Lao People's Democratic Republic

National Committee for the Control of AIDS

UNGASS Country Progress Report 2010

Foreword

Lao People's Democratic Republic is unique in its HIV situation, and can be considered as the only country in the Greater Mekong Region that has maintained a low HIV prevalence in the general population. However Lao PDR's low prevalence does not mean low risk. As Laos' commitment to economic expansion transitions the country from "a landlocked to a land-linked country" the risk to HIV vulnerabilities is evident. Increased mobility across borders coupled with the existing sex worker-client vulnerabilities and the several emerging high-risk groups, places Lao PDR on a continued alert of a new HIV threat.

In response to its precarious HIV 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, and coordination and collaboration have strengthened greatly since the first UNGASS Country Progress report.

Lao PDR recognizes that the UNGASS Country Progress Report is an opportunity to reflect on advancements and scrutinize gaps to plan for remedial actions. The process of developing this report has served as a first step in the evaluation of the current National Strategic and Action Plan for HIV/AIDS (NSAP) 2006 -2010 which is coming to close.

There has been much progress as this report will describe, from improved political commitment and enabling environment to scale up of HIV prevention and treatment services to major improvements in the HIV monitoring and evaluation system. 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. Developing this report has also provided valuable input on where the priorities should be placed for the coming NSAP 2011 – 2015. Increasing capacity to monitor and evaluate the current response and thwart any looming potential for an accelerated spread of the epidemic is paramount as there is still much that is not understood, particularly in newly emerging vulnerable groups. Prevention activities will need to continue to target past and current high-risk groups, but most importantly extend to the newly emerging vulnerable populations. As new anti-retroviral treatment eligibility is incorporated, providing medicines to the expanding population in need will pose resource constraints.

Maintaining a proactive multi-stakeholder response in a low epidemic country is a challenge, and obtaining support and resources through both internal and external commitments will require the Lao government to continuously stay one step ahead of the epidemic. These concerns will guide the multi-sectoral for the next 5 years as it works to obtain universal access, to achieve the 2015 Millennium Development Goal of halting and reversing the spread of the epidemic.

Vientiane, 24 March 2010
Chair, National Committee for the Control of AIDS

Acknowledgements

The development of this report was prepared through an inclusive and consultative process, under the strong leadership of the Center for HIV/AIDS/STI (CHAS), with a guidance from the National Committee for the Control of AIDS (NCCA). The NCCA would like to thank CHAS, the UNGASS reporting team, and staffs who provided the support, work and sources of data to prepare this document.

We would like to express our thanks to all the national partners both government and civil society who have contributed and participated in the national response and provided important input to the report process. These include Ministry of Health, Education, Information and Culture, Labour and Social Welfare, National Defence, 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 civil society organizations, including LYAP, PEDA, and LNP+.

We would like to thank our international partners UNICEF, UNFPA, UNDP, WHO, UNODC, UNIFEM, WB, IOM, WFP, AFD, ARC, BI, PSI, NCA, FHI and others for their continued collaboration and technical expertise, and invaluable input towards this report. A special thanks to UNAIDS for their financial support to develop this report and the international consultant for all their technical assistance during the development of this report.

Table of Contents

Foreword **2**

Acknowledgements **3**

Acronyms and Abbreviations **6**

I. Status at a glance **8**
- **A. Preparation of Lao PDR's UNGASS 2010 country progress report** **8**
- **B. Status of the epidemic** **9**
- **C. Policy and programmatic response** **10**
- **D. Overview of UNGASS indicator data** **11**

II. Overview of the AIDS Epidemic **16**
- **A. Overall Summary** **16**
- **B. Drivers of the epidemic** **18**
  - Migrant Workers 19
  - Female sex workers 20
  - Men who have sex with men 21
  - Injecting Drug Users 21
  - General population 22
- **C. Overall dynamics of the epidemic and future trends** **23**

III. National response to the AIDS epidemic **25**
- **A. National commitment and action** **25**
  - Lao PDR's commitment to the "Three Ones" principle 25
  - One National AIDS Coordinating Authority 25
  - One agreed HIV/AIDS Action Framework 26
  - Political commitment 27
  - Human Rights 28
  - Civil Society Involvement 29
  - AIDS Spending 30
- **B. National Programs** **32**
  1. Prevention Programs 32
  2. Care, treatment, and support programs 38

