹ Based on the SSF Annual Report for 2012, the number of people who received HIV

⁴⁹ Lao PDR Policy Brief JUNIMA

testing and counseling services and received their results reached 29,602.⁵⁰ GF SSF PUDR 2013 revealed that the number of people who received HIV testing and counseling services and received their results reached 34,354 versus the target of 40,597 achieving 85%. These results showed improvement since the time LSIS in 2011-2012 was conducted that among those survey, only 2.53% of women and men aged 15-49 received a HIV test in the past 12 months and knew their results (Refer to Figure 5).⁵¹

There is still a need for improved HIV education since HIV testing for the general population is not mandatory in Lao PDR. It is not required for entry, work or residence. It is also not required for GMS migration. What the government requires is the health test, excluding HIV, for all outgoing labour migrants and pre-departure HIV/AIDS education. This was based on the series of decrees issued by the Lao PDR Ministry of Labour and Social Welfare (MLSW) from 2002-2007.



The 2013 SSF PUDR revealed that the number of people who received HIV testing and counselling services and received their results was 34,354 with the a cumulative target of 40,597 achieving 85%.

2.2 Provision of antiretroviral therapy (ART)

This indicator measures the number of adults and children currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO standards) at the end of the reporting period.

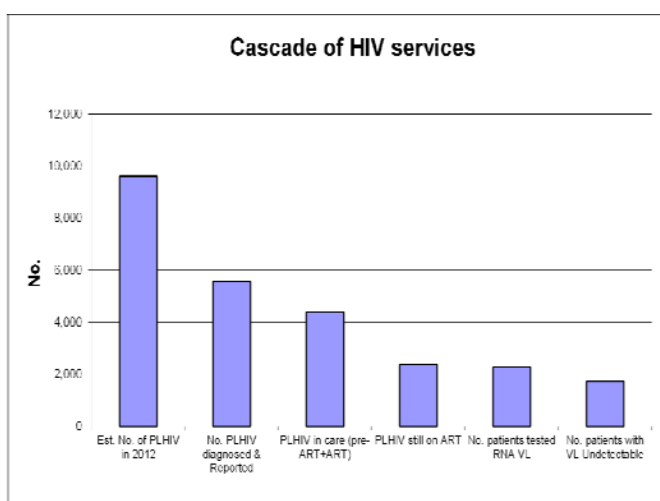
In 2011, a total of 1,988 PLHIV in need of treatment had received ART representing coverage of 52.3%. There are a total of nine ART sites including a new site established in 2013. There was also an increased number of percentage of adults and children receiving ART at 58.26% in 2013, 55.36% in 2012 and 52.3% in

⁵⁰ SSF Annual Report 2012

⁵¹ Lao Social Indicator Survey 2011-2012

2011 respectively. Global Fund reported ART coverage a total of 2,787 versus its target of 2,650 adults and children. The latest GF SSF PUDR 2013, revealed that the number and percentage of children and adults with advanced HIV infection currently receiving ART in accordance with the national treatment protocol was 2,787 with a target of 4,784 (AEM 2013) achieving 58.26% coverage. This was higher than the ones achieved in 2011 (52.30%) and 2012 (55.36%) respectively.

Figure 6. Cascade of HIV Services



Lao PDR has experienced strong success in treatment of HIV. The number of PLHIV receiving ART has increased by 16% with 2,375 eligible adults and children receiving ART in 2012, compared to 1,988 in 2011. The percentage of PLHIV receiving ART in 2012 was 55.36%, an increase from 52.3% in 2011 and 50.8% in 2010 (See Graph 6). ART initiated between January to December 2012 is at 524, of which 85.5% are still alive on ART 12 months after initiation. The dropouts from the programme reflected those who died (7.6%) and were lost to follow-up (6.9%).⁵² ART initiated between January to December 2013 was at 498, of which 83.78% are still alive on ART 12 months after initiation. The dropouts from the programme reflected those who died (6.63%) and were lost to follow-up (6.02%).⁵³ The motivating factors that encourage PLHIV to

⁵² SSF Annual Report 2012.

⁵³ SSF Annual Report 2013.

access ART include access to free ARV, presence of supportive health care providers, and provision of psycho-social support of non-government organization and self-help groups such as LaoPHA and LNP+.

Adherence to ART over time is high, with 85.50% retention over 12 months in 2012⁵⁴ and 83.73% over 12 months in 2013⁵⁵. Despite this progress, ART coverage is still limited. On the supply side, Lao PDR still needs to intensify access to ART particularly the government's role on the provision of service. The majority of care and support work is done by civil society organisations and informal networks of KAP. In addition, there is little coordination and integration between community organisations and national programmes. The country strives to provide the needed ART services with a new site established in 2013 complementing the nine ART centres already operational. The ART sites are overburdened with the huge number of patients needing to be served and the anticipated increased HIV incidence, coupled with more individuals accessing ART with improved VCT and HIV education. Currently, most of the PLHIV accessing ART are already with advanced stages of HIV infections. This reduces the possibility of treatment being effective. On the demand side, some of the hindering factors that prevent PLHIV either to initiate or continue with ART is the cost of transportation going to the ART sites to get the medicines. In most cases, the medicines are not always available and there are stockouts of ARV drugs.

2.3 Co-management of HIV and Tuberculosis

Lao PDR has made some progress in the reduction of tuberculosis deaths in PLHIV. There is an increased percentage of HIV-positive among TB cases that received treatment for both TB and HIV. National guidelines on HIV and TB co-infection developed and implemented following the PICT approach. The HIV-TB programme and service integration in Lao PDR is on track with successful national coordination and implementation in health facilities. The government also works with the IOM to implement a health project for migrants and mobile populations which provides active TB mass screening in hard-to-reach populations including migrant workers who receive free TB treatment.⁵⁶

In 2012, 3,645 people registered as HIV positive were screened for TB at least once during the year. The number of people receiving treatment for both TB and HIV has increased from 49.2% in 2010 to 55.96% in 2012 (See Figure 7).⁵⁷

⁵⁴ ART Patient Registers 2011-2012, Spectrum Estimates 2012, Programme Annual Report 2012

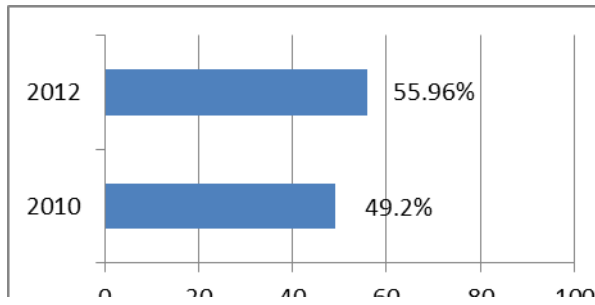
⁵⁵ Ibid

⁵⁶ Policy Brief.

⁵⁷ ARV Patient Registers and Estimates from WHO Stop TB Database 2012

Figure 7: Percentage (%) of estimated HIV-positive incident TB cases that received treatment for both TB and HIV in 2010 and 2012 (Source: ARV Patient Records

2012)



The key technical team overseeing the implementation of the HIV and TB program is the HIV/TB Committee which meets once monthly. The purpose of the Committee is for data gathering and looks at the issues of patients with HIV and TB. This includes TB testing for HIV patients and conversely HIV testing for TB patients. More often HIV positive individuals would not like to go for TB testing for the fear that other people may know their status. In terms of treatment, ARV drugs are provided monthly, however the TB drugs are provided daily using the Directly Observed Treatment Short course chemotherapy (DOTS) that inconvenience the patient to come to the DOTS center on a daily basis.

B. Knowledge and behaviour change

1. Knowledge about HIV prevention and sexual behavior

Young people. One of the identified interventions conducted by the government targeting the general population is the introduction of life skills education in secondary schools in Vientiane Capital and Savannakhet province. Expansion of similar initiative is welcome especially that the overall knowledge regarding transmission of HIV in Lao PDR remains low. The Lao Social Indicator Survey (LSIS) 2011-2012 found only 25.13% young women and men aged 15-24 were able to give correct answers to all five questions regarding HIV transmission. . There were more males than females being able to provide correct information at 27.64% and 23.98%, respectively.⁵⁸

The survey measured the number of respondents who gave correct responses to the following questions: (1) Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?; (2) Can a person reduce the risk of getting HIV by using a condom every time they have sex?; (3) Can a healthy-looking person have HIV?; (4) Can a person get HIV from mosquito bites?; and, (5) Can a person get HIV by sharing food with someone who is infected? Common misconceptions remain prevalent with only 41.71% correctly answering on the question of HIV transmission through mosquito bites

and only 60.42% correctly answering HIV transmission from sharing food with someone who is infected. There were 75% who were able to correctly identify that the risk of getting HIV is reduced by having sex with only one uninfected partner and by using a condom every time they have sex, there is still a need to improve understanding among young people on HIV prevention.⁵⁹

Based on the LSIS, 6.40% of females and 2.70% of males aged between 15 and 24 years reported having had sexual intercourse before the age of 15. Females have earlier onset of sexual activity compared with males. This is due to the fact that 10.90% of Lao female youth who had sex in the last 12 months had done it with man 10 or more years older. This is significantly higher than that of Cambodia at 0.30% only.

Early sexual onset is positively correlated among those with no education and belonging in poorest wealth quintile. Those from Northern Lao PDR more frequently reported early onset of sexual activity. Young women from households where the language spoken was Hmong-Mien⁶⁰ more frequently reported early sex than those in other language groups. Rural dwellers have earlier onset of sexual activity for both males (3.20% rural vs. 1.40% urban) and females (8.20% rural vs. 2.10% urban).

Sex workers. In 2011, it was estimated that the number of SW was around 14,000 in Lao PDR. The IBBS 2011 conducted among sex workers found HIV prevalence at 1% in 6 surveillance provinces with the highest prevalence in Luang Prabang at 1.80% and the lowest at 0.70% in Vientiane, Champasak and Savannakhetⁱ. This was the fourth round of surveillance survey conducted among this population and HIV prevalence has not increased in the last 10 years⁶¹

Recently more sex workers, especially young SW, use mobile phones to contact clients or are engaged in opportunistic sex work, working only for a few monthsⁱⁱ. Little is known about their behaviors or this trend. Workshop participants noted that sex workers (including female SWs, MSM and transgender SW) constantly fear arrest, lack negotiating skills, often lack legal status, suffer from violence from clients, partners, and police and are unable or unwilling to access HIV prevention services and treatment. Stigma and discrimination, their illegal status and social norms make SW particularly vulnerable to violence and unprotected sex.

The changing behaviour on how sex work operates in the country is partly driven by the improved technology and increased migration. Sex workers, particularly the young ones, use mobile phones to hook up with their clients.⁶²

MSM. Condom use among MSM and TG were low with rates of reported sexually transmitted infection (STI) high.⁶³ In the 2012, the Second Round HIV/STI Prevalence and Behavioural Tracking Survey among Male-to-

⁵⁸ Lao Social Indicator Survey. HIV Knowledge, Attitudes and Behaviour in Lao Households.

⁵⁹ MTR 2013

⁶⁰ Ibid

⁶¹ Global AIDS Response Progress – Country Report Lao PDR, 2012 quoting Burnet Institute/CHAS report

⁶² UNICEF. Rapid Assessment: Most-at-Risk Adolescents and Young People to HIV in Lao PDR, 2011.

⁶³ MTR 2013

Female Transgender in Lao PDR conducted by PSI revealed the following: consistent joint use of a condom and water-based lubricant with regular partners in the last month increased significantly from 42.40% in 2010 to 58.40% in 2010; consistent joint use of a condom and water-based lubricant with casual partners in the month increased significantly from 47.90% in 2010 to 59.80% in 2012; and there was no significant change in consistent use of condom and water-based lubricant between commercial partners, between 2010 and 2012, either where the respondent was the paying partner, or the partner was receiving money for sex. Small scale surveys revealed that 57.80% of TG using condoms with clients and only 45.90% with regular partners.⁶⁴ With these limited data, there is a need to further study the behaviour of this population to improve intervention.

PWID. Lao PDR conducted a rapid assessment conducted by HAARP project and CHAS supported by AusAID and USAID. Programme interventions have an allocation of \$3.6 million supported by AusAID between 2011-2015 to promote safe injecting equipment and condoms. Pilot harm reduction project was implemented in 2012 through the NSAP.⁶⁵ Currently there are no OST programmes operating in Lao PDR.

2. Gender equality

The government supports upholding gender equality. It is listed as a guiding principle in NSAP 2011-2015. The country also ratified the Convention on the Elimination of all forms of Discrimination against Women. The government committed to conduct a review of existing legislation relating to domestic violence against international standards. In terms of programme implementation, the government coordinates with Lao Women Union to seek the views and support of women's organizations

There is limited information and data measuring gender inequality and that relates to physical and sexual abuse.⁶⁶ LSIS 2011-2012 revealed concerning views on acceptable behaviour in relationships with 24.90% of women believing a husband is justified in beating his wife/partner if she refuses sex with him and 32.10% if she goes out without telling him.

Whilst there is no comprehensive data on GBV, the National Commission for the Advancement of Women (NCAW) and the Lao Statistics Bureau (LSB) are about to undertake a national survey on Gender-based violence. The study focuses on violence between men and women in intimate partnerships. There are currently no questions within the survey targeting same-sex partnerships or violence within the transgender community. Globally, it is known that transgender people and MSM suffer from gender-based violenceⁱⁱⁱ⁶⁷.

Violence, in addition to being a human rights violation, has been clearly demonstrated as a risk factor for HIV acquisition and women living with HIV are more likely to suffer from gender-based violence. Workshop participants in the "Gender Assessment of the National HIV Response in the Lao PDR, October, 2013"

⁶⁴ PSI/CHAS. Report on Transgender HIV, STI & Behavioural Survey (2010)

⁶⁵ HAARP Report 2012

⁶⁶ CHAS/MOH, Lao PDR HIV Response: Progress against 2011 Political Declaration p18

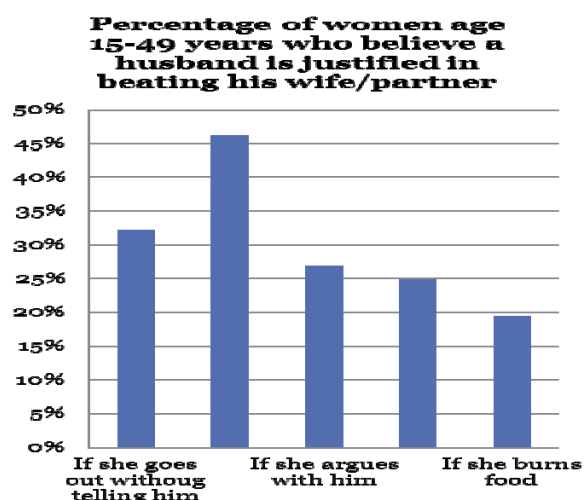
⁶⁷ WHO, 2010f; Stephenson, 2007; Jewkes et al., 2006a; Manfrin-Ledet and Porche, 2003; Dunkle et al.

reported that many women living with HIV are rejected by their husbands and families, when diagnosed. This is compounded by the factors in a patriarchal society such as the norms of masculinity reduce women’s role and voice in society and reduce their voice within the home; when society allows, even encourages, men to have multiple sexual partners; where women lack negotiating power for example to use a condom or to say yes or no to sex; and when what happens in a home is ‘private’ and beyond the realm of the community or police in terms of intervention⁶⁸.

In Lao PDR, 87% of transmission is through sexual contract (both hetero sexual and homo/bisexual)⁶⁹. ‘Low-risk’ women (Defined as women who have a low-risk perception and behavior, including married women, ex-sex workers and young girls) make up increasing numbers of new HIV infections in Lao PDR⁷⁰. The results of the LSIS highlight their compounding vulnerabilities that include: poverty and low levels of education; high rates of early onset of sexual intercourse and cross-generational relationships; low usage of male condoms; virtually no use of female condoms; lack of knowledge of HIV transmission and prevention; and unequal status within relationships. All these factors combine to make married/partnered women at particular risk in Lao PDR^{iv}.

The MTR 2013 reported that there exists a poor community understanding of gender inequality and very little understanding of the challenges associated with tackling gender equality.

Figure 8.



3. Stigma and discrimination

Stigma and discrimination listed as a guiding principle in the NSAP 2011-2015. The government strives to bridge the gap on stigma and discrimination by highlighting the issue in National Law of HIV/AIDS and STI

⁶⁸ LWU.October 2013.Workshop on “Gender Assessment of the National HIV Response in the Lao PDR” 2013”

⁶⁹ Global Aids Response Progress – Country Report, 2012, Lao PDR, p17

⁷⁰ HIV Knowledge, Attitudes and Behaviour in Lao Households: Results of the First Lao Social Indicator Survey. Final Draft October 2012. P36

and health education session conducted for Line Ministries and mass organizations addressing stigma and discrimination issues. The NSAP is progressive in addressing stigma and discrimination issues but there is a need to popularize the law for the general public.

Another major initiative is the conduct of the LSIS in 2011. The GARP indicator measures the number of respondents aged 15–49 years who responded “No” or “It depends” to any of the two questions: (1) Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?; and, (2) Do you think children living with HIV should be able to attend school with children who are HIV negative? For the first question, LSIS adopted it in the survey while for the second question, LSIS asked “Do you think that a teacher who is HIV positive should be allowed to teach in school?” In addition, it also asked these questions “Would you care for a family member sick with AIDS?” and “Would you want to keep the positive HIV status of a family member a secret?”

The study found that there are high levels of stigma and discrimination against people living with HIV in Lao PDR households with fewer than half of the sample would buy fresh vegetables from a shop vendor with the AIDS virus. Results showed that only 43.3% of women and 39.3% of men aged between 15 and 49 years would care for a member of their family sick with AIDS in their own home. Only 17.0% of women and 14.2% of men aged between 15 and 49 years expressed accepting attitudes on all 4 indicators. Overall, a greater proportion of women than men express accepting attitudes on all indicators, although women have poorer knowledge of HIV.

The result of the Stigma Index Survey also found that there PLHIV are likely to belong in poor households 63% PLHIV are living with poor families compared to 2008 level of the national poverty rate at 27%. The SIS is based on a survey of 305 PLHIV in three provinces. The study showed that 15% of PLHIV have permanent job, 17% full time employment but not as permanent position. About 24% PLHIV are self-employed while 15% were unemployed. There were also some forms of discrimination against sex workers and drug users and PWID.

The approval for Stigma Reduction Intervention Project in 2013 supported by UNAIDS is anticipated to counter stigma and discrimination for PLHIV.

Fourteen self-help groups in 12 provinces to support PLHIV including eliminating stigma and discrimination

Figure 9.



