

Scaling-up towards Universal Access

Lao People's Democratic Republic

1. Executive Summary

1.1 Process

The Lao PDR started a participatory, consultative process to update its National Strategy and Action Plan for 2006-2010 in early 2005. Based on the mid-term review of the national strategy and action plan 2002-2005, stakeholder meetings at provincial and at central level provided the opportunity to discuss achievements, obstacles and opportunities to stabilize the HIV epidemic in Laos at the current low levels. The final consultation was held on 23 January 2006, and the strategy and action plan were endorsed by the National Committee for the Control of AIDS on 24 January 2006. At the same time the national policy was revised.

1.2 Epidemiology

With HIV spreading predominantly among vulnerable groups (sex workers and clients), national seroprevalence remains low at 0.08%, but starts to accelerate among sex workers and increased from 0.9% (2001) to 2% (2004) nationwide (with a range between 1.1% and 3.9%). One group not captured by surveillance yet is labour migrants, and data on actual AIDS cases suggest that the epidemic is older than initially estimated, and may be wider spread among labour migrants and their families (a sero-study was carried-out recently and data are presently being analyzed).

1.3 Key Obstacles

The following were identified as the main obstacles for an expanded response:

- Most of the prevention, care and treatment programmes are pilot initiatives and reach only a small portion of target populations
- Comprehensive interventions reach only a fraction of the population in need.
- There are no or limited interventions for certain vulnerable groups, such as labour migrants, drug users and men who have sex with men
- Implementation capacity remains low at all levels
- Coordination of HIV/AIDS/STI programmes and activities is insufficient
- No comprehensive strategy to increase high-level multi-sectoral political commitment
- Incomplete M&E system for the National HIV/AIDS/STI Programme
- Resource deficits as regards both human and financial resources.

1.4 Action and Targets

The new National Strategy and Action Plan sets detailed targets for prevention interventions aiming at a 90% reach for groups and people in need, and foresees a phased geographical approach for a comprehensive response based on selected vulnerability criteria. The establishment of at least 3 new treatment facilities should allow for a nearly 100% coverage on treatment for people in need.

The new National Strategy states: *"The shift from individually funded "projects" to a "programme", from inputs to result orientation, from donor interest to national priorities, from capacity building of central structures to strengthening of implementation capacity, and from a health sector response to a multi-sector approach will require time*

and resources. This is, however, the precondition for an effective and efficient national response.”

1.5 Financial Resource Needs

For 2006-2010 an estimated US\$ 26.5 million will be needed to implement the national action plan. Till to date, around US\$ 11 million are pledged (including 2 grants from the GFATM), which leaves a resource deficit of nearly US\$ 15.5 million for the next 5 years. This, obviously, is one of the key-constraints to mount an expanded, effective response.

Lao PDR will try to increase its domestic funding for an expanded response, but competing development priorities make it difficult to raise adequate resources.

1.6 Action Required at Global and Regional Level

Clearly, financial and technical support ranks highest if it comes to needed global and regional action. In our view it may also require a policy shift to more programme funding, a realization of donors that ODA, in certain situations (i.e. health sector strengthening) may also be needed for recurrent expenditures, and that funding should focus on national priorities.

More frequent regional and sub-regional dialogue and consultations would also increase both the needed bi- and multilateral country cooperation and exchange of experiences.

2. Epidemiological Background

Overall, the Lao PDR remains a low prevalence country with an estimated 0.08% HIV seroprevalence¹ in the adult population. But there are several factors which may either mask a higher HIV prevalence, or may contribute to an accelerated spread of the epidemic. The second round of HIV surveillance targeted mainly sex workers and certain groups of their potential clients in 6 provinces. The seroprevalence among sex workers was between 1.1% and 3.9%, among clients between 0% to 0.8%. But the epidemic is accelerating in 2 of the surveyed 6 provinces (i.e. Bokeo 3.9% in 2004, and Savannakhet from 1% in 2001 to 3.3% in 2004).

Sexually transmitted infections (STIs) remain high among sex worker and clients. Among sex workers bacterial STIs ranged from 19.9% to 46% for chlamydia and/or gonorrhoea (national average 36% for chlamydia, and 18% for gonorrhoea).

By June 2005, the official cumulative number of people identified with HIV was 1636, of whom 362 were known to be living with AIDS. 584 had already died. 62% of reported HIV cases were male and 38% female. Based on cumulative HIV case reports, more than 50% of those infected are between the ages of 20 and 39 years. Of those whose mode of transmission was known, 95.1% had been transmitted through heterosexual sex, 3.6% transmitted from mother to child, 0.7% through homosexual sex, 0.3% through blood products and 0.08% through intravenous drug use.

One group for which only very limited data are available are labour migrants, especially those working in neighbouring countries².

