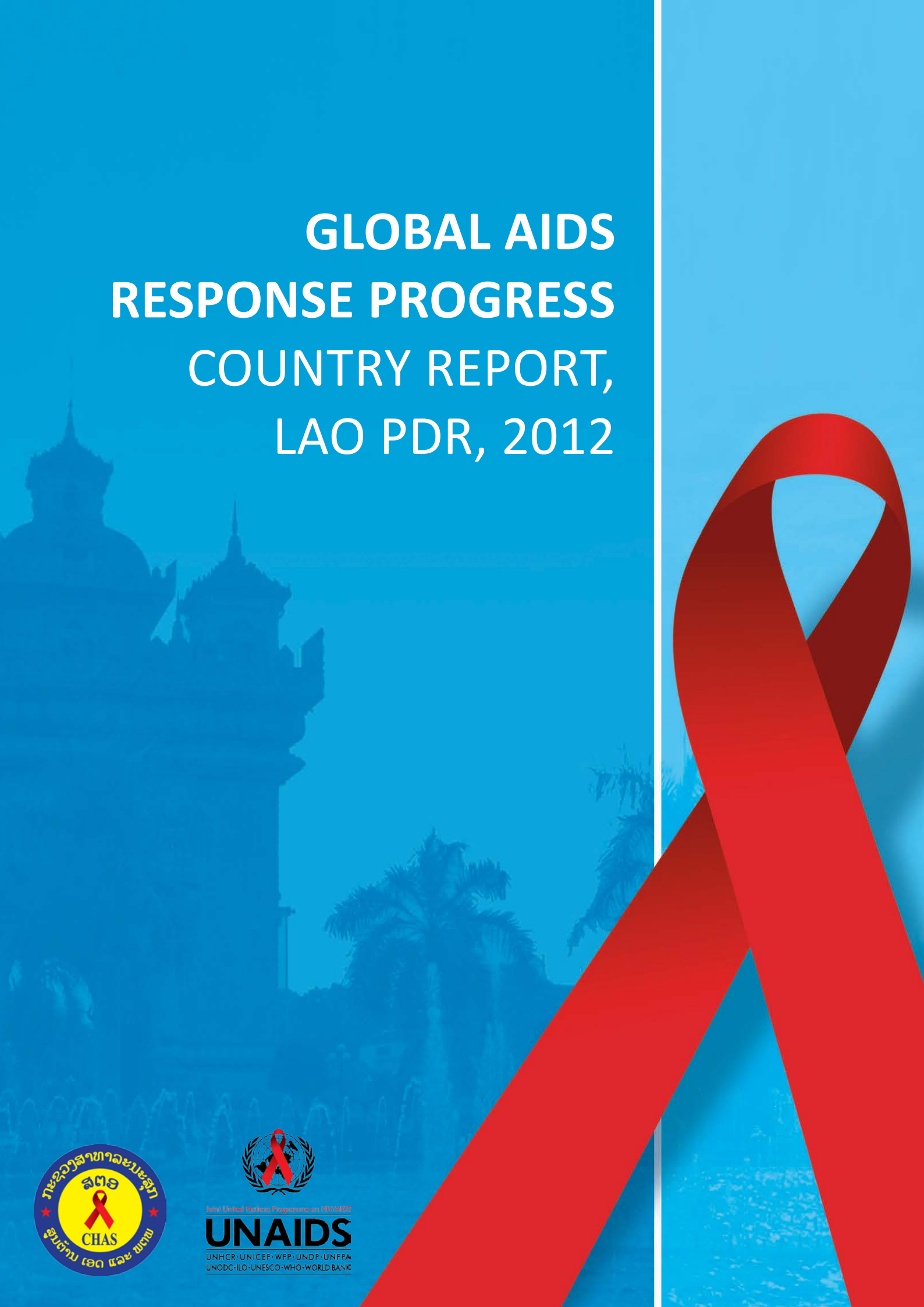
GLOBAL AIDS RESPONSE PROGRESS

COUNTRY REPORT, LAO PDR, 2012



CHAS

Joint United Nations Programme on HIV/AIDS

UNAIDS

UNHCR·UNICEF·WFP·UNDP·UNFPA
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Foreword

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

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

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

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

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

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

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

Assoc.Prof. Bounkong SYHAVONG

Acknowledgement

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

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

Our gratitude also goes to international partners, including ADB, AFD, ARC, AusAID, Burnet Institute, DHAP, ESTHER, FHI, GFATM, IOM, Luxembourg, 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.

Contents

List of Abbreviations

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

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

SW	Sex workers
TB	Tuberculosis
TWG	Technical Working Group
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
USCDC	United States Centre for Disease Control
VCT	Voluntary Counselling and Testing
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

Glossary

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

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

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

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

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

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

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

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

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

I. STATUS AT A GLANCE

1. Inclusiveness of the stakeholders in the report writing process

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

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

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

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

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

2. The Status of the Epidemic

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

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

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

Figure 1:

Source: ADB

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

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

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

2.1. Sex workers

In 2011, it was estimated that the number of SW was around 14,000 SW in Lao PDR (NSAP). The latest Integrated Biological and Behavioural Survey (IBBS) conducted among this population in 2011 found HIV prevalence at 1% among SW in 6 surveillance provinces, with the highest prevalence in Luang Prabang at 1.8% and lowest at 0.7% (in Vientiane, Champasak and Savannakhet). This is the fourth round of surveillance survey conducted among this population, HIV prevalence has not increased in the last ten years (2% in 2004; 0.43 in 2008 and 1% in 2011).Though commercial sex is illegal in Lao PDR, sex workers normally can be found in entertainment venues e.g. Karaoke, drink bars, restaurants, or in guesthouses. The IBBS 2011 found that half of the surveyed SW had been reached by prevention programme (55%) and 87% of them have been given condoms in the last 12 months. Despite this, only one fifth (22%) have had an HIV test and know their results. The reported number of SW that has been reached by peer-led intervention was around 75% of the estimated number of SW in 2011.[6]Recently, more SW, especially young SW, use mobile phone to contact clients or are engaged in opportunistic sex work and they stay only few months in sex work and then move on looking for other work.[7] Little is known about this trend of behaviours, thus the need to collect more information about this sub-group in order to design suitable preventive interventions to reach them.

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

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

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

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

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

MSM and transgendered	2007	2009	2010 (Transgender)
Site	VTC	LPB	VTC, SVK
Have been reached by prevention programme (%)*	58.3		84.7
Have been tested for HIV and know results (%)	6	14	73.2
Condom use in the last sex with a male partner (%)			
With male client	n/a	66	57.8
with regular male partner	n/a	67	45.9
with casual male partner	n/a	68	48.0
Have used condom consistently in the last …(%)	3 months	3 months	1 month
with casual male partners	24.2	37	63
with male clients	32.8	40	n/a
with regular male partner	14.4	n/a	55.3
Condom use in the last sex with female client (%)	n/a	64	
Condom use in the last sex with female sex worker (%)	n/a	59	
Condom use in the last sex with a female partner (%)	n/a	55	
Have used drug (%)	21.1	27	n/a
Have injected drugs in the last 12 months (%)	0.7	12	n/a
Have sex with women (%)	39.4	47	n/a
HIV+ (%)	5.6	0	4.2
Received treatment for STI symptoms	42.2		6.2

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

Source: CHAS Surveillance Database

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

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

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

2.3. PUD/PWID:

Northern Lao PDR is in the golden triangle known for high production and trafficking of drugs to other countries. Bordering with Lao to the North is Yunnan, China; and to the North East is Dien Bien, Viet Nam, both of these neighbouring provinces are known to have high prevalence of PWID, as well as high prevalence of HIV (50% in Yunnan, China in 2007, 55% in Dien Bien, Viet Nam in 2009)[10] among PWID. This condition has triggered WHO, AusAID, UNODC, CHAS, and the Lao National Commission for Drugs Control and Supervision (LCDC) to conduct a rapid assessment on drug use and HIV situation in the two provinces of Houaphanh and Phongsaly. The finding was 1.5% of PUD who took unlinked anonymous HIV test found to be HIV – positive. So far, this is the only survey conducted among this key affected population (KAP), which estimated at around total of17,000 PUD (including injecting and non-injecting), of which estimated 10% are PWID in Lao PDR in 2011. More studies are needed to find out drug taking behaviours as well as other HIV-related vulnerable behaviours among this group, as it is known that the use of contaminated injecting equipment is the highest transmission route of HIV.

2.4. Men with multiple sex partners:

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

2.5. Low- risk women:

Eighteen percent (18%) of current reported PLHIV recorded by CHAS are housewives. It is unknown on the HIV status of this group as well as their behaviours. The estimation and projection show a slight increase in prevalence of this group till 2020.

2.6. Young people:

Lao young population (under 25 years old) makes up 60% of the total population (UNFPA) and it is this population that the recently rapid socio-economic development in Lao PDR has had the most impact on. Lack of opportunity for higher education, coupled with more opportunities to travel and seek employment, has increased vulnerabilities for young people, especially for those coming from poor families in rural areas. There are more adolescents and young people engaged in commercial sex, and use drugs.[12] A study conducted in 2009 on drug use (mainly Amphetamine Type Stimulants – ATS) among young people aged 15-24 in Vientiane, found that 46% of the survey respondent reported current use of drug, of whom, 1.4% injected.[13] There is evidence suggests that young people have engaged in high-risk behaviours and further information should be collected to support prevention intervention for this group.

3. Policy and Programmatic Response

The National AIDS Response (NAR) in the Lao PDR is led by NCCA. It is a multi-sectoral body chaired by H.E Prof. Dr. Eksavang Vongvichit Minister of Health, who has taken this position since 2011. NCCA brings together expertise and commitment of senior representatives of twelve Line Ministries and Mass Organizations, plus recently proposed Representatives of the National Assembly; the Lao Network of

[10] USAID – country profiles
[11] CHAS. Routine report 2011
[12] UNICEF. Rapid Assessment Most-at-Risk Adolescents and Young People to HIV in Lao PDR. 2011
[13] CHAS/Burnet Institute. Amphetamine Type Substance Use and Sexually Transmitted Infection Risk Among Young People in Vientiane Capital and Vientiane Province, Lao PDR, 2009.

PLHIV; Ministry of Justice; Lao Chamber of Commerce and Industry; Lao National Commission for Drug Control and Supervision; Buddhist Association (see annex 5).

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

3.1. Policy environment and Leadership:

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

- In 2011, the Minister of Health, Chair of NCCA together with a high level delegation from Lao PDR attended the UN High Level Meeting on AIDS in New York and in this occasion, the Minister endorsed the 2011 Political Commitment Declaration with its seven targets. The Three Zero Strategy has also been endorsed by the country.
- The 7th National Socioeconomic Development Plan 2011-2015 has emphasised the country's commitment to reach the Millennium Development Goals (MDG), of which MDG 6 on HIV, TB and Malaria is on track, though much efforts is still needed to achieve the target on HIV.
- The NSAP 2011-2015 confirms the commitment of the Government of Lao PDR to reach MDG 6 and the Three Zeros strategy. The development of this NSAP has been a new level of multi-stakeholder engagement with inclusive participation and involvement from all international partners working on AIDS as well national associations, PLHIV, of Key Affected Populations (KAP). The detailed costed action plan has earmarked budget for key stakeholders was a progressive step. For this period, the NCCA recognised the need to double the total budget to US$ 54million compared to the previous period, though much of it still needs to be mobilized.
- In 2009, the Prime Minister's Decree on the Association Establishment came into effect providing the legal framework for the establishment of local non-profit associations (NPA). Since then, three associations working on HIV have been registered: LaoPHA, PEDA and LNP+. This Decree formally recognises the work of these organizations, and is advantageous especially in terms of attracting and mobilising funds. The Decree provides the foundation for greater civil society participation in the National AIDS Response.
- The National Policy on HIV/AIDS has been reviewed and updated.
- In 2011, the Law on HIV/AIDS Control and Prevention (hereafter refers to as the HIV Law) was approved by the National Assembly and then promulgated by the President. The Law is progressive in terms of addressing stigma and discrimination and promoting equity. However, the international community is concerned about the clause in Article 52 which prohibits individual from engaging in risky behaviour which influencing the spread of HIV.[15]The section of the Decree relating to enforcement of the law and which will stipulate how the law should be implemented is still under consideration.
- The last two years have witnessed strong and progressive involvement of civil society in the National AIDS Response, especially in the areas of prevention, care and supports. Highlights are the proposal of LNP+ as a member of NCCA; participation and involvement of civil society in the development process of the NSAP and the HIV Law; participation of KAP informal networks in outreach prevention interventions; involvement of civil society, especially in the care and support services provided to PLIHV and those affected by AIDS; surveys and research.

[14] UCO survey, 2011 – Lao PDR
[15] Law on HIV/AIDS Control and Prevention

3.2. Programmatic Response:

- **Prevention:**

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

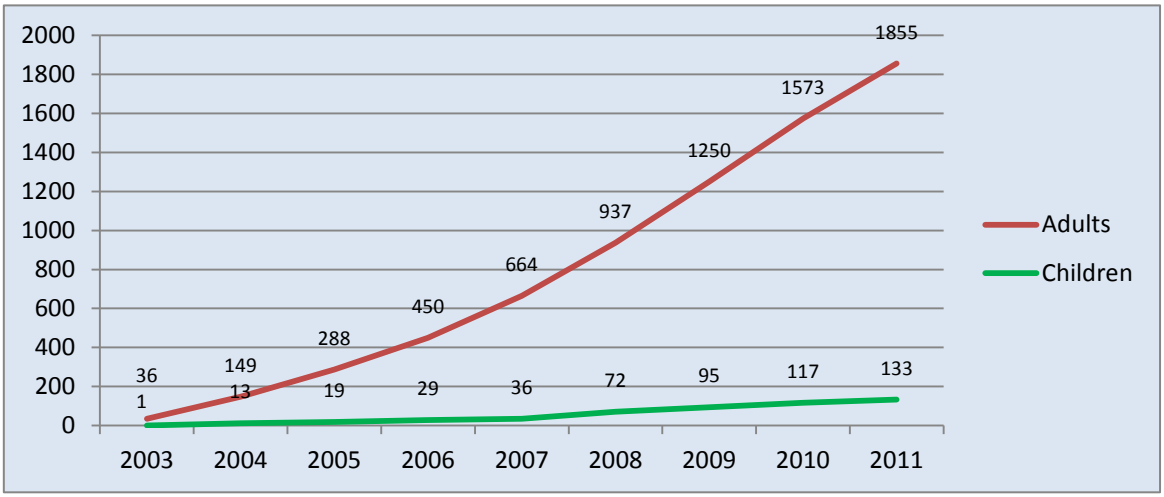
  - In 2011, there were 10,530 SW (75% of estimated SW) and 3,915 MSM (23% of estimated MSM) have reportedly been reached by the peer-led interventions. The NAR has managed to keep the HIV prevalence among SW lower than it first detected in 2004 which was at 2%. More work is needed to reach out for MSM and the emerging more mobile SW.
  - 100% condom use programme, supported by GFATM, together with other sources of condom (UNFPA) has tried to distribute condom through all different channels: social marketing, free condom at entertainment bases (karaoke bars, restaurants).[16]
  - STI services: Apart from health facilities, STI services for KAP were provided at DIC. 2011 saw a drop in numbers of SW and MSM who came and received STI treatment at DICs because of shortage of STI test kits and drugs due to delayed GFATM procurement procedures. Private clinics also provide STI management services to both general population and KAP but data are not attainable from this sector. There's the need to partner with private sector to monitor the trends of clients at private clinics. Periodic presumptive treatment (PPT) for STI has been provided among SW for many years but due to financial constraints, its coverage has declined during the last few years (WHO).
  - PMTCT: since the start of the pilot programme in 2006 in six provinces, the percentage of estimated HIV-positive pregnant women who received ART prophylaxis has remained low (around 14% - 15%). There are estimated about 180,000 pregnancies per year in the country (WHO) but although antenatal care (ANC) coverage rates are increasing across the country, those most at risk are not accessing ANC services.[17]More efforts are needed to encourage women, especially women at risks to attend ANC for HIV screening. At the same time with the acceleration of the national maternal neonatal and child health (MNCH) comprehensive package of services, including counselling and screening for HIV for referral, it is crucial to implement this vigorously in areas which are identified in the NSAP as in need of comprehensive intervention.
  - Blood safety: Lao PDR has been doing well with 100% of blood units screened for HIV, with external quality assurance as recommended by WHO.
  - General population:
    - Life-skills education has been implemented in 74% of secondary schools in the country in 2009. As mall rapid assessment done by UNICEF in 2009 found that children attended school with life-skills curriculum had better understanding about HIV and knew more about means of protection. For out of school children, this is still a gap in intervention.[18]
    - HIV in the work place: no further action was taken to follow up on implementation of the 2009 tripartite declaration on HIV at workplace that took place in 15 hotels in Luang

[16] CHAS, Condom Social marketing Programme assessment, 2010
[17] MOH. National Health Statistic Report 2009/2010
[18] UNICEF – Assessment of Life-skills curriculum Project Lao PDR, 2011

Prabang and Vientiane Capital, under support from Ministry of Labour & Social Welfare; Lao Chamber of Commerce and Industry; and Lao Federation of Trade Union.

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

Figure 2 - Number of PLHIV received ART 2003 - 2011



Source: CHAS. Routine Report Data

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

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

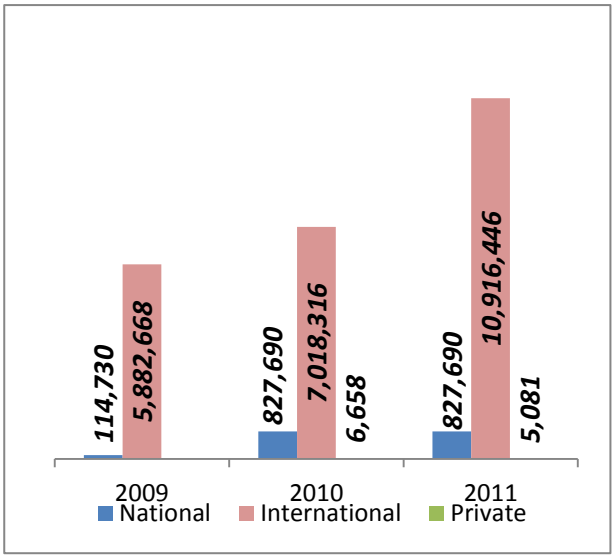
3.3. AIDS expenditure

In the two years 2010 and 2011, the expenditure on AIDS has increased compare to 2009, from around US$6 million to US$ 7.85 million in 2010 and UD$11.74 million in 2011 (see annex 1 – NASA for detailed expenditure). Most of the source of expenditure comes from international funds (see figure 3). Nearly 40% of expenditure on AIDS is spent on prevention programme, followed by management and human resource (see figure 4).

The key feature of budget on AIDS is the predominance of fund from external sources with small contribution of Government (7.4% in 2011) and the private sector at 0.04% in 2011.

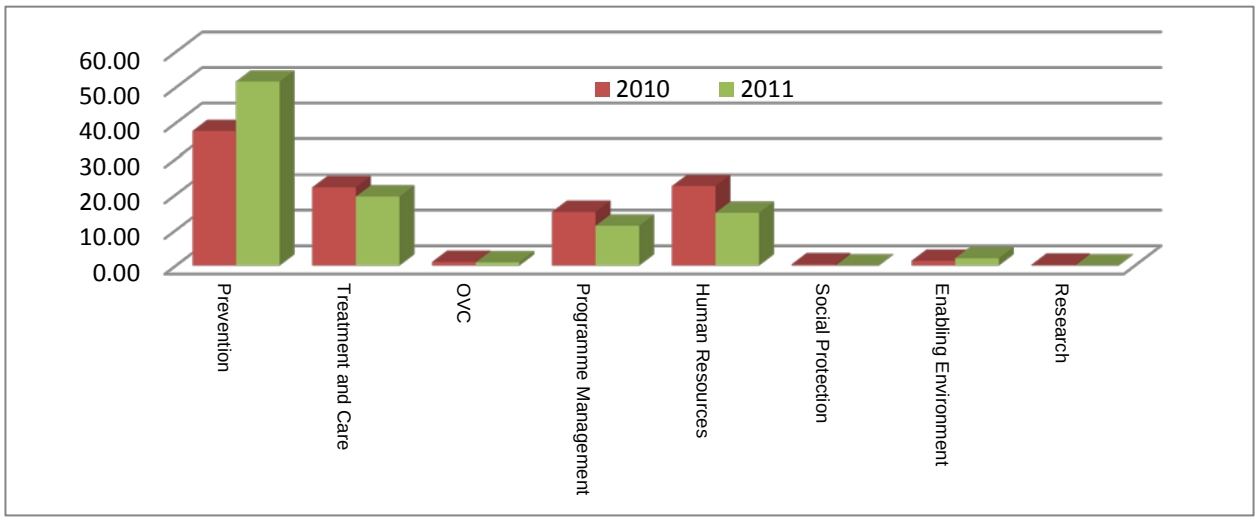
Of all external resources, GFATM provides the largest share, at 64.4% for 2011. This figure was followed by bilateral agencies at 15.7% and UN at 8% as top three funding sources for the NAR in Lao PDR (see Chapter VI for more details). The funds from external sources will be going down in the near future, hence the need to mobilise more resources and increase domestic investment. The national response relating to the policies and programmes of prevention, treatment, care and support are analysed in chapter III of the report. The details of key reported indicators are presented in Annex 4, and summarised in Chapter 4 of this report.