C. Impact alleviation

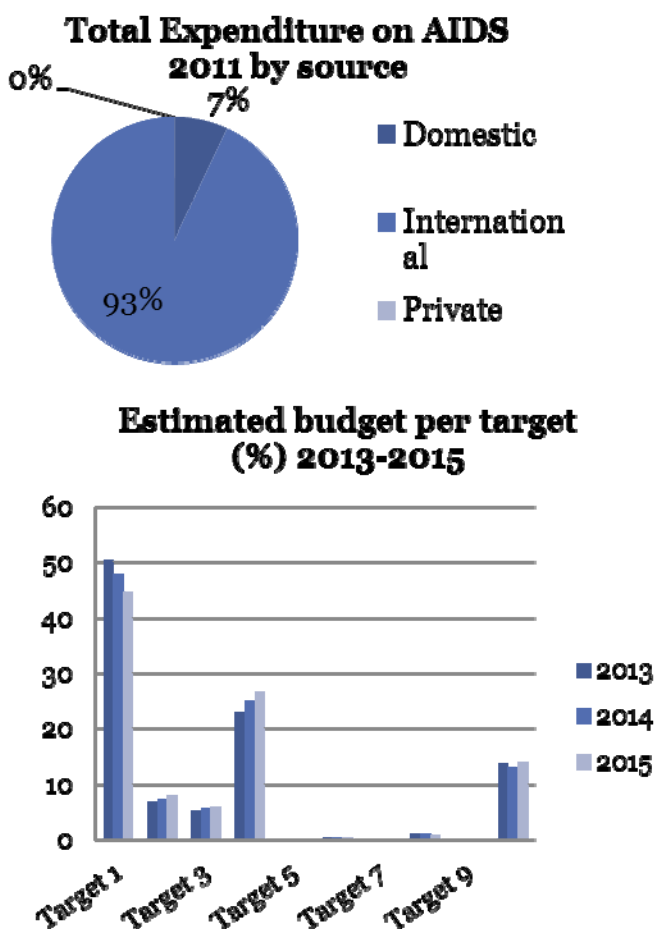
To address the impact of HIV prevalence, Lao PDR commits to achieve the Political Declaration Targets, MDG's and Three Zero's and implement the NSAP 2011-2015. There is an increased involvement of national assembly and key stakeholders and mainstreaming HIV/AIDS into the National Infrastructure Development project. Internal integration mechanism within Ministry of Health has been established, including NCCA, PCCA, sector wide coordination mechanism, CCM oversight committee, HIV/AIDS Taskforce, Joint UN Team on AIDS, ASEAN Taskforce on AIDS, GMS MOU on HIV/AIDS and Mobility

The MTR 2013 identified the needed improvements which include community systems strengthening required to develop the role of community organizations, KAP and communities in the assessment, planning, design, implementation, and monitoring and evaluation of HIV services. It also identified the improvement in the HIV M&E data collecting system to be fully integrated and coordinated, alignment of the NSAP 2011-2015 targets with the Ten Targets and improvements on the coordination between national programme and project implementers.

To ensure that the Ten Targets, MDG's and Three Zero's are achieved, the government Increased expenditure on HIV services. It conducted comprehensive budget estimation per programme until 2015. It also pursued resource mobilization from domestic sources to fund HIV programmes. As the government's contribution to the national programmes supported by the Global Fund, counterpart fund has reached 20%. The government needs to strengthen resource mobilization since funding from international sources is projected to be reduced in the future. Whereas the national government has an allocated funding on HIV and AIDS, the provincial governments do not have the budget to support the implementation of their

programs.

Figure 10.



IV. Best Practices

There are a number of best practices that Lao PDR can capitalize on to scale up HIV programme implementation to achieve the Ten Targets.

Political leadership and policy support to implement NSAP and HIV Law

The Government of Lao PDR has moved quickly to strengthen its strategy to respond to the HIV epidemic situation of the country. It has provided strong political commitment by endorsing the Declaration of Commitment at United Nations General Assembly Special Session on AIDS in 2001 to support a multi-sectoral response.

There were two other milestones that were passed namely: National Strategic and Action Plan for HIV/AIDS

and STI Prevention and Control 2011-2015 (NSAP). These two milestones confirm the commitment of the Government of Lao PDR to reach MDG 6 and the Three Zeros strategy and the Law on HIV/AIDS Control and Prevention (hereafter refers to as the HIV Law) was approved by the National Assembly and then promulgated by the President of Lao PDR in 2010. The Law is progressive in terms of addressing stigma and discrimination and promoting equity.

The NCCA and CHAS are in the forefront of spearheading support to HIV. They reflect strong political leadership of NCCA and CHAS to improve multi-sectoral response to HIV. They are actively collaborating with the different sectors to ensure the efficiency and effectiveness of the national AIDS response.

There is also a supportive policy environment with the implementation of the NSAP and HIV Law. The implementation of these programmes and policies provide a backdrop to mobilise resources and promote support towards improved NAR.

The following activities exemplified the political leadership and policy support to implement NSAP and the HIV Law: The Minister of Health and Chair of the NCCA endorsed the results of the MTR of the Ten Targets; he talked about the issues of stigma and discrimination to PLHIV on the occasion of World AIDS Day and supported the drafting of GARPR Lao PDR 2012 and finally endorsed it; The Deputy Minister of Health (Associate Prof. Dr. Bounkong Syhavong) participated in the Tripartite Meeting during the HAARP Phase 2 program which reviewed major programme design modifications; CHAS Director chairs the ASEAN Task Force on AIDS (ATFOA) and participated in the Consultative Meeting with the PCCA Officials for the ADB Project together with the Deputy Directors; CHAS Director also participated in the 11th ICAAP, presented several papers, held in Bangkok, Thailand, November 2013 and in Leadership Forum 2013:Asia Pacific Getting to Three Zeros, 17-18 November, Bangkok, Thailand; CHAS GF Coordinator participated in the 11th ICAAP; High ranking Government officials attended CCM meetings; and PCCA organised the HIV and AIDS activities during special cultural and religious events (Boat racing festival, WAD, Thatluang festival, etc.).

In 2012 and 2013, around 800 people participated in the World AIDS Day campaign. This was highlighted by the presence of high ranking officials such as the Vice Minister, Vice President of the LWU, Deputy Director of Planning and Investment of the Ministry of Planning and Investment, Vice Governor of Vientiane Capital, members of the mass organisations, representatives of the different ministries and the general public. During these celebrations, booth exhibition was handled by the stakeholders to provide free medical examination, teach resuscitation procedures, distribute IEC materials and condoms, and conducted a quiz show. Umbrellas, t-shirts and condoms were given out as prizes. Lao Red Cross had a booth for voluntary blood donation. In 2012, speeches were provided on HIV and AIDS by the Vice Minister of Health, UNAIDS Country Coordinator and the Vice President of the LWU. In 2013, the Vice Minister and the Vice Governor of the Vientiane Capital gave their speeches as well.

The two celebrations were capped with parades led by the Pioneers Organisation with the drum-band. The celebration ended up with the group aerobic dancing and visited the exhibition booths.

Peer-led interventions sustain the operations of prevention, treatment, care and support programmes

The scale-up of effective prevention programmes include a number of initiatives mostly led by international organisations in partnership with local civil society groups. These include outreach workers and educators are engaged to support prevention programmes implemented in Drop-In Centres for sex workers, men who have sex with men and transgender. By the end of 2011, there were 25 outreach workers; 586 peer educators working with sex workers and 401 peer educators working with men. Two Drop-In Centres provide counselling, STI management, and referral to HIV testing and ARV treatment.⁷¹

Another project is the one initiated by the government and IOM targeting migrants and mobile population. The goal of the project is to increase HIV awareness for road construction workers, truck drivers, sex workers and communities along road project sites. They are also implementing a second project which focuses on hard-to-reach population and migrant workers to provide active TB mass screening and free TB treatment.⁷²

The ADB Project Greater Mekong Subregion (GMS) Capacity Building for HIV/AIDS Prevention Project

An example of a capacity-building initiative is the project initiated by ADB, with funding support from AusAid. The ADB Project Greater Mekong Subregion (GMS) Capacity Building for HIV/AIDS Prevention Project (2012) supports Lao PDR and Viet Nam to address current gaps in reaching high-risk and vulnerable populations in border areas along economic corridors in the GMS. It aimed to: build capacity of local authorities in addressing HIV so that they are ready for heightened level of activity when road construction begins; prepare communities living along the proposed route for the road upgrade for any new HIV vulnerabilities that will be associated with the road development; address the immediate HIV transmission risks already present in the communities during the current phase – prior to beginning of road construction; and build capacity of health systems required to support HIV programming like VCT and Sexual and Reproductive Health services including STI management services.

Beneficiaries of this Project were: llocal people, mostly rural villagers, including different ethnic groups. The project helped these people to understand HIV, consider their own risks, and prepare for further HIV risks which will occur as more people visit the province during and after road construction. This was based on the concept of Early Warning and Rapid Response. Potential HIV and STI risks identified were: if the local village women have sex with the male road construction workers, for money, for exchange of goods or services, or in hope of future marriage; if more men and women start using drugs because the road makes drug trafficking easier (there is HIV associated with drug using in the nearby provinces of Viet Nam); and if the number of MSM increases: as has often happened elsewhere in Asia, this is very likely as the provincial capital Xam Neua grows from a small town to a small city.

⁷¹ Policy Brief

⁷² Policy Brief

How the project worked: The project focused on building long term sustainability of responses to HIV through the development of the district Project Working Teams. This ensured long term engagement in responses to HIV by people who themselves live in the districts. It was built on their understanding of HIV, then helped them to analyse local situations, future challenges, and planning of long term responses. The district Project Working Teams included staff from the provincial Health and Transport authorities, along with others from the Provincial Committee for Control of AIDS. Partners included the Lao Women's Union; the Lao Youth Union; the Lao Trade Union; the provincial staff of the Ministry of Information, Culture and Tourism (who produce radio and television services for the province); provincial staff of the Ministry of the Interior; Police; and the Military. These local organisations will continue to allocate staff time to responding to HIV in the long term. The members of the district PWT are people from different sectors, and their salaries were not paid by the project. They understand their own communities better than any outsiders.

The project focused on building their understanding of HIV and how this might affect their own communities. The project also encouraged them to think about the economic benefits of having a new road for the province, and how the local people might work to maximise these benefits. The district PWT Teams worked with their own local communities. They helped these communities to prepare for changes in HIV transmission that are likely to occur once the road construction commences, and after the road is completed.

The project built capacity in HIV awareness, situation analysis, mapping of services, peer education, communication skills, referrals to HIV and STI services, and some enhancement of those services. A Burnet Project Officer lived in Houaphanh Province for the period of the project. In the later stages, the Project Officer was an STI expert seconded from the national Centre for HIV/AIDS and STI (CHAS). This ensured even closer collaboration between national and provincial partners.

Key lessons include: sustainability is best built through multi-sectoral Project Working Teams; cross country learning exchanges are valuable for increasing capacity both ways; pre-construction phase projects require saturation of all communities as there is no clarity on where road construction workers will focus themselves during road construction; and in the final six months, the Project Working Teams prepared their own proposals for sustainable responses to HIV during the next phases of road construction and post construction.

The Lao-Thai-Australian Collaboration in HIV-Nutrition

The Lao-Thai-Australian Collaboration in HIV-Nutrition or simply Lao-TACHIN project was awarded the 2011 South-South Cooperation Award for Partnership at the Global South-South Development Expo 2011 by the United Nations Development Programme (UNDP). This global level recognition reflected outcomes documented at both a national and project level and supported by evaluation studies among collaborating partners, health care workers and beneficiaries. The project received positive evaluation from the field. Project outcomes include the following: "increased nutrition knowledge for HIV-infected patients receiving nutrition assessment, education and counselling; improved nutrition status of HIV-infected patients receiving nutrition assessment, education and counselling demonstrated by increased body weight calorie

intake; increased capacity of health care providers in HIV nutrition care; improved HIV management in the hospitals by improved documentation of client records and service flow at HIV clinics; improved referral system between peer support group and antiretroviral therapy (ART) clinic; increased HIV testing in pregnant women attending antenatal clinic and delivery room; and, HIV testing increased dramatically to 30% in 2011, compared with 19% in 2010.”⁷³

This project was extended from July 2011 to June 2012 both in Champasak and Savannakhet provinces. HIV-infected individuals and their families were attended to at Champasak and Savannakhet Provincial Hospitals. PLHIV also participated in activities at the positive peer support groups in Champasak and Savannakhet provinces.

During the extension period, the Project has achieved the following:

1. Trained and provided on the job mentoring to TRCARC in international health development and project management.
2. Established an HIV nutrition clinic at Champasak Provincial Hospital and Savannakhet Provincial Hospital and provided training and ongoing mentoring to the nurse-nutritionists.
3. Established small group nutrition education by District Breast-Feeding (DBF) support group, and strengthened the role of peer educators in all HIV nutrition services. Referral system and communication pathways between DBF and the HIV nutrition clinic were also established.
4. Strengthened HIV clinical services in Champasak Health Services and Savannakhet Health Services through the provision of training and mentoring in VCT, PITC, rapid test training, and PPTCT management.
5. Strengthened service delivery through the development and localisation of standards of practice and streamlining client flow and referral processes.
6. Visit of NCHAS from Cambodia. Fifteen staff from NCHAS Cambodia have field visit to learn about the Lao TAICHIN Project to explore the possibility of replication in Cambodia.

Drop-In Centre (DIC) provides one-stop shop for KAP to access needed HIV interventions

The Lao Model Drop in Centre is operated in conjunction with other prevention programmes. The project showcases the successful collaboration of multi-stakeholders engaging government, civil society, and private sector partners. The project supported by the Global Fund To Fight AIDS Tuberculosis and Malaria (GFATM), USAID and Family International (FHI) and working in close collaboration with the CHAS, MOH and other partners. The project implements the peer-led DIC (*Heuan Mai*) initiative. The project shows how an effective HIV and STI intervention can be built through close collaboration between, with a strong element of peer leadership in delivery of products and services to the target group.

The project was first established in 1999 and there are now nine active DIC, one in each of the following provinces Xieng Khouang, Bokeo, Luang Prabang, Savannakhet and Champasak and four in Vientiane Capital. The main objectives of the DIC initiative includes the delivery of a comprehensive package of

⁷³ Lao-Thai-Australian Collaboration in HIV-Nutrition Project. Project Document.

services (CPS) which includes intensive inter-personal communication (IPC) activities to promote behaviour change, offering VCT services with free HIV rapid testing, diagnosing and treatment of STI, referrals to HIV care and treatment, provision of male and female condoms, and lubricant .

The provision of quality comprehensive package of services (CPS) to female sex workers (FSWs) through drop-in centers (DICs) has reached 80% of FSW in target provinces. The IBBS data indicates that high coverage of FSW through DIC result in a significant reduction of STI prevalence and increase in condom use among FSWs across six provinces of Lao PDR. Some of the services provided are HCT, STI, and referral information and services, learning skills related to condom use (including condom negotiation), safe behavior, life skills, and receive free consultation and treatment from a doctor. The on-site HCT provides same day result and STI screening and treatment services, including symptomatic treatment and monthly periodic asymptomatic presumptive treatment. The DIC also distribute free of charge male and female condom, lubricants and other referral services.

PSI continued to operate their New Friends (*Peun Mai*) Drop-in center (DIC) to provide transgender individuals with access to quality health products, services and information. These DICs aimed to provide a safe space where at-risk MtF TG and their partners can access quality sexual services. These are located in Vientiane Capital and Savannakhet. New Friends peer outreach teams conducted daily visits to hot spots providing HIV and STI prevention products, information and referrals to testing and treatment. In addition to these services PSI Lao PDR created HIV/STI prevention products (i.e. condoms with sachet of flavored lubricant and STI treatments) specifically tailored to this target group. The programme promotes consistent condom use and water-based lubricant used for anal sex with all sexual partners, with special focus on sex acts between regular partners (i.e. boyfriend) and commercial partners⁷⁴.

V. Major Challenges and Remedial Actions

A. Progress made on key challenges reported

The challenges reported in GARPR 2012 include lack of information to understand the risk and vulnerability of behaviours. Sub-groups were analysed with the continuous studies and targeting of KAP or geographic-specific population like the road construction project. In addition there is an on-going Greater Mekong Subregion Capacity Building for HIV/AIDS Prevention Project which started in January 2013 projected to run until 2018, the objective of which is improving coverage and quality of services for key affected populations in border provinces.

⁷⁴ Second Round HIV/STI prevalence and Behavioural Tracking Survey among Male-to-Female Transgender in Lao PDR 2012

Another challenge identified was the stigma and criminalisation attached to HIV which inhibits PLHIV to access health services. The popularisation of the HIV Law and the conduct of Stigma Index Survey showed the support of the country to improve the understanding of the public towards HIV and increase information on the level of stigma and discrimination for PLHIV.

Further, integrating HIV related health services is a challenge that requires a paradigm shift. The need to integrate services in a continuum of care is valued by the government. One of the best practices identified in this report is the integration of HIV with nutrition programme. This similar kind of mainstreaming of HIV interventions into the regular health systems to ensure there are no missed opportunities and services are given in stages of the life cycle of a PLHIV and prevention programmes for all types of population.

B. Challenges faced throughout the reporting period

The challenges faced throughout the reporting period include the ambitious targets committed to be achieved by 2015. There is also a disparity of the Ten Targets of the Political Declaration and the targets identified in the NSAP 2011-2015. The variation in the targets makes it challenging to assess the progress with the difference in the definitions of indicators and in some cases. There are three Indicators that have not been monitored systematically. For the Ten Targets, three targets are off-track that need further interventions, six are on-track and one is achieved.

Another challenge experienced during the period is the overlapping of funding for some projects particularly those relating to huge projects like that of the Global Fund programming for 2014 and projects supported by international non-government organizations or UN agencies. There may be either duplication of support to similar activities or with similar target groups or local implementing institutions.

C. Concrete remedial action

There were various actions done on the key components taking into consideration the recommendations in the MTR 2013 report:

On programme management, there has been some training and discussion meetings to strengthen the role and build capacity of NCCA, PCCA, and stakeholders in improve management and coordination of programmes. The Lao Government has provided counterpart funding for the Global Fund Project to assure resource mobilisation to sustain programmes. CHAS took the lead to ensure that project reports and plans including funding stream are coordinated with them. Resources are maximised, like revenues of the PSI from the GF social marketing is funneled back to Project activities.

There was a greater involvement of CSOs in the programmes reviews, management, planning, field implementation and research which are very valuable. CSOs have supported the popularisation HIV Law by informing key affected population their rights and salient points of the Law.

On monitoring and evaluation, the review of M&E Plan was updated in June 2013 which involved members from government and CSOs. The review included CHAS, MOH, GF/PR, LaoPHA, PSI, UNAIDS, WHO with technical support from two international consultants. In April 2012, in preparation process of the GF proposal for Single Stream Fund (SSF) second phase, a programme external review was conducted of which the National M&E system was one of the reviewed component. Two software for data collection was improved, one for data collection clinical reports known as the “HIVCAM Plus”, and the other one is for prevention reports, e.g, VCT known as the monitoring evaluation reporting system (MERS). CHAS M&E and Surveillance Unit has now become a Unit with its own staff. The staff had undergone training on HIVCAM and MERS.

Another action is to scale up prevention programmes, CSOs continued to do peer-led interventions, drop in centres, integration programmes, 100% condom use programmes, and HIV education for the general population and KAP such as sex workers and clients, MSM, Transgender including PLHIV. Targeting PWID has been conducted through the HAARP Project and expansion is underway.

For the treatment, care and support services, ARVs and OI drugs are provided for ART sites for those who need them. VCT sites continued to provide HIV testing. CSOs continue to provide care and support activities including self-help groups.

For stigma reduction, Framework and Action Plan on Elimination of HIV and AIDS stigma and discrimination with targets and indicators been developed. CSOs continued to involve in activities to reduce discriminatory attitudes against PLHIV.

VI. Support from the Country's Development Partners

A. Key Support Received from Development Partners to Ensure Achievement of GARP Targets

The SSF of the GFATM is the consolidation of Round 6, Round 8, and RCC4. It started in November 2010 and ended on 31 December 2012 for Phase 1. The Year 1 of Phase 1 was from 1 November 2010 to 31 December 2011 and the Year 2 of Phase 1 was 1 January 2012 to 31 December 2012. The following are the coverage and timelines of each Round: Round 6 (2007-2012, prevention, treatment, and care), Round 8 (2009-2014, prevention, treatment, and care), and RCC4 (2010-2015, prevention only).

The over-all goal of SSF was to reduce the transmission of HIV and maintain the present low seroprevalence of HIV (0.2% among population 15-49 years) as related to the over-all goal of previous rounds (6, 8, and RCC4). The implementation of the project is done through a multisectoral partnership led by the Sub-

Recipient (SR), the Center for HIV/AIDS and STI (CHAS), Ministry of Health (MOH). All the activities undertaken at the provincial level are in collaboration with PCCA.