As a matter of fact, the number of officially registered AIDS related deaths is much higher than the estimated number of people dying of AIDS based on 0.08% prevalence. This would mean that

¹ WHO/UNAIDS 2004, CHAS 2005

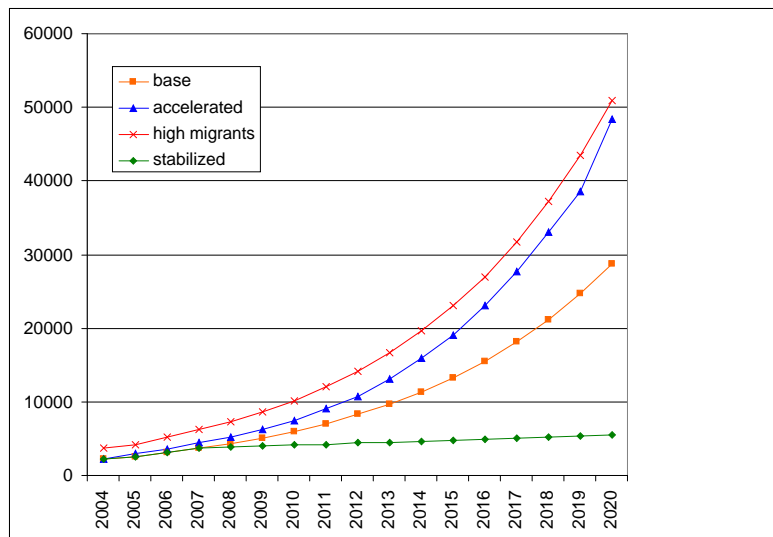
² A HIV sero-study is presently conducted among labour migrants by CHAS

either a group with a relatively high HIV prevalence was not captured in the second round of surveillance, and/or that the epidemic in the Lao PDR started much earlier as assumed. The latter would point to labour migrants to Thailand, who may have brought HIV back to Laos in the early 90s.

The following scenarios show how the epidemic could develop in the Lao PDR. For this exercise the following assumptions were made:

- 1) “Base”: the epidemic develops further, but without significant increase in risk behaviour on side of clients or sex workers. The response continues at present levels.
- 2) “Accelerated”: the epidemic accelerates, for example through increased injecting drug use or increased risk behaviour. The response continues at present levels.
- 3) “High migrants”: this assumes a HIV prevalence among labour migrants of 2-4% in 2004. The epidemic started earlier and risk behaviour among labour migrants continues. The response continues at present levels.
- 4) “Stabilized”: The epidemic stabilizes around 0.09% due to an expanded response both as regards prevention and care.

People Living with HIV/AIDS in the Lao PDR:



The scenarios show that an expanded response would, by 2015, prevent between 10,000 and 20,000 infections. Increased prevention and care efforts would not only save thousands of lives, but would also save the Lao economy yearly millions of dollars.

Low levels of awareness, limited access to prevention and protection, including condoms, heighten the risk of rising prevalence of HIV/AIDS in the Lao PDR. Other factors such as the low socio-economic status of women, high levels of poverty and a widening generation gap compound the risk of spread of the disease. Increased population mobility, internal and external labour migration and changes in lifestyles and sexual behaviour are all important ingredients for an accelerated spread of the epidemic. Moreover, in recent years, the use of recreational drugs has rapidly expanded in the Lao PDR. An alarming number of sex workers are thought to be injecting drugs. International evidence shows that intravenous drug use (sharing of injecting equipment) may substantially accelerate the spread of the HIV epidemic. Alcohol also plays a significant role in the spread of HIV, particularly in relation to commercial sex and condom use.

Although between 2001 and 2004 the overall response to the epidemic improved considerably, the number of sex workers, clients and labour migrants reached with interventions is still low, and none of the surveyed provinces achieved a full set of prevention services.

3. The National Response

3.1 Key-Constraints

The following key-constraints were identified in the consultations for the preparation of the new National Strategy and Action Plan 2006-2010:

- Most of the prevention, care and treatment programmes are pilot initiatives and reach only a small portion of target populations
- Comprehensive interventions reach only a fraction of the population in need.
- There are no or limited interventions for certain vulnerable groups, such as labour migrants, drug users and men who have sex with men
- Implementation capacity remains low at all levels
- Coordination of HIV/AIDS/STI programmes and activities is insufficient
- No comprehensive strategy to increase high-level multi-sectoral political commitment
- Incomplete M&E system for the National HIV/AIDS/STI Programme
- Resource deficits as regards both human and financial resources.

3.2 Opportunities

The newly developed and endorsed national Strategy and Action Plan on HIV/AIDS/STI 2006-2010 tries for the first time to prioritize interventions and geographic regions, has targets to scale-up towards universal access, and is costed. Its full implementation could stabilize the epidemic at low prevalence levels.