Figure 3 - Total expenditure on AIDS 2009-2011 (USD)



Source: National AIDS Spending Account, 2011. CHAS

Figure 4 - Total budget by programme (%), 2010 - 2011



Source: NASA, 2011

Summary

In the last two years, progress on NAR has been on many fronts: policy and leadership commitment as the HIV law and the NSAP 2011-2015 have come to effect, combined with the government's commitment to achieve the MDG targets. More PLHIV in needs of ARV have received treatment, care and support. The coordination among different partners, including local associations and informal networks, private sector has got stronger, results in partnerships in prevention, care and supports. Comprehensive prevention has resulted in keeping the HIV prevalence among SW stable and reaching out to other harder

to reach populations of MSM, PWID. The NAR has received increasing funds from external sources for its implementation. For the NASP 2011-2015, the costed budget also doubled to approximately 54 million USD, in order to achieve its ambitious national targets.

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

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

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

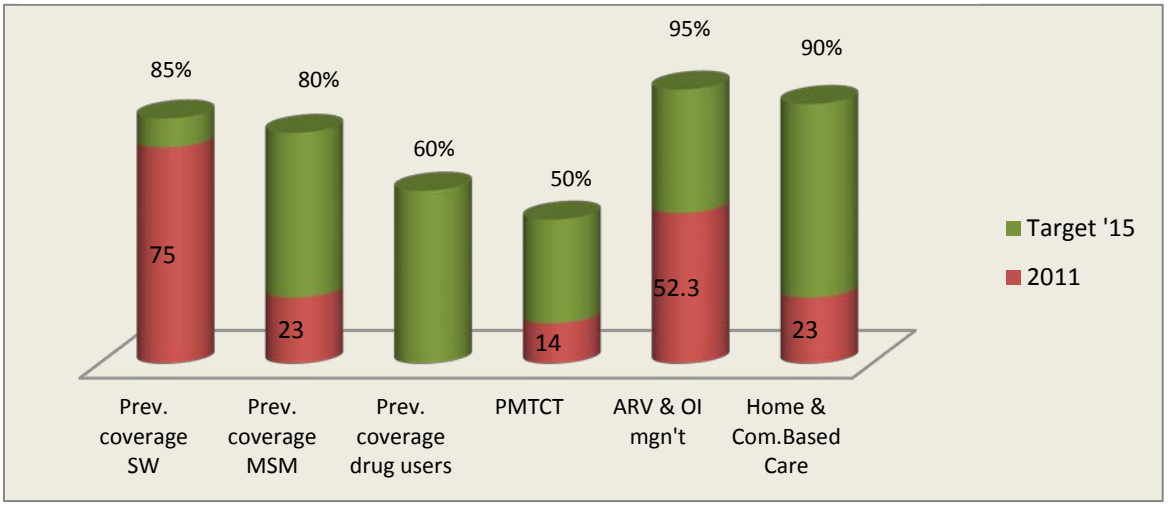
At national level, the National Socio-economic Development Plan, the National Health Sector Development Plan, the NSAP, and the United Nations Assistance Framework (UNDAF) also end its cycle in 2015.

For the National AIDS Response, the NSAP 2011-2015 has set targets for six areas covering prevention, treatment, and care and support. The figure 5 below shows the set targets and the gaps to be covered if the National AIDS Programme is to meet its targets set in the NSAP for 2015.

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

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

Figure 5 - Reaching NSAP targets: current status, 2011



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

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

- ***Institutional structure****:* Stronger involvement and coordination from NCCA members. NCCA should meet more often.
- ***Policy and Legal environment***: Enhance the new HIV Law enforcement, including dissemination of the law and development of the under law decree for implementation; improving the registration process for national associations, especially a legal aid system to support HIV casework.
- ***Leadership***: Stronger leadership from NCCA and affiliated ministries; more involvement from the Government and Party leaders; further engagement from National Assembly at all administrative levels.
- ***National Strategic Planning*****:** strengthen monitoring implementation process of the current NSAP, especially activities that are carried out by civil society organizations;
- ***Civil Society Involvement*****:** the momentum created in 2009-2010 during the development processes of the HIV Law and the NSAP should be kept and continued with more involvement of CS at community level as well as at policy making level through their membership in NCCA. Promote capacity building among CSO, especially local associations and networks as a means to empowerment and stronger involvement.
- ***Prevention*****:** More effort is needed to access the hard-to-reach KAP (non-entertainment based SW; sub-populations of MSM; PWID and clients of SW). Strengthen prevention programme monitoring in order to have effective interventions.
- ***Treatment, care and support*****:** There is a need to encourage PLHIV in advanced stage to come to treatment early as well as strengthen follow-up system, in order to maintain a high survival rate among ART patients. Scale-up of care and support at home and community levels and palliative care. Improve monitoring and reporting of care and supports in order to measure this against the national target.
- ***Resources***: More domestic investment on AIDS as an essential part of sustainable AIDS response. Fund-raising and resource mobilisation strategy to be developed in order to attract funds from other sources outside GFATM. Building infrastructure, and human capacity for CHAS/ NCCA system as well as local associations and networks working on AIDS.
- ***Strategic Information*****:** The national M&E plan needs to be finalised, in line with NSAP. Improving the Monitoring (M) of the M&E through strengthening the system, capacity building and completion of the national indicators.
- ***Impact Mitigation***: Currently, there is no baseline information on this aspect of the NAR in Lao PDR though the Government of Lao PDR has programmes to support the poor and vulnerable. There is the need to link poverty reduction with impact mitigation due to the heavy socioeconomic burden that the HIV epidemic can cause at household level.

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

4. Overview of indicator data

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

	GARP Reporting Indicator	Source	Value	Remarks
Target 1 - Reduce sexual transmission of HIV by 50% by 2015				
General population				
1.1	Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission		N/A	Population-based survey on health and HIV related issues is not available.
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15		N/A	
1.3	Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months		N/A	
1.4	Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used condom during their last sexual intercourse		N/A	
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results		N/A	
1.6	Percentage of young people aged 15-24 who are living with HIV		Not applicable	This indicator is for generalized epidemic
Sex workers				
1.7	Percentage of sex workers reached with HIV prevention programmes	IBBS 2011	FSW: 55.0 <25 yr: 53.6 >25 yr: 64.1	This survey was conducted among female sex workers in 6 provinces, the sample size was 1,434
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	IBBS 2011	92.5 <25 yr: 92.5 >25 yr: 91.9	
1.9	Percentage of sex workers who received an HIV test in the past 12 months and know their results	IBBS 2011	22.2 <25 yr: 21.3 >25 yr: 28.1	
1.10	Percentage of sex workers who are living with HIV	IBSS 2011	1.0 <25 yr: 0.8 >25 yr: 2.1	
Men who have sex with men				
1.11	Percentage of men who have sex with men reached with HIV prevention programmes		N/A	
1.12	Percentage of men reporting the use of a condom the last time they had		N/A	Data from one survey on

	anal sex with a male partner			transgendered in Vientiane was not representable for the country.
1.13	Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results		N/A	
1.14	Percentage of men who have sex with men who are living with HIV		N/A	
Target 2 - Reduce transmission of HIV among people who inject drugs by 50% by 2015				
2.1	Number of syringes distributed per person who injects drugs per year by Needle and Syringe Programmes		N/A	Assessment survey among drug users and people who inject drug was not representable to the country situation
2.2	Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse		N/A	
2.3	Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected		N/A	
2.4	Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results		N/A	
2.5	Percentage of people who inject drugs who are living with HIV		N/A	
Target 3 - Eliminate mother to child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths				
3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	Routine reports; AEM estimation	2010: 8.5 2011: 14.6	
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Routine PMTCT report, CHAS	2010: 1.1 2011: 9.1	There were 3 tests in 2010 and 29 tests done in 2011, use of PCR technique.
3.3	Mother to child transmission of HIV (Modelled)		N/A	
Target 4 - Have 15 million PLHIV on antiretroviral treatment by 2015				
4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	Routine report	**2010**: Total: 50.8 Children: 31.2 Adults: 53.3 **2011**: Total: 52.3 Children: 32.1 Adults: 54.7	Change in calculation of the denominator: Since 2010, criteria for eligible for ART is CD4 count 350 and less as WHO guideline
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral	Routine report 2011	Total: 87.5 Children: 88.4 Adults: 87.3	This data is for those who initiated in 2010 and still alive 12 months later

	therapy			
Target 5 - Reduce TB deaths in PLHIV by 50% by 2015				
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Routine report 2010;	2010: 49.2	Estimate of TB cases among HIV + for 2011 is not available
Target 6 - Reach a significant level of annual global expenditure (US$22-24billion) in low and middle income countries				
6.1	International AIDS spending by categories and financing sources	NASA	Annex 1	
Target 7 - Critical enablers and synergies with development sectors				
7.1	National Commitments and Policy Instruments (NCPI)	NCPI	Annex 2	
7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months		N/A	No population based survey has been conducted on these topics
7.3	Current school attendance among orphans and non-orphans aged 19-14		N/A	
7.4	Proportion of the poorest households who received external economic support in the past 3 months		N/A	

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

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

II. OVERVIEW OF THE HIV EPIDEMIC

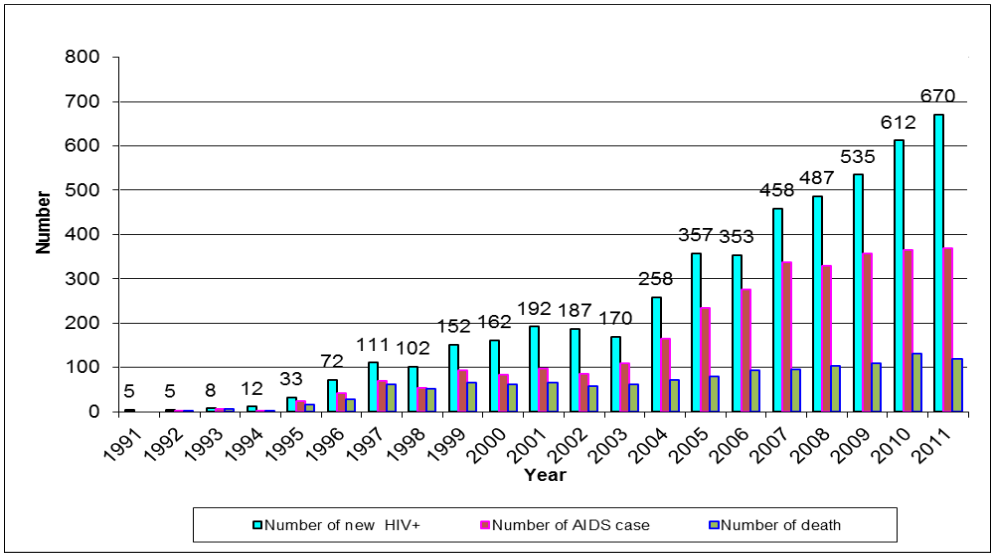
1. Status of the epidemic

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

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

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

Figure 6 - Overview HIV epidemic in Lao PDR



Source: CHAS. Routine Report, 2011

By December 2011, there were reported total case-reports of 4,942 people living with HIV (PLHIV) with the male: female ratio at 1:0.8. The reported HIV-positive cases include those who have died of AIDS related causes in the same period. The actual PLHIV was around 3,650 which is one third of the estimated 10,350 PLHIV for 2011. This indicates a low detection rate among current PLHIV in Lao PDR in the case reporting system.

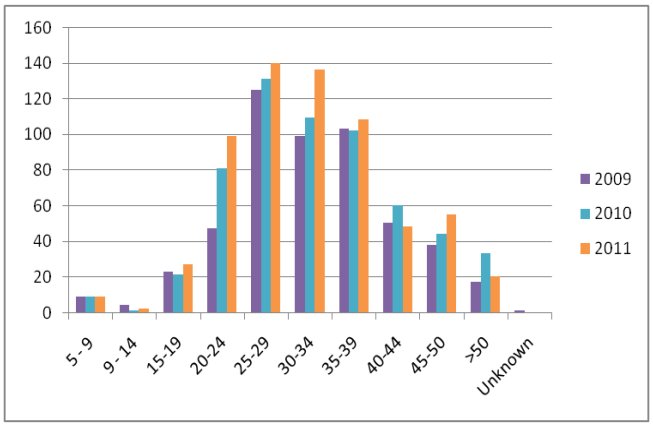
For the same period, there have been reported total of 1,290 people died of AIDS related causes and number of PLHIV developed to AIDS is still increasing (see chart in figure 6). The number of reported new HIV infection is increasing by year and estimated to reach accumulated 14, by 2015.[23]

[20] CHAS/MOH routine report, 2011
[21] NSAP, 2011-2015
[22] HAARP/ ADB. Rapid Assessment and Response to Drug Use and Injecting Drug Use in Houaphanh and Phongsaly in Lao PDR . 2010
[23] CHAS/UNAIDS/WHO Estimation and Projection, AEM modeling workshop outcomes

As case reports for 2010 and 2011 show, there are 612 and 670 new HIV infections detected respectively. The most affected age group is 25 to 35 years old (figure 7). Nearly one fifth of PLHIV (18%) is housewives, followed by other occupations (e.g. labourers, migrant workers, business persons).

Among the 670 new infections reported in 2011 through case reporting, the highest proportion of them falls in the age group of 20 to 40 (see figure 7 for details).These are cases collected through case-reporting system which currently is the only source that can provide trend data, although quality of data is not always reliable.

Figure 7 - Age structure of reported new HIV infections



Source: CHAS/MOH, programme routine reporting, 2011

Geographically, most of reported PLHIV live in the two big cities Vientiane Capital (33%) and Savannakhet (34%), other provinces have significantly lower number of PLHIV (9% in Champasak and 4% or less in all other provinces) (CHAS, 2011). The latest NSAP provided a map with prioritised focus provinces and districts (NSAP 2011 – 2015, Page22).

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

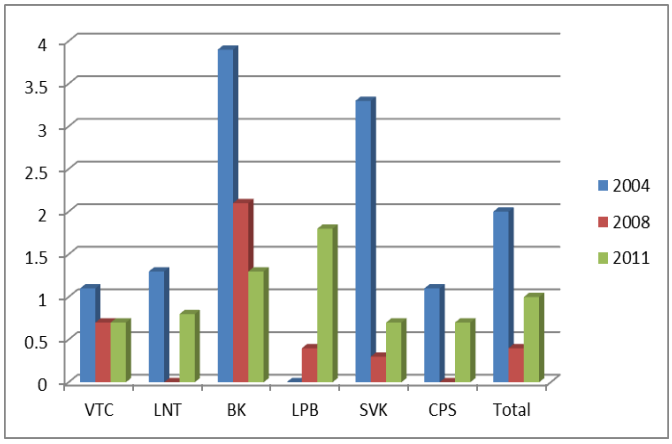
Based on number of surveillance surveys and behavioural surveys that have been conducted in the last ten years, the key-affected-population (KAP) with the highest prevalence is SW with prevalence of 1% (IBBS 2011-draft), an increase from 0.43% in 2008 (IBBS). Other populations that have been under surveillance,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

2.1. Female sex workers

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

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

Figure 8 - HIV Prevalence in SW found in IBBS 2004 - 2011



Source: CHAS. IBBS 2008, 2011

[24]UNODC/AusAID HAARP Programme - Rapid Assessment and Response to Drug use and injecting drug use in Houaphanh and Phongsaly Province, Lao PDR. 2010

[25]UNICEF.Rapid Assessment of Most-at-Risk Adolescent and Young People to HIV in Lao PDR

The IBBS 2011 found that HIV prevalence in this population was 1% with the highest prevalence in Luang Prabang at 1.8% and lowest at 0.7% in Vientiane, Savannakhet and Champasak (see figure 8). Condom use during sex with the most recent client was found lowest in Luang Prabang at 86%, compared to total average of 92.5%. Findings also show that HIV prevalence was higher among SW older than 25 years old (2.1%) compare to SW younger than 25 years old (0.8%). This feature occurs in four out of six surveillance provinces, the two provinces where HIV was not detected among SW >25 are Vientiane Capital and Bokeo. The number of SW>25 that entered the survey was also very small 34/304 in Vientiane and 10/150 in Bokeo. Except for Luang Prabang that HIV prevalence found in IBBS 2011 increased compared to findings of previous surveys, the prevalence in other provinces has gone down or stable. This indicates a success in the prevention programme targeting this population.

Table3: Characteristics of SW found in surveys, 2008 – 2011.

Sex workers	IBBS 2008	BSS 2009	IBBS 2011
Sites	6 provinces	5 provinces	6 provinces
Sample size	1,425	912	1,434
Have been reached by prevention programme (%)	45	70	55.0
Have been tested for HIV and know results (%)	15	14	22.2
Used condom with most recent client (%)	95	97	92.5
Used condom consistently with clients in the last 3month (%)	60	n/a	69.4
HIV+ (%)	0.4	n/a	1
Have injected drug in the last 12 months (%)	1	1	n/a

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

The projection trends show a stable epidemic for the period 2010-2020, with current efforts of preventive intervention (figure 17).With new emerging of young, mobile, more vulnerable and hard-to-reach sex workers, it is important to keep tracking their behaviours and open for new approaches reaching to these sub-populations – as it is mentioned in the UNICEF assessment.[28] However, it should be noted that the study was conducted among a small number of adolescent and young people (sample size was 49).

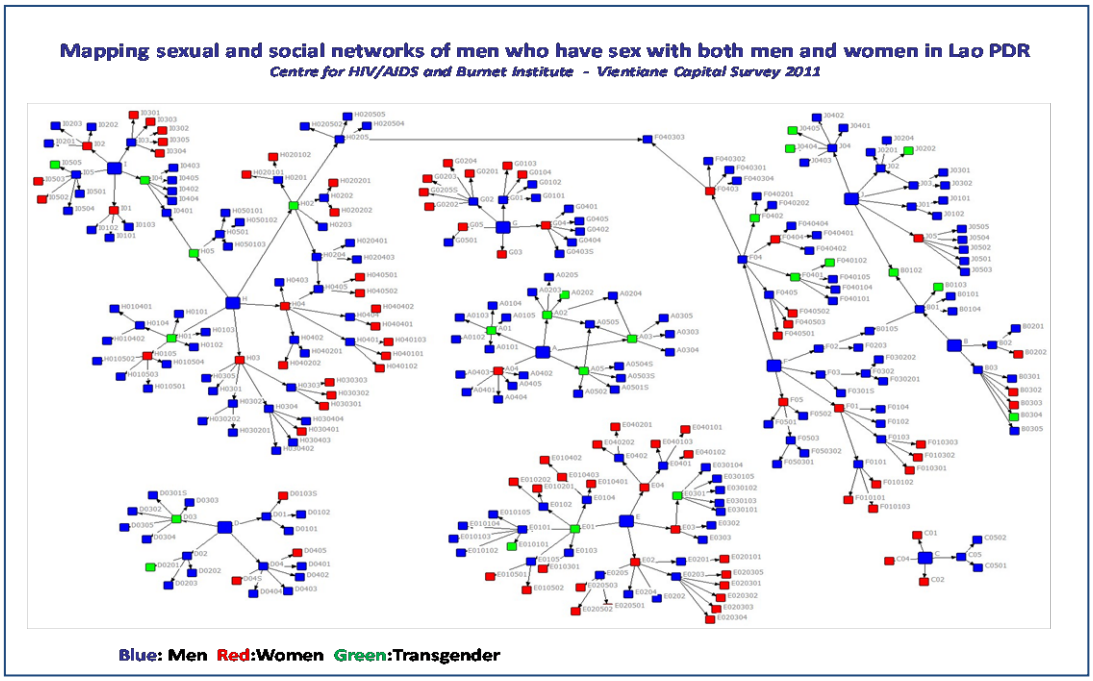
2.2. Men who have sex with men

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

[26]In Lao: Phongsaly, Bolikhamxay, Attapeur; in Vietnam: Sonla, Hatinh and Gialai
[27]HSPI/CHAS.HIV Transmission at the Vietnam - Lao Border Area Current Status and Solutions - HSPI Report, 2009
[28]UNICEF. Rapid Assessment Most-at-Risk Adolescent and Young People to HIV in Lao PDR. 2011
[29] Burnet Institute/CHAS. Social Mapping among men who have sex with men and with women in Vientiane. 2009
[30]CHAS/PSI. First Round HIV/STI Prevalence and Behavioural Tracking Survey among Transgendered in Vientiane Capital and Savannakhet, Lao PDR (2010)

figure 9)[31]. These patterns of behaviours and social context are reflection of the social and sexual behaviours reported in the other study on this specific population.[32]

Figure 9:



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

The IBBS 2008 on MSM and the tracking survey on MSM/TG in 2010 have collected and analysed information on the scope of their sexual network and condom use behaviours. The common behaviours identified were that MSM and MSM/TGs have regular and casual partners of both male and female; at the same time, they also both sell and buy sex from and to male and female commercial partners. Condom use was at the highest level when having sex with most recent male commercial partners involved (78%)[33] and lowest with regular transgender partner (13%).[34] The survey among transgender in Vientiane Capital showed low condom use with both clients and regular partners (57.8% and 45.9%), these figures were similar with consistent use of condoms in the last month among MSM/TG in Vientiane Capital (despite that 58.6% of them have been reached by prevention services).[27,34] Due to the survey being conducted among a specific sub-group of MSM/TG in two cities of Vientiane Capital and Savannakhet in 2010, the data are not considered sufficiently representative hence, cannot be generalised as national data on MSM. Therefore, no data is reported for indicators 1.11 – 1.14 in this report.