UN agencies collaborated to establish a Joint UN Team on AIDS (JUNT) and implemented the joint programme of support on AIDS. A total of 1,504,587 US dollars were mobilised to fund initiatives that contributed to the achievement of UNDAF Outcome 6 activities in 2013. Contributions came from UNODC, WHO, UNICEF, UNFPA, UNAIDS and ILO.⁷⁵ The accomplishments include:

- I. Establishment of Joint UN Team on AIDS and implementation of joint programme of support on AIDS. Commitment to the JUNT team maintained.
- II. UN support to the national response to AIDS through strengthening the Three Ones . The Joint UN Team on AIDS (JUNT) Matrix 2013 optimizes UN expertise and resources in support to a set of priority high impact interventions guided by the Getting to Zero Strategy to (1) reduce HIV sexual transmission, (2) HIV transmission among people who injected drugs, (3) mother to child HIV transmission, (4) stigma against PLHIV and (5) increase treatment intake. The UN support enhanced coordination and cohesion across 5 of the 10 Getting to Zero targeted directions. This was achieved thru the JUNT joint UN work plan which capitalized on UN agencies' expertise and comparative advantage. The UNAIDS Secretariat ensured effective coordination and adequate cohesion across the different strategic directions. Based on available evidences, resources were allocated in the areas of: reducing HIV transmission, increasing treatment uptake, and in addressing social enablers. Resource mobilization efforts to sustain the response were also initiated. The JUNT work plan was implemented, monitored, and reported for in UNDAF Devinfo and Global Joint Programme Monitoring System. The JUNT/UNDAF outcomes on HIV/AIDS 2012 were reported in Devinfo against 20 clearly defined targets for national dissemination.
- III. HIV/AIDS in the Workplace. Functional HIV/AIDS response at the work place was put in place. Number of agencies with a UN cares assigned a focal point. There were 10 UN agencies/entities with a UN Cares Focal Point. These includes: UNFPA, UNDP, UNICEF, WHO, UNV, FAO, WFP, UNODC, UN Women and UN Habitat. Moreover, a new UN Cares Country Focal Person (WHO) had been identified. The UN staff and dependents were aware of HIV/AIDS related issues through the implementation of the UN 2009 HIV Learning Plan. Through the Lao HIV Learning Team, UN staff members and dependents have been oriented about HIV/AIDS in the UN Workplace policy, program and services. The participation of the Lao PDR team at the "Meeting of the Mind" 2013 and in the "Training of HIV Learning Facilitators" have deepened its understanding on the current global and regional pictures of UN Cares programme against the backdrop of the global vision of "Getting to Zero" and honed its skills in facilitating the learning processes.

Another major partner is the Asian Development Bank (ADB). The road construction project is funded by ADB, with funding support from AusAID, to strengthen border area health services, and provide comprehensive HIV prevention packages for migrant populations in construction corridors, economic and tourism zones. It supports the Sub-project 10: Pre-construction HIV Prevention Associated with the Second Northern GMS Transport Network Improvement Project. The project coordinated with national authorities

⁷⁵ RCAR 2013, HIV/AIDS. Project document, 20 Jan 2014.

to develop Project Working Teams in three districts close to where a new road is being built. These Project Working Teams, made up of people from different sectors in Houaphanh, implemented activities in HIV prevention, and HIV and STI testing and treatment. The project included funding for Burnet Lao technical and management staff, occasional international advisers from Burnet Australia, travel and workshop costs, and travel costs to support involvement of technical staff from CHAS and MPWT.

The Lao-Thai-Australian Collaboration in HIV-Nutrition (Lao-TACHIN) Project was a collaboration project between three partners from three countries including the Thai Red Cross AIDS Research Centre (TRCARC), The Albion Centre (Albion), Australia and the Center for Control HIV/AIDS and STI (CHAS), Ministry of Health, Lao PDR. Lao-TACHIN was an extension project of the Thai-Australian Collaboration in HIV-Nutrition (TACHIN) project which was first implemented in Thailand from 2005 to 2008 by TRCARC, Albion and the Institute of Nutrition, Mahidol University, Thailand. The project developed a range of nutrition services which have been integrated into HIV treatment, care and support provided by TRCARC. Its goal is to improve the health of PLHIV, with an emphasis on quality of life and to ensure project sustainability, through supporting changes to the Lao PDR national HIV and nutrition strategy. It has four components, namely, Clinical Nutrition Services, Community Nutrition Interventions, HIV Management, and Partnership Development.

B. Actions that Need to be taken by Development Partners to Ensure Achievement of Targets

The development partners should closely collaborate with the national and local authorities to ensure that programmes are effectively and efficiently implemented. There is also a need to continuously provide funding support with the anticipated increase in trend on HIV incidence and intensified prevention and VCT programmes.

CSOs articulated that weaknesses in implementing the HIV and AIDS projects should be monitored in order to immediately install corrective measures. Innovative approaches programme/project should be identified and involve all stakeholders,

VII. Monitoring and Evaluation Environment

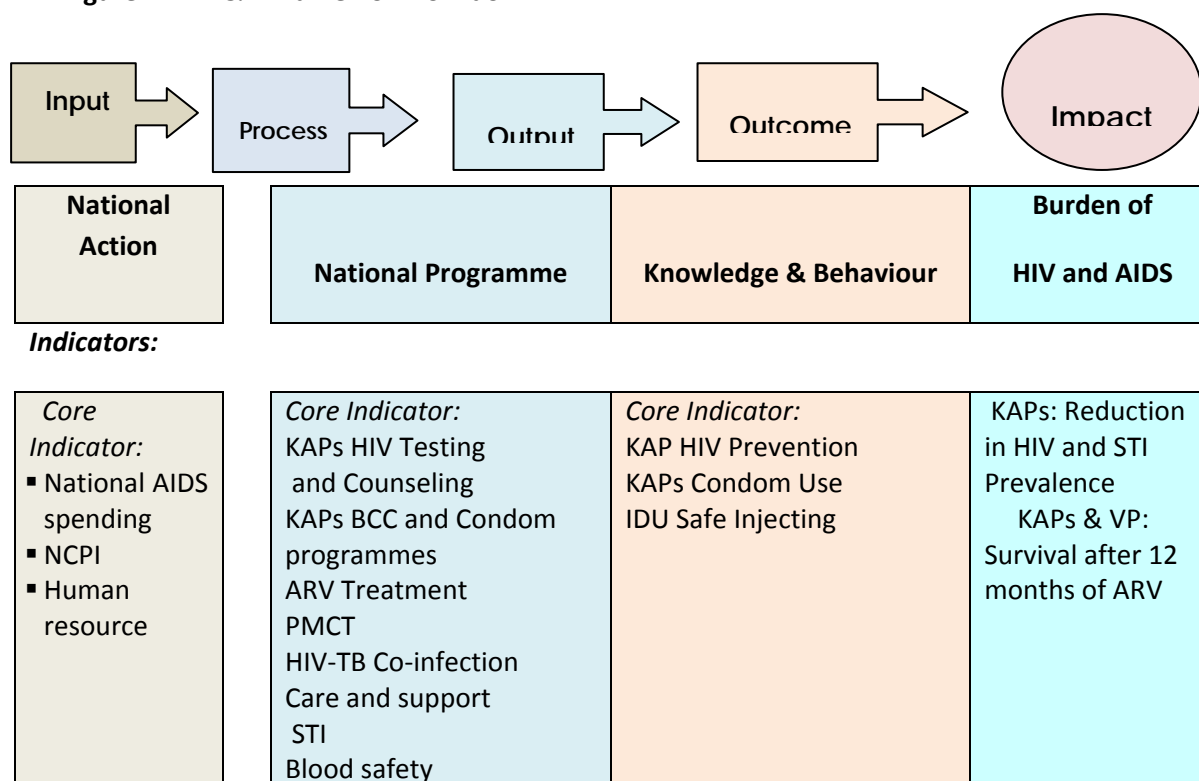
A. Overview of the Current Monitoring and Evaluation (M&E) System

The M&E System is guided by the M&E Strategy and Action Plan for 2011-2015. It facilitated the development of a unified national M&E system to measure the progress made in key health indicators including that of HIV. The M&E plan will guide the National AIDS Programme to monitor the implementation of the NSAP. There is a version of the M&E plan covering the period 2012-2013.

M&E is part of the cycle of the management of programs or projects. M&E provides a feedback loop to assess how the plans are being implemented. In HIV, M&E is vital since the consequences of not knowing goes beyond just programmatic issues. A programme with a functioning M&E actually results to saving lives and improving the quality of life of those infected and affected.

While there are different frameworks for indicator selection, using the logical approach to program management and planning, the commonly agreed framework, input-process-output-outcome-impact will be used (Figure11). The framework reflects measurements of the operational results (based on inputs) and developmental results (based on outputs, outcome and impact) of the interventions done, thus presenting a countrywide picture of the response to HIV in the country⁷⁶.

Figure 11- M & E Framework for Lao PDR



⁷⁶ National HIV Monitoring and Evaluation Strategy and Action Plan 2012-2015

Prior to revising the current draft HIV M&E Plan, CHAS together with other partners have conducted a HIV M&E system assessment, based on the recommended 12 component M&E system strengthening check list developed by UNAIDS/MERG in 2009, as well as other data verification tools developed by MEASURE EVALUATION/ University of North Caroline in 2007. This section provides an overview of the findings of the assessment and the recommendations of which this M&E Strategy and Action Plan (SAP) is based on. The review involved members from seven organisations: CHAS, MOH, GF/PR, LaoPHA, PSI, UNAIDS, WHO with technical support from one international consultant. The Plan was updated in June 2013 by CHAS staff and two international consultants.

The reorganisation structure of at the central level includes the establishment of a new Unit namely Monitoring, Evaluation and Surveillance Unit in CHAS The Unit oversees the routine reporting system, collects information from PCCA and from other partners, coordinates with other department within CHAS to collate data at national level for reporting to NCCA and MOH, and provide final information for global reports such as the GARPR and Universal Access (UA) report and conduct assessment studies and research.

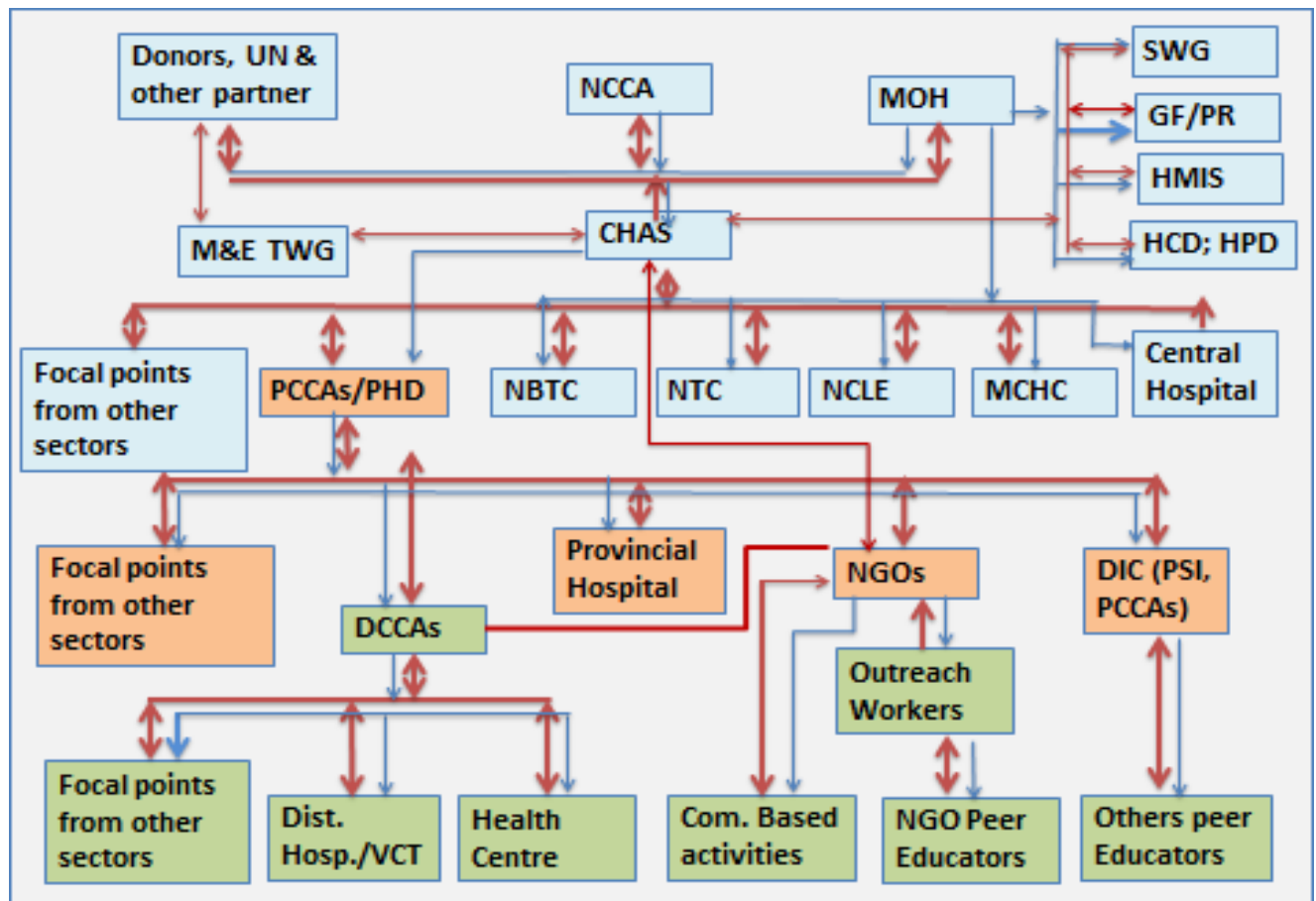
The M&E plan reported having six full-time government permanent staff tasked primarily for M&E functions. Their tasks include overseeing the reporting system, coordinating final national data as well as supportive supervision to provincial level sites. The staff complement have specific qualifications such as epidemiology, IT and data management.

At provincial and district level, there is no M&E Unit except for Vientiane Capital. Recent interview with PCCA reported having only one current staff in the M&E Unit who is tasked to do routine reporting while the head of PCCA takes the overall responsibility. Reporting functions in the DCCA and VCT are shared responsibility among staff.

The routine reporting of HIV programme in Lao PDR covers seven different programmes: prevention including BCC and condom distribution; VCT; STI; ART; care and support.

CHAS has developed a set of standard reporting forms that collect data from service delivery sites (ART; VCT; DIC) to district, provincial and central levels. These forms are monthly collated and sent to higher level (see chart in figure 13 for the flow of information). The CHAS standard training helps staff to understand the form and enable them to enter and calculate data. From district level down to service delivery sites (except ART sites), all the forms are handled by hand and computer is used from provincial and above. However, the registration data are designed by staff working at the sites, as the results, currently there are no standardised log-books for entry of primary information, with the exception of VCT logbook. This standardization is underway with training for use of the log-books planned for 2014.

Figure 12 Flow of Information



At the receiving end, the reports are checked for accuracy; however, the quality of data is very much depending on the staff who handles the report at each of the steps in this system but data quality assurance is a part of the supervisory checklists for MSM and Peer activities and the ART Logbooks to use in M&E staff field visits..

CHAS has developed the national HIV M&E software (HIV CAM) to support the routine reporting component and started to use it in August 2013, entering new data and also data from patients back to 2003. Currently 8 sites are using this software. CHAS has trained the staff at the ART sites and started to generate the data. Report from this software was expected to be available by the end of 2013.

For this component, PCCA plays an important role in managing and use of the information provided by the routine reports. At the moment, PCCA's task for this component is mainly to compile and report data from service delivery sites, districts and other partners to CHAS. There PCCA has 1 or 2 staff doing the report but does not use the information for provincial programme management and decision making. Overall, except for central level, the routine reports are not used at other levels.

Of all programmes, VCT collects a comprehensive range of information and has its standard log-book for data register. But the VCT set-ups are different between hospitals based or DIC sites and the staff share the responsibility of register and collate data for the report. But the centres don't use information collected at sites. At this stage data collected from VCT sites cannot provide aggregated numbers of KAP in reporting forms; particularly MSM who access VCT services because in the past, the form allowed reporting by two sexes – male and female, but in May 2013, the forms were updated to allow entering of information on MSM and FSW and pregnant women and IDU and general population, by gender and age group.

All female patients from DIC are understood as FSW including housewives because reporting form from DIC does not distinguish. It merely shows aggregated data of HIV patients. When details are required, the only way to find out is to go through the logbooks, but logbook system is not yet standardized as mentioned above, as a result, details can be found in some sites where the responsible staff pays attention to record all details necessary. Of the indicators collected for this programme, there's need to revise the form for clients and form at central and provincial levels including those who come to VCT (disaggregated by occupation, age, and gender) and the number of people getting pre and post-test counselling.

To date, the data collected on this programme is for reporting to GF and for global reports (GARPR). The HIV Cam is included in the GARPR and has a standard set of ART related indicators in place for monitoring purpose. There is now an early warning indicator for the management of ART programme included in the logbook. The HIV CAM software and is a part of the reporting from these tools. Stock-out of drugs is not in the HIV CAM but is a part of the ARV Management Logbook and the CDC is working with CHAS to analyze the current data and set up an Early Warning System to detect potential stock-out of ARV drugs.

There are two software packages being used concurrently for reporting ARV treatment: FUCHIA and HIV CAM. The HIV CAM is a locally-designed software while the FUCHIA had been used before and currently is used in Savanakheth and Setthathirath hospitals. For those who use the HIVCAM, hand written forms are still

completed first before the data is entered in the software. There's the need to update regularly and the software can't export the data needed for reporting.

There is now an integrated monitoring system for the continuum of prevention-care-treatment (Integrated MERS, HCT and HIVCAM). The plan for utilization of data for continuous quality improvements (CQI) is underway and being monitored.

In summary, there were 67 indicators that were revised and to be collected, new reporting system including tools and forms has been developed to match the 67 indicators. CHAS is now in the process of developing the SOP and the Handbook for M&E. The protocol for IBBS has been revised and standardized and will be used for 2014 survey supported by US-CDC and Ministry of Public Health, Thailand. In addition, CHAS plans to conduct national training workshop on new M&E System, tools/forms for all reporting units/sites (VCT, DIC, ART, Laboratory, hospital and health centres, CSOs and partners) in the country.

B. Challenges Faced in the Implementation of a Comprehensive M&E System

The need to improve collection of data, disaggregation of data, routine report flows and use of strategic information has already been done with the M&E Framework and Action Plan available but still working on the standard operating procedures (SOP) and Handbook. Training new forms is needed. Remedial Actions Planned to Overcome the Challenges

C. Remedial Actions Planned to Overcome the Challenges

CHAS needs to facilitate the completion of the SOP and Handbook in order to develop the training plan for its use at the national and local level. There is a need to review further whether disaggregation of data covers sex, age, ethnicity and geographical location.

Develop an overall long-term national capacity building plan, including training of basic epidemiology, data management and analysis, M&E concept, mapping, estimation and projections; determine funding for training and use of the four modules of the national M&E training curriculum in 2014, either through reprogramming or from ADB.

For provincial level, there is a need to have a plan for building capacity in line with the national plan, once it's made and conduct routine staff performance assessment/appraisal

Strengthen the role of PCCA: at least 1 full-time staff is responsible for M&E duties, with clear TOR, including support for the DCCA on M&E related activities and informing the DCCA about the M&E reports and follow-up actions. The new reporting forms will improve the accuracy and flow of reporting from District to Province and will form part of the M&E Handbook.

Strengthen Information Technology (IT) System for central and provincial level, such as online reporting and improve email communication.

D. The Need for M&E Technical Assistance and Capacity Building

CHAS developed a capacity building plan with the TA hired through TSF in October 2013. Also, the CDC 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 through the TA of WHO. Training on forecasting for ARV drugs will be included as related to estimation of cases in the coming years.

The training on M&E provided last year was on HIVCAM. Currently, there is only one professional staff working in the M&E and Surveillance Unit. The use of the software for clinical monitoring using HIVCAM and MERS should be done to all levels.

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: Consultation/preparation process for the country report on monitoring the process towards the implementation of the 2011 Declaration of Commitment on HIV and AIDS

The process of data gathering was initiated during the third week of February 2014. The Center for HIV, AIDS and STI (CHAS) Director Dr. Bounpheng Philavong together with UNAIDS Regional Investment and Efficiency Adviser Dr. Ma. Elena Borromeo decided to recruit a consultant to assist the whole process of the Global AIDS Response Progress Reporting (GARPR) for Lao PDR. The process of recruitment and approval through the UNAIDS Technical Support Facility (TSF) of the consultant took less than one week. Immediately after, the Terms of Reference was put into action which included first and foremost the process of gathering data needed for the GARPR.