3.3 Advocacy, Public Policy and Legal Framework

Major Obstacles	Goals for 2010
<ul style="list-style-type: none"> • Competing development priorities in a low prevalence setting • Low engagement and ownership of sectors other than health 	<ul style="list-style-type: none"> • HIV/AIDS mainstreamed in all national development plans • Sectoral HIV/AIDS strategic and action plans developed, resourced, and implemented

Solutions:

- Continuing advocacy efforts targetting decision makers (i.e. National Assembly, mass organizations, political leadership, and provincial and district authorities)
- Strengthened capacity of selected line ministries and/or mass organizations to develop their own strategy and costed action plans within the overall national strategy. Advocacy to increase domestic resources.

Roadmap and resources: see attached national action plan. The mainstreaming into the 6th National Socio-Economic Development Plan should be done by March 2006, and the development of sectoral HIV/AIDS strategic and action plans should be finalized by 2008.

3.4 Strategic Planning, Alignment and Harmonization

Major Obstacles	Goals for 2010
<ul style="list-style-type: none"> • Fragmented, donor driven response • Weak coordination and management capacity at all levels • Weak M&E system 	<ul style="list-style-type: none"> • Three Ones fully implemented • Strengthened managerial and coordination capacity • Effective surveillance and strong, performance based M&E system

Solutions:

- Development of intervention models for scaling-up
- Overarching national strategy and action plan which is prioritized and result oriented
- Strengthening of both surveillance and M&E systems
- Strengthening of central and decentralized coordination and management capacity

Roadmap and resources: see attached national strategy and action plan. All proposed solutions should be in place not later than July 2007.

3.5 Sustainable Funding

Major Obstacles	Goals for 2010
<ul style="list-style-type: none"> • Huge financial resource gap • Project approach and fund flow issues • Low domestic investment 	<ul style="list-style-type: none"> • Results based programme funding • National AIDS account • Increased domestic resources

Solutions:

- Resource mobilization
- Progressively changing from 'project' to 'programme' approach, ideally with basket funding into a national AIDS account
- Increase in human, in-kind, and financial domestic resources

Roadmap and resources: see attached national strategy and action plan. Resource mobilization will be done throughout 2006, and it is hoped that by 2010 programme funding will be the main source of financing the national programme.

3.6 Human Resources

Major Obstacles	Goals for 2010
<ul style="list-style-type: none"> • Weak implementation capacity at all levels • Not sufficient human resources at provincial and district level 	<ul style="list-style-type: none"> • Strengthened human capacity at all levels • Increased human resources at all levels

Solutions:

- Financial resources to strengthen implementation capacity costed and prioritized in the national action plan;
- Integration of HIV/AIDS into other programmes using existing human capacity;
- More partnerships at provincial and district level

Roadmap and resources: see attached national strategy and action plan. The timeline for all proposed solutions is the end of 2007.

3.7 Infrastructure

Major Obstacles	Goals for 2010
<ul style="list-style-type: none"> • Missing treatment facilities • Decentralized VCT sites 	<ul style="list-style-type: none"> • At least 3 more treatment sites operational • VCT available in all prioritized districts

Solutions:

- Training of human resources and capital investment in infrastructure

Roadmap and resources: see attached national strategy and action plan. The additional treatment sites should be operational latest by end 2009, VCT available in all prioritized districts by 2010.

3.8 Partnerships

Major Obstacles	Goals for 2010
<ul style="list-style-type: none"> • Weak capacity of PLWHA • Low involvement of private sector 	<ul style="list-style-type: none"> • Self-reliant PLWHA groups • Active and resourced response from the private sector

Solutions:

- Active support to capacity building of PLWHA groups
- Advocacy and technical support to private sector.

Roadmap and resources: see attached national strategy and action plan.

4. Service Coverage and Resource Needs

Annex 1 shows the planned targets to increase service coverage from 2006 to 2010. It also includes the costing of interventions. These targets were endorsed in the last meeting of the National Committee for the Control of AIDS, on 24 January 2006.

Annex 2 summarizes estimated resource needs, pledged support, and resource gap.

5. Needed Global and Regional Action

Clearly, increased financial and technical support tops the need list for global and regional action. A donor policy shift from “projects” to “programme” funding (and the necessary technical support to prepare for it), more ODA investment in recurrent costs for health sector strengthening, global and regional negotiations on cheap (generic) ARV, and a better streamlined regional and sub-regional dialogue and consultation process would also greatly facilitate the scaling-up towards universal access. Technical support to develop scaleable models, sustainable both in terms of quality and financing, and to strengthen implementation capacity will be needed to translate plans into action.