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

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

[31] Aidsdatahub.com/lao-pdr_all-indicators
[32] Lyttleton, Chris. Mekong Erotics: Men Loving/Pleasuring/Using Men in Lao PDR. Bangkok: UNESCO Bangkok, 2008.
[33] CHAS/MOH IBBS 2008
[34] PSI/CHAS. Report on Transgender HIV, STI & Behavioral Survey (2010)

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

To date, there have been very few studies looking at drug use situation conducted among population of PUD and PWID. Of the studies taken recently, one was looking into the behaviours of drug users, mainly ATS users in Vientiane Capital. The other was conducted in Houaphanh and Phongsaly, the two provinces that bordering with China and Viet Nam where prevalence of PUD and PWID is suspected to be high. Results of the latter study were disseminated in 2010 but not considered as generalizable across the country, in particular, the sample size for PWID was very small (N=46). Hence no data can be reported for target 2 indicators. Findings show that the majority respondents smoked opium (>60%), with small proportion (37 [12%] in Houaphanh and 9 [3.6%] in Phongsaly) injecting drugs. However, the use of sterile needle and syringes and condom was low. None of the correspondents have ever been tested for HIV, although the unlinked anonymous HIV testing within the context of this study detected HIV prevalence at 1.5% (8/549) among PUD in 2009.[35]It should be noted that all eight people with HIV positive detected were PWID.

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

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

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

Even though the overall situation of PUD and PWID in these two provinces was not so significant in the national context, it is important to take in account the fact that these two locations border provinces with high HIV prevalence among PWID, which are Yunnan, China and Dien Bien, Viet Nam have prevalence up to 50% and 55% respectively.[36] With the amount of development, movement and trading activities crossing the borders, it is becoming essential to monitor the situation closely due to the very high risk of HIV infection among PWID. Moreover, it seems that injecting drugs is more likely to be prevalent among actual or former users of opium which traditionally exists in remote villages in the mountainous areas along the borders.

2.4. Among clients of sex workers

Mobile men (migrants, construction workers, business, and traders) are those likely to buy sex.[37] Unfortunately, surveillance survey has stopped tracking behavioural patterns of these groups after 2004. The data from the cross border survey shows that awareness about HIV and how HIV is transmitted among these groups is high although there are clients who stated they refused to use condoms.[38]The government of Lao PDR is now seeking to develop a major regional transit hub and economic corridors for overland trade and travel between the Greater Mekong Sub-region and the Chinese and East Asian economies, within the framework of the Asian Highway network.[39] With this scale of construction, in parallel with cross-border socio-economic development, namely cross-border trade, investment, labour

[35]*HAARP.Rapid Assessment and Response to Drug Use and Injecting Drug Use in Houaphanh and Phongsaly Provinces, Lao PDR. 2010*
[36]USAID - HIV/AIDS Country Profile.*http://www.usaid.gov/locations/asia/countries/vietnam/; cited on Mar12, 2012*
[37] NSAP, 2011-2015
[38]HSPI/CHAS.HIV Transmission at the Vietnam - Lao Border Area Current Status and Solutions. 2009
[39] http://www.iom.int/jahia/Jahia/lao-pdr

movements in and out of Lao PDR, especially among the economic corridors along China, Vietnam and Thailand border, this creates a vulnerable environment for HIV to spread.[40] This makes monitoring and surveillance all the more essential to track on this population.

2.5. Young People

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

2.6. Low-risk-men and women

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

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

[40] http://beta.adb.org/publications/greater-mekong-subregion-economic-cooperation-programme-overview?ref=countries/lao-pdr/publications
[41] http://www.avert.org/aids-hiv-south-east-asia.htm

III. THE NATIONAL RESPONSE

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

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

1. Policy and Political Environment

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

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

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

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

The first achievement in the policy for AIDS in Lao PDR in this period is the NSAP 2011-2015 which was developed in an inclusive, participative approach, with involvement from PLHIV and CSO. The second achievement is the establishment of the Law on HIV/AIDS Control and Prevention (hereafter refers to as the HIV Law) which was approved by the National Assembly (NA) and promulgated by the President in 2010. Article 5 in the HIV Law states that the government is committed to the response to AIDS in its role of developing policies, laws and setting up organizational structures, providing staffing and necessary budget, medicine and other essential equipment. It also addresses issues related to stigma and discrimination.

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

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

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

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

2. Civil Society involvement

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

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

- **Policy and planning development process**: members of CSO were invited to take part and contribute in consultative meetings for GFATM proposals Round 11. They also took part in the development of the NSAP, as well as the HIV Law. The proposal to include LNP+ and other local organization to join the NCCA was a strong sign of recognition of their work by the Government sector. CSO now are sub-recipients of GFATM and have been included and earmarked budget for their activities in the NSAP 2011-2015. LNP+ has been a strong advocator for NAR and for PLHIV and has been playing an active role in bringing the experiences from community to the policy making and planning arena.
- **Community Involvement**: In the last two years, community has played an essential part in the NAR, especially in care and supports for PLHIV and affected populations. The work that has been managed and implemented at community are nutrition pilot project in Savannakhet and Champasak;

LaoPHA Community based Advocacy Partnership project with collaboration from community, government and private partners to deliver a comprehensive package of care, support, behaviour change communication (BCC) and referral service for HIV testing, ARV and STI treatment. The drama group, supported by LaoPHA and UNICEF in bringing advocacy message on stigma and discrimination through performances played by the children living with or affected by HIV. The pilot harm reduction project for PWID in four districts in Houaphanh and Phongsaly has used the supports from community authorities (head of villages, police, youth union) to create an enable environment for peer educators and outreach workers to provide information, condoms and clean needles and syringes to PWID, who otherwise will be very hard to identify and reach.

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

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

3. Prevention

3.1. Comprehensive prevention programme:

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

3.1.1. Peer-led intervention includes outreach workers and peer educators of SW or former SW, MSM, transgender (MSM/TG) and recently, in the pilot project on harm reduction in Houaphanh and Phongsaly for PWID. By the end of 2011, there were 25 outreach workers; 586 peer educators working with SW and 22 outreach workers; 401 peer educators working with MSM. They provide BCC, condoms and referral service to VCT and ART when needed. Currently, the network of peer and outreach workers are supported and managed by PCCA, INGOS and national associations with majority of funding coming from GFATM. In Phongsaly and Houaphanh, there is a team of twelve PWID peer educators working in a pilot project on harm reduction in four districts. They have been trained, with supports from local and community authorities, to reach out to PWID, providing sterile needles and syringes and condom, as well as BCC. This pilot project is supported by AusAID through UNODC and WHO.

3.1.2. Drop-in-Centres (DIC) provides counselling, STI management, and referral to HIV testing and ARV treatment. There are two types of DIC, one to provide prevention services to SW and supported by FHI, the other to MSM/TGs supported by PSI. Rapid testing for HIV is provided for free at the three PSI DIC. Recently FHI is ending this activities and the DIC for SW

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

has been handed over to PCCA. Currently there are seven DIC for SW in Vientiane Capital, Savannakhet, Champasak, Bokeo and Luang Prabang. For MSM, there are three DIC in Luang Prabang, Vientiane and Savannakhet. Other areas, MSM will be reached by peer educator. GFATM and USAID support these centres.

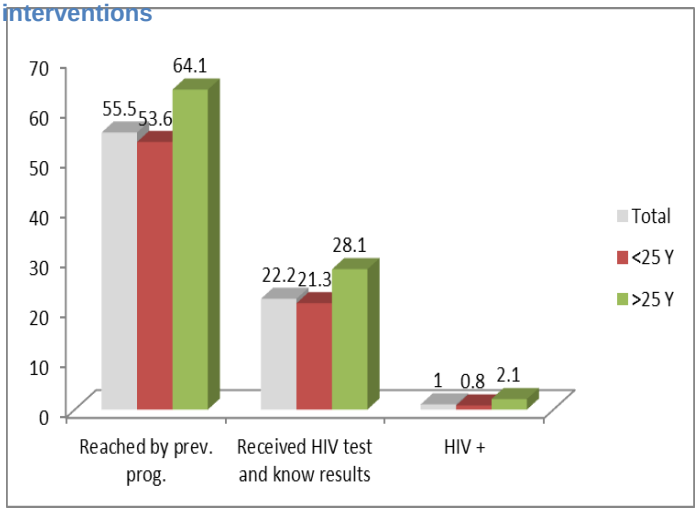
3.1.3. Outcomes:

Sex workers and clients

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

The IBBS 2011 shows that 55.0% of SW in the six surveillance provinces has been reached by prevention services. Among respondents who answered to two questions i) do you know where you can go if you wish to receive an HIV test? ii) in the last 12 months, have you been given condoms? 58.3% and 93.8% of SW answered "Yes" to the questions, respectively.

Figure 10 - Percentage of SW as of results of key prevention interventions



Source: CHAS/PSI, IBBS among SW, 2011

For outcome on BCC, this survey also found that 22.2% (21.3% for <25 years old and 28.1% among 25 and older) of SW who participated in the survey have received an HIV test and know their results. More work is needed to increase the proportion of female SW who received HIV tests and know their HIV status (see figure 10).

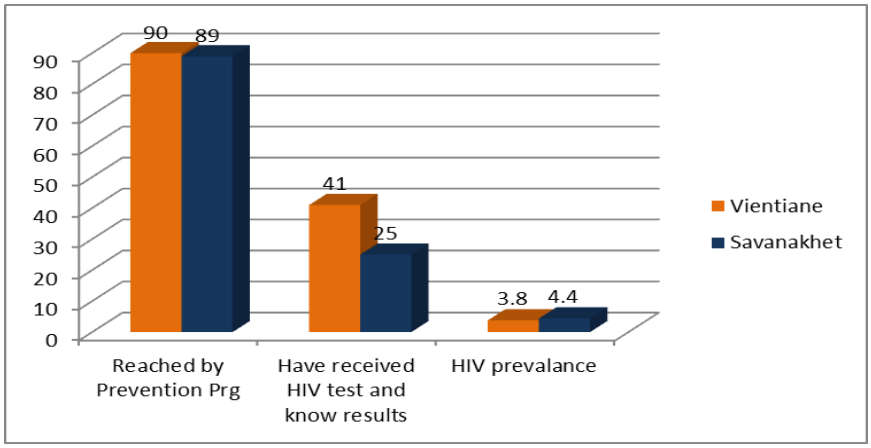
92.5% of SW interviewed in IBBS 2011 survey reported **condom use** with the most recent client; compared to 69.4% of them reported consistent condom use in the last three months. There is no significant difference in condom use between SW younger or older than 25 years old. The presence of SW use telephone to operate instead of having a base, also more young people selling sex,[43] have made the SW behaviours more multi-dimensional and complex. This poses a new challenge to the prevention programme for SW. This requires innovative prevention approaches that should be suitable and sensitive enough to reach and provide prevention services to as many as possible. Hence, more evidence is needed to understand behavioural patterns and to identify possible ways to reach this sub-population. It's hoped that with stronger participation of CSO, they can be the bridge to reach out to this group.

Men who have sex with men

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

[43]UNICEF. Rapid Assessment of Most-at-Risk Adolescents and Young People to HIV in Lao PDR, 2011
[44] National Strategy and Action Plan for HIV/AIDS/STI Control and Prevention 2011-2015

Figure 11 - Percentage of MSM/TG in relation to key prevention results



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

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

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

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

Lao PDR has recognised the need to reach this population with effective preventive interventions and have earmarked $3.6 Million and targets national HIV prevention services to reach 60% of estimated 1,300 people who inject drugs, to use safe injecting equipment and condoms, as stated in the NSAP 2011-2015.

3.2. Condom programme

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

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

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

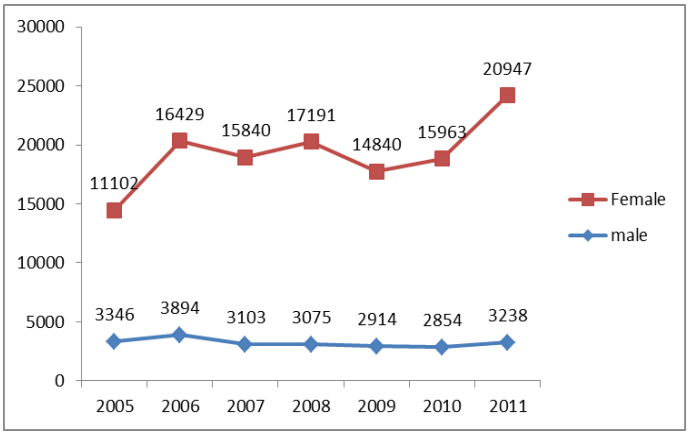
which directly procures its condoms through the UNFPA procurement system. UNFPA condom supply is available for reproductive health and family planning programme in the country.

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

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

3.3. STI management

Figure 12 - Number of STI treatments among target populations



Source: CHAS/MOH. Routine STI Report. 2011

By the end of 2011, there were total of nearly 21,000 STI treatments for females and 3,000 for male of targeted populations, according to CHAS report. This makes the total treatments that have been provided to the target population to around 24,000 in 2011(see figure 12). This number is likely much bigger considering that more people would go to private clinics and pharmacies for treatment and presently data is not attainable from private sector.

DIC also provides STI treatments for MSM, SW and their partners. For 2011, the total numbers of sex workers who seek STI treatments at DIC are 884. The number for MSM came to DIC for STI treatment were 140 in 2010 and 37 in 2011. The reason for less MSM came to DIC for STI treatment in 2011 was the shortage of STI test kits and drugs due to delay in GFATM procurement procedure.

3.4. Prevention of Mother to Child Transmission (PMTCT)

Despite improvements in ANC rates across the country with an average figure of 71%[48] the number of pregnant women being tested has not increased since 2009. Monitoring of PMTCT pilots in five target provinces between 2007 and 2008 showed that as VCT was not provided at the point of ANC service, there were high rates of loss to follow up. Identification by ANC staff of high risk pregnant women has shown to be problematic without sufficient training in counselling and addressing stigma and discrimination. Women who received ARV treatment during pregnancy to reduce the risk of PMTCT represent between 8.5% (27) and 14.6% (49) of the total estimated number of HIV positive women who are pregnant in 2010 and 2011 respectively (see figure 14). This shows that most pregnant women at high risk of HIV infection are not accessing ANC services and reinforces the need for stronger programmatic linkages between interventions for high-risk women and ANC promotion especially for sex workers women already living with HIV.

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

[47] CHAS. Condom Social Marketing assessment 2011
[48] Rates for at least one ANC visit ranged from 169% in Vientiane Capital to 27% in Oudomxay Province (NHSR09/10)
[49] National Health Statistic Report 2009/2010.MOH, 2010.
[50] WHO. Lao country data

Figure 14- Number of pregnant women received HIV test and number of HIV+, 2008-2011

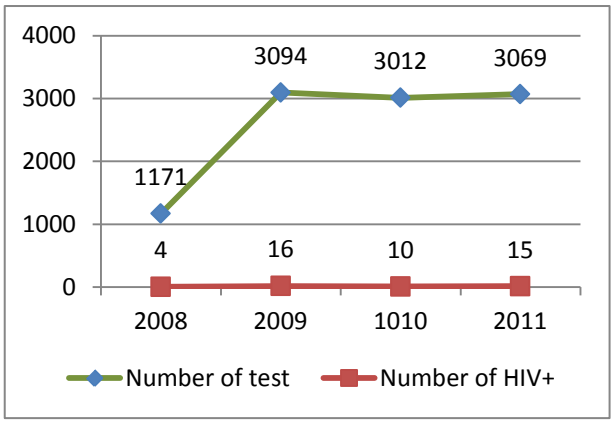
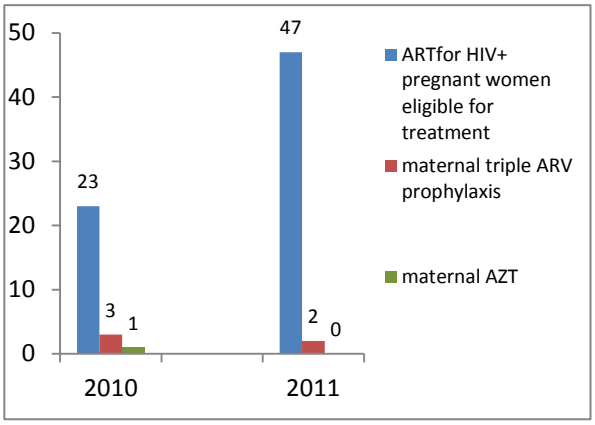


Figure 13 - Number of pregnant women HIV positive received ART by regimen



Source: CHAS/MOH. ART Routine Report, 2011

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

The number of pregnant women who received HIV test and know their results for 2010 and 2011 were 3,012 and 3,069 respectively. The number of HIV-positive cases among pregnant women were ten (0.33%) for 2010 and 15 (0.48%) in 2011. Figure 13 presents the trend of number of pregnant women who got HIV test and the number of HIV positive detected in this group in the last four years.

3.5. Others

3.5.1. Blood Safety

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

3.5.2. General population

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

HIV in the Workplace - In 2009, with support from UNAIDS through ILO, a tripartite declaration to address HIV/AIDS issues was signed among three key sectors working with and for worker and migrant

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

workers: Ministry of Labour and Social Welfare; The Lao Federation of Trade Unions and the Lao National Chamber of Commerce and Industry. The declaration adopts the ILO Code of Practices for HIV at work place and was implemented in 15 hotels in the two cities of Vientiane Capital and Luang Prabang. The final report of this initiative found that this approach has succeeded in bringing together the partners and mobilising staff in the involved hotels. There was the need to scale up to more hotels and to geographical areas.

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

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

3.6. Health system strengthening

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

- Improve drug supply chain management system to assure good quality, safe and effective drugs for HIV, TB and Malaria.
- Improve health system
- Improved efficiencies of drug quality assurance (registration, inspection, sampling and testing, good manufacturing practices, storage, distribution and pharmacy practices, and regulatory processes).

This component is under management of three different Departments under the MOH: Curative; Food and Drug; and Medical Product Supply Centres. The progress has been slowed, especially on drug quality and supply management (see table 6 below).

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

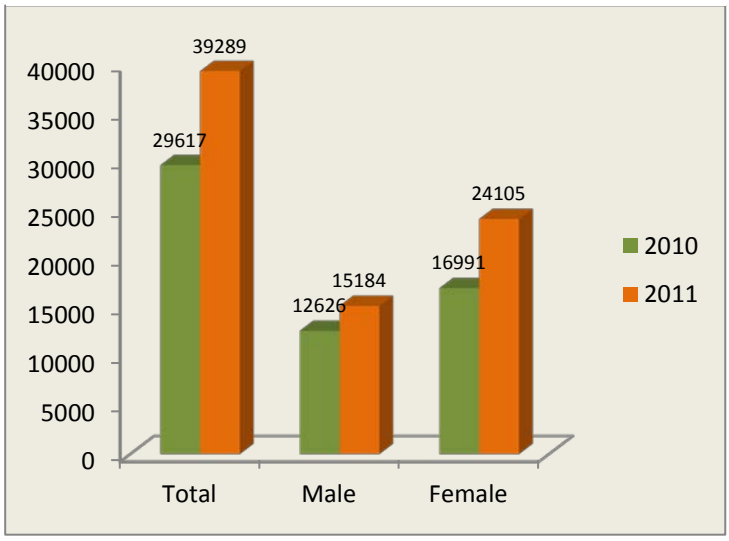
	GFATM indicators	Target	Result
1	Number and percentage of inspectors trained in GMP and passed post-training test among those trained.	National: 9 District: 10 P: 90 %	National : 0 District: 0 P: 0 %
2	Number of health facilities renovated (district hospitals and health centres)	20	14
3	Number of hospitals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

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

4. Treatment, Care and Support

4.1. Voluntary Counselling and Testing

Figure 15 - Number of people who have received HIV tests and know results, 2010 - 2011



Source: CHAS/MOH, 2011.

In the period 1990 - 2011, there were total of 318,659 HIV tests provided, of which 43,918 and 46,839 tests were conducted in 2010 and 2011. The numbers of people who have received HIV test and know their results in the last two years continued to increase (see figure 15). Among SW, compare to 2009 IBBS, the percentage of FSW who have received HIV test and know their results also increased from 14% (2009) to 22.2% (2011). The same indicator for MSM was 14% of MSM in Luang Prabang (2009); 73% among MSM/TG in Vientiane Capital and Savannakhet (2011).

To date, VCT are available in all provincial hospitals, ART sites as well as in district hospitals in Vientiane Capital and Savannakhet. In total there were seven sites at central level; 40 VCT sites at provincial level; 89 VCT sites at district level and three sites at health centres and 10 DIC provide VCT in 2011.

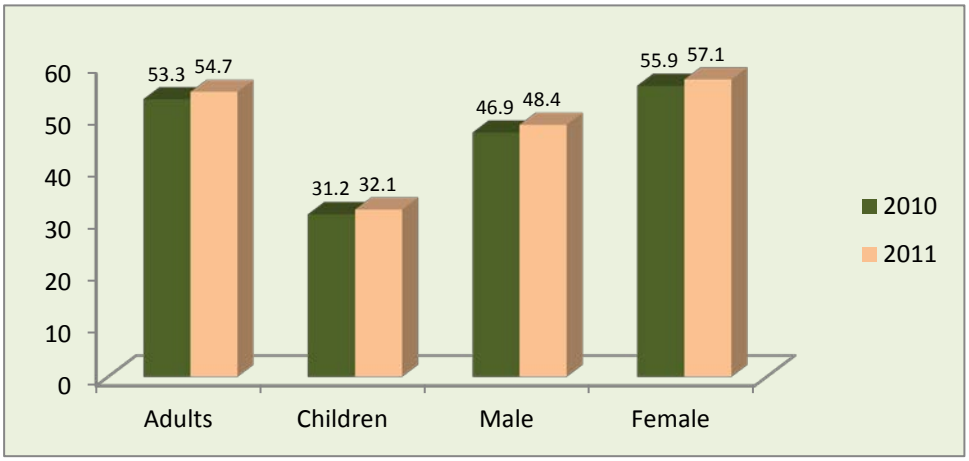
GFATM grant has provided fund for VCT and provided HIV test kits. There is the need to improve supply management, including coordination as stock out of test kits has occurred in the past due to procurement process. With increasing involvement of local networks and associations as their role has been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

4.2. Treatment:

Treatment has been one of the success stories of the NAR in Lao PDR in 2008-2009 periods.[52]By the end of 2011, total of 1,988 adults and children PLHIV who were in need have received ART. This is equivalent to52.3% of estimated PLHIV eligible for ARV have received ART, a small increase compare to 50.8% in 2010 (figure 16). For 2010 and 2011, despite continuous increase in the absolute number of PLHIV who received ART, the percentage rates dropped due to change in calculation for estimate eligible PLHIV for ART as mentioned in chapter I, section 3.3 (see figure 2).