Three days (February 19-21, 2014) was given to the consultant to do desk/literature review of various documents necessary for the preparation of the GARPR. The documents reviewed were but not limited to:

- Global AIDS Response Progress Reporting 2014, which deals with construction of core indicators for monitoring the 2011 United Nations Political Declaration on HIV and AIDS;
- Global AIDS Response Progress Country Report, Lao PDR, 2012;
- Cambodia Country Progress Report: Monitoring the Progress Towards the Implementation of the Declaration of Commitment on HIV and AID;

- Reports from High Level Meeting Targets, External Review, Mid-term Review of the High-Level Ten Targets, 2013;
- National Strategic and Action Plan (2011-2015) for HIV/AIDS and STI Prevention and Control;
- M&E Framework and Action Plan; and
- other relevant reports used in consultation with UNAIDS, WHO and CHAS such as project reports on specific information on HIV surveillance activities and programmes from NGOs, CSOs and other stakeholder groups

Additionally, the CHAS Director also provided relevant reports and presentations to various meetings and fora about Lao PDR's contribution to the National Response to HIV and AIDS. These included the following:

- Lao PDR HIV Response Progress Against 2011 Political Declaration, Background Document for 2013 Mid-Term Review
- National HIV Monitoring and Evaluation Strategy and Action Plan (2012-2015), CHAS, MOH
- Lao PDR: HIV and Labour Migrations in the GMS - JUNIMA POLICY BRIEF
- Nurturing the MOU-JAP Through Country-level Initiatives: HIV Prevention and Infrastructure Mitigating Risk in the Greater Mekong Subregion: Sub-Project 10: Pre-construction HIV Prevention in Lao PDR and Viet Nam (July 2011- June 2013), Bounpheng Philavong, MD, MPH, DrPH Director of Centre for HIV/AIDS and STI, Ministry of Health of Lao PDR, **Satellite session:** Reducing Vulnerability among Migrant and Mobile Populations and Communities in Cross-Border Areas in the GMS, 18-22 November 2013 11th ICAAP, Bangkok, Thailand
- Lao PDR HIV Response Progress Against 2011 Political Declaration, Slide Presentation of Background document for Mid-Term Review 2013, Presented by CHAS, MOH
- Lao PDR Government Policy and Implementation towards Continuum Accessibility to ART of Laotian Living with HIV in Thailand, Bounpheng Philavong MD, MPH, DrPH Director of Centre for HIV/AIDS and STI, Ministry of Health of Lao PDR 11th ICAAP, 18-22 November 2013, Bangkok, Thailand
- Leadership Forum 2013: Asia Pacific Getting to Three Zeros, 11th ICAAP, 17-18 November 2013 Bangkok, Thailand, Eliminating HIV and AIDS Stigma and Discrimination: Experiences and Lessons Learned in Lao PDR, Dr Bounpheng Philavong, MD, MPH, DrPH, Director of Centre for HIV/AIDS and STI, Ministry of Health of Lao PDR
- HIV Prevention among Female Sex Workers (FSW) : The Lao Model Drop in Centre (DIC)
- Lao-Thai-Australian Collaboration in HIV-Nutrition (Lao-TACHIN) Project
- HIV Prevention and Infrastructure: Mitigating Risk in the Greater Mekong Subregion. Sub-Project 10: Pre-construction HIV prevention in Lao PDR and Viet Nam (July 2011- June 2013)

1. The output of the review was the Road Map for Data Collection. The Roadmap 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 Country Report for Lao PDR for 2014.

2. The Road Map for Data Collection was presented to CHAS Director and the CHAS Global Fund Coordinator who was to be part of the ad hoc CHAS Team to support the data collection. During the discussion of the data collection, the CHAS Director finally formed an ad hoc CHAS Team to be co-chaired by the CHAS M&E and Surveillance Unit Head and the CHAS Global Fund Coordinator, who is also the CHAS HIV/AIDS and STI Management Unit Head. Members of the ad hoc CHAS Team were the CHAS M&E Unit Deputy Head and staff members of the M&E and Surveillance Unit. The terms of reference of the ad hoc CHAS Team was to assist in the data collection, getting the responses to the questionnaires, both from the government and the non-government agencies, assist in putting together AIDS Spending matrix data, and providing the updated data for the core indicators.

The report preparation was comprised of seven (7) phases. This section presented the major tasks involved in each phase, sub-activities involved, timelines and schedules, and outputs expected to be accomplished and submitted within the period. Throughout the data collection process, inclusiveness of the different stakeholders was observed.

Phase 1: Desk/Literature Review (February 19-21, 2014)

The Desk/Literature Review Phase involved identification of reports and tools and sources for data collection for each indicator. The purpose of this phase was to gather data and HIV estimates on the needed indicators prescribed in the GARPR and identify information gaps. This phase included the review of the definition of GARPR and country level indicators. Specific definition for each of the indicators' numerator and denominator was reviewed and consensus with stakeholders was drawn to ensure correct and relevant reporting. Stakeholders were consulted for any variance in the definitions.

The data monitored presented the progress against the commitments and targets of the 2011 UN Political Declaration on HIV and AIDS and the AIDS related MDGs. Using the checklist of GARPR indicators, the data were updated and references recorded. The checklist served as a summary of the presentation of results on the status of the ten (10) targets and elimination commitments. The specific indicators under each of the targets included were enumerated in *Annex I. Checklist of Core Indicators for GARPR 2014*.

Phase 2: Country Consultation (Feb 24-28, 2014)

The Country Consultation Phase involved the conduct of meetings with stakeholders with the support of CHAS, Ministry of Health (MOH). CHAS Director initially wrote the stakeholders about the GARPR data

gathering and introduced the International consultant who would assist in the process. The purpose of the meetings was to review and validate indicator data and narrative report. The review of data was undertaken in consultation with the Lao PDR GARP stakeholders. The consultation provided inputs to gather additional guidelines from implementing partners on data review and collection processes including a review on expectation, operational issues, processes used for determining final responses reflected in the report. Organisational representatives were interviewed. The data gathered were used to validate relevance of indicators for inclusion in the report. The stakeholders may opt not to report prescribed indicator data and should inform the reason for non-reporting. The proposed questions for further discussions with stakeholders were presented.

The NCPI data gathering was conducted among the government officials for PART A and the representatives from civil society groups, UN organisations, and international donors for PART B. Part A covered the topics on strategic plan, political support and leadership, human rights, prevention, treatment, care and support and monitoring and evaluation. Part B covered the topics on civil society involvement, political support and leadership, human rights, prevention, treatment, care, and support.

The actual collection of data was done through focus group discussions (FGD) and key informant interview (KII) with the respondents. Key informant interviews were undertaken with government agencies, UN agencies and bilateral partners, non-government organisation, and civil society groups. Eight (8) KIIs were conducted, which was more than what was planned for, six (6). The interview followed the prescribed KII guidelines. The FGD also followed prescribed guide questions.

On the government side, officials from the CHAS from the Director, Deputy Directors and Head of the various Units were given questionnaire based on the Global AIDS Response Progress Reporting 2014 document produced by UNAIDS, UNICEF and WHO. Each Unit at CHAS reviewed, discussed and responded to the questionnaire collectively led by the head of the Unit. The provincial government was also included in the process. CHAS Director invited the consultant assisting the gathering of data at a consultative meeting in Thalat, Vientiane Province supported by the ADB. The consultant conducted KII with Head of the PCCA Secretariat of Champasak Province and the Deputy Heads of PCCA Secretariat of Bokeo and Houaphanh provinces. Other government agencies other than CHAS were given questionnaire for them to respond to and send it back to questionnaire to CHAS with their responses. These were representatives from the Medical Product Supply Center (MPSC), Department of Hygiene and Health Promotion, Principal Recipient of the Global Fund and mass organizations such as the Lao Women Union (LWU), Lao Youth Union (LYU) and Lao Front Union. The consultant conducted an FGD with the civil society groups, such PSI, LaoPHA, LPN plus, PEDA and NCA. KII was conducted among the UN family such as WHO, UNODC, UNFPA and the donor community such as ADB and AusAID. Questionnaires were sent to other agencies which were retrieved later and followed up by the CHAS Team including representatives from the WHO.

The following were the activities during this phase:

Briefing on roadmap and activities with:

1. MOH-CHAS Director Dr. Bounpheng Philavong

2. UNAIDS Regional Investment and Efficiency Adviser Dr. Ma. Elena Borromeo
3. Dr. Khanthanouvieng Savabounthavong, CHAS Head of HIV/AIDS and STI Management Unit and Global Fund Coordinator

Meetings conducted together with Dr. Borromeo :

1. PSI- Rob Gray- Country Project Manager
2. Lao Women Union- Dr. Lavanh Southisan
3. WHO- Dr. Thipphasone Vixaysouk and Dr. Chintana Somkhane
4. WHO- Dr. Dominic Ricard initial consultations through email

CHAS Ad hoc Team

1. Dr. Kheophouvanh Douanphachanh, CHAS Head of M&E and Surveillance Unit
2. Dr. Khanthanouvieng Sayabounthavong, CHAS Head of HIV/AIDS and STI Management Unit and Global Fund Coordinator
3. Dr. Bouathong Simanovong, CHAS Deputy Head M&E and Surveillance Unit
4. Dr. Khanti Thongkham, CHAS M&E and Surveillance Unit Staff
5. Dr. Phengphet Phetvixay, CHAS Head of EIC Unit and ADB Project Coordinator
6. Dr. Phonesay Rattanavong, CHAS EIC Unit Staff
7. Dr. Siphone Sitthavongseng, CHAS ADB Project Officer

KII conducted with:

1. PCCA Secretariat Head- Champasak Provincial Government- Dr. Ratsamy Siphanh
2. PCCA Secretaria Deputy Head- Ms. Khammanh Silipanya, Bokeo Province
3. PCCA Secretariat Deputy Head- Dr. Vayphone Chathavikhom Houaphan Province
4. UNODC/AusAID- Ms. Irene Lorete, Technical Advisor, HIV/AIDS Asia Regional Program for Laos (HAARP), Australian Aid; Mr. Soulivanh Phengsy, HAARP National Programme Officer
5. WHO- Dr. Thipphasone Vixaysouk, Health and Promotion Officer, HIV and AIDS; Dr. Chintana Somkhane, Care and Treatment Officer, HIV and AIDS
6. UNFPA – Ms. Siriphone Sally Sakulku, Senior Reproductive Health Coordinator
7. ADB- Mr. Scott Bamber, Chief of Technical Adviser, GMS, Capacity Building for HIV and AIDS Prevention Project

Focus Group Discussion:

1. PSI- Mr. Sihamano Bannavong, Marketing Manager
2. NCA- Dr. Phonsavanh Chansy, Project Coordinator
3. LaoPHA- Mr. Viengkhone Suriyo, Project Manager
4. PEDAs- Mr. Santi Douanpaseuth, Director

Phase 3: Report Writing (March 1-5)

The GARPR 2014 included the presentation of indicator data and narrative report based on the country reports and other information sources, including analysis and interpretation of data. The Country Progress Report followed the template as prescribed in the GARPR Guidelines 2014 and incorporating the changes in the 2014 reporting round. The report reflected the core indicators, NCPI and narrative country progress report. A report on the AIDS spending National Funding Matrix submitted. The report outline followed the Country Progress Report Template.

The GARP reporting format followed the sequence of the targets. Specifically, these were:

- Target 1. Reduce sexual transmission of HIV by 50% by 2015
- Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015
- Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths
- Target 4. Have 15 million people living with HIV with lifesaving antiretroviral treatment by 2015
- Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015
- 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
- Target 7. Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV
- Target 8. Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realisation of all human rights and fundamental freedoms
- Target 9. Eliminate HIV-related restrictions on entry, stay and residence
- Target 10. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts

The main sources of data that were used in collating the relevant indicators were from secondary sources, through document reviews; and primary sources, through key informant interviews (KII), consultation meetings, and focus group discussion. Reports for desk review included the following: national health surveys, behavioural surveillance surveys, surveys of specific population groups, patient tracking systems, health information systems, sentinel surveillance, national HIV estimates, and the National Commitments and Policy Instrument (NCPI) questionnaire.

For the GARP core indicators with no available national level indicators, alternative population based surveys were adapted to measure the core indicators upon consultation and approval of the stakeholders.

Phase 4 validation meeting of initial findings (March 6, 2014)

A validation meeting with stakeholders representing the government agencies, international development partners, non-government organizations and civil society organizations was conducted on March 6. The purpose of which was to have the stakeholders review the compiled indicator data and review the narrative report, including conclusion and recommendations. The meeting facilitated the discussion on the analysis of findings to understand the national response on AIDS and identify opportunities to improve the response vis-à-vis policy, implementation of HIV programmes, behaviour change among key population groups and changes in the epidemic.

The conduct of the meeting was chaired by the CHAS Director. He introduced to the stakeholders the purpose of the meeting and the GARPR process. Then he introduced the consultant to present the findings based on the Road Map. He also introduced the ad hoc Team who would assist in the data collection process. He reiterated that the HIV/AIDS Task Force has not convened for a while and therefore opted to discuss with the members individually, beside most of the original members of the HIV Task Force were no longer around.

Present during the validation meeting were representatives from WHO, PEDTA, NCA, PSI, LaoPHA, LNP+, UNODC, HAARP Project, ADB Project, Lao Red Cross, CHAS M&E and Surveillance Unit, CHAS HIV/AIDS and STI Management Unit, and CHAS Planning Unit.

The consultant presented the following:

- The purpose of the GARPR document which provides guidance to the National AIDS programmes and partners actively involved in the country response to AIDS and use of core indicators to measure and report on the national response.
- The background of the Global AIDS Progress Reporting 2014, on UN Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS” (General Assembly resolution 65/277), which was adopted at the United Nations General Assembly High Level Meeting on AIDS in June 2011, mandated UNAIDS to support countries to report on the commitments in the 2011 UN Political Declaration on HIV and AIDS.
- The Global AIDS Response Progress Reporting (GARPR) indicators (before 2012 known as UNGASS indicators) were until 2012 reported at the global level every second year but the data from 2013 data was to be collected every year.
- Issues discussed during the meeting include stigma and discrimination, the core indicators that needs to be updated based on the 2014 GARPR Guidelines, the achievements, challenges and recommendations based on the 2013 Mid-tern review of the of the Political Declaration targets and elimination commitments referred to as the “ten targets”.
- The summary of changes for 2014 Global AIDS Response progress reporting was also presented. The summary of changes included were:

Target 1 Reduce sexual transmission of HIV by 50% by 2015

Indicators for sex-workers (Indicator 1.7, 1.8, 1.9 and 1.10) have, in addition to sex-disaggregation by female/male, also transgender as a possible disaggregation.

Sex Workers:

1.7 Percentage of sex workers reached with HIV prevention programmes

1.8 Percentage of sex workers reporting the use of a condom with their most recent client

1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results

1.10 Percentage of sex workers who are living with HIV

Target 1 Reduce sexual transmission of HIV by 50% by 2015

Indicators for HIV testing among key populations (Indicators 1.9, 1.13 and 2.4) have the explanation of the denominator changed back to that of 2010.

1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results

1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results

Target 2 Reduce transmission of HIV among people who inject drugs by 50% by 2015

2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results

Target 3 Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths (MDG indicator)**

The prevention of mother-to-child indicator (Indicator 3.1) has updated language to clarify the disaggregations and the links to Spectrum. Further, the indicator to measure coverage of PMTCT during breastfeeding has been added directly after this indicator (Indicator 3.1a, previously labelled Indicator 3.8).

3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission

3.1a Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding

Target 4 Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

The indicator for ART coverage (Indicator 4.1) has a new denominator, now including all people living with HIV, not only those eligible for treatment. For a more detailed explanation for this change, please see the detailed indicator description for Indicator 4.1 (page 76). Further disaggregation of those newly initiated on ART (in the last 12 months) has been included (in previous rounds labelled 4.1a).

4.1 Percentage of adults and children currently receiving antiretroviral therapy

The 12-month ART retention indicator (Indicator 4.2) has the possible disaggregations for pregnancy status and breastfeeding status at initiation included.

4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Target 5 Reduce tuberculosis deaths in people living with HIV by 50% by 2015

The indicator for co-management of tuberculosis and HIV treatment (Indicator 5.1) has “adults” changed to “adults and children” in the numerator and “advanced” deleted from “advanced HIV infection”.

5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV

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

The AIDS Spending indicator (6.1) has split up bilateral donors into PEPFAR and other bilateral donors.

6.1 Domestic and international AIDS Spending by categories and financial sources

Target 7 Eliminating gender inequalities

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. All indicators with sex-disaggregated data can be used to measure progress towards target 7

Target 8 Eliminating stigma and discrimination

A new indicator has been added related to Target 8: Discriminatory attitudes towards

people living with HIV (Indicator 8.1). This indicator is new, so it is likely that most countries will not be able to report on the indicator during the 2014 reporting round. Instead countries are requested to report data from a previous version of one of the two questions of this indicator: “Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had the AIDS virus?” This question has been routinely collected in DHS, and other surveys in many countries. In future reporting rounds, countries should report on the full indicator.

Target 9 Eliminate travel restriction.

Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed.

Target 10 Strengthening HIV integration

*10.1 Current school attendance among orphans and non-orphans aged 10-14**

10.2 Proportion of the poorest households who received external economic support in the last 3 months

- A full National Commitments and Policy Instrument (NCPI) is requested; the NCPI has been through slight revisions.

Key issues new in the 2013 reporting round that remain the same in the 2014 reporting round

- As in 2012 survey data that have not been updated since the last reporting round (i.e. 2012 or 2013 depending on when the last time reporting submitted) do not need to be re-entered (i.e. indicators 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 1.13, 1.14, 1.22, 2.2, 2.3, 2.4, 2.5, 7.1, 10.1, 10.2).
- The questions on key population size estimations from the 2012 reporting round are kept, but are now found among the indicators for Target 1 and Target 2.
- The two indicators about prevalence of male circumcision and number of men circumcised that were added in 2013 for the 16 countries with high HIV-prevalence and low prevalence of male circumcision are still included (GARPR Indicators 1.22 and 1.23).
- Joint reporting of the Global AIDS Response Progress Reporting indicators and additional health sector indicators from WHO and UNICEF will continue. The additional health sector indicators can be found in Part II of these guidelines.

Road Map

Milestones and Timelines	Key Tasks	Status
Phase 1: Desk/Literature Review	<i>Review of literature</i>	Developed Road Map for Data
	<i>Prepare and present a roadmap for</i>	Collection

(Feb 19-21)	<p><i>data collection progress report writing and validation. Draft KII and consultation discussion guide.</i></p> <p><i>Initial contact: CHAS/MOH, WHO, UNAIDS, UNODC, UNICEF, UNFPA, PSI, LWU</i></p>	
<p>Phase 2: Country Consultations</p> <p>(Feb 24-28)</p>	<p><i>Conduct country consultations</i></p> <p><i>Finalise validation meeting agenda</i></p> <p><i>Consolidate and review data on GARP indicator</i></p> <p><i>Undertake at least 6 KII</i></p> <p><i>Provide email updates</i></p>	<p>GARP indicator consolidated</p> <p>Briefing on roadmap and activities was conducted among stakeholders</p> <p>KII and FGD Conducted</p>
<p>Phase 3: Report Writing</p> <p>(Mar 1-5)</p>	<i>Draft Narrative Report</i>	<p>On-going process until the submission of the final draft</p> <p>Follow up data needed</p>
<p>Phase 4: Validation Meeting</p> <p>(Mar 6)</p>	<i>Conduct validation meeting</i>	Presented initial data gathered
<p>Phase 5: Off-site Support</p> <p>(Mar 8-16)</p>	<i>Off-site support to the ad hoc CHAS Team</i>	Consolidate report, continuously write the draft.
<p>Phase 6: Final Report Writing</p> <p>(Mar 26- April 1)</p>	<p><i>Finalise Report and Submit to CHAS ad hoc Team</i></p> <p><i>Meeting with Dr. Bounpheng Philavong and ad hoc Team – scheduled March 21.</i></p> <p><i>Meeting with stakeholders March 24, 2014</i></p> <p><i>Meeting with the NCCA March 26, 2014</i></p>	<p>Submit initial draft before March 21 meeting with CHAS ad hoc Team</p> <p>Meeting with stakeholders March 24, 2014, Rashmis Hotel</p> <p>Meeting with the NCCA March 26, 2014, Rasshmis Hotel</p>
<p>Phase 7: Post Report Writing</p> <p>(Mar 26-Apr 1)</p>	<p><i>Core indicators uploaded in the GARPR online reporting tool found on this website:</i></p> <p>https://aidsreportingtool.unaids.org/</p>	<p>Upload before March 31, 2014</p> <p>Debrief UNAIDS Regional Office April 1, 2014</p>

Phase 5 Off-site support (March 8-16, 2014)

Off-site support was provided by the consultant to the GARPR ad hoc CHAS Team as necessary. Further consultations were done through exchanges of emails to request from the Team and stakeholders to provide the necessary information needed in the GARPR and the clarification of the data gathered.