IV. Best practices **44**
- **A. Improved HIV outcomes - scale-up of targeted prevention** **44**
- **B. Improved STI outcomes - scale up of STI services, a systems approach to HIV management** **45**
- **C. Improved coverage of treatment - scale up of supply and demand side interventions** **45**

V. Major challenges and remedial actions **47**
- **A. Progression on previous key challenges** **47**
- **B. Challenges faced during 2008-2010** **47**
- **C. Remedial Actions to achieve UNGASS targets** **48**

VI. Support from the country's development partners **53**

A. Key support received from development partners 53
B. Actions that need to be taken by development partners 54

VII. Monitoring and evaluation environment 56
A. Overview of current monitoring and evaluation system–strengthening the third "One" 56
B. Challenges faced in implementation of comprehensive M&E system 58
C. Remedial actions planned to overcome challenges 59
D. Need for M&E technical assistance and capacity building 59

Annex 1: Consultation/preparation process 61

Annex 2: National composite policy index questionnaire 62

Annex 3: AIDS Spending Matrix 99

Acronyms and Abbreviations

ADB: Asian Development Bank
AFD: French Development Agency
AIDS: Acquired Immuno-Deficiency Syndrome
ANC: Antenatal Care
ART: Anti-retro Viral Therapy
ARV: Anti-retro Viral
AusAID: Australian Government Overseas Aid Program
BCC: Behavior Change Communication
CCM: GFATM Country Coordinating Mechanism
CDC: Centre for Disease Control
CHAS: Center for HIV/AIDS/STI
CUP: Condom Use Programme
DCCA: District Committee for the Control of AIDS
FHI: Family Health International
FSW: Female Sex Worker
GFATM: Global Fund to Fight AIDS, Tuberculosis, and Malaria
GTZ: Deutsche Gesellschaft für Technische Zusammenarbeit
HIV: Human Immuno-Deficiency Virus
IDU: Injecting Drug User
IEC: Information, Education and Communication
KABP: Knowledge, Attitude, Belief and Practice
Lao PDR: Lao People's Democratic Republic
LTU: Lao Trade Union
LRC: Lao Red Cross
LYU: Lao Youth Union
LWU: Lao Women Union
M&E: Monitoring and Evaluation
MCH: Maternal and Child Health
MoE: Ministry of Education
MoH: Ministry of Health
MoIC: Ministry of Information and Culture
MoLSW: Ministry of Labor and Social Welfare
MoND: Ministry of National Defense
MoPS: Ministry of Pubic Security
MoPWT: Ministry of Public Work and Transport
MSF: Medecin Sans Frontiere
MSM: Men who have Sex with Men
NASA: National AIDS Spending Assessment
NCCA: National Committee for the Control of AIDS
NPFA: National Partnership Forum on AIDS

NSAP: National Strategy and Action Plan
OI: Opportunity Infections
OVC: Orphan vulnerable Children
PCCA: Provincial Committee for the Control of AIDS
PLHIV: People living with HIV and AIDS
PMTCT: Prevention from Mother to Child Transmission
PPT: Periodic Presumptive Treatment
PR: Principal Recipient
PSI: Population Services International
RDT: Rapid Diagnostic Test
SOP: Standard Operational Procedure
STI: Sexually Transmitted Infection
TB: Tuberculosis
TOR: Term of Reference
TWG: Thematic Working Group/Technical Working Group
VCT: Voluntary Counseling and Testing
WHO: World Health Organization

I. Status at a glance

A. Preparation of Lao PDR's UNGASS 2010 country progress report

Lao's 2010 Country Progress report was prepared through an inclusive and consultative process, led by the Center of HIV/AIDS/STI (CHAS), with guidance from the National Committee for the Control of AIDS (NCCA). Key stakeholders in the national response were closely involved, including, government institutions, civil society organizations, including people living with HIV/AIDS (PLHIV), and development partners. The report's endorsement followed a three-stage process with initial consensus by key stakeholders, NCCA validation, and final approval from Minister of Health who chairs the NCCA.