[52]NCCA. UNGASS Country Progress Report 2010

Figure 16 - Percentage of eligible PLHIV have received ART, 2010-2011



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

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

For survival rate 12 months after ART initiation, Lao PDR has done well. Compare to last report, the rate is lower: 95% for adults in 2009 compare to 87.3% in 2011; and 100% compare to 88.4% (see table 7).

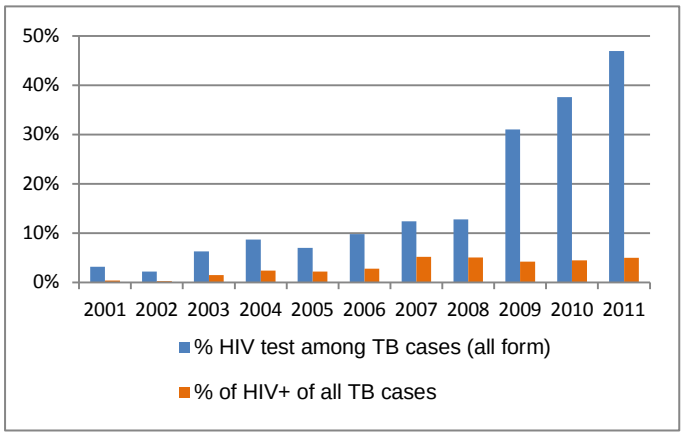
Table 7: Percentage of PLHIV known to be on treatment 12 months after initiation of ART.

< 15 years old			15 years old +		
2007	2009	2011	2007	2009	2011
93%	100%	88.4	90%	95%	87.3%

Source: CHAS/MOH. Routine reporting 2011

Management of TB-HIV has been improved significantly since the establishment of the National Committee for TB–HIV coordination in 2008 and with the support from GFATM. At the end of 2011, all HIV patients have access to ART sites have been screened for TB and vice versa with TB patients registered to the National TB centres. HIV – TB linkage has been initially implemented and scaled up nationally. In 2010, 49% of adults received ART also have started on TB treatment, in 2011, this number is 146, compare to 118 in 2010. [53]

Figure 17 - HIV screening among TB cases 2001 - 2011



Source: WHO, TB Programme Mission Report, 2011

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

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

Setthathirath Hospital in Vientiane Capital

[53]CHAS. Routine report 2010 and 2010

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

4.3. Care and Support

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

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

UNICEF has taken the main share in supporting Orphaned and Vulnerable Children (OVC) and their families by variety of approaches at community level, through social protection in money and in-kind; home supports; Enabling environment and Community Development.

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

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

Based on experience from this project, the Standard Operational Procedure on Nutrition for PLHIV will be disseminated nationwide. The challenge of this type of programme is that adherence of recommended

[54]WHO. TB programme mission report, 2011

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

food intake is low due to poverty status of most of PLHIV. However, this project has raised the requirement to include PLHIV into the target of National Nutrition Programme of MOH, to scale up and assure sustainability of this component. The project evaluation will be conducted and results will be disseminated nationwide.

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

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

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

5.1. HIV prevalence and incidence:

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

As indicated in figure 18 and 19 below, the new infection is still increasing, mainly among male-to-male sex; husband to wife transmission as the husbands are likely in the population of men with multiple partners which are more vulnerable to HIV as mentioned above; and among those who share needles (PWID) although this number is not significant. The HIV incidence will stay almost stable for the population for sex workers, who engage in casual sex and among low-risk females.

Figure 19:

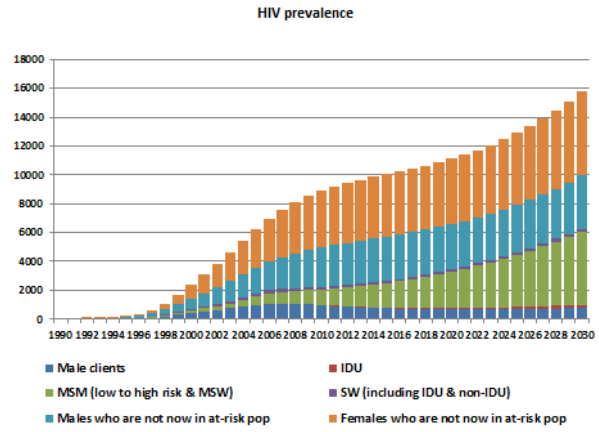
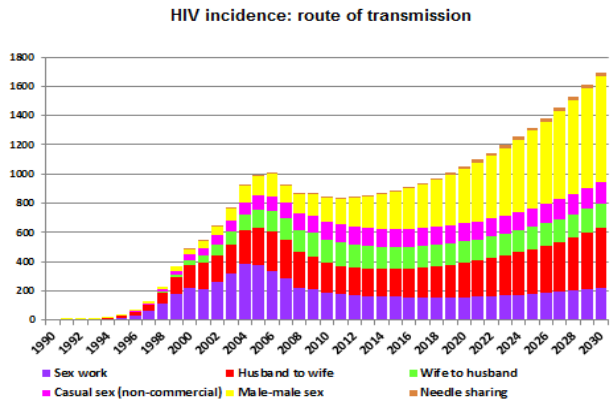


Figure 18:



Source: Estimation and Projection workshop, 2012

5.2. Policy analysis:

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

Figures 20 and 21 below show the results of new infections in adults with different scenarios. As it indicates, combine preventive intervention 4 is the most effective as it results in the least new number of infection among adults, including ART effect. However, it should be noted again that attention should be given SW, MSM and men with multiple partners, since they are likely to transmit HIV infection to their spouse. It is important to promote use of condom among high-risk groups to reduce transmission of husband to wife.

Figure 21: New HIV infection in Adults, including ART effects

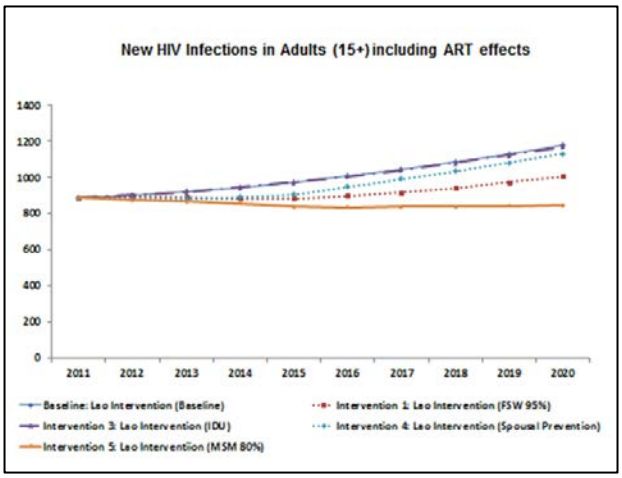
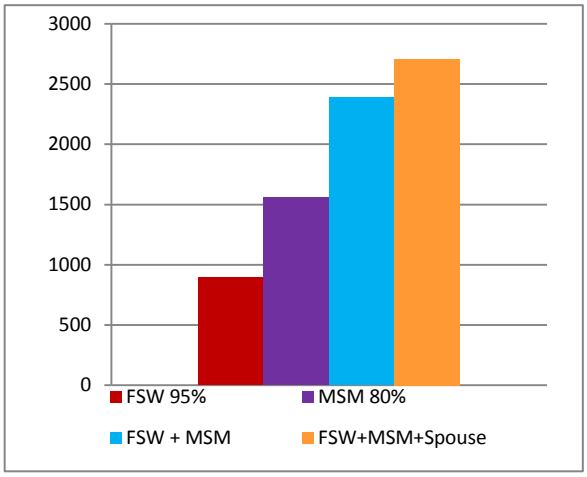


Figure 20 - Total HIV infections averted in the next 10 years



Source: Estimation and Projection workshop, 2012

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

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

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

IV. BEST PRACTICES

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

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

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

Lao PDR is on the strategic location of drug trafficking of opiates and stimulants in the golden triangle when its northern mountainous areas in poverty stand for 10% of global opium production. By bordering Mekong countries, ethnic minorities in border Provinces have adopted the behaviour of injecting of illegal drugs in northern Viet Nam and Yunnan while using opium as part of culture. Rapid assessments in early 2010 identified one in six infected with HIV in a small sample of heroin injectors in two Northern Provinces. An AusAID funded UNODC project in Lao PDR, in collaboration with UNAIDS and WHO, made the response to launch the first ever needle syringe programme in four remote health centre of four border districts of Phongsaly and Houaphanh Provinces. Twelve nurses and twenty PWID peer educators have been assigned for outreach and other support services to hidden clients in the remote setting, distributed some three thousand clean needles in 2011. It denotes strong commitment and prompt response of MOH and Lao PDR Commission on Drug Control and Supervision reporting to National Task Force on HIV and Drugs following the successful study tour to Viet Nam in 2011. Lao National Strategic Plan 2011-15 earmarks $3.6 Million and targets national HIV prevention services to reach 60% of estimated 1150 people who inject drugs, to use safe injecting equipment and condoms.

Figure 22 - Training of PWID peer educators and health workers in Houaphanh (*Source: UNODC, Lao PDR*)

Two Provincial and four District Project Management Committees take the overall responsibility of advocacy and liaising with law enforcement and drug control authorities, and work directly with village community heads and what is used to exist as village health committees. While services from health centres reaching to villages, messages from project peer educators and increased communication from nurses are bringing some hidden clients into picture. Since it is the first remote outreach programme ever

in the South East Asia context, challenges exist to reach out to drug users who are shifting to drug injecting after several years of smoking opium and Vietnamese and Chinese migrants in the construction business.

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

(Submitted by Harm Reduction Project team, UNODC)

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

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

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

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

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

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

To implement this initiative successfully, the people working at communities, as well as Lao PHA and donors have overcome challenges to win the recognition of their work from key government agencies as well as to fight stigma and discrimination within communities. This first example of strong partnership and collaboration between civil society organizations, private and government sectors that actually works for

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

the benefit of the community as well as of KAP and PLHIV. It *is "Building capacity for a good partnership"* as a member of LaoPHA emphasised.

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

Capacity Building:

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

Empowerment

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

Coordination with National Level Stakeholders

- LNP+ also gained experience engaging with various different stakeholders on the national level, including government entities (MOH and CHAS) whilst adopting the survey methodology and coordinating with ARV centres to conduct interviews.
- In particular, in order to conduct a study on HIV and AIDS in Laos, an organization must receive approval from CHAS and the Ethical Committee of CHAS. As this is the first survey assessing issues of stigma and discrimination, to receive approval indicates a change in the political environment of the Lao PDR. Even more impressive is that CHAS provided technical assistance to the survey teams carrying out the interviews.
- The SIS is meant to serve as a baseline survey regarding issues related to PLHIV in the Lao PDR – and one that will guide future research and feed into an observatory on stigma and discrimination. This observatory is in the nascent stages of development but has the overall goal to act as a monitoring mechanism for stigma and discrimination and feed into the National Assembly, which is responsible for monitoring the implementation and effectiveness of the HIV/AIDS Law, recently adopted in 2010.

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

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

Support to an Effective Lao National Assembly Joint Programme (SELNA) is a UN joint Programme to enhance the effectiveness and efficiency of the National Assembly of the Lao PDR. The programme

supports the National Assembly to further strengthen its legislative, oversight and representational capacity through initiatives targeted for assembly members, the committees, their support staff, and the assembly secretariat for the period 2009 – 2012.[57]

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

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

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

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

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

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

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

With support from USAID and GFATM, and working in close collaboration with the Lao PDR Centre for HIV/AIDS/STI (CHAS) and other partners, PSI Laos implements the peer-led *New Friends (Pheuan Mai)* program. The project is active in three provinces of Laos where there is a high concentration of MSM and TGs – Vientiane Capital, Luang Prabang, and Savannakhet. Through the *New Friends* program, PSI delivers a comprehensive package of services (CPS) which includes intensive inter-personal communication (IPC) activities to promote behaviour change, Drop-in Centres in 3 provinces offering VCT services with free HIV rapid testing, referrals to fully-subsidized STI treatment (for Gonorrhoea &

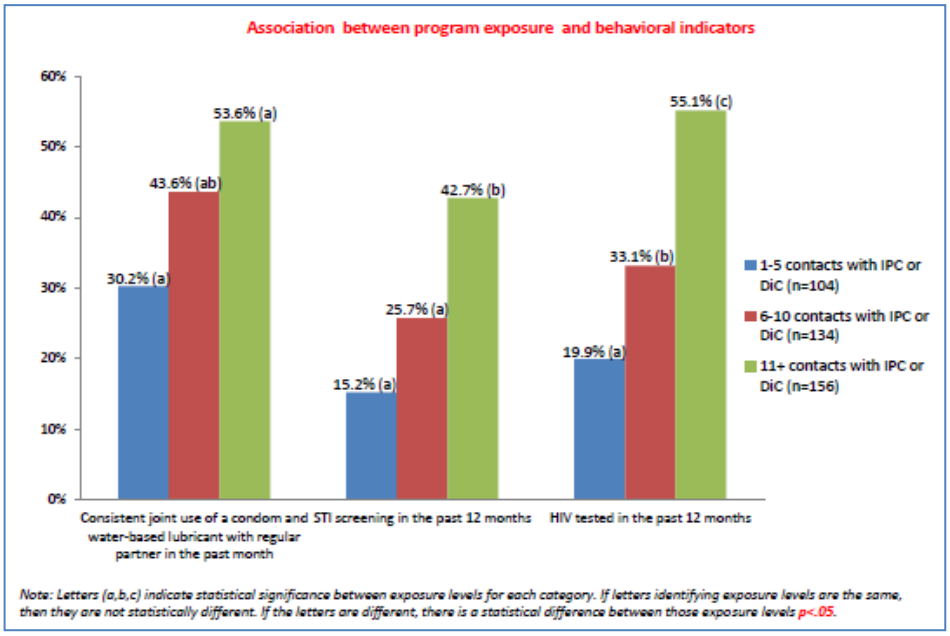
[57] http://www.undplao.org/whatwedo/factsheets/democratic/2010/2010-06_SELNA%20Fact%20Sheet_final.pdf

Chlamydia) at private sector clinics, referrals to HIV care and treatment, ensured accessibility to pre-packaged STI treatment, male condoms, and lubricant at 90% of pharmacies and 80% of guesthouses, and a cell phone SMS health messaging system. Many of the core services on the *New Friends* project are operated largely by transgender, themselves.

The campaign aims to measurably reduce HIV/STIs and promote healthy sexual behaviours among MSM, especially Male to Female (MtF) transgender (TG) and partners. As shown in the chart below, the project has achieved significant and measurable improvements in key HIV/STI prevention behaviours among TGs. Behavioural data collected during a joint CHAS/PSI behavioural survey in 2010 shows that TGs with more exposure to PSI program activities have higher rates of desired behaviours, including higher rates of consistent condom and lubricant use with regular partners, higher reported STI screening, and higher rates of HIV testing (See Graph in figure 23).

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

Figure 23



(Submitted by PSI Lao PDR)

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

1. Progression on previous challenges

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

2. Challenges for the National AIDS Response

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

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

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

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

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

3. Remedial Actions

The NSAP 2011-2015 sets two goals:

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

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

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

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

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

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

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

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

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

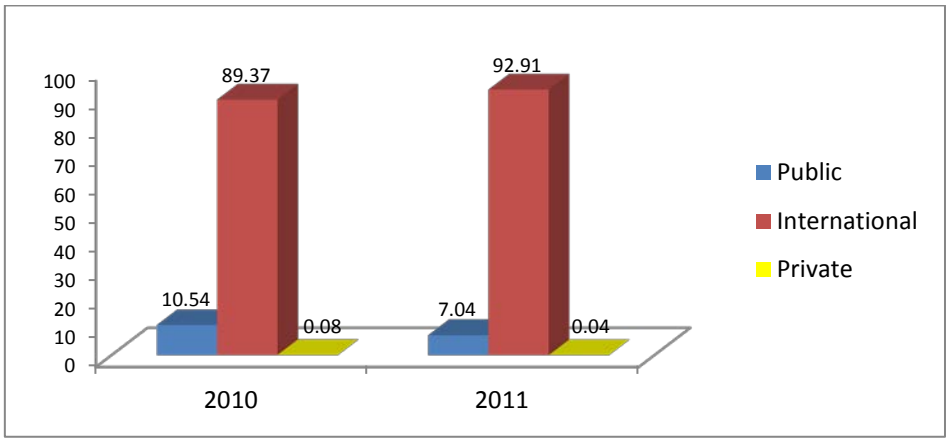
3. **Resource mobilization –** The main source of fund for NAR in Lao PDR is from external partners, of whom GFATM plays the biggest role. With the current situation of global economic down turn where all donor countries are facing budget cuts. GFATM also is facing shortage of funds and in the process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

VI. SUPPORT FROM THE COUNTRY DEVELOPMENT PARTNERS

1. Key support received from development partners

Lao PDR relies heavily on external support, both technically and financially, for the implementation of the National AIDS Response. Figure 24 shows the proportion of external fund in the reporting period, in comparison to the other sources of fund.

Figure 24 - Structure of AIDS budget by sources 2010 - 2011

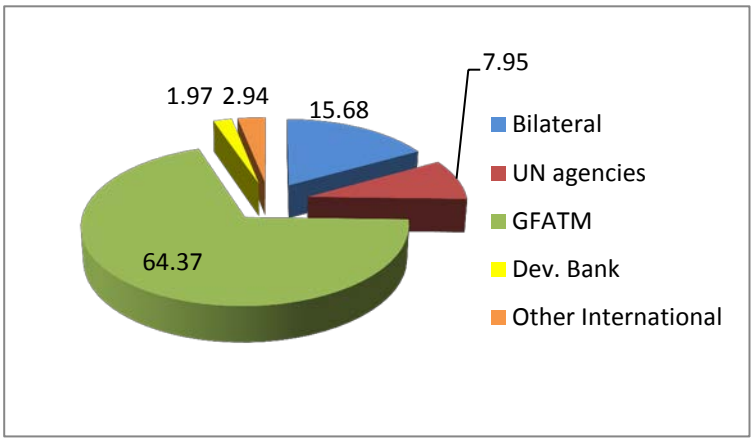


Source: NASA report, 2011.

Compare to the previous UNGASS reporting period, this structure has not changed. GFATM still is the biggest donor for the AIDS Response in Lao PDR at 64.4%, followed by Bilateral Agencies (15.7%) and UN agencies (8%)(see figure25). The trend has been increase among bilateral and UN funding and GFATM now has started restructuring its funding mechanism to cope with strongly funding cut from its donors.

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

Figure 25 - Structure of external funds in Lao PDR

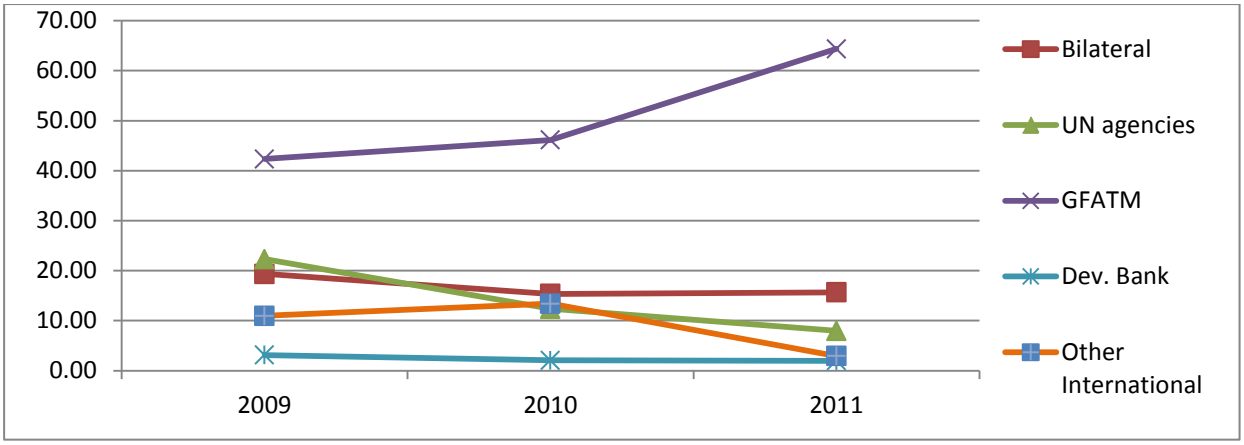


Source: NASA 2009 - 2011

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

structure; M&E; coordination; HIV in the work place; advocacy; nutrition; community based care and support…

Figure 26 - Trend of funding by external partners (% USD)



Source: NASA 2009 - 2011.

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

International NGOs have taken the key part in the work at community, supporting network of PLHIV and of other most-at-risk populations to provide preventive, care and supports. PSI has conducted a first round HIV/STI prevalence and behavioural tracking survey among transgendered in Vientiane Capital and Savannakhet. FHI supported CHAS in surveillance survey and also managed 14 drop-in centres for SW in four provinces. FHI just ended the project and handed over the centres to PCCA. PSI operates 63 DIC for MSM in ten provinces and manages the condom social marketing programme in the country since 2003.

Development Banks – ADB has supported HIV prevention activities in ADB funded road construction projects inside the country and throughout the region.

Figure 26 shows trends of external funds to the NAR in the last three years.