Phase 6 Final Report Writing (March 26-29, 2014)

Finalisation of report was done after the initial validation meeting and additional two consensus meetings on the data indicators, narrative reports, key findings and recommendations. On March 21, 2014, CHAS ad hoc team reviewed and updated again the documents in preparation for the consensus meeting with the CSOs, NGOs, INGOs, UN and bilateral/multilateral donors scheduled on March 24, 2014 and March 26, 2014 for the NCCA members respectively. The CHAS Team also formulated the agenda for both meetings. Power point presentation was developed.

The consensus meeting on March 24, 2014 was chaired by the CHAS Director and the presentation of results was done by the international consultant. Participants were from LaoPHA, LPN+, ADB, WHO, USCDC and CHAS. Comments and clarifications were focused on the updates of the indicators as well as the use of projection tools such as the AEM and Spectrum.

On March 25, 2014, CHAS Director and the Deputy Director joined the ad hoc team to further review the documents for presentation to the NCCA Consensus meeting. Power point presentation was developed for the meeting.

The NCCA Consensus Meeting was held on March 26, 2014 at Rashmis Hotel. The meeting was chaired by the Vice Chair of the NCCA who was also the Vice Minister of Education and Sports. The Head of the NCCA Secretariat and also the Director of CHAS made the presentation of results of the GARPR, Lao PDR 2014. The Vice Chair of the LWU facilitated the open forum. Questions were focused on issues regarding PWID and SW, whether there are policies and Laws that obstruct these population groups' access to services. After hearing the explanation of participants, the consensus was no, since there are interventions prevention programs for these population groups in place. The NCCA Consensus Meeting ended up by endorsing the report effecting the changes made during the discussion including authorizing CHAS to add more updated data if available. There were 42 participants of the meeting from different ministries, government agencies and mass organizations or unions namely: Ministry of Education and Sport; Ministry of Labor and Social Welfare; Ministry of Security; Ministry of Transportation; Ministry of Foreign Affairs; Ministry of Information and Culture; Lao Women Union (LWU); Lao Youth Union (LYU); Lao Front; Lao Federation of Trade Union; Committee of Social and Culture, National Assembly; Center for Information and Education in Health (CIEH); National TB Center (NTBC); Principal Recipient (PR); LRNC, IPA, Health Care

Department; Maternal and Child Health Center (MCHC); Lao National Commission on Drugs Control (NCDC); Military Medical Department (MMD/Ministry of Defense); Department of Training and Research (DTR/MOH); Association of Positive Network (APN+); National Blood Transfusion Center/Lao Red Cross (NBTC/LRC); Medical Products and Supply Center (MPSC) and WHO. The changes from the validation meeting and consensus meetings were integrated and the final report was submitted to CHAS, MOH, National HIV/AIDS and STI Prevention and Control Programme and UNAIDS RST-AP. A report briefing was submitted. The final report was submitted on March 31, 2014.

Phase 7 Post-report writing (March 30- April 1, 2014)

Upon finalisation of report, the consultant debriefed UNAIDS Regional Office on the conclusion of the 2014 GARPR. In coordination with the MOH, the core indicators were uploaded in the GARPR online reporting tool found on this website: <https://aidsreportingtool.unaids.org/> on (March 31, 2014). A 2-page report was submitted detailing the recommendations on future reporting on the GARPR. The final output for this project was the submission of the TSF contract completion report.

Annex 2: National Commitments and Policy Instrument (NCPI)

Part A: For government officials

NCPI – PART A [to be administered to government officials]

Organization	Name/Position	Respondents in Part A (indicate which part was queried on)					
		A.I	A.II	A.III	A.IV	A.V	A.VI
CHAS	Dr. Bounpheng Philavong/Director	✓	✓	✓	✓	✓	✓
CHAS	Dr. Phouthone Southalack/Deputy Director	✓	✓	✓	✓	✓	✓
CHAS	Dr. Chanthone Khamsibounheuang/Deputy Director	✓	✓	✓	✓	✓	✓
CHAS	Dr. Keophouanh Douangphachanh/Head of M&E and Surveillance Unit	✓	✓	✓	✓	✓	✓
CHAS	Dr. Khanthanouvieng Sayabounthavong/Head of HIV/AIDS and STI Management Unit	✓	✓	✓	✓	✓	✓
CHAS	Dr. Beuang Vang Van/Head of Planning and Cooperation Unit	✓	✓	✓	✓	✓	✓
CHAS	Dr. Phengphet Phetvixay/Head of EIC unit	✓	✓	✓	✓	✓	✓
CHAS	Dr. Bouathong Simmavong/Deputy Head M&E and Surveillance Unit	✓	✓	✓	✓	✓	✓
CHAS	Dr. Ketmala Banchongphanith/Deputy Head of HIV/AIDS and STI Management Unit	✓	✓	✓	✓	✓	✓
CHAS	Dr. Amphone Philaket/Deputy Head of Administration and Finance Unit	✓	✓	✓	✓	✓	✓
CHAS	Dr. Phouthaly Keomoukdal/Deputy Head of EIC Unit	✓	✓	✓	✓	✓	✓
CHAS	Dr. Khanti Thongkam/Technical Staff of M&E and Surveillance	✓	✓	✓	✓	✓	✓

	Unit						
PCCA Champasak	Dr. Ratsamy Siphanh/Head of PCCA Secretariat	✓	✓	✓	✓	✓	✓
PCCA Bokeo	Ms. Khammanh Silipanya/ Deputy Head of PCCA Secretariat	✓	✓	✓	✓	✓	✓
PCCA Houphanh	Dr. Vayphone Chathavikhom/ Deputy Head of PCCA Secretariat	✓	✓	✓	✓	✓	✓
PR, MOH	Dr. Chansouk Chanthapadith/Head of M&E Unit PR	✓	✓	✓	✓	✓	✓
LWU	Ms. Lavanh Southisane/Director of Training Center	✓	✓	✓	✓	✓	✓
MPSC	Ms. Manisone Sayasane/Coordinator of the MPSC GF Project	✓	✓	✓	✓	✓	✓
FDD	Dr. Sourisack Sounvoravong/Deputy Director of Food Inspection Division, Food and Drug Department	✓	✓	✓	✓	✓	✓
HHPD	Dr. Chandavone Phoxay/Deputy Director General of Department of Hygiene and Promotion	✓	✓	✓	✓	✓	✓

Add details for all respondents.

NCPI – PART B [to be administered to civil society organizations, bilateral agencies and UN organizations]

Organization	Name/Position	Respondents in Part A (indicate which part was queried on)					
		A.I	A.II	A.III	A.IV	A.V	A.VI
UNODC/AusAID	Ms. Irene Lorete/Technical Advisor, HIV/AIDS Asia Regional Program for Laos (HAARP)	✓	✓	✓	✓	✓	✓
UNODC/AusAID	Mr. Soulivanh Phengsay, HAARP National Programme Officer	✓	✓	✓	✓	✓	✓
WHO	Dr. Dominique Ricard/Medical Officer, HIV/AIDS and STI	✓	✓	✓	✓	✓	✓

WHO	Dr. Thipphasone Vixaysouk, Health and Promotion Officer	✓	✓	✓	✓	✓	✓
WHO	Dr. Chintana Somkhane, Care and Treatment Officer, HIV and AIDS	✓	✓	✓	✓	✓	✓
UNFPA	Ms. Siriphone Sally Sakulku, Senior Reproductive Health Coordinator	✓	✓	✓	✓	✓	✓
ADB	Mr. Scott Bamber/ Chief of Technical Adviser, GMS, Capacity Building for HIV and AIDS Prevention Project	✓	✓	✓	✓	✓	✓
PSI	Mr. Rob Gray/Project Manager	✓	✓	✓	✓	✓	✓
PSI	Mr. Sihamano Bannavong, PSI Laos National Coordinator	✓	✓	✓	✓	✓	✓
LaoPHA	Mr. Vieng Akone Suriyo/Project Manager	✓	✓	✓	✓	✓	✓
LPN Plus	Mr. Kynoi Phondeth/Chair, LPN+	✓	✓	✓	✓	✓	✓
PEDA	Mr. Santi Doungpaseuth/Director	✓	✓	✓	✓	✓	✓
NCA	Dr. Phongsavanh Chansy/Project Coordinator	✓	✓	✓	✓	✓	✓

National Commitments and Policy Instrument (NCPI)

Part A

(to be administered by government officials)

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

[Yes]	No
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IF YES, what is period covered *[write in]*:

National Strategic Action Plan (NSAP) 2011-2015

- The current NSAP 2011-2015 which is in its penultimate year of implementation emphasises the geographic coverage and the quality of services.
- It incorporates low-risk men under the same category of “clients of sex workers” in this current NSAP, instead of individual sub-groups as written in the previous NSAP (2006-2010).
- The budget for this period of NSAP has been doubled compared to the previous NSAP
- The current NSAP is envisaged to reach the Universal Access target in 2015

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one.

IF NOT or NOT APPLICABLE, briefly explain why.

IF YES, complete questions 1.1 through 1.10; **IF NO**, go to question 2.

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?

Name of government ministries or agencies *[write in]*:

- Center for HIV/ AIDS and STI (CHAS)
- Ministry of Health
- National Committee for the Control of AIDS (NCCA)
- Provincial Committee for the Control of AIDS
- District Committee for the Control of AIDS

1.2. Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

SECTORS	Included in Strategy	Earmarked Budget
---------	----------------------	------------------

Education	[Yes]	No	[Yes]	No
Health	[Yes]	No	[Yes]	No
Labour	[Yes]	No	[Yes]	No
Military/Police	[Yes]	No	[Yes]	No
Social Welfare	[Yes]	No	[Yes]	No
Transportation	[Yes]	No	[Yes]	No
Women	[Yes]	No	[Yes]	No
Young people	[Yes]	No	[Yes]	No
Other (write in)	[Yes]	No	[Yes]	No
Red Cross	[Yes]	No	[Yes]	No
PHLIV Network and Affected Families	[Yes]	No	[Yes]	No

IF NO earmarked budget for some or all of the above sectors,
explain what funding is used to insure implementation of their specific activities

1.3. Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
Discordant couples	[Yes]	No
Elderly persons	[Yes]	No
Men who have sex with men	[Yes]	No
Migrant mobile populations	[Yes]	No
Orphan and other vulnerable children ³	[Yes]	No
People with disabilities	Yes	[No]
People who inject drugs	[Yes]	No
Sex workers	[Yes]	No
Transgender people	[Yes]	No
Women and girls	[Yes]	No
Young women/young men	[Yes]	No
Other specific vulnerable subpopulations ⁴	[Yes]	No
Men with multiple partners	[Yes]	No
SETTINGS		
Prisons	[Yes]	No
Schools	[Yes]	No
Workplace	[Yes]	No
CROSS CUTTING ISSUES		
Addressing stigma and discrimination	[Yes]	No
Gender empowerment and/gender equality	[Yes]	No
HIV and poverty	[Yes]	No
Human rights protection	[Yes]	No
Involvement of people living with HIV	[Yes]	No

IF NO, explain how key populations were identified?

- People with disabilities were not part of the multisectoral strategy in the current NSAP; however some of the respondents feel that people with disabilities should be part of the multisectoral strategy in the future because they also carry the risk of being vulnerable.

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
People living with HIV	[Yes]	No
Men who have sex with men	[Yes]	No
Migrants/mobile populations	[Yes]	No
Orphans and other vulnerable children	[Yes]	No
People with disabilities	Yes	[No]
People who inject drugs	[Yes]	No
Prison inmates	[Yes]	No
Sex workers	[Yes]	No
Transgender people	[Yes]	No
Women and girls	[Yes]	No
Young women/ young men	[Yes]	No
Other specific key populations/vulnerable subpopulations [write in]	Yes	No

1.5. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

[Yes]	No
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1.6. Does the multisectoral strategy include an operational plan?

[Yes]	No
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1.7. Does the multisectoral strategy or operational plan include:

a) Formal programme goals?	[Yes]	No	N/A
b) Clear targets or milestones?	[Yes]	No	N/A
c) Detailed cost for each programmatic area?	[Yes]	No	N/A

d) An indication of funding sources to support Programmatic implementation?	[Yes]	No	N/A
e) A monitoring and evaluation framework?	[Yes]	No	N/A

1.8. Has the country ensured “full involvement and participation” of civil society in the development of the multisectoral strategy?

Active Involvement	Moderate Involvement	No Involvement
---------------------------	----------------------	----------------

IF ACTIVE INVOLVEMENT, briefly explain how this was organized:

- PLHIV group like LNP+ was involved in the process for developing the NSAP 2011-2015 from the start until the plan was finally developed and implemented
- CSO’s specially those involved with the implementation of the HIV, AIDS and STI Programme and Projects were invited to all consultative meetings during the development process
- All partners had a hand in endorsing the NSAP after the consolidation meetings with specific activities and budget allocation
- Other government agencies involved in the HIV, AIDS, STI Programme got invited to all meetings for planning and report outcome of HIV related activities

IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case:

1.9. Has the multisectoral strategy been endorsed by most external development partners bi-laterals, multi-laterals?

[Yes]	No	N/A
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1.10. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

[Yes, all partners]	Yes, some partners	No	N/A
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IF SOME PARTNERS or NO , briefly explain which areas there is no alignment/harmonization and why :

2.1. Has the country integrated HIV in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS			
Common Country Assessment/UN Development Assistance Framework	Yes	No	N/A
National Development Plan	Yes	No	N/A
Poverty Reduction Strategy	Yes	No	N/A
National Social Protection Strategic Plan	Yes	No	N/A
Sector-wide approach	Yes	No	N/A
Other <i>[write in]</i> :	Yes	No	N/A
	Yes	No	N/A

2.2. IF YES, are the following specific HIV-related areas included in one or more of the development plans?

HIV-RELATED AREA INCLUDED IN PLAN(S)			
Elimination of punitive laws	Yes	No	N/A
HIV impact alleviation (including palliative care for adults and children)	Yes	No	N/A
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	No	N/A
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes	No	N/A
Reduction of stigma and discrimination	Yes	No	N/A
Treatment, care, and support (including social protection or other schemes)	Yes	No	N/A
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	No	N/A
Other <i>[write in]</i> :	Yes	No	N/A

	Yes	No	N/A
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3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

[Yes]	No	N/A
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3.1. IF YES, on a scale of 0 to 5 (where 0 is “Low” and 5 is “High”), to what extent has the evaluation informed resource allocation decisions?

LOW					HIGH
0	1	[2]	3	4	5

4. Does the country have a plan to strengthen health systems?

[Yes]	No	N/A
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Yes?
<p>Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications?</p> <p>Health System Strengthening components, capacity building for medical and health staff to improve quality of services, strengthen quality control of medicines, logistic and medical supply distribution</p> <ul style="list-style-type: none"> - Blood screening for HIV tests and access to safe blood; increase in sites for VCT, targeting MARPs to ensure efficiency; access to antenatal services; HIV+ pregnant to receive ARV prophylaxis; training of healthcare workers in STI diagnosis and treatment

5. Are health facilities providing HIV services integrated with other health services?

Area	Many	Few	None
a) HIV counselling & testing with sexual & reproductive health	✓		
b) HIV counselling & testing and tuberculosis	✓		
c) HIV counselling & testing and general outpatient care	✓		
d) HIV counselling & testing and chronic non-communicable diseases		✓	
e) ART and tuberculosis	✓		
f) ART and general outpatient care		✓	

g) ART and chronic non-communicable diseases		✓	
h) PMTCT with antenatal care/ maternal & child health	✓		
i) Other comments on HIV integration:		✓	

6. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate strategy planning efforts in your country’s HIV programmes in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been key achievements in this area?

- The HIV prevalence has remained low below 1% in Lao PDR
- The HIV prevalence among sex workers has remained low below 5%
- The HIV programme has managed to actively engaged the CSO especially for the Global Fund Projects, including the PLHIV groups
- The HIV programme has many sectors involved in the programme
- The provincial government through PCCA has been greatly involved with the HIV programme in collaboration with the partners at the provincial and district levels
- The supervision and monitoring efforts of the CHAS to the Provincial level was highly appreciated by the PCCA and partners
- The ART sites have continuously received ARV and OI drugs for its patients
- The HIV programme has increased the number of VCT sites
- The HIV Law and other HIV policies and regulations has strengthened other health programmes , example, the development of the regulations of medical device and drugs registration and processes, developed by FDD based on the ASEAN Medical Device Directive, these include HIV test kits, ARV and OI drugs quality assurance, and the quality of the supply chain has been through the GFATM funding.

What challenges remain in this area?

- The coverage for the referral system of ART to health facilities is not 100% because not all facilities can provide ART and PMTCT, example not all provincial hospitals are providing ART, only 9 sites are providing it; only few district hospitals provide PMTCT and not all provide HIV counseling and testing (HCT).
- There is a need to provide capacity building for the personnel to do quality management for products such as drugs and medical device
- There is a limited budget for follow up in the quality assurance in the GF medicine products.
- The coverage of intervention among migrant workers, school-based population and workplace intervention should be scaled up.

II. POLITICAL SUPPORT AND LEADERSHIP

Strong political support includes: government and political leaders who regularly speak out about HIV and AIDS and demonstrate leadership in different ways: allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. Do the following high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

A. Government ministers

[Yes]	No
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B. Other high officials at sub-national level

[Yes]	No
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1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.)

[Yes]	No
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Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:

- The Ministers of Health and Chair of the NCCA endorses the results of the MTR of the Ten Targets
- The Deputy Minister of Health (Associate Prof. Dr. Bounkong Syhavong) participated in the Tripartite Meeting during the HAARP Phase 2 program which reviewed major programme design modifications.
- The Minister of Health talked about the issues of stigma and discrimination to PLHIV on the occasion of World AIDS Day
- CHAS Director chairs the ASEAN Task Force on AIDS (ATFOA)
- CHAS Director and Deputy Directors participated in the Consultative Meeting with the

- PCCA Officials for the ADB Project
- CHAS Director participated in the 11th ICAAP, presented several papers, held in Bangkok, Thailand, November 2013.
 - CHAS Director participated in Leadership Forum 2013:Asia Pacific Getting to Three Zeros, 17-18 November, Bangkok, Thailand
 - CHAS GF Coordinator participated in the 2013 ICAAP
 - Government official attendance to CCM meetings
 - PCCA organized the HIV and AIDS activities during special cultural and religious events (Boat racing festival, WAD, Thatluang festival, etc.)

2. Does the country have an officially recognized national multisectoral HIV coordination body (i.e., a National HIV Council or equivalent)?

[Yes]	No
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IF NO, briefly explain why not and how HIV programmes are being managed?