A roadmap was created in October 2009 identifying the overall activities, timeline, roles and responsibilities for developing the country's UNGASS 2010 report. A team to oversee, manage and implement the collection of data, analysis, and writing of the report, was appointed consisting of staff from CHAS, the Department of Hygiene, and the Curative Department, with UNAIDS technical assistance and an international consultant. Data collection and analysis took place between October 2009 and January 2010, including the completion and analysis of the National Composite Policy Index (NCPI) and National AIDS Spending Assessment (NASA). A series of data validation meetings attended by key stakeholders in the response were held in early February 2010.

Data on the UNGASS and related indicators were collected from a range of sources, including published surveys (Behavioral Surveillance Survey, Integrated Behavioral and Biological Survey, Reproductive Health Survey, etc.) and routine data reported to the Ministry of Health and other line ministries such as the Ministry of Education. These data were analyzed and vetted extensively, including triangulation against other indicator data, the NCPI, and AIDS spending results. Partners were consulted for quality issues as well as corroboration and interpretation of findings. Final indicator data values and key messages were presented in a data validation meeting involving all the relevant focal points in order to obtain consensus and feedback. Other related information for the report such as on programming and strategic direction was obtained from desk review and key stakeholder interviews.

The part A of the NCPI questionnaire was administered to fourteen multi-sectoral representatives from key government ministries and departments[1]. The part B of the NCPI was administered to three civil society organizations (CSO), nine international NGOs (INGO), three bilateral agencies/multilateral agencies, and eight UN agencies[2]. The UN agencies had a consultation meeting to obtain consensus and provide one UN answer for the NCPI part B questions. Responses were collated and with the majority answer included in a draft with all compiled comments. A one-day consultation was held for all participating stakeholders where the results of the questionnaire were summarized, inconsistencies

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[1] Part A: Ministry of Health including the Department of Hygiene and Preventive Medicine and the Department of Curative Care, Ministry of Education, Ministry of Information and Culture, Ministry Labour and Social Welfare, Ministry of National Defence, Ministry of Public Security, Ministry of Public Work and Transportation, Lao Red Cross, Lao Youth Organization, Lao Women's Union, Lao Trade Union, and Lao Front for National Construction.

[2] Burnet Institute, Family Health International, Population Services International, APHEDA, NCA, PEDA, ARC, World Vision, LNP+, LYAP, ESTHER, World Bank, AFD, WFP, UNICEF, UNFPA, UNDP, UNODC, IOM, WHO, UNAIDS

addressed, main messages identified and any new needed consensus obtained. This exercise proved particularly useful in identifying and understanding the basis for the areas in the national response where there were differences of opinion (see section on NCPI). In a number of cases, government respondents changed their opinion after fruitful discussion with non-governmental partners, and vice versa. The NCPI results were analyzed, including trend data, and incorporated into appropriate sections of the report.

The National AIDS Spending Assessment (NASA) was conducted for the first time in Lao PDR as part of the 2004 UNGASS reporting process. For this round, government, non-governmental organizations and development partners were asked to complete the AIDS Spending Matrix. Results were tabulated, analyzed, and key messages corroborated in the data validation meeting.

A first complete draft of this Country Progress Report followed shortly which was distributed to stakeholders that participated in the process. A second draft incorporated feedback and updated and was presented in mid March for endorsement by the NCCA and other partners. The final version was signed off by the NCCA Chair on March 24, 2010.

B. Status of the epidemic

Lao PDR is unique in its HIV situation, and can be considered as the only country in the Greater Mekong Region (GMR) with a continuing low prevalence in the general population. Most recent estimates of prevalence are close to 0.2% among 15 to 49 year olds (2009) with the estimated number of people living with HIV (PLHIV) is 8000 (2009). The main mode of transmission is heterosexual and historically high-risk has been linked to the "three Ms" –men, mobility, and money – typical of the spread of HIV in GMR[3]. Mobile men are more likely to use the money they earn engaging in high-risk behaviors making them vulnerable to HIV. When they return home HIV positive they expose their partners and ultimately their unborn children.