2. Actions that need to be taken by development partners

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

In 2011, Lao PDR became 'lower middle income country' and this could affect the flow of official development assistance (ODA) to the country. The development partners should promote and support the Government of Lao PDR to increase domestic investment and HIV should be one of the priorities due to the socio-economic impacts that HIV can have at household level and that can bring those affected to poverty. International partners should advocate for promotion of income generation by supporting better access to education, vocational training and financial supports for poor people, especially those affected by AIDS

International partners were a strong force behind the development of evidence-based NSAP 2011-2015. It is important to continue this support for strengthening and supporting data collection, analysis and use

for stronger M&E system to support programmatic planning, especially to reach out to the hard-to-reach (informal SW, MSM, migrant, PWID); policy dialogues and advocacy.

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

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

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

VII- MONITORING AND EVALUATION ENVIRONMENT

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

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

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

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

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

	M&E components		Status at 2011 and Remarks
1.	Organizational structure with HIV M&E functions	-	There is a structure of M&E with information flow (mainly upward to higher administrative level).
		-	Budget for M&E still low
		-	Lack of M&E staff at provincial and district levels
		-	Surveillance, and treatment is under another Unit within CHAS which hinder the data collection process
2.	Human Capacity for HIV M&E	-	All staff at M&E Unit in CHAS have been trained but further training is needed in specific area such size estimation, data analysis; evaluation; design M&E plan; use of M&E tools….
		-	Inadequate training for staff at provincial and lower levels, especially at service delivery facilities. This affects the quality of data collected.
		-	Staff at district and community level has multiple tasks, one of them is collecting data for M&E, and therefore they cannot perform sufficiently due to work overload.
3.	Partnership to plan, coordinate and manage the HIV M&E system	-	The national M&E TWG has been established but has not met regularly.
		-	Data from other ministries and CSO are not always reported routinely but available when requested
4.	National multi-sectoral HIV M&E plan	-	Drafted but not yet finalised
5.	Annual cost M&E work plan	-	None. Plan to develop in the future
6.	Advocacy, communication and culture for HIV M&E	-	TWG has not met hence advocacy for data use and the role of M&E in programmatic planning and strategy development.
		-	There's plan for M&E TWG to meet in the near future.
7.	Routine HIV programme Monitoring	-	National guidelines and data collection forms to be developed
		-	Monthly reports are collected from service delivery sites to district and provincial level then to CHAS
		-	No available reports from line ministries

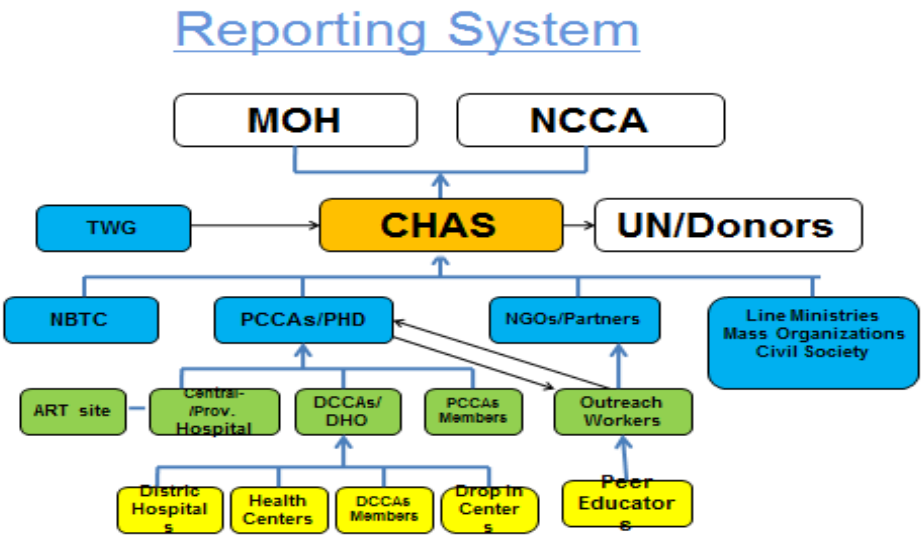
8.	Survey and surveillance	- IBBS/BBS has been conducted most regularly though surveyed populations is not always consistent, as well as methods and questionnaires. - 2010: tracked IBBS conducted among MSM/TGs in VientianeCapital and Savannakhet. - 2011: IBBS conducted among female SW in six provinces - Lao Social Indicator Survey (LSIS) is in process. Data will be available around 2013.
9.	National and Sub-national data base	- M&E unit in CHAS currently hosts HIV national data base but not sub-national data base - Care and treatment monitoring software is applied
10.	Supportive supervision and data auditing	- Regular supervision visits to provinces and data checking on sites.
11.	HIV evaluation and research	- Condom Social Marketing Programme Evaluation conducted in 2010.
12.	Data dissemination and use	- Data mainly used for global reporting, and for the formulation of the NSAP. - Data is used for planning and policy making at national and sub-national levels - Estimation and projection of key affected populations, epidemics and estimate ARV needs, policy analysis to support enable policy timely and accurately.

Routine Reporting – the primary data is collected and compiled at community based service providers such as VCT sites, DIC, peer educators and outreach workers, as well as health centres, district hospital, DCCA members. This data, together with reports from ART sites, is reported monthly to relevant provincial level, of which will compile and report as provincial data to relevant vertical line central level, who then report to M&E Unit at CHAS (see figure 27 below).

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

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

Figure 27 - Data flow in routine HIV programme monitoring system



Source: CHAS/MOH

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

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

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

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

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

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

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

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

- The NSAP recommended 3.5% of its total budget for M&E, still lower than the UNAIDS recommended seven to ten prevent of the total NAR budget if to have a sustainable and functioning national HIV M&E system.

3. Remedial actions planned to overcome the challenges

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

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

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

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

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

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

Source: CHAS/ MOH

Table10shows that there is lack of continuity of information for most of the target populations, except sex workers.

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

ANNEX

ANNEX 1: NATIONAL AIDS SPENDING ASSESSMENT (NASA)

Year 2010	National Funding Matrix												
Calendar: No	AIDS Spending Categories by Financing Sources												
Fiscal Year: Oct. 209 to Sep. 2010													
Currency used in Matrix: US$	Financing Sources												
Average Exchange Rate for the year: 8000 LAK		Public Sources			International Sources							Private Sectors	
AIDS Spending Categories	Total	Public Sub-Total	central/National	Sub-National	International Sub-Total	Bilateral	Multilaterals				All other International	Private Sub-Total	For-profit institution/Corporation
							UN Agencies	Global Fund	Dev.Bank Reimboursable (e.g. Grants)	All other Multilateral			
1. Prevention-related activities	**2,960,288**	**43,324**	**43,324**	**-**	**2,910,306**	**703,749**	**438,217**	**1,513,639**	**58,380**	**-**	**196,321**	**6,658**	**6,658**
1.01 Communication for social and behavioural change	25,294	-	-	-	25,294	-	-	17,280	-	-	8,014	-	-
1.02 Community mobilization	-	-	-	-	-	-	-	-	-	-	-	-	-
1.03 Voluntary counselling and testing	100,546	-	-	-	100,546	-	-	100,546	-	-	-	-	-
1.04 Risk-reduction for vulnerable and accessible populations	-	-	-	-	-	-	-	-	-	-	-	-	-
1.05. Prevention - Youth in school	166,202	-	-	-	166,202	-	166,202	-	-	-	-	-	-
1.06 Prevention - Youth out-of-school	124,777	-	-	-	124,777	-	124,777	-	-	-	-	-	-
1.07 Prevention of HIV transmission aimed at people living with HIV	5,409	-	-	-	5,409	-	-	5,409	-	-	-	-	-
1.08 Prevention programmes for sex workers and their clients	720,238	-	-	-	720,238	449,677	-	259,311	-	-	11,250	-	-
1.09 Programmes for men who have sex with men	122,472	-	-	-	122,472	-	11,351	104,819	-	-	6,302	-	-
1.10 Harm-reduction programmes for injecting drug users	213,054	-	-	-	213,054	169,972	36,000	7,082	-	-	-	-	-
1.11 Prevention programmes in the workplace	203,068	-	-	-	196,410	-	38,381	4,649	58,380	-	95,000	6,658	6,658
1.12 Condom social marketing	86,039	-	-	-	86,039	-	-	86,039	-	-	-	-	-
1.13 Public and commercial sector male condom provision	10,000	-	-	-	10,000	-	-	10,000	-	-	-	-	-

1.14 Public and commercial sector female condom provision	10,000	-	-	-	10,000	-	-	10,000	-	-	-	-	-
1.15 Microbicides	-	-	-	-	-	-	-	-	-	-	-	-	-
1.16 Prevention, diagnosis and treatment of sexually transmitted infections	-	-	-	-	-	-	-	-	-	-	-	-	-
1.17 Prevention of mother-to-child transmission	51,506	-	-	-	51,506	-	51,506	-	-	-	-	-	-
1.18 Male Circumcision	-	-	-	-	-	-	-	-	-	-	-	-	-
1.19 Blood safety	905,815	43,324	43,324	-	862,491	-	10,000	852,491	-	-	-	-	-
1.20 Safe medical injections	-	-	-	-	-	-	-	-	-	-	-	-	-
1.21 Universal precautions	-	-	-	-	-	-	-	-	-	-	-	-	-
1.22 Post-exposure prophylaxis	-	-	-	-	-	-	-	-	-	-	-	-	-
1.98 Prevention activities not disaggregated by intervention	7,082	-	-	-	7,082	-	-	7,082	-	-	-	-	-
1.99 Prevention activities not elsewhere classified	208,787	-	-	-	208,787	84,100	-	48,932	-	-	75,755	-	-
2. Treatment and care components	**1,730,290**	**189,417**	**189,417**	**-**	**1,540,873**	**40,880**	**140,366**	**1,074,458**	**-**	**-**	**285,169**	**-**	**-**
2.01 Outpatient care	**1,336,289**	**-**	**-**	**-**	**1,336,289**	**39,680**	**-**	**1,074,458**	**-**	**-**	222,151	**-**	**-**
2.01.01 Provider- initiated testing and counselling	83,000	-	-	-	83,000	-	-	83,000	-	-	-	-	-
2.01.02 Opportunistic infection outpatient prophylaxis and treatment	12,295	-	-	-	12,295	12,295	-	-	-	-	-	-	-
2.01.03 Antiretroviral therapy	739,203	-	-	-	739,203	-	-	733,734	-	-	5,469	-	-
2.01.04 Nutritional support associated to ARV therapy	-	-	-	-	-	-	-	-	-	-	-	-	-
2.01.05 Specific HIV-related laboratory monitoring	19,225	-	-	-	19,225	-	-	-	-	-	19,225	-	-
2.01.06 Dental programmes for people living with HIV	-	-	-	-	-	-	-	-	-	-	-	-	-
2.01.07 Psychological treatment and support services	316,045	-	-	-	316,045	27,385	-	250,642	-	-	38,018	-	-
2.01.08 Outpatient palliative care	-	-	-	-	-	-	-	-	-	-	-	-	-
2.01.09 Home-based care	166,521	-	-	-	166,521	-	-	7,082	-	-	159,439	-	-
2.01.10 Traditional medicine and informal care and treatment	-	-	-	-	-	-	-	-	-	-	-	-	-
2.01.98 Outpatient care services not disaggregated by intervention	-	-	-	-	-	-	-	-	-	-	-	-	-
2.01.99 Outpatient Care services not elsewhere classified	-	-	-	-	-	-	-	-	-	-	-	-	-
2.02 In-patient care	394,001	189,417	**189,417**	**-**	**204,584**	**1,200**	**140,366**	**-**	**-**	**-**	**63,018**	**-**	**-**

2.02.01 Inpatient treatment of opportunistic infections	51,718	-	-	-	51,718	1,200	-	-	-	-	50,518	-	-
2.02.02 Inpatient palliative care	-	-	-	-	-	-	-	-	-	-	-	-	-
2.02.98 Inpatient care services not disaggregated by intervention	53,258	-	-	-	53,258	-	53,258	-	-	-	-	-	-
2.02.99 In-patient services not elsewhere classified	-	-	-	-	-	-	-	-	-	-	-	-	-
2.03 Patient transport and emergency rescue	12,500	-	-	-	12,500	-	-	-	-	-	12,500	-	-
2.98 Care and treatment services not disaggregated by intervention	189,417	189,417	189,417	-	-	-	-	-	-	-	-	-	-
2.99 Care and treatment services not-elsewhere classified	87,108	-	-	-	87,108	-	87,108	-	-	-	-	-	-
3. Orphan and Vulnerable children --OVC	**76,992**	**-**	**-**	**-**	**76,992**	**-**	**76,992**	**-**	**-**	**-**	**-**	**-**	**-**
3.01 OVC Education	7,500	-	-	-	7,500	-	7,500	-	-	-	-	-	-
3.02 OVC Basic health care	-	-	-	-	-	-	-	-	-	-	-	-	-
3.03 OVC Family/home support	69,492	-	-	-	69,492	-	69,492	-	-	-	-	-	-
3.04 OVC Community support	-	-	-	-	-	-	-	-	-	-	-	-	-
3.05 OVC Social services and administrative costs	-	-	-	-	-	-	-	-	-	-	-	-	-
3.06 OVC Institutional care	-	-	-	-	-	-	-	-	-	-	-	-	-
3.98 OVC services not disaggregated by intervention	-	-	-	-	-	-	-	-	-	-	-	-	-
3.99 OVC services not-elsewhere classified	-	-	-	-	-	-	-	-	-	-	-	-	-
4. Program Management and Administration	**1,185,803**	**69,902**	**27,960**	**41,942**	**1,115,901**	**251,848**	**235,784**	**500,472**	**29,230**	**-**	**98,567**	**-**	**-**
4.01 Planning, coordination and programme management	638,690	-	-	-	638,690	32,011	218,850	381,080	-	-	6,749	-	-
4.02 Administration and transaction costs associated with managing and disbursing funds	191,290	69,902	27,960	41,942	121,388	45,750	-	17,237	18,120	-	40,281	-	-
4.03 Monitoring and evaluation	155,772	-	-	-	155,772	22,071	16,934	91,580	-	-	25,187	-	-
4.04 Operations research	-	-	-	-	-	-	-	-	-	-	-	-	-
4.05 Serological-surveillance (Serosurveillance)	15,950	-	-	-	15,950	-	-	-	-	-	15,950	-	-
4.06 HIV drug-resistance surveillance	-	-	-	-	-	-	-	-	-	-	-	-	-
4.07 Drug supply systems	-	-	-	-	-	-	-	-	-	-	-	-	-
4.08 Information technology	65,109	-	-	-	65,109	65,109	-	-	-	-	-	-	-
4.09 Patient tracking	3,602	-	-	-	3,602	-	-	3,602	-	-	-	-	-

4.10 Upgrading and construction of infrastructure	86,112	-	-	-	86,112	83,787	-	2,325	-	-	-	-	-
4.11 Mandatory HIV testing (not voluntary counselling and testing)	-	-	-	-	-	-	-	-	-	-	-	-	-
4.98 Program Management and Administration Strengthening not disaggregated by type	12,725	-	-	-	12,725	-	-	2,325	-	-	10,400	-	-
4.99 Program Management and Administration Strengthening not-elsewhere classified	16,555	-	-	-	16,555	3,120	-	2,325	11,110	-	-	-	-
5. Human resources	**1,754,652**	**525,047**	**47,810**	**477,237**	**1,229,605**	**209,859**	**-**	**494,486**	**75,984**	**-**	**449,276**	**-**	**-**
5.01 Monetary incentives for human resources	1,351,938	525,047	47,810	477,237	826,891	190,924	-	357,475	75,984	-	202,508	-	-
5.02 Formative education to build-up an HIV workforce	19,187	-	-	-	19,187	7,510	-	-	-	-	11,677	-	-
5.03 Training	374,078	-	-	-	374,078	6,625	-	132,362	-	-	235,091	-	-
5.98 Incentives for Human Resources not specified by kind	7,125	-	-	-	7,125	4,800	-	2,325	-	-	-	-	-
5.99 Incentives for Human Resources not elsewhere classified	2,325	-	-	-	2,325	-	-	2,325	-	-	-	-	-
6. Social Protection and Social Services excluding Orphans & Vulnerable Children (sub-total)	**27,050**	**-**	**-**	**-**	**27,050**	**-**	**-**	**17,779**	**-**	**-**	**9,271**	**-**	**-**
6.01 Social protection through monetary benefits	2,325	-	-	-	2,325	-	-	2,325	-	-	-	-	-
6.02 Social protection through in-kind benefits	2,325	-	-	-	2,325	-	-	2,325	-	-	-	-	-
6.03 Social protection through provision of social services	2,325	-	-	-	2,325	-	-	2,325	-	-	-	-	-
6.04 HIV-specific income generation projects	12,873	-	-	-	12,873	-	-	3,602	-	-	9,271	-	-
6.98 Social protection services and social services not disaggregated by type	3,602	-	-	-	3,602	-	-	3,602	-	-	-	-	-
6.99 Social protection services and social services not elsewhere classified	3,602	-	-	-	3,602	-	-	3,602	-	-	-	-	-
7. Enabling Environment	**102,524**	**-**	**-**	**-**	**102,524**	**-**	**79,865**	**22,659**	**-**	**-**	**-**	**-**	**-**
7.01 Advocacy	4,325	-	-	-	4,325	-	2,000	2,325	-	-	-	-	-
7.02 Human rights programmes	2,325	-	-	-	2,325	-	-	2,325	-	-	-	-	-
7.03 AIDS-specific institutional development	7,602	-	-	-	7,602	-	4,000	3,602	-	-	-	-	-
7.04 AIDS-specific programmes focused on women	3,602	-	-	-	3,602	-	-	3,602	-	-	-	-	-
7.05 Programmes to reduce Gender Based Violence	12,602	-	-	-	12,602	-	9,000	3,602	-	-	-	-	-

7.98 Enabling Environment and Community Development not disaggregated by type	68,467	-	-	-	68,467	-	64,865	3,602	-	-	-	-	-
7.99 Enabling Environment and Community Development not elsewhere classified	3,602	-	-	-	3,602	-	-	3,602	-	-	-	-	-
8. Research excluding operations research	**15,065**	**-**	**-**	**-**	**15,065**	**-**	**1,422**	**-**	**-**	**-**	**13,643**	**-**	**-**
8.01 Biomedical research	-	-	-	-	-	-	-	-	-	-	-	-	-
8.02 Clinical research	-	-	-	-	-	-	-	-	-	-	-	-	-
8.03 Epidemiological research	-	-	-	-	-	-	-	-	-	-	-	-	-
8.04 Social science research	1,422	-	-	-	1,422	-	1,422	-	-	-	-	-	-
8.05 Vaccine-related research	-	-	-	-	-	-	-	-	-	-	-	-	-
8.98 Research not disaggregated by type	-	-	-	-	-	-	-	-	-	-	-	-	-
8.99 Research not elsewhere classified	13,643	-	-	-	13,643	-	-	-	-	-	13,643	-	-
Grand Total	**7,852,664**	**827,690**	**308,511**	**519,179**	**7,018,316**	**1,206,336**	**972,646**	**3,623,493**	**163,594**	**-**	**1,052,247**	**6,658**	**6,658**

Public	10.54	National	37.27
International	89.37	Sub National	62.73
Private	0.08		

Prevention	37.70
Treatment and Care	22.03
OVC	0.98
Programme Management	15.10
Human Resources	22.34
Social Protection	0.34
Enabling Environment	1.31
Research	0.19

Public	10.54
Bilateral	15.36
UN agencies	12.39
GFATM	46.14
Dev. Bank	2.08
Other Multilateral	0.00
Other Inter	13.40
Private	0.08

Year 2011	National Funding Matrix												
Calendar: No	AIDS Spending Categories by Financing Sources												
Fiscal Year: Oct. 2010 to Sep. 2011													
Currency used in Matrix: US$	Financing Sources												
Average Exchange Rate for the year: 8000 LAK		Public Sources			International Sources							Private Sectors	
AIDS Spending Categories	Total	Public Sub-Total	central/National	Sub-National	International Sub-Total	Bilateral	Multilaterals				All other International	Private Sub-Total	For-profit institution/Corporation
							UN Agencies	Global Fund	Dev.Bank Reimbursable (e.g. Grants)	All other Multilateral			
1. Prevention-related activities	**6,060,478**	**43,324**	**43,324**	**-**	**6,012,073**	**1,344,510**	**366,756**	**4,047,867**	**231,690**	**-**	**21,250**	**5,081**	**5,081**
1.01 Communication for social and behavioural change	243,981	-	-	-	243,981	-	5,000	138,675	90,306	-	10,000	-	-
1.02 Community mobilization	-	-	-	-	-	-	-	-	-	-	-	-	-
1.03 Voluntary counselling and testing	36,180	-	-	-	36,180	-	-	36,180	-	-	-	-	-
1.04 Risk-reduction for vulnerable and accessible populations	-	-	-	-	-	-	-	-	-	-	-	-	-
1.05. Prevention - Youth in school	144,456	-	-	-	144,456	-	144,456	-	-	-	-	-	-
1.06 Prevention - Youth out-of-school	65,000	-	-	-	65,000	-	65,000	-	-	-	-	-	-
1.07 Prevention of HIV transmission aimed at people living with HIV	-	-	-	-	-	-	-	-	-	-	-	-	-
1.08 Prevention programmes for sex workers and their clients	907,589	-	-	-	907,589	54,000	-	842,339	-	-	11,250	-	-
1.09 Programmes for men who have sex with men	878,210	-	-	-	878,210	193,260	30,000	654,950	-	-	-	-	-
1.10 Harm-reduction programmes for injecting drug users	508,952	-	-	-	508,952	508,952	-	-	-	-	-	-	-
1.11 Prevention programmes in the workplace	5,081	-	-	-	-	-	-	-	-	-	-	5,081	5,081
1.12 Condom social marketing	452,140	-	-	-	452,140	452,140	-	-	-	-	-	-	-
1.13 Public and commercial sector male condom provision	1,088,170	-	-	-	1,088,170	-	-	1,088,170	-	-	-	-	-
1.14 Public and commercial sector female condom provision	-	-	-	-	-	-	-	-	-	-	-	-	-