2.1. IF YES:

IF YES , does the national multisectoral HIV coordination body:		
Have terms of reference?	Yes	No
Have active government leadership and participation?	Yes	No
Have an official chair person?	Yes	No
IF YES , what is his/her name and position title?		
<ul style="list-style-type: none"> - Prof. Dr. Eksavang Vonvichet- Minister of Health and NCCA Chair - Dr. Bounpheng Philavong- CHAS Director and Head of NCCA Secretariat 		
Have a defined membership?	Yes	No
IF YES , how many members?	17	
Include civil society representative?	Yes	No
IF YES , how many	1	
Include people living with HIV	Yes	No
IF YES , how many?	1	
Include the private sector?	Yes	No

Strengthen donor coordination to avoid parallel funding and duplication of effort of programming and reporting	Yes	No
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3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

[Yes]	No	N/A
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IF YES, describe the main achievements
<ul style="list-style-type: none"> - MOH sector-wide coordination mechanism, which includes several working groups such disease prevention and control. In this working group every stakeholder is invited to join in the activities, example policy working group will include all stakeholders including public and private sector, UN agencies, embassies, NGOs, and CSOs. - The CHAS/MOH plays a coordinating role among the stakeholders at the national and provincial level. - There are several thematic working groups on different topics such as MSM; FSW; treatment care and support; prevention; programmatic management group, including M&E. - National AIDS forum: review of the national AIDS response progresses annually. - GFATM CCM has an Oversight Committee (OC) to oversee the implementation of all GFATM grants. - NCCA network goes down to district level is responsible for coordinating the implementation of the AIDS response. This includes the PCCA at the provincial level and the DCCA at the district level.

What challenges remain in this area?
<ul style="list-style-type: none"> - Regularity of meetings of NCCA and PCCA - Limited time of the members of NCCA to fully participate in HIV programme activities. - Cross-sectoral coordination needs to be improved for more effective participation, especially of the CSOs. - Limited budget allocation especially at province and district level.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

26% [for national civil society only]
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5. What kind of support does the National HIV Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Capacity building	Yes	No
Coordination with other implementing partners	Yes	No
Information on priority needs	Yes	No
Procurement and distribution of medications or other supplies	Yes	No
Technical guidance	Yes	No
Other [write in below]:	Yes	No

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?

Yes	No
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6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?

Yes	No
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IF YES, name and describe how the policies/laws were amended?

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies
<ul style="list-style-type: none"> - HIV Prevention and Treatment Gaps: The NASP (2011-2015) outlines strategies to target mobile populations, however needs to have a more specific policy response for the large numbers of irregular migrants – including undocumented migrants from Lao PDR working in the GMS and undocumented foreign migrants from GMS countries working in Lao PDR. - Irregular migrants in both source and destination countries have limited access to affordable HIV treatment and comprehensive sexual and reproductive health services due to their irregular status and vulnerability to exploitation. - The NSAP also needs to include a more comprehensive policy and program response for documented foreign migrants who are working in Lao PDR in order to better define their entitlements to HIV, health care and social protection in Lao PDR. - For Laotian workers moving abroad, legislation contains no specific provisions mandating recruitment agencies to ensure access to health and medical care, as is the case in legislation of certain other sending countries in the region. - Under the government’s decree on the export of Lao workers abroad, recruitment agencies are tasked with providing protection for workers in accordance with employment contracts,

which may include provisions for employers to cover health access.

- For those workers travelling to Thailand, those who have completed documentation processes have access to health care either via the *Compulsory Migrant Health Insurance Scheme* or via the Thai *Social Security Scheme*, alongside Thai workers. The scheme under which a documented worker is eligible to access health care is dependent on the steps they have completed towards full registration in Thailand.

7. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the political support for the HIV programme in 2013?

Very Poor											Excellent
0	1	2	3	4	5	6	7	8	9	10	

Since 2011, what have been key achievements in this area?

- The Mid-term review of the 2011 Political Declaration Targets and its alignment to the five year NSAP 2011-2015.
- Continuous dissemination of the HIV Law by the parliamentarians since it was passed by the National Assembly and promulgated by the President afterwards.
- The commitment of the NCCA chair to achieve MDGs (including MDG6) and reaching Three Zero strategies.
- Involvement of the National Assembly in the dissemination of the contents of the Law on HIV to the public, especially addressing the issue of stigma and discrimination.
- Consideration of the extension of the NCCA membership to key affected population and private sector.
- Membership of the CCM includes heads and or deputy heads of government agencies including parliamentarians and the CSO sector.
- Chairing of CHAS Director to ATFOA
- PCCA of all provinces are chaired either by the Governor or Deputy Governor
- Central and Provincial Hospital Directors actively support the 9 ART sites

What challenges remain in this area?

- Allotted time of NCCA members because the membership is not full-time.
- Law enforcement should be strengthened
- More participation of leadership in HIV related activities and fund raising is needed.
- More local budget allocation is needed aside from the national budget which usually comes from the donor funds
- HIV Law and Policy should be more widely disseminated by local authority

III. HUMAN RIGHTS

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Circle yes if the policy specifies any of the following key populations and vulnerable groups:

KEY POPULATIONS AND VULNERABLE GROUPS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrant/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations (write in)	Yes	No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non discrimination?

[Yes]	No
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IF YES to Question 1.1. or 1.2., briefly describe the content of the laws:

- **Constitution of the Lao PDR: Article 25.** The State attends to improving and expanding public health services to take care of the people’s health. The State and society attend to building and improving disease prevention systems and providing health care to all people, creating conditions to ensure that all people have access to health care, especially women and children, poor people and people in remote areas, to ensure the people’s good health. **Article 29.** The State, society and families attend to implementing development policies and supporting the progress of women and to protecting the legitimate rights and benefits of women and children.
- **Law on Development and Protection of Women: Article 16.** Equal Cultural and Social Rights - The State promotes and creates conditions for women to enjoy equal cultural and social rights as men, such as rights to participate in socio-cultural activities, art performances, sports, education, public health, [and] in research and invention in socio-culture, and science and technology. Society and family should create conditions and provide opportunities for women to participate in the socio-cultural activities mentioned above.

- **Law on the Protection of the Rights and Interests of Children:** *Article 6. Non-Discrimination against Children* - All children are equal in all aspects without discrimination of any kind in respect of gender, race, ethnicity, language, beliefs, religion, physical state and socio-economic status of their family. *Article 17. Care of Children Affected by HIV/AIDS* - The State and society shall create conditions for children affected by HIV/AIDS to have access to health care and education, to live. *Article 31. Education for Children Affected by HIV/AIDS* -The State creates conditions for children affected by HIV/AIDS to receive education and to participate in various activities in school without discrimination. Disclosure of the HIV/AIDS status of children is forbidden.
- **Law on Drug control, prevention, protection, treatment and rehabilitation for addict:** *Article 2* of the law stated that children infected and /or affected by HIV/AIDS are among those children who are in need of special protection
- **Law on HIV/AIDS Control and Prevention:** *Article 34: Non-discrimination and non-stigmatisation* – People living with HIV/AIDS as well as affected people are equal to other people in the society with regards to living in the society and daily life activities without stigmatisation and discrimination. *Article 52: Prohibitions for individuals and other organizations* – 6. Discriminate, stigmatize, look down on , use violence, threaten and say bad things about people living with HIV and AIDs or affected people and health service providers.
- **Family Law:** *Article 2. Equality between men and women in family relations* - Men and women has equal rights in all aspects pertaining to family relations. *Article 5. Protection of interest of mothers and children* - The state and society protect the interest of mothers and children in family life and when a married couple may not lead further common life. *Article 35. Parental obligation in child care* - Parents have the obligation to care for their children still under age or having reached maturity but unable to provide for themselves. (http://www.apwld.org/pdf/lao_familylaw1990.pdf, downloaded 21h, 7 Mar 2012)
- **Penal Law.** *Article 160 : Mistreatment and torture of accused or prisoners* - Any individual mistreating, torturing, using measures or other acts not conform to tile laws against accused or prisoners during their arrest, the procedures of judgment or the execution of penalties, is punishable of three months to three years of imprisonment or of correctional penalties without privation of liberty.

Briefly explain what mechanisms are in place to ensure these laws are implemented:

-
- Lao citizen, foreigners and people with other nationality residing in the Lao PDR have right to access to information on HIV/AIDS control and prevention. The government, organizations and societies have provided information consistently with regulations, laws, traditional cultures and local texts.
- The National Assembly is in the process of establishing an HIV interest group of

parliamentarians who will be tasked with monitoring the implementation and effectiveness of the new HIV Law.

- Decree of the President of the Lao PDR was issued to promulgate the Laws
- Decree of the Prime Minister of the Lao PDR was issued to implement the Laws
- The Laws have been disseminated through various means to all sectors concerned and general public
- National commission for advancement of women has been established to monitor the implementation of CEDAW and other legislation regarding the development and protection of women and children
- The line ministries and organisations (Lao Women Union, Lao Youth Union) take responsibility to disseminate and develop under law legal framework for implementation and oversee the implementation of the related laws.
- The Lao National Assembly regularly meets and is able to discuss issue related to the implantation of this law. The responsible Committees within the National Assembly is responsible to supervise the implementation of the laws

Briefly comment on the degree to which they are currently implemented:

- The Law on HIV has been disseminated nationwide, in collaboration with the National Assembly and affiliated ministries.
- The National Assembly and Ministry of Justice have gone to selected provinces and communities to address the contents of the law to the public
- The HIV Law is in its early phase of implementation.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

Yes	No
-----	----

IF YES, for which key population and vulnerable group?		
People living with HIV	Yes	No
Elderly persons	Yes	No
Men who have sex with men	Yes	No
Migrant/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No

Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations (write in)	Yes	No

Briefly describe the content of these laws, regulations or policies:

Briefly comment on how they pose barriers

IV. PREVENTION

- Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?

[Yes]	No
-------	----

<i>IF YES</i> , what key messages are specifically promoted?		
Delay sexual debut	Yes	No
Engage in safe(r) sex	Yes	No
Fight against violence against women	Yes	No
Greater acceptance and involvement of people living with HIV	Yes	No
Greater involvement of men in reproductive health programmes	Yes	No
Know your HIV status	Yes	No
Males to get circumcised under medical supervision	Yes	No
Prevent mother-to-child transmission of HIV	Yes	No
Promote greater equality between men and women	Yes	No
Reduce the number of sexual partners	Yes	No
Use clean needles and syringes	Yes	No
Use condoms consistently	Yes	No

Other (write below)	Yes	No

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

[Yes]	No
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2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?

[Yes]	No
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2.1.

Is HIV education part of the curriculum in:		
Primary schools	Yes	No
Secondary schools	Yes	No
Teacher training	Yes	No

2.2 Does the strategy include

a) age-appropriate sexual and reproductive health elements?

[Yes]	No
-------	----

b) gender-sensitive sexual and reproductive health elements?

[Yes]	No
-------	----

2.3. Does the country have an HIV education strategy for out-of-school young people?

[Yes]	No
-------	----

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations?

[Yes]	No
--------------	----

Briefly describe the content of this policy or strategy
<p>NSAP (page 29)</p> <ul style="list-style-type: none"> - Ministry of Education to expand life-skills education In schools and include HIV and sexual health, based on recent evaluation - Expand outreach interventions by concerned sectors for out of school youth and disadvantaged children based on the recent MARA assessment <p>Policy for HIV/AIDS/STI in Lao PDR: (page 7)</p> <ul style="list-style-type: none"> - In-school Youth: School children will be equipped with skills, knowledge and attitudes to avoid HIV and STI infection through life-skills education - Out of school youth: The Central Lao Youth Union Is responsible for out of school youth throughout the country, to carry out the survey to determine their risk behaviours, to carry out interventions, education, with a focus on group discussion to raise awareness on HIV and STI

3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address?

Check which specific populations and elements are included in the policy/strategy

	IDU	MSM	Sex workers	Customer of sex workers	Prison inmates	Other populations (write in)
Condom promotion	✓	✓	✓	✓	✓	
Drug substitution therapy	✓					
HIV testing and counseling	✓	✓	✓	✓	✓	General Population
Needle & syringe exchange	✓					
Reproductive health, including sexually transmitted infections prevention and treatment	✓	✓	✓			Youth
Stigma and discrimination Reduction	✓	✓	✓	✓	✓	General Population
Targeted information on risk reduction and HIV education	✓	✓	✓	✓	✓	
Vulnerability reduction (e.g. income generation)	✓					PLHIV

3.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate policy efforts in support of HIV prevention in 2013?

Very Poor											Excellent
0	1	2	3	4	5	6	7	8	9	10	

Since 2011, what have been the key achievements in this area?

- Prevention coverage by peer-lead Interventions to SW and MSM has increased
- Increased VCT uptake including increased number of VCT sites
- Increased number of pregnant women received HIV tests and know their results
- Integration of HIV into Comprehensive MNCH package of service;
- Condom distribution through different channels had made condoms widely available
- Drop-in-centre in partnership with civil society is functioning
- Dissemination of Law and Policy
- Training workshop for spouses of VIP and businesswomen
- Training workshop for members of mass organization, such as LWU, LYU, LTU
- TV and Newspaper interview of the CHAS Director

What challenges remain in this area?

- Quality of preventive packaged interventions needs to be improved, for example VCT.
- Sustainability of prevention programme, especially in the context of shortage of fund
- Behavioural trends of target populations are evolving, which make it hard for the programme to reach the targets.
- Lack of systematic information to monitor the target population and the programme.
- Capacity of implementers, needs continuous training and updating.
- The GF budget for IEC has been reduced

4. Has the country identified specific needs for HIV prevention programmes?

[Yes]	No
--------------	----

IF YES, how were these specific needs determined?

- Strengthening services for PMCTC among pregnant women
- Most at risk population easily access to condom
- Sex workers and MSM/TG have access to STI services
- Infants born to identified HIV + mothers to receive ART
- Young women and men correctly identify ways of preventing sexual transmission of HIV
- Promote prevention intervention on HIV and AIDS among the general population

- Intensify VCT access among MSM and SW
- Improved quality of peer-led intervention and DIC
- Engage private sector such as construction companies in HIV prevention for construction workers and migrant workers
- Strengthen intervention prevention activities for other vulnerable group of people such as ethnic group, out-of-school youth, foreign migrant workers (sex workers), etc. particularly in border areas.
- Improve cross-border collaboration to increase access to HIV intervention for Lao migrant workers working in neighboring countries.

IF NO, how are HIV prevention programmes being scaled-up?

4.1 To what extent has HIV prevention been implemented?

The majority of people in need have access to...	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	[4]	N/A
Condom promotion	1	2	3	4	N/A
Economic support e.g. cash transfers	1	[2]	3	4	N/A
Harm reduction for people who inject drugs	1	2	3	4	N/A
HIV prevention for out-of-school young people	1	[2]	3	4	N/A
HIV prevention in the workplace	1	[2]	3	4	N/A
HIV testing and counseling	1	2	3	[4]	N/A
IEC on risk reduction	1	2	[3]	4	N/A
IEC on stigma and discrimination reduction	1	2	[3]	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	[3]	4	N/A
Risk reduction for intimate partners of key Populations	1	[2]	3	4	N/A
Risk reduction for men who have sex with men	1	2	3	4	N/A
Risk reduction for sex workers	1	2	3	[4]	N/A
Reduction of Gender based violence	1	2	3	4	N/A
School-based HIV education for young people	1	2	[3]	4	N/A
Treatment as prevention	1	2	3	4	N/A
Universal precautions in health care settings	1	2	[3]	4	N/A
Other [write in]:	1	2	3	4	N/A

5. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in implementation of HIV prevention programmes in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

[Yes]	No
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<i>If YES, Briefly identified the elements and what has been prioritized:</i>
<ul style="list-style-type: none"> - Quality VCT services in 94 priority districts - ARV/OI treatment integrated in all provincial hospitals - Co-infection HIV/TB by PICT approach implemented nationwide - PLHIV support groups exist in 13/17 provinces

Briefly identify how HIV treatments, care and support services are being scaled-up?
<ul style="list-style-type: none"> - Meaningful engagement of PLHIV self-help groups in care and support - Involvement of CSO, networks and associations to take part in care and supports and referral for treatment. - Increase VCT coverage - Referral system for ART from drop-in-centres that targets KAP - Mainstream ART in general public health system - Cross screening of HIV among TB patients and vice-versa.

- 1.1. To what extent have the following HIV treatment, care and support services been implemented?

The majority of people in need have access to...	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	[3]	4	N/A
ART for TB patients	1	2	[3]	4	N/A
Cotrimoxazole prophylaxis in people living with	1	2	[3]	4	N/A

HIV					
Early infant diagnosis	1	2	[3]	4	N/A
Economic support	1	2	[3]	4	N/A
Family based care and support	1	2	[3]	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	[3]	4	N/A
HIV testing and counseling for people with TB	1	2	[3]	4	N/A
HIV treatment services in the workplace or treatment referral system through the workplace	1	2	[3]	4	N/A
Nutritional care	1	2	[3]	4	N/A
Paediatric AIDS treatment	1	2	[3]	4	N/A
Palliative care for children and adults	1	2	[3]	4	N/A

The majority of people in need have access to...	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Post-delivery ART provision for women	1	2	[3]	4	N/A
Post- exposure prophylaxis for non-occupational Exposure (e.g., sexual assault)	1	2	[3]	4	N/A
Post- exposure prophylaxis for occupational exposure to HIV	1	2	[3]	4	N/A
Psychosocial support for people living with HIV and their families	1	2	[3]	4	N/A
Sexually transmitted infection management	1	2	3	[4]	N/A
TB infection control in HIV treatment care facilities	1	2	3	[4]	N/A
TB preventive therapy for people living with HIV	1	2	[3]	4	N/A
TB screening for people living with HIV	1	2	[3]	4	N/A
Treatment of common HIV-related infections	1	2	[3]	4	N/A
Other [write in]:	1	2	3	4	N/A

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?

[Yes]	No
-------	----

Please clarify which social and economic support is provided:
<ul style="list-style-type: none"> - Psycho-social support for PLHIV by CSOs and self-help groups - Set up revolving funds for PLHIV and those affected by HIV and AIDS - Vocational promotion for PLHIV and those affected by HIV and AIDS - Provision of travel cost and per diem for PLHIV to come to ART sites for medicines and testing - Support for orphan both financial and psychological

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3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?

Yes	No	[N/A]
-----	----	-------

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications?

[Yes]	No	N/A
-------	----	-----

IF YES, for which commodities?
<ul style="list-style-type: none">- GFATM system provides regional procurement and supply management mechanism for ARV, condoms and essentials drugs and test kits, including emergency purchase of important commodities.- Purchase equipment through regional procurement process

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementations of HIV treatment, care and support programmes in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been the key achievements in this area:
<ul style="list-style-type: none">- Increased number of people receiving ART both in children and adults in ART sites- Treatment guidelines and PMTCT guidelines are printed and disseminated- Equal access to ART treatment and care and support for PLHIV- Co-management of TB and HIV; TB/HIV guideline printed and disseminated- Increased VCT coverage and uptake- More CSO involvement in care and support at community level- Improved monitoring system- Expand ART site to ensure that remote provinces are covered

What challenges remain in this area:

- GFATM procurement procedures at sometimes causes stock-out of commodities
- Forecasting of buffer for stock-outs
- Highly dependent on GFATM support for treatment
- PLHIV still come for treatment at late stage, when CD4 count is already very low (less than 200)
- Provision of CD4 machine to all ART sites
- Establishment of National ART Committee to provide technical support and guidance to ART site medical staff and support team for training and research
- Increase awareness of the availability of drugs and services
- Improvement of activity to address ARV toxicity, adverse reactions and drug resistance

6. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?

[Yes]	No	N/A
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6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

[Yes]	No
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6.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No
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7. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2013?