Lao PDR appears to be in a latent epidemic stage[4]. But in fact it has a special historical epidemiology. An interesting observation is that the number of individuals reported with AIDS is larger than the estimated cases based on the current prevalence calculated from epidemiological models[5]. This higher than expected number of cases is due to the epidemic occurring in two waves. A previously hidden first wave occurred in the early 1990's following the "three Ms" scenario, with HIV positive male migrants returning from neighboring countries, passing HIV to their partners. A second wave took place in the early 2000's driven by entertainment establishments, namely female sex workers and their clients, and has continued to be the major driver of Lao's epidemic. The current epidemiological models take into account recent data from representative studies and hence do not reflect historical episodes that lead to the higher than expected number of AIDs cases.

During the last decade, the level of HIV prevalence has mirrored the rate of sexually transmitted infections (STIs), particularly in female sex workers (FSW). Over the last decade STI prevalence in female sex workers has been of epidemic proportions with the first half of the decade experiencing very high STI rates and in 2004, the prevalence of HIV peaked at 2% in female sex workers, with a

[3] HIV and the Greater Mekong Subregion, Strategic Directions and Opportunities; Asian Development Bank, 2007.
[4] Redefining AIDS in Asia, Crafting an Effective Response; Report of the Commission on AIDS in Asia; Oxford University Press, 2008.
[5] Methodology described by UNAIDS/WHO Reference Group on Estimates Modeling and Projections: http://www.unaids.org/eng/HIV_data/Methodology/default.asp.

group of their potential clients, electricity workers at a prevalence of almost 1% (SGS, 2004)[6]. However, through the government's rapid response in joint STI/HIV targeted prevention efforts, the prevalence of STI's, albeit still high, have almost halved and HIV for both these groups has declined to less than 0.5% each (SGS, 2008)[7].

Most recently, men who have sex with men (MSM) have joined the most affected target population, with migrants potentially following. The current HIV situation in these two high-risk groups is still unclear. Two studies in MSM showed conflicting rates, 5.6% in the capital Vientiane, versus 0% in Louang Prabang (BBS 2007, BBS 2009)[8,9]. No recent prevalence data exist for migrants, but a study from 2006 point to female migrants as an important target with close to 1% prevalence, and no HIV found in the male migrants sampled[10]. More efforts are needed to better understand the HIV status and level of risk these two groups have as potential drivers of the HIV epidemic in Lao PDR.

Increasing high-risk behaviors among the youth, in particular with increased use of drugs and alcohol, underlines the need to monitor the vulnerabilities in this group. In addition, the most recent BSS surveys in the different high-risk groups demonstrated increased use of drugs, particularly injecting drugs, across all populations sampled. If this behavior grows, it could threaten the recent stabilized rate in female sex workers and exacerbate the rate in men who have sex with men as well as migrants. Most importantly, with the exception of FSW and their clients, preventive measures have been limited for most high-risk groups, and only recently have efforts started to expand targeted prevention to these other vulnerable populations.

Despite its seeming imperviousness to the HIV levels of its neighboring countries, Lao is continuously vulnerable to an expanding epidemic. Lao is landlocked by countries which report double digit prevalence for their most at risk populations, with three of these countries only recently moving out of a generalized epidemic. Lao's recent economic expansion has increased tourism and mobility across borders. This increased access and movement, coupled with the existing sex worker-client vulnerabilities and the several emerging high-risk groups, places Lao PDR on the verge of a new HIV threat.

C. Policy and programmatic response

The Lao government is strongly committed to integration in the regional and global trade system, and is thus transitioning from a landlocked to a land-linked country through the creation of economic corridors across its territory. With this economic growth, there has been recognition of the potential increase in vulnerability, as described above, to an HIV epidemic similar to that of its neighbors. Political action has thus followed suit, and priority areas identified to address the determinants that are likely to fuel the epidemic.

Priority areas include establishment of legislation, focused resource generation for scaling up of quality HIV prevention, care and treatment programs to targeted populations, and strengthening of civil society in the response. All of these endeavors can ensure the sustainability of a successful HIV response while eliminating stigma and discrimination that can often hamper programmatic effort.

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[6] Second Generation Surveillance 2nd Round on HIV, STI, and Behavior – Lao People's Democratic Republic, 2004.
[7] Second Generation Surveillance 3rd Round on HIV, STI, and Behavior – Lao People's Democratic Republic, 2008.
[8] Biological and Behavioral Survey among MSM in Luang Prabang Province – Lao People's Democratic Republic, 2007.
[9] Biological and Behavioral Survey among MSM in Vientiane – Lao People's Democratic Republic, 2009.
[10] HIV Prevalence Study among Migrant Workers at 8 Border Provinces of Lao People's Democratic Republic, 2006.