1.15 Microbicides	-	-	-	-	-	-	-	-	-	-	-	-	-
1.16 Prevention, diagnosis and treatment of sexually transmitted infections	314,151	-	-	-	314,151	-	-	172,767	141,384	-	-	-	-
1.17 Prevention of mother-to-child transmission	180,200	-	-	-	180,200	-	122,300	57,900	-	-	-	-	-
1.18 Male Circumcision	-	-	-	-	-	-	-	-	-	-	-	-	-
1.19 Blood safety	1,100,210	43,324	43,324	-	1,056,886	-	-	1,056,886	-	-	-	-	-
1.20 Safe medical injections	-	-	-	-	-	-	-	-	-	-	-	-	-
1.21 Universal precautions	6,276	-	-	-	6,276	6,276	-	-	-	-	-	-	-
1.22 Post-exposure prophylaxis	-	-	-	-	-	-	-	-	-	-	-	-	-
1.98 Prevention activities not disaggregated by intervention	-	-	-	-	-	-	-	-	-	-	-	-	-
1.99 Prevention activities not elsewhere classified	129,882	-	-	-	129,882	129,882	-	-	-	-	-	-	-
2. Treatment and care components	**2,274,525**	**189,417**	**189,417**	**-**	**2,085,108**	**26,400**	**91,000**	**1,861,250**	**-**	**-**	**106,458**	**-**	**-**
2.01 Outpatient care	**2,007,350**	**-**	**-**	**-**	**2,007,350**	**26,400**	**50,000**	**1,861,250**	**-**	**-**	**69,700**	**-**	**-**
2.01.01 Provider- initiated testing and counselling	2,600	-	-	-	2,600	-	-	-	-	-	2,600	-	-
2.01.02 Opportunistic infection outpatient prophylaxis and treatment	-	-	-	-	-	-	-	-	-	-	-	-	-
2.01.03 Antiretroviral therapy	1,634,238	-	-	-	1,634,238	-	50,000	1,584,238	-	-	-	-	-
2.01.04 Nutritional support associated to ARV therapy	-	-	-	-	-	-	-	-	-	-	-	-	-
2.01.05 Specific HIV-related laboratory monitoring	-	-	-	-	-	-	-	-	-	-	-	-	-
2.01.06 Dental programmes for people living with HIV	-	-	-	-	-	-	-	-	-	-	-	-	-
2.01.07 Psychological treatment and support services	48,149	-	-	-	48,149	26,400	-	-	-	-	21,749	-	-
2.01.08 Outpatient palliative care	-	-	-	-	-	-	-	-	-	-	-	-	-
2.01.09 Home-based care	322,363	-	-	-	322,363	-	-	277,012	-	-	45,351	-	-
2.01.10 Traditional medicine and informal care and treatment	-	-	-	-	-	-	-	-	-	-	-	-	-
2.01.98 Outpatient care services not disaggregated by intervention	-	-	-	-	-	-	-	-	-	-	-	-	-

2.01.99 Outpatient Care services not elsewhere classified	-	-	-	-	-	-	-	-	-	-	-	-	-
2.02 In-patient care	**267,175**	**189,417**	**189,417**	**-**	**77,758**	**-**	**41,000**	**-**	**-**	**-**	**36,758**	**-**	**-**
2.02.01 Inpatient treatment of opportunistic infections	24,258	-	-	-	24,258	-	-	-	-	-	24,258	-	-
2.02.02 Inpatient palliative care	-	-	-	-	-	-	-	-	-	-	-	-	-
2.02.98 Inpatient care services not disaggregated by intervention	-	-	-	-	-	-	-	-	-	-	-	-	-
2.02.99 In-patient services not elsewhere classified	-	-	-	-	-	-	-	-	-	-	-	-	-
2.03 Patient transport and emergency rescue	12,500	-	-	-	12,500	-	-	-	-	-	12,500	-	-
2.98 Care and treatment services not disaggregated by intervention	41,000	-	-	-	41,000	-	41,000	-	-	-	-	-	-
2.99 Care and treatment services not-elsewhere classified	189,417	189,417	189,417	-	-	-	-	-	-	-	-	-	-
3. Orphan and Vulnerable children --OVC	**111,000**	**-**	**-**	**-**	**111,000**	**-**	**111,000**	**-**	**-**	**-**	**-**	**-**	**-**
3.01 OVC Education	-	-	-	-	-	-	-	-	-	-	-	-	-
3.02 OVC Basic health care	-	-	-	-	-	-	-	-	-	-	-	-	-
3.03 OVC Family/home support	66,000	-	-	-	66,000	-	66,000	-	-	-	-	-	-
3.04 OVC Community support	-	-	-	-	-	-	-	-	-	-	-	-	-
3.05 OVC Social services and administrative costs	-	-	-	-	-	-	-	-	-	-	-	-	-
3.06 OVC Institutional care	45,000	-	-	-	45,000	-	45,000	-	-	-	-	-	-
3.98 OVC services not disaggregated by intervention	-	-	-	-	-	-	-	-	-	-	-	-	-
3.99 OVC services not-elsewhere classified	-	-	-	-	-	-	-	-	-	-	-	-	-
4. Program Management and Administration	**1,320,045**	**69,902**	**27,960**	**41,942**	**1,250,143**	**298,752**	**84,520**	**781,971**	**-**	**-**	**84,900**	**-**	**-**
4.01 Planning, coordination and programme management	434,036	-	-	-	434,036	13,620	25,170	372,126	-	-	23,120	-	-
4.02 Administration and transaction costs associated with managing and disbursing funds	226,763	69,902	27,960	41,942	156,861	55,660	-	96,201	-	-	5,000	-	-
4.03 Monitoring and evaluation	301,202	-	-	-	301,202	61,812	59,350	142,500	-	-	37,540	-	-
4.04 Operations research	-	-	-	-	-	-	-	-	-	-	-	-	-
4.05 Serological-surveillance (Serosurveillance)	62,840	-	-	-	62,840	-	-	54,000	-	-	8,840	-	-
4.06 HIV drug-resistance surveillance	-	-	-	-	-	-	-	-	-	-	-	-	-

4.07 Drug supply systems	33,408	-	-	-	33,408	6,000	-	27,408	-	-	-	-	-
4.08 Information technology	-	-	-	-	-	-	-	-	-	-	-	-	-
4.09 Patient tracking	-	-	-	-	-	-	-	-	-	-	-	-	-
4.10 Upgrading and construction of infrastructure	161,660	-	-	-	161,660	161,660	-	-	-	-	-	-	-
4.11 Mandatory HIV testing (not voluntary counselling and testing)	-	-	-	-	-	-	-	-	-	-	-	-	-
4.98 Program Management and Administration Strengthening not disaggregated by type	62,974	-	-	-	62,974	-	-	52,574	-	-	10,400	-	-
4.99 Program Management and Administration Strengthening not-elsewhere classified	37,161	-	-	-	37,161	-	-	37,161	-	-	-	-	-
5. Human resources	**1,741,969**	**525,047**	**47,810**	**477,237**	**1,216,922**	**172,110**	**40,000**	**871,452**	**-**	**-**	**133,360**	**-**	**-**
5.01 Monetary incentives for human resources	1,440,480	525,047	47,810	477,237	915,433	39,181	-	871,452	-	-	4,800	-	-
5.02 Formative education to build-up an HIV workforce	9,490	-	-	-	9,490	-	-	-	-	-	9,490	-	-
5.03 Training	266,999	-	-	-	266,999	132,929	15,000	-	-	-	119,070	-	-
5.98 Incentives for Human Resources not specified by kind	-	-	-	-	-	-	-	-	-	-	-	-	-
5.99 Incentives for Human Resources not elsewhere classified	25,000	-	-	-	25,000	-	25,000	-	-	-	-	-	-
6. Social Protection and Social Services excluding Orphans & Vulnerable Children (sub-total)	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
6.01 Social protection through monetary benefits	-	-	-	-	-	-	-	-	-	-	-	-	-
6.02 Social protection through in-kind benefits	-	-	-	-	-	-	-	-	-	-	-	-	-
6.03 Social protection through provision of social services	-	-	-	-	-	-	-	-	-	-	-	-	-
6.04 HIV-specific income generation projects	-	-	-	-	-	-	-	-	-	-	-	-	-
6.98 Social protection services and social services not disaggregated by type	-	-	-	-	-	-	-	-	-	-	-	-	-
6.99 Social protection services and social services not elsewhere classified	-	-	-	-	-	-	-	-	-	-	-	-	-
7. Enabling Environment	**241,200**	**-**	**-**	**-**	**241,200**	**-**	**241,200**	**-**	**-**	**-**	**-**	**-**	**-**
7.01 Advocacy	31,200	-	-	-	31,200	-	31,200	-	-	-	-	-	-
7.02 Human rights programmes	75,000	-	-	-	75,000	-	75,000	-	-	-	-	-	-

7.03 AIDS-specific institutional development	50,000	-	-	-	50,000	-	50,000	-	-	-	-	-	-
7.04 AIDS-specific programmes focused on women	75,000	-	-	-	75,000	-	75,000	-	-	-	-	-	-
7.05 Programmes to reduce Gender Based Violence	-	-	-	-	-	-	-	-	-	-	-	-	-
7.98 Enabling Environment and Community Development not disaggregated by type	10,000	-	-	-	10,000	-	10,000	-	-	-	-	-	-
7.99 Enabling Environment and Community Development not elsewhere classified	-	-	-	-	-	-	-	-	-	-	-	-	-
8. Research excluding operations research	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
8.01 Biomedical research	-	-	-	-	-	-	-	-	-	-	-	-	-
8.02 Clinical research	-	-	-	-	-	-	-	-	-	-	-	-	-
8.03 Epidemiological research	-	-	-	-	-	-	-	-	-	-	-	-	-
8.04 Social science research	-	-	-	-	-	-	-	-	-	-	-	-	-
8.05 Vaccine-related research	-	-	-	-	-	-	-	-	-	-	-	-	-
8.98 Research not disaggregated by type	-	-	-	-	-	-	-	-	-	-	-	-	-
8.99 Research not elsewhere classified	-	-	-	-	-	-	-	-	-	-	-	-	-
Grand Total	**11,749,217**	**827,690**	**308,511**	**519,179**	**10,916,446**	**1,841,772**	**934,476**	**7,562,540**	**231,690**	**-**	**345,968**	**5,081**	**5,081**

Public	7.04	National	37.27
International	92.91	Sub National	62.73
Private	0.04		

Prevention	51.58
Treatment and Care	19.36
OVC	0.94
Programme Management	11.24
Human Resources	14.83
Social Protection	0.00
Enabling Environment	2.05
Research	0.00

Public	7.04
Bilateral	15.68
UN agencies	7.95
GFATM	64.37
Dev. Bank	1.97
Other Multilateral	0.00
Other Inter	2.94
Private	0.04

ANNEX 2: NATIONAL COMMITMENTS AND POLICY INSTRUMENT (NCPI)

NCPI Header

Country: Lao PDR

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any: Centre for HIV/AIDS/STI, Ministry of Health

Postal Address: Km3 Thadeua Road, Vientiane Capital, Lao PDR

Describe to process used for NCPI data gathering and validation: consultative meetings, and consolidation meeting for final results.

List of stakeholders:

NCPI Part A – administered by Government Agencies

Organisations	Names/Positions:
Department of Hygiene and Prevention, MOH	Dr. Douangchanh KeoAsa/Director General
Department of Hygiene and Prevention, MOH	Dr. Sibounhom Akkhavong/Head of Prevention Division
CHAS	Dr. Bounpheng Philavong/Director
CHAS	Dr. Phouthone Southalack/Deputy Director
CHAS	Dr. Chanthone Khamsibounheuang/Deputy Director
CHAS	Dr. Keophouvanh Douangphachanh/Head of Administrative and Technical unit
CHAS	Dr. Khanthanouvieng Sayyabounthavong/Head of STI unit
CHAS	Dr. Beuang Vang Van/Head of Planning unit
CHAS	Dr. Phengphet Phetvixay/Head of IEC unit
CHAS	Dr. Bouathong Simmavong/Technical M&E
CHAS	Dr. Siphone/Consultant M&E
CHAS	Dr. Ketmala Banchongphanith/Head of Surveillance and Treatment unit
CHAS	Dr. Amphone Philaket/Deputy Head of Planning unit
CHAS	Dr. Chanvilay Thammachak/Technical of Surveillance and Treatment unit
Ministry of Education and Sport	Ms. Chanthavone Phandoung/HIV and AIDS Focal Point
Ministry of Information, Culture and Tourism	Mr. Vayolinh Phrasavath/Deouty Director of Cabinet
Ministry of Public Work and Transport	Mr. Bandith Sulayakham/HIV and AIDS Focal Point
Ministry of Labour and Social Welfare	Ms. Phanthaly/HIV and AIDS Focal Point
Ministry of National Defence	Dr. Chanthaphone Oudomsouk/NCCA member
Ministry of Public Security	Ms. Kongchinh Sihavong/HIV and AIDS Focal Point
Lao Red Cross	Dr. Soulany Chansy/HIV and AIDS Focal Point

Lao Youth Union	Mr. Thongdeng Sonepraseuth/HIV and AIDS Focal Point
Lao Women Union	Ms. Lavanh/HIV and AIDS Focal Point
CHAS	Dr. Phouthaly Keomoukda/Deputy Head of IEC unit
CHAS	Dr. Latthiphone Oula/Deputy Head of STI unit
CHAS	Dr. Khanti Thongkham/Technical Official
National Blood Bank	Dr. Chanthala Souksakhone/HIV and AIDS Focal Point

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

Organization	**Names/Positions**
UNAIDS	Dr. Pascal Stenier/UNAIDS Country Coordinator
UNAIDS	Dr. Khamlay Manivong/National Country Programme Adviser
UNFPA	Ms. TA Garraghan/ASRH & HIV Coordination
UNFPA	Ms. Viengthong/ ASRH & HIV Coordination
UNICEF	Ms. Suzie Albone/ HIV and AIDS Focal Point
UNICEF	Ms. Onevanh Phiahouaphanh/HIV and AIDS Focal Point
UNODC	Mr. Sendeuane Phomavongsa/National Project Officer
UNODC	Mr. Soulivanh Phengsy/HAARP National Programme Officer
UNWOMEN	Mr. Tingthong Phetsavong/HIV and AIDS Focal Point
WHO	Dr. Dominique Ricard/Medical officer HIV/AIDS/STI
World Bank	Dr. Phetdara Chanthala/Operation Officer
ADB	Ms. Emiko Masaki/HIV Regional
ADB	Ms. Phoxay Xayyavong/ HIV and AIDS Focal Point
Burnet Institute	Dr. Niramon Chanlivong/Project Manager
FHI	Ms. Phayvieng Philakone/Project Manager
LaoPHA	Mr. Viengakorn Sourivong/Project Manager
LNP+	Mr. Kynoi Phongdeth/Chair of PLNP+
NCA	Mr. Phonsavanh Chansy/Project Coordinator
PEDA	Mr. Santi Douangpaseuth/Director
PSI	Mr. Rob Gray, Project Manager
APHEDA	Mr. Khampasong Siharath, Lao Programme Manager
ESTHER	Ms. Somchay, Project Coordinator
World Vision	Dr. Sanya Vathanakoune/National HIV/AIDS/STI Coordinator

NATIONAL COMMITMENTS AND POLICY INSTRUMENT (NCPI)

Part A [to be administered to government officials]

I. STRATEGIC PLAN

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

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

[Yes]	No

IF YES, what was the period covered *[write in]*: 2011- 2015

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. ***IF NO or NOT APPLICABLE***, briefly explain why
- Emphasize on both coverage and quality of the services - Incorporate low-risk men under same category of "clients of sex workers" in this current NSAP, instead of individual sub-groups as written in the previous NSAP - Budget required for this NSAP is double the amount required for the last NSAP period - The current NSAP sets ambitious targets to reach Universal Access in 2015

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]*: CHAS/ MOH NCCA

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 and Social Welfare	**[Yes]**	No	**[Yes]**	No
Military/Police	**[Yes]**	No	**[Yes]**	No
Transportation and Public Work	**[Yes]**	No	**[Yes]**	No
Women	**[Yes]**	No	**[Yes]**	No
Young People	**[Yes]**	No	**[Yes]**	No
Other *[write in]*:	**[Yes]**	No	**[Yes]**	No
Lao Red Cross				
Information, Culture and Tourism Lao Trade Union; Civil Society				

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-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		
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
Sex workers	**[Yes]**	No
Transgendered people	**[Yes]**	No
Women and girls	**[Yes]**	No
Young women/young men	**[Yes]**	No
Other specific vulnerable subpopulation[1]: 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/or 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?

[1] Other specific vulnerable populations other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners and refugees)

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

KEY POPULATIONS
SW; MSM; PUD/PWID; Young people; Men with multiple partners

1.5. Does the multisectoral strategy include an operational plan? ***[YES]***

1.6. 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 progamme implementation?	**[Yes]**	No	N/A
E) A monitoring and evaluation framework?	**[Yes]**	No	N/A

1.7. Has the country ensured "full involvement and participation" of civil society[2] in the development of the multisectoral strategy?

Active involvement	**[Moderate involvement]**	No involvement

IF ACTIVE INVOLVEMENT, briefly explain how this was organised:

IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case:
- CSO attended all consultative meetings during the development process, however, their contribution was still limited due to the lack of English language skills to understand and take part in the discussion fully. - The contribution and participations from local organisations could have been stronger. - All partners are invited to and they endorsed the strategy after the consolidation meeting including the national strategy and the plan of action with specific activities and budget allocation - Government agencies got invited to all meetings for planning and report outcome of HIV related activities

[2] Civil society includes among others: networks and organisations of people living with HIV, women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

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

[Yes]	No	N/A

1.9. 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

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

[Yes]	No	N/A

2.1. IF YES, is support for HIV integrated 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
Sector-wide approach	**[Yes]**	No	N/A
Other *[write in]*:			

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 PLANS			
HIV impact alleviation	**[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 security or other schemes)	**[Yes]**	No	N/A
GF support free antiretroviral therapy for eligible PLHIV	**[Yes]**		

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

[Yes]	No	N/A

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 strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

[Yes]	No

5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS? [3]

[Yes]	No

5.1. Have the national strategy and national HIV budget been revised accordingly?

[Yes]	No

5.2. 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

5.3. Is HIV programme coverage being monitored?

[Yes]	No

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

[Yes]	No

(b) ***IF YES***, is coverage monitored by population groups?

[Yes]	No

IF YES, *for which population groups?*
MSM; sex workers; IDU/DU; pregnant women; children
Briefly explain how this information is used:
- for planning, follow up on activities; supervising the achievement of indicators/targets

(c) Is coverage monitored by geographical area?

[Yes]	No

IF YES, *at which geographical levels (provincial, district, other)?*
Provincial and Districts

[3] Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, A/RES/65/277, 10 June 2011

Briefly explain how this information is used:
- Planning, supervision, informing decision-making; fund-raising - Reporting; advocacy

5.4. Has the country developed a plan to strengthen health systems?

[Yes]	No

Please include information as to how this has Impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:
- HIV is one of the components of the health sector; and the HIV-related infrastructure, human resource, capacity and logistical system is within the framework of the NHSDP. It supports and strengthens the development of the health sector in general. (For example: GF Health system strengthening component; The capacity building for staff of other sectors - those are members of the NCCA e.g. infrastructure project;

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 2011?

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

Since 2009, what have been key achievements in this area:
- Other Government Agencies (Transport, Public Security, Women Union, Lao Red Cross) have developed its own HIV strategy with HIV component and budget allocation included. - The new HIV law just been approved by the national assembly and the President - New strategy and action plan with budget for 2011- 2015 develop with full participation and endorsement of partners - Despite the global situation and funding gaps, funding for 2011 and 2012 mostly have been secured.
What challenges remain in this area:
- Technical assistance: need external technical support for strategy and plan development; - Local expertise, if available, is hard to mobilize - Limited resources, both financial and human resources. Need to mobilize more fund for 2013 onward.

II. POLITICAL SUPPORT AND LEADERSHIP

Strong political support includes: government and political leaders who regularly speak out about HIV/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

B. Other high officials at sub-national level

[Yes]	No

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

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:
- Ministers of Health, Major of Vientiane Capital went for a "Walk for AIDS" campaign on World AIDS Day 2011. - The minister of health talked about the issues of stigma and discrimination to PLHIV on the occasion of World AIDS Day

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

[Yes]	No

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:	**[Yes]**	No
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?* Prof. Dr. Eksavang Vongvichith - Minster of Health.		

Have a defined membership?	**[Yes]**	No

***IF YES**, how many members?*	**14**	
Include civil society representatives?	**[Yes]**	No
***IF YES**, how many?*	***4 mass organizations***	
Include people living with HIV?	Yes	**[No]**
***IF YES**, how many?*		
Include the private sector?	Yes	**[No]**
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	**[Yes]**	No

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

IF YES, briefly describe the main achievements:
- 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 to oversight the implementation of all GFATM grants. - NCCA network goes down to district level is responsible for coordinating the implementation of the AIDS response.
What challenges remain in this area:
- Limited time of the members of NCCA to fully participate in HIV programme. - Cross-sectoral coordination needs to be improved for more effective participation, especially with civil society. - 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? 9% (for national civil society only)

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]:		

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

Yes	**[No]**

6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?

[Yes]	No

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:

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 2011?