Very Poor										Excell ent
0	1	2	3	4	5	6	7	8	9	10

- Since 2011, what have been the key achievements in this area?**
- Increased number of children receiving ARV in ART sites
 - Equal access of children to ARV treatment, care and support,
 - Co-management of TB and HIV
 - More CSO involvement in care and support at the community level
 - Improved monitoring system

What challenges remain in this area:

- Highly dependent on GFATM supports for treatment
- Weak coordination with Ministry of Labor and Social Welfare to address OVC
- No specific project/plan addressing OVC
- No monitoring indicator on OVC
- Mapping of OVC

VI. MONITORING AND EVALUATION

1. Does the country have one Monitoring and Evaluation (M&E) plan for HIV?

Yes	In Progress	No
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Briefly describe any challenges in development or implementation:

- The M&E and Surveillance Unit of CHAS was previously under the Planning Unit but now organized as one of the Units at CHAS, M&E and Surveillance Unit, which needs additional staff
- There is shortage of M&E staff at the provincial and district level
- There is a need to have a unified routine data collection system
- There is a need to increase the capacity of staff to collect data at primary level
- There is a need to install feedback mechanism and quality assurance system
- Strategic information has not been used fully, hence lack of the needs to develop a functional unified system
- Behavioral data are still collected on ad-hoc bases
- Inadequate capacity on data analysis

1.1. IF YES, years cover [write in]:

2012 -2015

1.2. IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	Yes, some partners	No	N/A
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Briefly describe what the issues are:

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy	Yes	No
IF YES, does it address:		
Behavioral survey	Yes	No
Evaluation / research studies	Yes	No
HIV Drug resistance surveillance	Yes	No
HIV surveillance	Yes	No
Routine programme monitoring	Yes	No
A data analysis strategy	Yes	No
A data dissemination and use strategy	Yes	No
A well-defined standardized set of indicators that includes sex and age disaggregation (where appropriate)	Yes	No
Guidelines on tools for data collection	Yes	No

3. Is there a budget for implementation of the M&E plan?

Yes	In Progress	No
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3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

5%

4. Is there a functional M&E Unit?

Yes	In Progress	No
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Briefly describe any obstacle:

- There is shortage of M&E staff at provincial and district levels
- There is a lack of unified routine data collection system at some provinces
- There is a need to train the staff to collect data at the provincial and district levels.
- There is lack of a feedback mechanism and quality assurance system
- Strategic information needs to be fully utilized to develop a functional unified system
- There is a need to augment the budget which is 5% of the total budget at the moment

4.1. Where is the national M&E Unit based?

In the Ministry of Health?	Yes	No
In the National HIV Commission (or equivalent)?	Yes	No
Elsewhere <i>[write in]</i> :	Yes	No

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION <i>[write in position titles in spaces below]</i>	Fulltime	Part time	Since when?
Permanent Staff <i>[Add as many as needed]</i>	5		2013
Head of M&E and Surveillance Unit	1		2013
	Fulltime	Part time	Since when?

4.3 Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

[Yes]	No
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Briefly describe the data-sharing mechanisms:

- Key partners (national and international) are supposed to send their programme monthly reports to CHAS for compilation and analysis
- There is the mechanism for submission of reports from the district level, to the provincial level, and to the national level described in the National M&E Plan
- There is an annual meeting among stakeholder on the Programme/Project results.
- There are special meetings for ad hoc studies or researches presented to various stakeholders such as IBBS results, studies on MSM and TG among others
- Quarterly meeting with USAID and PSI to report on project implementation progress
- Access to PUDR submitted by Sub-Recipients to the PR
- Ad hoc meeting of the National HIV Task Force on AIDS
- Sharing of information during annual NCCA meeting

What are the major challenges in this area:

- Some partners don't report about their project activities on HIV and AIDS to the National Programme of HIV, AIDS and STI, based in CHAS, therefore the CHAS does not have the information of these project activities and report is wanting.
- There is a variation in the submission of reports from various implementers due to varying requirements of donors, example Global Fund requires submission every six months and some quarterly.
- There is a coordination issue, many partners send their report late or only sent when requested.
- Many reports are sent incomplete.

5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

Yes	No
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6. Is there a central national database with HIV-related data?

Yes	No
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***IF YES,* briefly describe the national database and who manages it.**

- CHAS M&E Unit collects data and information from all partners including PCCA, ART sites, NGOs and CSOs, the data and information are collated, analyzed, documented and disseminated.

- CHAS also conducts regular studies and research such as rapid assessment, IBBS, in collaboration with partners

6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes, all of the above	Yes, but only some of the above	No, none of the above
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IF YES, but only some of the above, which aspects does it include?

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6.2. Is there a functional Health Information System?

At national level	Yes	No
At subnational level	Yes	No
IF YES, at what level(s)? <i>[write in]</i>		

7.1. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of Current and Future Needs	Estimates of Current Needs Only	No
---------------------------------------	---------------------------------	----

7.2 Is HIV programme coverage being monitored?

[Yes]	No
-------	----

a) IF YES, is coverage monitored by sex (male, female)?

[Yes]	No
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b) IF YES, is coverage monitored by population groups?

[Yes]	No
-------	----

IF YES, for which population groups?

- Sex workers (SW)
- Men having sex with men (MSM)
- People living with HIV (PLHIV)
- Pregnant women
- Client of sex workers
- Partners of MSM
- PWID

Briefly explain how this information is used:

- Projections are made on the number SW, MSM, and PLHIV in order to project the packaged of services needed for the prevention intervention programmes, such as the number peer of educators needed to reach the projected number of peers, the number of outreach workers, the number of trainings for the outreach workers and peer educators, the number of STI kits for STI management, number of HIV test kits, number of VCT conducted, and number of condoms needed either for social marketing or free distribution.
- For PLHIV, number who people who will need ARV and OI drugs, laboratory procedures such CD4 cell count, viral load and other basic laboratory procedures, care and support services, economic support, nutritional support among others

c) Is coverage monitored by geographical area?

[Yes]	No
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IF YES, at which geographical levels (provincial, district, other)?

- Provincial and District level

Briefly explain how this information is used:

- The provinces with ART sites are given allocation for the number of ARVs and OIs needed based on their projected number of PLHIVs.
- CHAS and partners provide free condoms for the provinces according the projected demand.

- Provinces with more projected SW and MSM are given priority in terms of focused prevention intervention activities.

8. Does the country publish an M&E report on HIV, including HIV surveillance data at least once a year?

Yes	No
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9. How are M&E data used?

For programme improvement?	Yes	No
In developing / revising the national HIV response?	Yes	No
For resource allocation?	Yes	No
Other [write in]:		

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:

- Planning purposes in terms of coverage and budget allocation
- Use for mid-term reviews, example MTR of Ten Targets, whether targets are on track
- Track the trends of various indicators
- Used to develop concept paper and proposal for funding support
- Used to revise the policy and strategy and develop the new NSAP 2016-2020, for annual plan

10. In the last year, was training in M&E conducted?

At national level?	Yes	No
IF YES, what was the number trained: 200		
At subnational level?	Yes	No
IF YES, what was the number trained:		
At service delivery level including civil society?	Yes	No
IF YES, how many? 7		

10.1. Were other M&E capacity-building activities conducted other than training?

[Yes]	No
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IF YES, describe what types of activities

- Training on the use of software “HIVCAM plus” by CDC/Thailand-US Collaboration
- Training on the use of software monitoring and evaluation reporting system (MERS)
- Bilateral training workshop (Lao-Thailand) on estimation and projection
- National workshop on M&E tools and reporting forms
- Development of SOP and handbook on M&E

11. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the HIV-related monitoring and evaluation (M&E) in 2013?

Very Poor											Excellent
0	1	2	3	4	5	6	7	8	9	10	

Since 2011, what have been the key achievements in this area:

- The use of Strategic Information through the strengthening of the M&E System by the use of the software called “HIVCAM” and now called the HIVCAM plus, for clinical monitoring of PLHIV, used in ART sites. The TA was provided by CDC/Thailand-US Collaboration who fixed the software.
- The launching of prevention software called the VCT software and the software for STI used for the Monitoring Evaluation Reporting System (MERS)
- Development of the new protocol for IBBS, set-up laboratory protocol for MSM and Sex Workers
- Procurement of 3 new CD4 machines
- Discussion has been made to improve laboratory quality assurance mechanism and reporting

What challenges remain in this area:

- Implementation of these new protocols which have been recently launched and piloted
- Adherence to the quality guidelines on the use of ARV, OI, PMTCT and Clinical Management
- Diverse capacity of reporting sites
- The new software is still in English version, there is need to translate to Lao for ease data entry and reporting

Part B: For CSOs, bilateral organizations and UN agencies

[to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations]

I. CIVIL SOCIETY INVOLVEMENT

1. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

LOW					HIGH
0	1	2	[3]	4	5

Comments and examples:

- Attended meetings, assisted in the drafting of strategy but needs to have more research to have evidenced-based information and to identify gaps
- The civil society has mainly a role in programme implementation, and only ad hoc technical task force meetings, but little involvement in programme quality control. For example, NCCA and PCCA committees have no civil society members involved.
- The civil society has little power and very little leverage with leaders and government, and can thus play only a limited role in formulation of national strategy
- The CSO receives Global Fund support from the government
- The CSO focuses on implementation and advocacy on MDG targets

2. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High” have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

LOW					HIGH
0	1	2	3	[4]	5

Comments and examples:

- The Global Fund Project provided the opportunity to be involved in planning and budgeting process and to attend meetings and review the draft. For PSI they were greatly involved with planning meetings with both GF and USAID funded projects.
- The civil society organisations have been mainly involved in the activity plan.
- CSOs while invited to attend planning meetings, the impression of some is that this is only a token, and that only rarely are the opinions and inputs of CSO sought and included. Where these are included, opinions that run contrary to the official line, or might be

construed as "critical" of government, or show the country in a negative light, are often censored in published or official documents.

3. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The National HIV strategy?

LOW					HIGH
0	1	2	3	4	5

b. The National HIV budget?

LOW					HIGH
0	1	2	3	4	5

c. The National HIV reports?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

- Increase investment and involvement by the civil society organisation targeting MARPS and Key Affected Population (KAP) in providing HIV prevention, treatment, care and support interventions.
- Services are mainly part of the National strategy, only from bilateral/multilateral/GF funding,
- HIV is integrated into the CSOs programme of support to government, both in maternal health and youth. CSOs do not provide funding to government budget but support through implementation of activities through agreed work plan.
- CSOs provide inputs to the national reports.

4. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society include in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the National M&E plan?

LOW					HIGH
0	1	2	3	4	5

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?

LOW					HIGH
0	1	2	3	4	5

c. Participate in using data for decision-making?

LOW					HIGH
0	1	2	3	4	5

Comments and examples:

- CSOs were all invited and only a few did not attend the M&E TWG;
- CSOs were invited and fully consulted for decision to be made particularly for the National HIV and AIDS meeting, Oversight and CCM meeting
- M&E system needs to be improved aligned to the quality of services;
- Implementers should be trained to use the tools of M&E
- The Center for HIV/AIDS and STI representing the national programme operation is in charge of the development of the national M&E plan. The Civil society had a limited role in the national M&E development, including indicator set-up.

5. To what extent (on a scale of 0 to 5 is “Low” and 5 is “High”) is civil society representation in HIV efforts inclusive of diverse organizations (e.g. organizations and networks of people living with HIV, of sex workers, community-based organizations, and faith-based organizations)?

LOW					HIGH
0	1	2	[3]	4	5

Comments and examples:

- Network of PLHIV such as LPN plus is represented in some of the areas supported by LaoPHA at the National level and at the provincial level
- Peers Network is involved supported by NCA.
- LNP+ is an active participant in both the Oversight Committee and Country Coordinating Mechanism of the Global Fund in the Lao PDR. The LNP+ just officially been registered as association early 2012.
- There is no sex-workers organisations and in general a limited number of NGOs involved however the government and some CSOs have been already working with them, e.g. DIC, peer-led intervention and survey
- Groups represented are mainly people living with HIV. While this group may include MSM, SWs or PWID, their issues are generally secondary, or even ignored.

6. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society able to access:

- a. Adequate financial support to implement its HIV activities?

LOW					HIGH
0	1	2	3	4	5

- b. Adequate technical support to implements its HIV activities?

LOW					HIGH
0	1	2	[3]	4	5

Comments and examples:	
<ul style="list-style-type: none"> - CSOs are not able to fully access financial and technical support from the government, although the government is providing the CSOs the opportunity to access those kind of support, GF support in prevention intervention activities provided to MARPs such as the SW and MSM including PLHIV - Since GF and bilateral funding are the main financial support to the civil society, local resource mobilization is limited. - Sustainable financial support is difficult to attain - Technical support from the government is limited to CHAS. TA for CSOs should be identified and be available if there's a request. 	

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for key-populations				
People living with HIV	<25%	25-50%	51-75%	>75%
Men who have sex with men	<25%	25-50%	51-75%	>75%
People who inject drugs	<25%	25-50%	51-75%	>75%
Sex workers	<25%	25-50%	51-75%	>75%
Transgender people	<25%	25-50%	51-75%	>75%
Treatment and Care				
Palliative care	<25%	25-50%	51-75%	>75%
Testing and counselling	<25%	25-50%	51-75%	>75%
Know your Rights/ Legal services	<25%	25-50%	51-75%	>75%
Reduction of Stigma and Discrimination	<25%	25-50%	51-75%	>75%
Clinical services (ART/IO)*	<25%	25-50%	51-75%	>75%
Home-base care	<25%	25-50%	51-75%	>75%
Programmes for OVC**	<25%	25-50%	51-75%	>75%

* ART = Antiretroviral Therapy; IO=Opportunistic infections

** OVC = Orphans and other vulnerable children

8. Overall on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”) how would you rate the efforts to increase civil society participation in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been the key achievements in this area:

- There is transparency in the process of recruiting and implementing as discussed in the MOH level and the CCM;
- Involved in the development of Global Fund Proposal in all rounds;
- Implement the National Strategy; Reaching high targets
- More civil society organisations have been legally recognised, however, there is a limited capacity and coordination.
- The Global Fund project has increased the efforts of civil society's participation in 2013
- The government has given opportunities to any organisation to register in the ministry of public security. There have been more than 200 organisations registered.
- Many organisation boost up to support HIV/AIDS project plans.
- Since this time LNP+ has been invited to participate in the Oversight Committee (OC) and the Country Coordinating Mechanism (CCM) on the Global Fund, as well as other national level policy discussions on HIV
- CSO involvement has been significantly and increasingly recognised and accepted
- All existing CS has been encouraged to be part of the national AIDS programme. Civil society organisations have been the main implementing partners in GFATM supported activities.
- LNP+ has been officially registered as an association.
- Examples of active involvement of CSO in partnership with the Government sectors include the Stigma Index Survey conducted with participation of LNP+, French Red Cross and CHAS; the pilot outreach harm reduction prevention for PWID in partnership with LNP+, UNODC and Lao Youth Union;
- The New Friend Network for MSM with participation from PSI and LNP+; and
- The outreach implementation of the AIDS Law through the development of a framework for reducing Stigma and increase access to service.

What challenges remain in this area:

- Not all CSO are invited to provide services, some are involved with little work to do but in fact they can do more work;
- CSOs don't have participation in the national M&E, example the GF, only CHAS is involved and not CSO;
- Balance of investment among CSO among partners;
- Meaningful participation of KAP and PLHIV;

- Capacity and coordination mechanisms are main challenges for involving civil society in the national programme;
- Limited access to funding and the budget is limited to HIV/AIDS work-plan only;
- The political climate hampers the CSOs access to broader participation;
- Inadequate condoms and STI drugs for civil society to support their programme activities;
- Major decisions like taking over of a project not completed by another CSO still need policy guidelines on how these changes should be handled to provide equity among other stakeholders;
- Participation is often tokenistic;
- Coordination and communication between the CSOs and government need to be improved;
- Language barriers and limited skills inhibit civil society organisations from participating in a more meaningful way;
- There's the need to involve and establish more networks (e.g. SW, MSM networks....) diversify and boost organisational structure of CSO;
- Need to scale up CSO involvement through capacity building and advocacy to get more CSO involvement in other forum (CCM, M&E).

II. POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?

Yes	No
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IF YES, describe some examples of when and how this has happened:

- Through consultative processes of the development, PLHIV and MSM are involved; however, due to limited capacity and power to negotiate with the policy makers, there is still a room for improvement.
- The government has facilitated support from donor, example Global Fund; in IDU Project access to funding was in partnership with the government
- PLHIV and MSM are included in important meetings
- PLHIV has representation at the CCM of the GF including representation in various local and international meetings and conferences.
- Through CHAS, PLHIV have been involved in governmental HIV policy design and programme implementation, for example the OC and CCM, the HIV National Strategic Action Plan and in the Secretariat of NCCA.
- Few PLHIV are invited to participate in these meetings while other vulnerable populations

are not involved,

- PLHIVs are invited to become members of the NCCA and PCCA
- PLHIV, LNP+ representatives and other SCO (NGO, faith-based organizations) have been invited to attend consultative meetings and discussion during the development process of the National AIDS Strategy and Action Plan; Law on HIV; proposal for GFATM grants. PLHIV and other CSO have taken part in surveys to feed up information on various high-risk groups and key affected groups (sex workers, MSM/TGs, migrants, PUD/PWID) to the national strategic information system.

III. HUMAN RIGHTS

1.1. Does the country have no-discrimination laws or regulations which specify protections for specific key-populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS AND VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants /mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations <i>[write in]:</i>	Yes	No

1.2 Does the country have a general (i.e. not specific to HIV-related discrimination) law on non-discrimination?

[Yes]	No
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IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:

- **Constitution of the Lao PDR: Article 25.** The State attends to improving and expanding public health services to take care of the people’s health. The State and society attend to building and improving disease prevention systems and providing health care to all people, creating conditions to ensure that all people have access to health care, especially women and children, poor people and people in remote areas, to ensure the people’s good health. **Article 29.** The State,

society and families attend to implementing development policies and supporting the progress of women and to protecting the legitimate rights and benefits of women and children.

- **Law on Development and Protection of Women:** *Article 16.* Equal Cultural and Social Rights - The State promotes and creates conditions for women to enjoy equal cultural and social rights as men, such as rights to participate in socio-cultural activities, art performances, sports, education and family should create conditions and provide opportunities for women to participate in the socio-cultural activities mentioned above.
- **Law on the Protection of the Rights and Interests of Children:** *Article 6. Non-Discrimination against – Children* - All children are equal in all aspects without discrimination of any kind in respect of gender, race, ethnicity, language, beliefs, religion, physical state and socio-economic status of their family. *Article 17. Care of Children Affected by HIV/AIDS* - The State and society shall create conditions for children affected by HIV/AIDS to have access to health care and education, to live with their family and to be protected from all forms of discrimination from the community and society. *Article 31. Education for Children Affected by HIV/AIDS* -The State creates conditions for children affected by HIV/AIDS to receive education and to participate in various activities in school without discrimination. Disclosure of the HIV/AIDS status of children is forbidden.
- **Law on Drug control ,Prevention ,protection, treatment and rehabilitation for addict-** *Article 2* of the law stated that children infected and /or affected by HIV/AIDS are among those children who are in need of special protection
- **Law on HIV/AIDS Control and Prevention:** *Article 34: Non-discrimination and non-stigmatisation* – People living with HIV/AIDS as well as affected people are equal to other people in the society with regards to living in the society and daily life activities without stigmatisation and discrimination *Article 52: Prohibitions for individuals and other organizations* – 6. Discriminate, stigmatize, look down on , use violence, threaten and say bad things about people living with HIV and AIDs or affected people and health service providers
- **Family Law:** *Article 2. Equality between men and women in family relations* - Men and women have equal rights in all aspects pertaining to family relations. *Article 5. Protection of interest of mothers and children* - The state and society protect the interest of mothers and children in family life and when a married couple may not lead further common life. *Article 35. Parental obligation in child care* - Parents have the obligation to care for their children still under age or having reached maturity but unable to provide for themselves. (http://www.apwld.org/pdf/lao_familylaw1990.pdf, downloaded 21h, 7 Mar 2012)
- **Penal Law.** *Article 160 : Mistreatment and torture of accused or prisoners* - Any individual mistreating, torturing, using measures or other acts not conform to tile laws against accused or prisoners during their arrest, the procedures of judgment or the execution of penalties, is punishable of three months to three years of imprisonment or of correctional penalties without privation of liberty.