There have been a number of advances in this regard since 2008, including but not limited to the drafting of an HIV law, the funding approval of two Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) grants focused on HIV treatment and care efforts, continued inclusion of HIV in national policy priorities beyond the health sector, the expansion of PLHIV networks and their involvement in HIV policy and program decision making, and the development of a multi-sectoral monitoring and evaluation five year strategic plan.

As the National Strategy and Action Plan 2006 to 2010 for HIV and AIDS (NSAP) comes to a close, Lao PDR has been reassessing its needs and priority areas for the next five years. In the previous plan, major focus was placed on prevention through targeted and comprehensive interventions, in order to respond to the rising prevalence in high-risk groups such as female sex-workers and their clients[11]. This comprehensive package of interventions included behavior change through peer education, establishment of outreach and drop-in centers, condom provision and social marketing, improved quality and provision of STI services, voluntary counseling and testing, enhancing enabling environments through local decision makers and community participation, as well as awareness via information, education, and communication (IEC) and mass communication efforts. In addition, priority was also placed on scale up ART coverage, as the number of people in need of ART was rising sharply and there had excessive number of deaths due to AIDS.

A mid-term review was conducted in 2008 to assess progress since 2006 and to identify continuing and new challenges, which are described in this report[12]. Results of the review showed a major expansion of the comprehensive package of interventions to provinces. Testing rates increased by two fold in conjunction with a 3-fold rise in testing sites (2009). There has also been a major increase in ART coverage reaching over 92% for adults and children in need. This successful scaling up can be considered best practice as a result of effective resource allocation, clear commitment, and rapid response from the government to support the multi-stakeholder response.

Despite the aforementioned accomplishments, Lao PDR still has many challenges to address. Increasing capacity to monitor and evaluate the current response and thwart any looming potential for an accelerated spread of the epidemic is paramount. Although there has been much improvement to increase data availability with the implementation of several studies and surveys in the last two years, there is still much that is not understood, particularly in newly emerging vulnerable groups. Prevention activities will need to continue to target past and current high-risk groups, but most importantly extend to the newly emerging vulnerable populations. Maintaining a proactive multi-stakeholder response in a low epidemic country is a major challenge, and obtaining support and resources through both internal commitment and external commitments will require the government of Lao to continuously stay one step ahead of the epidemic. These concerns will guide the new NSAP to best address the priorities for the next 5 years.

D. Overview of UNGASS indicator data

Lao PDR reported data for fourteen of the UNGASS indicators, including AIDS spending and NCPI. The remaining indicators either have no data available as it is not yet collected, or the data were not entirely consistent with the UNGASS definition. Table I provides the top level values for the

[11] National Strategy and Action Plan on HIV/AIDS/STI, Lao People's Democratic Republic National Committee for the Control of AIDS; 2006-2010.
[12] Report on mid-term review of the National Strategic Plan on HIV/AIDS/STI 2006-2010, Lao People's Democratic Republic National committee for the Control of AIDS and Center for HIV/AIDS/STI; September 2008.

indicators with available data. Please refer to Annex 3 for indicator 1, AIDS spending, and Annex 2 for indicator 2, responses to the NCPI.

More detailed explanation is included below for each of the indicators with no data reported in table 1.

<u>No data/not all data available</u>

- Indicator 6 – indicator is relevant, and numerator data is available and has been entered in online tool and reported in narrative, however 2009 denominator data not available from WHO, the 2006 value for number of estimated incidence TB cases in PLHIV = 161.
- Indicators 8, 9, 14, 20, 21 and 23 for IDU – indicators are relevant, but currently no studies have been conducted which collect UNGASS indicators. This is however, planned for the future.
- Indicator 7 – indicator is relevant, but no studies have collected this data, it will be included in the next national reproductive health survey
- Indicator 12 – indicator is relevant, but no studies have collected this data, it will be included in the next national household health survey.
- Indicators 13, 15, 16, & 17 – indicators are relevant, but no studies have collected this data, it will be included in the next national reproductive health survey, related indicator data available for adult women and men from 2005 Lao Reproductive Survey. Questions on HIV for the general population, including for collection of UNGASS indicator data will be included in next reproductive health household survey scheduled for 2010.