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

Since 2009, what have been key achievements in this area:
- HIV Law was passed by the National Assembly and promulgated by the President afterward. - New chair of NCCA confirms the national commitment to achieve MDGs (including MDG6) and reaching Three Zero strategies. - The five year NSAP 2011-2015 with costed mulit-sectoral plan has been approved and implemented. - 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. - HIV was in the agenda of the Round Table Meeting, especially for fund raising
What challenges remain in this area:
- Limited 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.

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 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
Transgendered people	**[Yes]**	No
Women and girls	**[Yes]**	No
Young women/ young men	**[Yes]**	No
Other specific vulnerable subpopulations [write in]:	Yes	No

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

[Yes]	No

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 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 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 organization (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, affiliated ministries.

- National Assembly has gone to selected provinces and communities to address the contents of the law to the public
- It is too early to have a view on the implementation of the HIV law.

2. Does the country have laws, regulations or policies that present obstacles[34] to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

[Yes]	No

IF YES, for which key populations and vulnerable groups?		
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
Transgendered 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:

Penal Law:

Article 122: Prostitution **-** Any individual making a living by selling their bodies for sexual use is punishable of three months to one year of imprisonment or of correctional penalties without privation of liberty. Any individuals providing assistance or facilities to acts of prostitution, is punishable of three months to one year of imprisonment or of correctional penalties without privation of liberty.

Law on anti-drugs and crimes prohibits injecting drugs.

Law on Illicit Drugs (unofficial translation):
Article 52: Criminal Measure - Any person who produce, mixture, trades, distribute, possession, transport, import, export or causes the transit through the Lao PDR for drugs type I: heroin, tetrahydro cannabinol and others will received different sentences from fine of 2million to 5 million LAK to maximum death penalty depending on the amount of drugs confiscated**.**

Briefly comment on how they pose barriers:

The work of peer-lead interventions requires sensitization of the local authorities in order to create an enable environment for them to reach out and work with sex workers and PWID - which under these law can be considered as illegal. Though it's stated differently in the Law on HIV - that Sex workers and PWID are patients.

IV - PREVENTION

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

[Yes]	No

IF YES, what key messages are explicitly promoted?		
Abstain from injecting drugs	**[Yes]**	No
Avoid commercial sex	**[Yes]**	No
Avoid inter-generational sex	**[Yes]**	No
Be faithful	**[Yes]**	No
Be sexually abstinent	**[Yes]**	No
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 in 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

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?

[Yes]	No

2.1. ***Is HIV education part of the curriculum in***

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 age-appropriate, 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

Briefly describe the content of this policy or strategy:
NSAP (page 29) - 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 Policy for HIV/AIDS/STI in Lao PDR: (page 7) - In-school Youth: School children will be equipped with skills, knowledge and attitudes to avoid AHIV 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. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable populations?

[Yes]	No

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	Customers of Sex Workers	Prison inmates	Other populations38 *[write in]*
Condom promotion	x	x	x	X		
Drug substitution therapy						
HIV testing and counseling	x	x	x			General population
Needle & syringe exchange	x					
Reproductive health, including sexually transmitted infections prevention and treatment	x		x			Youth
Stigma and discrimination reduction	x	x	x			General population
Targeted information on risk reduction and HIV education	x	x	x			
Vulnerability reduction (e.g. income generation)	x					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 2011?

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

Since 2009, what have been key achievements in this area:
- Prevention coverage by peer-lead Interventions to SW and MSM has increased - 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 are broadly available - Drop-in-centre in partnership with civil society is functioning
What challenges remain in this area:
- Quality of preventive interventions need to be improved. - 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 updated.

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

Yes	No

***IF YES,* how were these specific needs determined**?
- 100% condom use programme. Most at risk population easily access to condom - Sex workers have access to STI services - Infants born to identified HIV + mothers receive ART - Young women and men correctly identify ways of preventing sexual transmission of HIV
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				**[x]**	
Condom promotion				**[x]**	
Harm reduction for people who inject drugs		**[x]**			
HIV prevention for out-of-school young people		**[x]**			
HIV prevention in the workplace		**[x]**			
HIV testing and counseling			**[x]**		
IEC39 on risk reduction			**[x]**		
IEC on stigma and discrimination reduction			**[x]**		

Prevention of mother-to-child transmission of HIV		**[x]**			
Prevention for people living with HIV				**[x]**	
Reproductive health services including sexually transmitted infections prevention and treatment			**[x]**		
Risk reduction for intimate partners of key populations		**[x]**			
Risk reduction for men who have sex with men			[x]		
Risk reduction for sex workers				**[x]**	
School-based HIV education for young people			**[x]**		
Universal precautions in health care settings			**[x]**		
Other*[write in]*:					

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 2011?

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

IF YES, briefly describe the elements and what has been prioritized:
- 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 treatment, care and support services are being scaled-up?
- Increase VCT coverage - Involvement of community based organizations, networks and associations to take part in care and supports and referral for treatment. - Referral system for ART from drop-in-centres that target 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				**[x]**	
ART for TB patients				**[x]**	
Cotrimoxazole prophylaxis in people living with HIV			**[x]**		
Early infant diagnosis		[x]			
HIV care and support in the workplace (including alternative working arrangements)		[x]			
HIV testing and counselling for people with TB				**[x]**	
HIV treatment services in the workplace or treatment referral systems through the workplace		[x]			
Nutritional care		**[x]**			
Pediatric AIDS treatment		**[x]**			

The majority of people in need have access to….	**Strongly disagree**	**Disagree**	**Agree**	**Strongly agree**	**N/A**
Post-delivery ART provision to women		**[x]**			

Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)		**[x]**			
Post-exposure prophylaxis for occupational exposures to HIV			**[x]**		
Psychosocial support for people living with HIV and their families		**[x]**			
Sexually transmitted infection management				**[x]**	
TB infection control in HIV treatment and care facilities				**[x]**	
TB preventive therapy for people living with HIV				**[x]**	
TB screening for people living with HIV				**[x]**	
Treatment of common HIV-related infections				**[x]**	
Other*[write in]*:					

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:
- Set up revolving funds for PLHIV and those affected by AIDS - Vocational promotion for PLHIV and those affected by AIDS

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?*
GFATM procurement system for ARV, condoms and essentials drugs and test kits.

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 implementation of HIV treatment, care, and support programmes in 2011?

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

***Since 2009**,* what have been key achievements in this area*?*
- Increased number of people receiving ART both in children and adults - Treatment guidelines and PMTCT guidelines are printed and disseminated - Equal access to ART treatment and care and supports - Co-management of TB and HIV; TB/HIV guideline printed and disseminated - Increasing VCT coverage

- More civil society involvement in care and supports at community - Good monitoring system
What challenges remain in this area:
- GFATM procurement procedures sometimes causes stock-out of commodities - Highly dependent on GFATM supports for treatment - PLHIV still come for treatment at late stage, when CD4 count is already very low (less than 200)

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

[Yes]	No	N/A

6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

[Yes]	No

6.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	**[No]**

6.3. IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

[Yes]	No

6.4. IF YES, what percentage of orphans and vulnerable children is being reached?

N/A

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 2011?

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

Since 2009*,* what have been key achievements in this area*?*
- Increased number of people receiving ART both in children and adults - Equal access to ART treatment and care and supports - Co-management of TB and HIV - Increasing VCT coverage - More civil society involvement in care and supports at community - Good monitoring system
What challenges remain in this area:
- GFATM procurement procedures sometimes causes stock-out of commodities - Highly dependent on GFATM supports for treatment - PLHIV still come for treatment at later stage. - Dry blood test for early infant diagnostic is not available in Lao PDR

VI – MONITORING & EVALUATION

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

Yes	**In Progress**	No

Briefly describe any challenges in development or implementation:
- There is shortage of M&E staff at all levels - Lack of unified routine data collection system - Capacity of staff who collect data at primary level is need of training - Lack of a feedback and quality assurance system - Strategic information has not been used fully, hence lack of the needs to develop a functional unified system - Behavioural data are still collected on ad-hoc bases.

***1.1. IF YES, years covered** [write in]:*

2011-2015

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

Briefly describe what the issues are:
The M&E system has not yet fully functioned. The plan and framework has not yet finalised. There will be opportunity for all partners, including CSO to take part if these plans are to be finalised in the near future.

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy	**[Yes]**	No
IF YES, does it address:		
Behavioural surveys	**[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-defied standardised 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

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

3.5%

4. Is there a functional national M&E Unit?

Yes	**In Progress**	No

Briefly describe any obstacles:
- There is shortage of M&E staff at all level - Lack of unified routine data collection system - Capacity of staff who collect data at primary level is need of training - Lack of a feedback and quality assurance system - Strategic information has not been used fully, hence lack of the needs to develop a functional unified system - Budget of 3.5% is not enough

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 *[write in]*?	Yes	No

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

POSITION [write in position titles in space below]	Fulltime	Part time	Since when?
Head of Planning and M&E Unit	1		1998
Permanent staff	4		2005
	Fulltime	Part time	Since when?
M&E local consultant	1		2009

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

Briefly describe the data –sharing mechanism:
Key partners (national and international) are supposed to send their programme monthly reports to CHAS for compilation and analysis.
What are the major challenges in this area:
Coordination is the issues, many partners send their report late or only sent when requested. Many reports sent in incomplete.

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

Yes	**[No]**

6. Is there a central national database with HIV- related data?

Yes	**[No]**

IF YES, briefly describe the national database and who manages it:

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**

IF YES, but only some of the above, which aspects does it include?

6.2. Is there a functional Health Information System[40] ?

At national level	**[Yes]**	No
At subnational level	**[Yes]**	No
IF YES, at what level(s)? *provincial level*		

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

Yes	**[No]**

8. 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]*:	Yes	No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:
- Data was used to determine the target populations for the NSAP 2011- 2015. - Data also was used to guide preventive interventions for KAP. - Data was used for costing of the NSAP and resource allocations to partners.

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

At national level?	[**Yes**]	No
IF YES, what was the number trained: 79		

At subnational level? 61 at provincial level	[**Yes**]	No
IF YES, what was the number trained		
At service delivery level including civil society?	Yes	**[No]**
IF YES, how many?		

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

[Yes]	No

IF YES, describe what types of activities
USCDC supported estimation and projection workshop series in 2010-2011 have served two purpose: produce estimations and projections for the Lao epidemic; and to build capacity of CHAS in this area.

10. 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 2011?

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

Since 2009, what have been key achievements in this area*?*
- The use of data for NSAP development. - Monitoring treatment and prevention programmes.
What challenges remain in this area:
- The use of data for NSAP development. - Monitoring treatment and prevention programmes.

_____

40 Such as regularly reporting data from health facilities which are aggregated at district level and sent to national level; data are analysed and used at different levels)?

NATIONAL COMMITMENTS AND POLICY INSTRUMENT (NCPI)

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

I. CIVIL SOCIETY INVOLVEMENT

For the purposes of this document to assess civil society involvement it is necessary to clarify the different dimensions of civil society in the Lao context. Local / Lao civil society organizations have been in existence for over 20 years and have been affiliated or registered with Lao Front and LUSEA. The Decree on Associations of April 2009 provided a legal framework for the development of Non-profit Associations (NPAs). Currently many Local NPAs are in the registration process but only a handful has completed the registration process. International NGOs are also considered part of civil society and play a key role in reaching HIV key affected populations.
In Lao PDR, Mass organizations such as the Lao Youth Union, Lao Women's Union have also been considered part of civil society due to their broad mandate and structures that reach down to the community level. However, mass organizations are part of the government and party structure, with status equivalent to a Line ministry.
The ratings for civil society involvement are slightly lower in the 2012 GAPR compared to the previous UNGASS. This reflects changes in the political and supporting environment for local CSO involvement. Ratings are given based on greater expectations of the role NPAs can play and the extent to which NPAs have been able to move from participation to more active contribution.

1. ***To what extent (on a scale of 0 to 5 where o 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
- The Law on HIV/AIDS control and prevention: CSO was invited to comment and attend all consultative meetings during the development process of the law. - CSO were recognized and mentioned in all HIV/AIDS work plans - CSO were not identified as valuable participants in informing government policy until recently, after the Decree on Association Establishment was signed in 2009. As such, many civil society organizations have not been invited to participate in policy discussions on a national level. The President of LNP+ did participate in the development of the National Strategic Action Plan on HIV/AIDS/STIs 2011-2015 and the HIV Law, signed in 2010, on a tokenistic level. - Compare to the previous period, civil society has been invited to take part in the development processes of the national strategy on AIDS and on the draft law on HIV. However, to reach to strengthening political commitment of top leaders, CSO has not been taken part at presidential or Prime Minister level. Their contribution mainly at raising awareness at technical level. To be able to strengthening the commitment of top leader, CSO needs to form a stronger network/platform to enhance their roles and participation. - Highlight of their involvement was the event in which a representative of LNP+ was invited to attend the intersession of the National Assembly meeting, together with the Centre for HIV/AIDS/STI. The discussion was on reaching MDG 6 and this provided a positive experience for both CSO and for the member of the National Assembly. - CSO was also invited to comment of the draft law on HIV/AIDS. The comments are strongly on against stigma and discrimination, and their rights to have access to care and treatment and other services, including supports to PLHIV and their families.

2. *To what extent (on a scale of 0 to 5 where o is "Low" and 5 is "High") have civil society representatives been involved in the planning and budgeting process of 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 Law on HIV/AIDS control and prevention: CSO was invited to comment and attend all consultative meetings during the development process of the law. - CSO were recognized and mentioned in all HIV/AIDS work plans - CSO were not identified as valuable participants in informing government policy until recently, after the Decree on Association Establishment was signed in 2009. As such, many civil society organizations have not been invited to participate in policy discussions on a national level. The President of LNP+ did participate in the development of the National Strategic Action Plan on HIV/AIDS/STIs 2011-2015 and the HIV Law, signed in 2010, on a tokenistic level. - Compare to the previous period, civil society has been invited to take part in the development processes of the national strategy on AIDS and on the draft law on HIV. However, to reach to strengthening political commitment of top leaders, CSO has not been taken part at presidential or Prime Minister level. Their contribution mainly at raising awareness at technical level. To be able to strengthening the commitment of top leader, CSO needs to form a stronger network/platform to enhance their roles and participation. - Highlight of their involvement was the event in which a representative of LNP+ was invited to attend the intersession of the National Assembly meeting, together with the Centre for HIV/AIDS/STI. The discussion was on reaching MDG 6 and this provided a positive experience for both CSO and for the member of the National Assembly. - CSO was also invited to comment of the draft law on HIV/AIDS. The comments are strongly on against stigma and discrimination, and their rights to have access to care and treatment and other services, including supports to PLHIV and their families.

3. *To what extent (on a scale of 0 to 5 where o 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
- The work / services provided by CSO has been included in the NASP

- CSO participated in all work plans on HIV/AIDS control and prevention according the strategic plan on care and supporting
- The National HIV Strategy acknowledges the role of civil society organizations in the HIV response in the Lao PDR.
- LNP+ has never received any direct funding from the national HIV budget source.
- The NSAP development was participatory, and it reflects contributions from government, civil society and development partners. All these stakeholders participated in the Core Team for the NSAP review and revision, several technical working groups, and consultation workshops. Their contribution was also taken as input in the document. Experiences from CSO in service delivery, such as home care and support; prevention surveys together with INGOs experiences also used to feed up to the policy dialogue and formulation process
- Compare to last reporting period, there is increase in CSO involvement during the planning and budget phases of the AIDS programme, however, more could have been done in term of policy development and strategic information.
- During the budgeting phase, CSO was invited to comment on draft version. Since all CSO, except one, are recipient of funds, it's very little of what can be contributed to the national budget. However, there's allocation of budget to reach to CSO in the National Strategy. The only CSO organization that finances and implements their activities is World Vision.
- CSO does not report to National AIDS programme on their activities, but when required, they will report. There's a reporting system set up by the national programme, but there's lack of monitoring system to make sure reports are submitted on regular basis. For some small organization, they report their activities under their umbrella organization who then report to the national programme when required.

4. *To what extent (on a scale of 0 to 5 where is "Low" and 5 is "High")is civil society included 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
- A National M&E plan has not been finalised. So has the functioning of the national M&E working group, therefore there is not yet opportunity for LNP+ to participate in these activities. - LNP+ does provide reports on their activities to the government - For the M&E plan, GF supported M&E activities has been integrated in the draft national M&E plan. Therefore in term of CSO participation and involvement, mainly the GF sub-recipients participated and contributed actively throughout the process such as M&E planning, consultations. The national M&E plan is currently under review and not yet been finalized. - M&E reference group has just been formulated. The group so far has met on ad-hoc bases and a

TOR has not been established. However, data are reported for utilization of different purposes
- CSO also invited to take part in surveys to collect data that will feed in the national strategic information system.

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

Low					High
0	1	2	(3)	4	5

Comments and examples

- There have been increasing number or organizations / networks take part in the national AIDS programme, especially after the PM's Decree on association
- LNP+ is an active participant in both the Oversight Committee and Country Coordinating Mechanism of the Global Fund in the Lao PDR.
- Since the approval of the Prime Minister's Decree on Association Establishment in 2009, very few CSO organizations have registered. Lao PHA and LNP+ are new addition to the already existing CSO organizations that have been registered such as Buddhist association, Lao Youth Union, Women Union. What should be noted is that these two new organizations working on AIDS programme that registered in the last two years are organizations that founded by and for PLHIV. The LNP+ just officially been registered as association early 2012.

6.*To what extent (on a scale of 0 to 5 where o 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 implement its HIV activities?

Low					High
0	1	2	(3)	4	5

Comments and examples

- Government budget is not sufficient
- Insufficient technical staff required
- Finding sustainable sources of financial support is difficult and as mentioned above LNP+ receives no direct funding from the government.
- LNP+ receives technical support from a variety of stakeholders, including but not limited to Centre for HIV/AIDS Statistics (CHAS), UN Agencies, Lao Red Cross, French Red Cross, INGOs working in Lao PDR and international networks of PLHIV. Technical support from the government is limited to CHAS
- So far, the Government and its international partners (including UN and INGOs) have provided both financial and technical supports to strengthen capacity and effectiveness of CSO. Progress has been made. However, capacity of CSO to spot opportunity and to fund raise was still the issue of discussion during the process to complete this form. This leads to insufficient reporting of the actual AIDS situation in Lao PDR. Consequently, donors to do not feel strongly committed to

strengthen their support to the Lao National AIDS programme.
- There's a shift on the view of how technical assistance should be delivered. Technical assistant agencies still the main driver in this area and in this case. It should be that technical support needed should be identified and indicated by CSO and technical assistance to be available if there's a request. What is expected more from CSO is if they would be more self-motivated to identify and indicate what technical assistance they. The scenario is changing, there have been more organizations seeking for Technical assistance and have received it.

7. *What percentage of the following HIV programme/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%)
Transgendered people	<25%	25-50%	51-75%	(>75%)
Testing and Counselling	<25%	(25-50%)	51-75%	>75%
Reduction of Stigma and Discrimination	<25%	(25-50%)	51-75%	>75%
Clinical services (ART/OI)*	<25%	(25-50%)	51-75%	>75%
Home-based care	<25%	25-50%	(51-75%)	>75%
Programmes for OVC**	<25%	25-50%	51-75%	(>75%)

**ART= Antiretroviral Therapy; OI = Opportunistic infections*
***OVC = Orphans and other vulnerable children*

8. *Overall, on 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 2011?*

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

Since 2009, what have been key achievements in this area:

- The government has given opportunities to any organization to register in the ministry of public security. There have been more than 200 organizations registered.
- Many organization boost up to support HIV/AID project plans.
- All intended targets have been achieved: The Decree on Associations in 2009 allows civil society organizations to be registered as Non-Profit Associations and recognized as legitimate actors in the HIV and AIDS response.
- 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 recognized and accepted
- All existing CS has been encouraged to be part of the national AIDS programme. Civil society organizations 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

intervention for Sex Workers with participation from Lao PHA and CHAS. SELNA also supports the implementation of the newly approved Lao on HIV/AIDS through the development of a framework for reducing Stigma and increase access to service.
What challenges remain in this area:
- Funding to engage civil society in programme and funding to build capacity of civil society - Budget limited to HIV/AIDS workplan only - Condoms and STI drugs were not timely available for civil society to support their programme activities. - Participation is often tokenistic. Language barriers and limited skills inhibit civil society organizations from participating in a more meaningful way. Additionally neither civil society organizations or government bodies are particularly accustomed to collaboration in this way and therefore communication amongst these bodies is limited at best - 2 NGOs and one network (Lao PHA and LNP+) co-existed. There's the need to involve and establish more networks (e.g. SW, MSM networks….) diversify and boost organizational 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. POLITCAL SUPPORT AND LEADERSHIP

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

(Yes)	No

IF YES, describe some examples of when and how this has happened:

- In every process of getting advocacy, planning and implementation of programme, PLHIV, FSW and MSM are included in important meeting
- The people who living with HIV/AIDs can be the representative and participated in the government and international conference to comments on the laws on HIV/AIDs control and prevention in the national assembly.
- Due to political support from 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.
- However financial support is limited. Also only one person living with HIV is ever invited to participate in these meetings, and to the best of LNP+'s knowledge vulnerable populations are not involved
- Representatives of PLHIV are member of the CCS for GFATM. There's plan to include PLHIV in membership of Committee for AIDS Control at National and Provincial level – a TOR is being developed.
- 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 non-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
Transgendered 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**

IF YES to question 1.1 or 1.2, briefly describe the content of these laws:

- Lao has adopted the World AIDS Day in December 1st to be the National AIDS Day in order to encourage and mobilise efforts on AIDS control and prevention through various activities
- Law regarding the rights of PLHIV was signed in 2010.
- Law on the Development and Protection of Women was signed in 2004
- **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 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 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 organization (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:
• At present, not at all. 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 laws have not reached to all population due to the lack of efforts to disseminate and help communities understand the laws and their rights • Capacity of responsible line ministries to carry out their duty in law enforcement and implementation • Lack of a strong supportive legal structure for penalties for law disobedient

2. Does the country have laws, regulations or policies the present obstacles to 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
Transgendered people	Yes	**No**
Women and girls	Yes	**No**
Young women/ young men	Yes	**No**
Other specific vulnerable subpopulations [write in]:	Yes	**No**

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

[Yes]	**No**

Briefly describe the content of the policy, law or regulations and the populations included:
The Government provides counseling, economic supports 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

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

[Yes]	**No**

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:
- Rewards 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 ensconced 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.