Briefly explain what mechanisms are in place to ensure that these laws are implemented:

- Lao citizen, foreigners and people with no known nationality residing in the Lao PDR have right to access to information on HIV/AIDS control and prevention. The government, organisations and societies have provided information consistently with regulations, laws, traditional cultures and local texts.
-
- The National Assembly is in the process of establishing an HIV interest group of parliamentarians who will be tasked with monitoring the implementation and effectiveness of the new HIV Law.
- There was a Decree of the President of the Lao PDR to promulgate the Laws.
- There was a Decree of the Prime Minister of the Lao PDR was issued to implement the Laws.
- The Laws have been disseminated through various means to all sectors concerned and general public
- National commission for advancement of women has been established to monitor the implementation of CEDAW and other legislation regarding the development and protection of women and children
- The line ministries and organisation (Lao Women Union, Lao Youth Union) take responsibility to disseminate and develop under law legal framework for implementation and oversee the implementation of the related laws.
- The Lao National Assembly regularly meets and is able to discuss issue related to the implantation of this law. There is a Committees within the National Assembly is responsible to supervise the implementation both to government and the public and private sector.

Briefly comment on the degree to which they are currently implemented:

- At present, some Laws are not fully implemented. This is likely to change due to the incoming monitoring system outlined above and LNP+'s work to inform PLHIV in Lao PDR on their rights as protected in the law.
- The Law that protects women is being implemented from the national to the provincial down to the district level, including the gender-based violence is reported from the national to the provincial down to the district level.
- The laws have not reached to all population due to the lack of funding to disseminate and help communities understand the laws and their rights.
- There is little involvement of responsible line ministries to carry out their duty in law enforcement and implementation.
- There is an inadequate supportive legal structure for penalties for those who do not abide the law.

2. Does the country have laws, regulations or policies that present obstacles effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

Yes	No
-----	----

2.1. IF YES, for which sub-populations?

KEY POPULATIONS AND VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants /mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations <i>[write in]:</i>	Yes	No

Briefly describe the content of these laws, regulations or policies:

Briefly comment on how they pose barrier:

3. Does the have the policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?

[Yes]	No
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Briefly describe the content of the policy, law or regulation and the populations included.

- A National Commission for the Advancement of Women (NCAW) was set up in 2003 to drive national policy to promote gender equality and empower women, previously

under the Lao Women's Union. NCAW has developed its second National Strategy on the Advancement of Women for 2011-2015, which outlines how to translate political commitments to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and other international agreements into practical actions, as well as integrate gender equality principles into national laws and policies. 'Sub-CAW' units were established throughout the country at all ministries, state organizations and at provincial, district and village levels, to enhance central policy-making and aid in monitoring CEDAW.

- The 2004 Law on the Development and Protection of Women focuses on eliminating discrimination against women, combating violence, and creating an enabling environment for women's empowerment.
- The Family Code has been amended to remove discrimination against women in matters of marriage and inheritance, repealing a lowering of the marriage age of girls to 15.
- The Government provides counseling, economic support and social supports In 2010 the National Assembly organized a national consultation on VAW and formed a working group towards writing a Domestic Violence Law.
- There is a policy that reduces violence among women and family. NCA is implementing a project in Bokeo and Luang Namtha regarding this policy.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

[Yes]	No
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IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

- In the HIV Law, it says that all people are provided access to prevention, treatment, care and support
- Rewards given to individuals, families or organization who distinguished themselves by their compliance, this law enforcement primarily in the area of preventions, treatment, care and support for the people who living with HIV/AIDS.
- It is stated s one of guiding principles of the NSAP and is ensonced in the Law on HIV
- **The National AIDS Strategy and Action Plan: 6.3. Respect for Human Rights:** The national AIDS policy recognizes the intimate link between HIV/AIDs and human rights. People who are most at risk of HIV infection are often the most difficult to reach because commercial sex work and drug use are illegal, homosexuality remains a social taboo and drives men who have sex with men underground and trafficking is problematic to track effectively.
- The National Strategy and Plan and the National AIDS Policy mirror the constitution in taking universal human rights and the dignity of all Lao people, including their sexual and reproductive rights, as guiding principles. There should be no discrimination on the basis of gender, disease status, sexual behavior or sexual orientation. HIV testing without prior informed consent is never acceptable (unless anonymously unlinked for screening purposes) and it is essential that every HIV test result remains confidential.

- Not explicitly mentioned In NSAP for Drug User, access is evidenced-based human rights but not right to health.

5. Is there a mechanism to record, documents and address cases of discrimination experienced people living with HIV, key populations and other vulnerable populations?

Yes	No
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IF YES, briefly describe this mechanism:

6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle “yes” or “no” as applicable).

	Provided free-of-charge to all people in the country		Provided free-of-charge to some people in the country		Provided, but only in a cost	
	Yes	No	Yes	No	Yes	No
Antiretroviral treatment	Yes	No	Yes	No	Yes	No
HIV prevention services	Yes	No	Yes	No	Yes	No
HIV related care and Support interventions	Yes	No	Yes	No	Yes	No

If applicable, which populations have been identified as priority, and for which services?

- Antiretroviral treatment - this is provided free of charge to all PLHIV through the Global Fund.
- HIV prevention services - testing is free to all, million condoms (check number) are distributed free of charge and there is also condom social marketing. VCT is provided by the public sector.
- HIV-related care and support interventions - under the GF support travel cost and some DSA are provided to PLHIV by public ART sites, some civil society organizations also provide support for these interventions
- The National AIDS Strategy and Action Plan 2011 -2015 has identified sex workers, MSM, drug users/injecting drug users and men with multiple partners are priority target for prevention interventions.
- For all the prioritised populations, there are sub-populations that are hard to reach such as mobile (freelance) sex workers; men who have sex with both men and women; keeping drug can be perceived as illegal hence it's hard to reach to this population.
- Despite all efforts, the prevention services can only reach to those who have identified themselves, or reached by peer outreach group. Furthermore, stigma and discrimination have hindered the efforts to reach these populations.

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7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?

[Yes]	No
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7.1. In a particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for a women outside the context of pregnancy and childbirth?

[Yes]	No
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8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?

[Yes]	No
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IF YES, briefly describe the content of this policy/strategy and the populations included:

<ul style="list-style-type: none">- HIV Law includes access to services for everyone who needs it- General population, migrants and orphaned and children affected by HIV/AIDS are included in the national strategy and action plan and policy.- In the National Strategy, all Lao national has equal access to HIV programming <p>National AIDS Strategy and Action Plan 2011-2015:</p> <ul style="list-style-type: none">- A gender analysis framework must be applied to all planning, service delivery and research processes Increase coverage and quality of HIV prevention services, resulting in 80% coverage of most-at-risk populations including sex workers, MSM, drug users and their sex partners.- Scale-up workplace prevention for professional groups including behavioural change communication, condom promotion, STI treatment and HIV counseling and testing.

8.1. IF YES, does the policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?

[Yes]	No
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IF YES, briefly explain the different types of approaches ensure equal access for different populations:

- Sex workers and MSM can access to it. TG can also access VCT at DIC and participate in the survey and in peer-led intervention.
- Condom for social marketing purpose is widely available in the country for all.
- Voluntary counseling and testing is offered to all citizens.
- 9 ART hubs are offered to all patients nationwide.
- For FSW - DICs is the place to access services. MSMs also access DIC for services.
- Other populations can access public hospital for services.
- Community based care and support for PLHIV have been provided by community and peers. Services include care, support and encouragement as well as raising awareness about preventing from transmitting HIV to other people. No sign of stigma and discrimination found at communities.

9. Does the country have a policy or law prohibiting HIV screening for general employment purpose (recruitment, assignment/relocation, appointment, promotion, termination)?

[Yes]	No
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IF YES, briefly describe the content of the policy or law:

- Tripartite Declaration on HIV/AIDS at the Workplace between The Ministry of Labour and Social Welfare, The Lao Federation of Trade Unions and the Lao National Chamber of Commerce and Industry stipulate in point 6: HIV/AIDS screening should not be required of job applicants or persons in employment. Editor: The laws do not explicitly state that it prohibits HIV screen for general employment purpose.
- Law on HIV/AIDS: Article 34: Non-discrimination and non-stigmatisation - PLHIV as well as affected people are equal to other people in the society with regards to living in the society and daily life. In article 52.7: Individual and other organizations are prohibited from expel a healthy HIV positive person from his/her jobs or refuse to employ him/her
- (The HIV Law includes an article which prohibits HIV screening for general employment purposes and states that PLHIV have the same employment rights.)
- The Law prohibits HIV screening for employment but not for obtaining marriage license

10. Does the country have the following human rights monitoring and enforcement mechanisms?

a. *Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work.*

Yes	No
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- b. *Performance indicators or benchmarks for compliance with human rights standards in the context of HIVefforts.*

Yes	No
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IF YES on any of the above questions, describe some examples:

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11. In the last 2 years, have there been the following training and/ or capacity-building activities:

- a. *Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?*

[Yes]	No
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- b. *Programmes for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work?*

[Yes]	No
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12. Are the following legal support services available in the country?

- a. *Legal aid system for HIV casework*

Yes	No
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- b. *Private sector law firms or university-based centers to provide free or reduced-cost legal service to people living with HIV*

Yes	No
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13. Are there programmes in place to reduce HIV-related stigma and discrimination?

[Yes]	No
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IF YES, what types of programmes?		
Programmes for health care workers	Yes	No
Programmes for the media	Yes	No
Programmes in the work place	Yes	No
Other [write in]: Among factory workers	Yes	No
	Yes	No

14. Overall, on a scale of 0 to 10 (where 0 is “very Poor” and 10 is “Excellent”), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been the key achievements in this area:
<ul style="list-style-type: none"> - The Law on HIV/AIDS Control and Prevention has been approved by the National Assembly in 2011. - The National AIDS Strategy and Action Plan was developed and approved in 2010 but implemented in 2011-2015. This strategy was developed through a participatory and inclusive process with participation from all stakeholders through an evidence-based approach. - The right to have access to ART, VCT, STI drugs, and HIV rapid test is encouraged. - The policies and laws are promoted at all levels but not to the affected community

What challenges remain in this area?
<ul style="list-style-type: none"> - There are policies but no mechanism to promote. - Mechanism for monitoring needs to be developed to regulate the implementation of this law - Listening to the voice of the civil society organisations - Due to political situation, there is no blatant and open discussion on regulations, level of authority at all levels but not to the key affected population - Dissemination the Law to key stakeholders has not been done intensively. - The implementation and enforcement of the law is weak. - Contents of the laws have not reached to the general and concerned populations

15. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the effort to implement human rights related policies, law and regulations in 2013?

Very Poor											Excellent
0	1	2	3	4	5	6	7	8	9	10	

Since 2011, what have been the key achievements in this area:

- Policies are in place
- The AIDS Law is being implemented

What challenges remain in this area?

- Policies are in place but there is no mechanism to implement it.
- M&E mechanism with reference to human rights is required together with human resource and financial support for routine follow up and monitoring of the implementation.
- Have not seen the implementing rules and regulations even in the discussion at the local level
- Despite the availability of HIV testing, people who are in need still found it hard to access to HIV testing.

IV. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

[Yes]	No
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IF YES, how were these specific needs determined?

- Key Affected populations have the basic human rights, as such they have the right to access to treatment, care and support services, but there is a barrier to Sex worker access to services
- Civil society works with the KAP
- Some components, the needs are mainly determined by the national strategy; for example, M&E plan. Consultative processes were undertaken.
- Rapid Assessment of the IDU in 7 provinces
- Mapping of risk groups
- Using information from studies/ surveys
- Statistics provided by CHAS
- The specific needs for HIV prevention programmes are described in the National AIDS

Strategy and Action Plan. These needs were determined based on the evidence collected from surveillance survey findings, the mid-term assessments of the implementation of the NSAP, the UNGASS Country Progress Report, 100% Condom Use Programme Assessment and GFATM monitoring indicators; National AIDS Routine Reporting system and other ad hoc studies.

IF YES, what are these specific needs?

- Treatment, care and support for the PLHIV
- Information education among KAP
- ART, Prevention among key population
- VCT among IDU, no HIV testing for them available
- Minimum package of services, harm reduction package; all programs are donor dependent; data on IDU outside of Phongsaly; need for IDU to get treatment but afraid of arrest
- Monitoring and Evaluation of the specific needs

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access to ...				
	Strongly Agree	Disagree	Agree	Strongly Agree	N/A
Blood safely	1	2	3	[4]	N/A
Condom promotion	1	2	3	[4]	N/A
Harm reduction for people inject drugs	1	[2]	3	4	N/A
HIV prevention for out-of-school young people	1	2	[3]	4	N/A
HIV prevention in the workplace	1	2	[3]	4	N/A
HIV testing and counseling	1	2	[3]	4	N/A
IEC on risk reduction	1	2	[3]	4	N/A
IEC on stigma and discrimination reduction	1	2	[3]	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	[3]	4	N/A

HIV prevention component	The majority of people in need have access to ...				
	Strongly Agree	Disagree	Agree	Strongly Agree	N/A
Prevention for people living with HIV	1	2	[3]	4	N/A

Reproductive health services including sexually transmitted infections prevention and treatment	1	2	[3]	4	N/A
Risk reduction for intimate partners of key populations	1	2	[3]	4	N/A
Risk reduction for men who have sex with men	1	2	[3]	4	N/A
Risk reduction for sex workers	1	2	[3]	4	N/A
School-based HIV education for young people	1	2	[3]	4	N/A
Universal precautions in health care setting	1	2	3	4	N/A
Other [write in]:	1	2	3	4	N/A

2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV prevention programmes in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been the key achievements in this area:

- LaoPHA- Able to organize the network for PLHIV, achieved indicators for the GF project increase;
- PEDDA- prevention knowledge among KAP and PLHIV, including their inclusion to CCM;
- NCA- Peer Education for KAP, condom provision, participation in meeting to learn; access to treatment for women and children
- Able to get IDU data from other provinces
- Efforts are being made to link antenatal care with information on prevention of vertical transmission.
- Prevention among key population group has been enhanced through increasing engagement with CSO.
- Piloting of harm reduction (clean N&S exchange and condom distribution) for injecting drug users in 2 northern provinces of Lao PDR
- New law has been approved creates an enable environment for prevention programme implementation
- Scaling up of all preventive intervention among key populations (more project, more sites, more key population reached and have had access to interventions)
- Policy dialogue at national assembly level which also supports the prevention programme
- Increased budget have been allocated to prevention activities (doubled)
- Outreach worker protocol for MSM - risk behavior reduction manual

What challenges remain in this area?

- There is a limited support from the provincial government;
- There are some problems in terms of coordination and making the government understand about the project activities;
- There is a problem with orphans living with relatives who also are in poor health;
- There is a problem in adherence to treatment of these orphans and their RH needs when they become adult, mostly does not know their status;
- There is a problem in tracking of FSW and other target groups such as mobile population, duplication of number reached;
- There is an obstacle in reaching high risks groups and promote access to services, local policy may hinder the outreach activities to FSW;
- There is need to share information on HIV work with other stakeholders/implementers, communication is a challenge, inefficient use of resources;
- There is a limited funding to replicate good practices;
- Condoms and STI drugs don't arrive on time for implementers' use;
- There is a problem in the rising number of people living with HIV;
- There is a limited financial resources for the CSOs to run prevention programmes;
- It is only recently that injecting drug users have been acknowledged as populations that are at risk;
- There is a low ANC coverage; and
- There is a limited capacity of staff (government and nongovernment) at district, and community level

V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

[Yes]	No
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IF YES, briefly identified the elements and what has been prioritized:
<ul style="list-style-type: none"> - HIV Prevention prioritizing KAP, treatment, care and support, needs-based on CD4 determination; - HIV prevention among key population groups; - ART and care and support for PLHIV; and - Counselling, economic and social support

Briefly identified how HIV treatment, care and support services are being scaled-up?

- Prioritization of KAP, counseling "test and test"
- New ARV hubs were established one in the Northern Province and one in the Southern province.
- Training of medical personal in the use of ARV (Antiretroviral) drug according to the national guidelines
- The number of VCT sites have been increased and standardized base on the National AIDS Strategy and Action Plan
- HIV/AIDS Basic VCT training manual has been developed and delivered nationwide.
- The HIV/TB programme is being implemented but will need to extend to provincial level. The TB-HIV co-infection guideline and distributed nationwide.
- The National ART and OI guidelines has been approved by CHAS and will be disseminated soon
- HIV and Nutrition: PLHIV will be included as target populations of the National Nutrition Programme

1.1. To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support services	The majority of people in need have access to ...				
	Strongly Agree	Disagree	Agree	Strongly Agree	N/A
Antiretroviral therapy	1	2	3	[4]	N/A
ART for TB patient	1	2	3	[4]	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	[4]	N/A
Early infant diagnosis	1	2	3	[4]	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	3	[4]	N/A
HIV testing and counseling for people with TB	1	2	3	[4]	N/A
HIV treatment services in the workplace or treatment referral system through the workplace	1	2	3	[4]	N/A
Nutritional care	1	2	3	[4]	N/A
Paediatric AIDS treatment	1	2	3	[4]	N/A
Post-delivery ART provision to women	1	2	3	[4]	N/A

HIV treatment, care and support services	The majority of people in need have access to ...				
	Strongly Agree	Disagree	Agree	Strongly Agree	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	[1]	2	3	4	N/A
Post-exposure prophylaxis for occupational	1	[2]	3	4	N/A

exposures to HIV					
Psychosocial support for people living with HIV and their families	[1]	2	3	4	N/A
Sexually transmitted infection management	1	2	[3]	4	N/A
TB infection control in HIV treatment and care facilities	1	2	[3]	4	N/A
TB preventive therapy for people living with HIV	1	2	[3]	4	N/A
TB screening for people living with HIV		2	[3]	4	N/A
Treatment of common HIV-related Infections	1	2	3	[4]	N/A
Other [write in]: Referred to VCT/STI services	1	2	[3]	4	N/A

1.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2011, what have been the key achievements in this area:

- The HIV Counseling and Testing, referral system are in place;
- There is a regular follow up and adherence to treatment among PLHIV
- Most of the PLHIV who were identified positive were enrolled and received services.
- There is an increasing coverage of ARV
- The National ARV guidelines have been pre-printed and disseminated
- The National OI guidelines have been pre-printed and disseminated
- The Standard operational procedure (SOP) for voluntary counselling and testing has been pre-printed
- The Practical manual for linked response for PMTCT (CHAS, UNICE) is ready for printing
- The Minimum package for comprehensive treatment and care/continuum of care (COC) is being finalized
- HIV - TB linkage has been initially implemented and scaled up nationally
- PMTCT has been implemented and increased in coverage
- HIV - Nutrition has been implemented to some extent

What challenges remain in this area?

- Procurement of ARV and HIV testing kits normally delayed
- Delay in the delivery of drugs;
- access to counseling for children and TG;
- comprehensive package of care

- services such as psychosocial support
- quality monitoring are required to avoid stock out or expiration of ARV.
- Knowing what is going on with other interventions
- Lack of funding procurement and coordination in provision of treatment, care and support.
- Migration of PLHIV out of Lao, PDR, Incomplete information regarding the situation of PLHIV in the Lao, PDR.
- Estimation of ARV and HIV testing kits needs for planning and procurement purpose still needs to be improved
- There is no existing mechanism for continuum of care (COC)
- Comprehensive M&E system for treatment and care is not yet set up
- HIV and Nutrition programme should be integrated
- Funding relies only on GFATM

2. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?

[Yes]	No
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2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

[Yes]	No
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2.2. IF YES, does the country have national action plan specifically for orphans and vulnerable children?

[Yes]	No
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3. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?

Very Poor											Excell ent
0	1	2	3	4	5	6	7	8	9	10	

Since 2011, what have been the key achievements in this area:

- LaoPHA -established a network of Children in 3 provinces, Savannakhet, Champasack, Vientiane Capital
- NCA- supported scholarship up to secondary level and become peer counselor
- Provision for transportation for check up and get ARV from the facility, nutritional

support provision

What challenges remain in this area?

- There is an Increasing number of PLHIV,
- There is a limited budget for HIV treatment, care and support programme,
- There is a need to look at the nutrition provision for mother and child for PMTCT programme

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