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

Yes	**[No]**

IF YES, briefly describe this mechanism:
- The medical professional and people working in the area of HIV/AIDS should keep strictly keep confidential all information concerning HIV/AIDS patient whether they are still alive or already dead unless there is a court order a willingness of the person concerned - Not at present, although LNP+ is currently undertaking a baseline study into the experiences of stigma and discrimination against PLHIV as reported by them. This is the first step in creating a 'national observatory' which will act as the mechanism to record, document and address instances of discrimination against PLHIV.

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 at a cost	
Antiretroviral treatment	**[Yes]**	No	Yes	No	Yes	No
HIV prevention services44	**[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?
In regards to the above answers: - Antiretroviral treatment – this is provided free of charge to all PLHIV through the Global Fund. - HIV prevention services – testing is free to all, but other prevention services such as condoms are not. Much prevention services are provided by civil society organizations. - HIV-related care and support interventions – some of these costs are not covered (for example transportation); much of this is provided by civil society organizations. - 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 prioritized 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. Therefore, 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 hinder the efforts to reach these populations. - The Antiretroviral treatment policy has been funded 100% from external sources, it has been provided all free-of-charge to all people eligible to treatment in the country.

- HIV-related care and support interventions: i) community-based care to PLHIV and affected by HIV receive supports through CSO by building capacity and resources, as well as reduce barriers to access to social welfare, health services and education to these populations; ii) positive health – provide technical, organizational and financial support to self-help groups and network of PLHIV (LNP+) in all provinces (but not all PLHIV is member of a group or network)

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

7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth

[Yes]	No

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

IF YES, Briefly describe the content of the policy/ strategy and the populations included:
In the National Strategy, all Lao national has equal access to HIV programming National AIDS Strategy and Action Plan 2011-2015: - 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 this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?

[Yes]	No

IF YES, Briefly explain the different types of approaches to ensure equal access for different populations:
For FSW- Drop in Centre is the place to access services. MSMS also access drop in centre 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 including 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 purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes x	No

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

activities without stigmatization and discrimination

In article 52.7: Individual and other organsiations 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.)

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]**

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes	**[No]**

IF YES on any of the above questions, describe some examples:

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)[45] ?

[Yes]	No

b. Programmes for members of the judiciary and law enforcement[46] on HIV and human rights issues that may come up in the context of their work?

[Yes]	No

12. Are the following legal support services available in the country?

a. Legal aid systems for HIV casework

Yes	**[No]**

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

[Yes]	No

13. Are there programmes in place to reduce HIV-related stigma and discrimination?

	[Yes]	No
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]*:	**[Yes]**	No
Local authority		

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 2011?

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

Since 2009, what have been key achievements in this area:
- 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. This strategy was developed through a participatory and inclusive process with participation from all stakeholders with an evidence-based approach.
What challenges remain in this area:
- Dissemination the new law to key stakeholders has not been done intensively. - Lack of monitoring mechanism to regulate the implementation of this law - The implementation and enforcement of the laws is weak. - Contents of the laws have not reached to all general and concerned populations

15. Overall, on scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to implement human rights related to policies, laws and regulations in 2011?

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

Since 2009, what have been key achievements in this area:
What challenges remain in this area:
Despite the availability of HIV testing, people who 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

IF YES, how were these specific needs determined?
- Scaling up for prevention and control - 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 assessment of the implementation of the National AIDS Strategy 2006 – 2010; the UNGASS Country Progress Report 2010; 100% Condom Use Programme Assessment and GFATM monitoring indicators; National AIDS Routine Reporting system and other ad hoc studies.
IF NO, how are HIV prevention programmes being scaled-up?

1.1. To what extent has HIV prevention been implemented

HIV prevention component	The majority of people In need have access to				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety				(x)	
Condom promotion				(x)	
Harm reduction for people who inject drugs		(x)			
HIV prevention for out-of-school young people		(x)			
HIV prevention in the workplace		(x)			
HIV testing and counselling		(x)			
IEC on risk reduction			(x)		
IEC on stigma and discrimination reduction		(x)			
Prevention of mother-to-child transmission of HIV	(x)				

HIV prevention component	The majority of people In need have access to				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Prevention for people living with HIV		(x)			
Reproductive health services including sexually transmitted infections prevention and treatment		(x)			
Risk reduction for intimate partners of key populations		(x)			
Risk reduction for men who have sex with men		(x)			
Risk reduction for sex workers			(x)		
School-based HIV education for young people		(x)			
Universal precautions in health care settings			(x)		

Other*[write in]*: - Migrant workers - Factory workers			(x)		

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 2011?*

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

Since 2009, what have been key achievements in this area:
- The programme has reached high overage of target population - 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:
- Funding to continue and replicate good practice has been the challenge - Condoms and STI drugs were not timely available for implementers - Given the rising statistics of people infected with HIV, challenges remain across the board. - The statistics used are narrow and out of date so do not inform HIV prevention programmes effectively. - Prevention programmes are mainly run by civil society organizations with limited financial resources. - There is no national testing campaign and the appropriate populations are not tested. - It is only recently that injecting drug users have been acknowledged as populations that are at risk - Low ANC coverage - Low school attendance - Coordination among different stakeholders; between different sectors. - 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 supportservices?

[Yes]	No

IF YES, Briefly identify the elements and what has been prioritized:
Universal access Counselling, economic and social supports
Briefly identify how HIV treatment, care and support services have being scaled – up?
- The treatment for people living with HIV/AIDS that also have opportunity infections should follow instructions from the medical personal and receive ARV (Antiretroviral) drug according to the national guidance - 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: implement cross screening and cross treatment has been recognized and initiated at central level (CHAS and TB Centre) 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: the pilot project on community based nutrition counseling for PLHIV is to close, lessons learnt from this project should be disseminated nationwide. There's a plan to include PLHIV to the target populations of the National Nutrition Programme as coverage extension and for sustainability.

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

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy			[x]		
ART for TB patients			[x]		
Cotrimoxazole prophylaxis in people living with HIV				[x]	
Early infant diagnosis				[x]	
HIV care and support in the workplace (including alternative working arrangements)			[x]		
HIV testing and counselling for people with TB			[x]		
HIV treatment services in the workplace or treatment referral systems through the workplace		[x]			
Nutritional care		[x]			
Paediatric AIDS treatment				[x]	
Post-delivery ART provision to women			[x]		

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	[x]				
Post-exposure prophylaxis for occupational exposures to HIV		[x]			
Psychosocial support for people living with HIV and their families	[x]				
Sexually transmitted infection management			[x]		
TB infection control in HIV treatment and care facilities			[x]		
TB preventive therapy for people living with HIV			[x]		
TB screening for people living with HIV			[x]		
Treatment of common HIV-related infections				[x]	
Other[write in]: Referred to VCT/STI services			[x]		

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 2011?

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

Since 2009, what have been key achievements in this area:
- Basic VCT training manual (*Printed*) - National ARV guideline (*pre-printed*) - National OI guideline (*pre-printed*) - Standard operational procedure (SOP) for voluntary counselling and testing (*pre-printed*) - Practical manual for linked response for PMTCT *(CHAS, UNICE – pre-print)* - Minimum package for comprehensive treatment and care/continuum of care (COC) is being drafted - HIV – TB linkage has been initially implemented and scaled up nationally - PMTCT has been implemented to some extent - HIV – Nutrition has been implemented to some extent
What challenges remain in this area:
- 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 - ARV shortage and stock out - Procurement of ARV and HIV testing kits normally delayed - 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

- Efforts to set up the coordination mechanism for linkage programme – HIV/ TB; PMTCT; HIV Nutrition.
- Funding relies only on GFATM

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

[Yes]	No

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

[Yes]	No

2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

[Yes]	No

2.3 . IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

[Yes]	No

2.4. IF YES, what percentage of orphans and vulnerable children is being reached?

10 %

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 2011?

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

Since 2009, what have been key achievements in this area:
What challenges remain in this area:

ANNEX 3: LIST OF NCCA MEMBERS

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

ANNEX 4: DESCRIPTION OF REPORTING INDICATOR DATA

1.2. Sex Before the Age of 15

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

1.3. Multiple sexual partners

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

1.4. Condom Use During Higher Risk-Sex

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

1.5. HIV Testing in the General Population

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

1.6. Reduction in HIV Prevalence

Indicator Relevance:

Topic not relevant (Go to next indicator)

1.7. Sex workers: Prevention Programme

- Indicator Relevance: Topic relevant, indicator relevant, data available
- Survey and sampling methodology: Integrated Behavioural Surveillance Survey using simple random sampling method based on a nominative list.
- Please specify data measurement tool: The cross sectional survey using was conducted among sex workers in six provinces Luang Prabang, Vientiane capital, Bokeo, Luang Namtha, Savannakhet, Champasak.
- Data Collection Period: Wed, 2011-12-14 - Thu, 2011-12-29
- Additional information related to entered data. e.g. reference to primary data source (please send data to AIDSreporting@unaids.org if possible), methodological concerns:

  Consistent condom use in the last 1, 3 months; Breakdown of data to provinces, educational level; drug use; marital status; sexual contacts; knowledge and STI status. This survey is conducted among female sex workers only, hence data on male sex workers is not available for reporting.

Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source. Please send data to AIDSreporting@unaids.org if possible:

- Sample Size: Number of Survey Respondents: 1434

	All sex workers	Male	Female	<25	25+
Percentage (%) Percentage of sex workers who answered "Yes" to both questions	55.02	Missing	55.02	53.62	64.06
Numerator Number of sex workers who answered "Yes" to both questions	789	Missing	789	666	123
Denominator Total number of sex workers surveyed	1434	Missing	1434	1242	192
Percentage (%) Percentage of sex workers who answered "Yes" to question 1, "Do you know	57.88	Missing	57.88	56.36	67.71

where you can go if you wish to receive an HIV test?"					

Numerator Number of sex workers who replied "yes" to question 1	830	Missing	830	700	130
Denominator Total number of sex workers surveyed 1434 missing 1434 1242 192	1434	Missing	1434	1242	192
Percentage (%) Percentage of sex workers who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "	86.75	Missing	86.75	86.15	90.63
Numerator Number of sex workers who answered "Yes" to question 2 1244 missing 1244 1070 174	1244	Missing	1244	1070	174
Denominator Total number of sex workers surveyed	1434	Missing	1434	1242	192

1.8. Sex workers: Condom use

- Indicator Relevance: Topic relevant, indicator relevant, data available (Submit specified data)
- Survey and sampling methodology: Integrated Behavioural Surveillance Survey using simple random sampling method based on a nominative list.
- Please specify data measurement tool: A cross-sectional survey was conducted in 2009, using questionnaire on Integrated Biological and Behavioural Surveillance Survey. The survey was conducted in 6 provinces in December 2011
- Data Collection Period: Wed, 2011-12-14 - Thu, 2011-12-29
- Additional information related to entered data. e.g. reference to primary data source (please send data to AIDSreporting@unaids.org if possible), methodological concerns:
  Break down of data by province. Data on consistent condom use in 1 and 3 months, breakdown by age and province Information on drug use, marital status, sexual history, sexual violence, STI status and sexual partners For this question, the denominator is smaller than the total surveyed respondents because 29 respondent reported having not remembered whether they had sex or not in the last 12 months.

Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source. Please send data to AIDSreporting@unaids.org if possible:
Sample Size: Number of Survey Respondents: 1434

	All sex workers	Male	Female	<25	25+
Percentage (%) Percentage of female and male sex workers reporting the use of a condom with their most recent client	92.46	Missing	92.46	92.54	91.89
Numerator Number of female and male sex workers reporting the use of a condom with their most recent client	1299	Missing	1299	1129	170
Denominator Number of sex workers who reported having commercial sex in the last 12 months	1405	Missing	1405	1220	185

1.9. Sex workers: Testing

- o Indicator Relevance:
- o Topic relevant, indicator relevant, data available (Submit specified data)
- o Survey and sampling methodology:
- o Behavioural Surveillance Survey (please specify sampling strategy and location)
- o Please specify data measurement tool:
- o A cross-sectional survey was conducted in 2009 by using Questionnaire on Integrated Biological and Behavioural Surveillance Survey applying respondent driven sampling methods. The survey was conducted in 6 provinces in December 2011.
- o Data Collection Period: Wed, 2011-12-14 - Thu, 2011-12-29
- o Additional information related to entered data. e.g. reference to primary data source (please send data to AIDSreporting@unaids.org if possible), methodological concerns:
  Break down of data by province. Data on consistent condom use in 1 and 3 months, breakdown by age and province Information on drug use, marital status, sexual history, sexual violence, STI status and sexual partners.

Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source. Please send data to AIDSreporting@unaids.org if possible:
Sample Size: Number of Survey Respondents: 1434

	All sex workers	Male	Female	<25	25+
Percentage (%) Percentage of sex workers who received an HIV test in the last 12 months and who know their results	22.25	Missing	22.25	21.34	28.13
Numerator Number of sex workers who have been tested for HIV during the last 12 months and who know their results	319	Missing	319	265	54
Denominator Number of sex workers included in the sample 1434 missing 1434 1242 192	1434	Missing	1434	1242	192

1.10. Sex workers: HIV prevalence

Indicator Relevance: Topic relevant, indicator relevant, data available (Submit specified data)
Data Measurement Tool: HIV/STI Integrated Biological Behavioural Surveillance (IBBS) which is a cross sectional survey using simple random sampling method based on a nominative list.
Data Collection Period: Wed, 2011-12-14 - Thu, 2011-12-29
Additional information related to entered data. e.g. reference to primary data source (please send data to AIDSreporting@unaids.org if possible), methodological concerns:
Break down of data by province. Data on consistent condom use in 1 and 3 months, breakdown by age and province Information on drug use, marital status, sexual history, sexual violence, STI status and sexual partners. Denominator is smaller than sample size because three respondents refused to give blood for HIV test.
Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source. Please send data to AIDSreporting@unaids.org if possible:
Sample Size: Number of Survey Respondents: 1434

	All sex workers	Male	Female	<25	25+
Percentage (%) Percentage of sex workers who are	0.98	Missing	0.98	0.81	2.08

HIV-infected					
Numerator Number of sex workers who test positive for HIV	14	Missing	14	10	4
Denominator Number of sex workers tested for HIV	1431	missing	1431	1239	192

1.11. Men who have sex with men: Prevention programmes

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

1.12. Men who have sex with men: Condom Use

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

1.13. Men who have sex with men: HIV Testing

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

1.14. Men who have sex with men: HIV Prevalence

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

2.1. People who inject drugs: Prevention Programmes

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

2.2. People who inject drugs: Condom Use

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

2.3. People who inject drugs: Safe Injecting Practices

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

2.4. People who inject drugs: HIV Testing

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

2.5. People who inject drugs: HIV Prevalence

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

3.1 Prevention of mother to child transmission

Indicator Relevance:

- Topic relevant, indicator relevant, data available (Submit specified data)
- Data Measurement Tool: Numerator from ANC/PMTCT and ART register
- Data Collection Period: Sat, 2011-01-01 - Sat, 2011-12-31
- Additional information related to entered data. e.g. reference to primary data source (please send data to AIDSreporting@unaids.org if possible), methodological concerns:
- There is data available for 2010 which: Total HIV-positive women received ARV drugs during the last 12 months to reduce MTCT:
  27 of which 3 received ARV prophylaxis and 1 received AZT. Percentage of HIV positive pregnant women who received ARV to reduce to the risk of MTCT: 8.5% (denominator: 3160)

Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source. Please send data to AIDSreporting@unaids.org if possible.

For the women reported as receiving an "Other" regimen, please describe the ARV regimen(s) and the number of women receiving each regimen category:

	Data value
Percentage (%) of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	14.63
Numerator Number of HIV-infected pregnant women who received antiretroviral during the last 12 months to reduce mother-to child transmission	49
Disaggregation by ARV regimen	
Single-dose Nevirapene only	0
Maternal AZT (Option A)	0
Maternal Triple ARV (Option B)	2
ART for HIV-infected pregnant women eligible for treatment	47
Other (including the number of women receiving the dual regimen according to the WHO 2006 PMTCT ARV guidelines).	0
Denominator Estimated number of HIV-infected pregnant women in the last 12 months	335

3.2. Early Infant Diagnostic

- Indicator Relevance: Topic relevant, indicator relevant, data available (Submit specified data)
- Data Measurement Tool: EID Testing laboratories and Spectrum estimates
- Data Collection Period: Sat, 2011-01-01 - Sat, 2011-12-31
- Additional information related to entered data. e.g. reference to primary data source (please send data to AIDSreporting@unaids.org if possible), methodological concerns:
  The samples for EID test have to be sent to laboratory in Thailand for testing and results. EID test is not available in Lao PDR.
- Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source. Please send data to AIDSreporting@unaids.org if possible:

	Data value
Percentage (%) of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	8.66
Numerator Number of infants who received an HIV test within 2 months of birth	29
Test results	
Positive	0
Negative	29
Indeterminate	0
Rejected by laboratory	0
Other	0
Denominator Number of HIV-infected pregnant women giving birth in the last 12 months	335

3.3. Mother-to-Child transmission rate (modelled)

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

4.1. HIV treatment: Antiretrovirals Therapy

- Indicator Relevance: Topic relevant, indicator relevant, data available (Submit specified data)
- Data Measurement Tool: Antiretroviral Therapy Patient Registers and ANC estimates
- Data as of: Sat, 2011-12-31
- Additional information related to entered data. e.g. reference to primary data source (please send data to AIDSreporting@unaids.org if possible), methodological concerns:

Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source. Please send data to AIDSreporting@unaids.org if possible:

	All adults and children	Male	Female	Sex unknown	<15	<1	1-4	5-14	>15	Age unknown
Percentage (%) Percentage of eligible adults and children currently receiving antiretroviral therapy	52.29	48.41	57.11	missing	32.13	missing	missing	missing	54.74	Missing
Numerator Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period	1988	1020	968	missing	133	missing	missing	missing	1855	Missing
Denominator Estimated number of adults and children with advanced HIV infection	3802	2107	1695	missing	414	missing	missing	missing	3389	missing

- Number of people on antiretroviral therapy through the private sector: missing
- Clarification: The denominator for this year report is calculated based on the ART needs of PLHIV with CD4 counts of 350 and less
- Number of eligible adults and children who newly initiated antiretroviral therapy during the reporting period:
- For period 2010-2011: 95 children and 361 adults initiated ART in 2010; for 2011: 246 adults and 31 adults newly initiated ART

4.2. HIV Treatment: 12 Months retention

- Indicator Relevance: Topic relevant, indicator relevant, data available (Submit specified data)
- Data Measurement Tool: Antiretroviral Therapy Patient Registers

- Data Collection Period: Fri, 2010-01-01 - Sat, 2011-12-31
- Additional information related to entered data. e.g. reference to primary data source (please send data to AIDSreporting@unaids.org if possible), methodological concerns:
- Sample Size of Survey Respondents: 456

Header All Males Females <15 15+

	All	Male	Female	<15	15+
Percentage (%) Percentage of adults and children with HIV known to be on treatment 12 months after initiating antiretroviral therapy If data on 12-month retention are not available for patients that initiated antiretroviral therapy in 2010 specifically, but available for patients that initiated antiretroviral therapy during an earlier time period (e.g. 2009 or 2008), please specify the period in the comment field above: Started antiretroviral therapy between [month]/[year] and [month]/[year]	87.50	85.40	89.57	88.42	87.26
Numerator Number of adults and children who are still alive and on ART at 12 months after initiating treatment	399	193	206	84	315
Denominator Total number of adults and children who initiated ART during the twelve months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up	456	226	230	95	361

	Lost to follow up	Stopped therapy	Died
Additional info: In addition to 'alive and on ART', please report other outcomes at 12 months after initiating treatment	22	1	34

5.1. Co-Management of Tuberculosis and HIV Treatment

Indicator Relevance: Topic relevant, indicator relevant, data available (Submit specified data)

Data Measurement Tool: Antiretroviral Patient Registers and Estimates from WHO Stop TB database

Data Collection Period: Fri, 2010-01-01 - Fri, 2010-12-31

Additional information related to entered data. e.g. reference to primary data source (please send data to AIDSreporting@unaids.org if possible), methodological concerns:

Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source. Please send data to AIDSreporting@unaids.org if possible:

For 2011, numerator data is available, breakdown by sex and age but denominator is not available. All cases: 146; male: 84; female: 62; <15: 2; >15: 144

	All	Male	Female	<15	15+
Percentage (%) Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	49.17	missing	missing	missing	Missing
Numerator Number of adults with advanced HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines), within the reporting	118	missing	missing	missing	missing

year					
Denominator Estimated number of incident TB cases in people living with HIV. Estimated Number of Incident TB cases in people living with HIV – the denominator for indicator	240	missing	missing	missing	Missing

6.1 AIDS Spending – see annex 1

7.1. National Commitment and Policy Instrument – see annex 2

7.2. Prevalence of Recent Intimate Partner Violence (IPV)

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

7.3. Orphans and non-orphans school attendance

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

7.4. Economic support for eligible households

Indicator Relevance:

Topic relevant, indicator relevant, data not available (Submit other data if available)

ANNEX 5: ROADMAP FOR GARP – COUNTRY REPORTING PROCESS

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

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