<u>Data available but not consistent with UNGASS definition</u>

- Indicator 10 – indicator is relevant in sense that Lao provides support to all OVC and program data is available, the value of which is estimated at 70%. Survey data not yet collected, but will be included in the next household health survey. It should be noted that HIV is not major contributor to orphan situation in Lao PDR.
- Indicator 9 for MSM – indicator is relevant, and similar data collected in the BBS in 2009. However, questions were not consistent with UNGASS definition, and reflect receiving condoms in last 3 months, not in last 12 months, and hence would underestimate indicator value. No questions were asked on knowledge about where to get a test. Efforts will be made to harmonize indicator definitions and include relevant questions in next MSM study. Available data for 2009:
    - Received condom in last 3 months = 37%
- Indicator 14 for MSM – indicator is relevant & data are available in BBS 2007, however questions are not consistent with UNGASS definition & hence cannot calculate composite knowledge indicator. Efforts will be made to harmonize indicator definitions and include relevant questions in next MSM study. Available data are available for two of the individual questions:
    - Can a person get HIV by sharing meal = 80% correct knowledge

    - Can a person get HIV from mosquitoes = 67% correct knowledge

- Indicator 19 for MSM - indicator is relevant & data are available in BBS 2009, however questions are not consistent with UNGASS definition & reflects the last 3 months, not the last 6 months as indicated in UNGASS, hence available data value would most likely underestimate indicator. Efforts will be made to harmonize indicator definitions and include relevant questions in next MSM study. Available data:
    - Condom use at last anal sex with casual partner in past 3 months = 68%

Obtaining data for globally standardized indicators is part of the M&E systems strengthening and remedial plans over the next few years. The goal is at the minimum, to have complete, quality and timely data for all relevant UNGASS indicators. Ideally a set of comprehensive indicators will be available to explore different aspects or each priority area and have greater ability to look deeper into trends and patterns.

Table 1 UNGASS Core Indicators	Data Values	Targets		Comments
		2010*	2015**	
National Commitment and Action				
1. Domestic and international AIDS spending by categories and financing sources	2009: $5,997,398 2008: $5,017,038 2007:$5,146,613	N/A	N/A	Please see annex 3
2. National Composite Policy Index (NCPI)	Parts A & B completed	N/A	N/A	Please see Annex 2
National Programs				
3. Percentage of donated blood units screened for HIV in a quality assured manner.	2009: 100% 2007: 100%	100%	100%	6 blood units screened in EQA laboratories every six months
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.***	2009: 92% 2008: 79% 2007: 63% 2006: 48%	>90%	>90%	
5. Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission.***	2009: 14% 2008: 12% 2007: 14% 2006: 15%	Not available	Not available	Disaggregation by regimen type is available.
6. Percentage of estimated HIV-positive TB cases that received treatment for TB and HIV.	Not available	Not available	Not available	The numerator is available=85, however the estimated denominator for 2009 is not available from WHO for Lao PDR
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.	Not available	Not available	Not available	Please see text section 1.D.
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results.	FSW 2009: 14% FSW 2008: 15% FSW 2004: 9% MSM 2009: 14% IDU: Not available	Not available	Not available	FSW 2009 = BSS FSW 2008 = SGS 3rd round FSW 2004 = SGS 2nd round MSM 2009 = BSS Luang Prabang IDU: see text section 1.D.
9. Percentage of most-at-risk populations reached with HIV prevention programs.	FSW 2009: 70% FSW 2008: 45% MSM 2009: Not available IDU: Not available	Not available	Not available	FSW: 2009 = BSS 2008 = SGS 3rd round MSM: see text section 1.D. IDU: see text section 1.D.
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child.	Not available	Not available	Not available	Please see text section 1.D.
11. Percentage of schools that provided life skills-based HIV education within the last academic year.	74%	**30%**	Not available	Results from 1,052 High schools surveyed in target provinces.
Knowledge and Behavior				
12. Current school attendance among orphans and among non-orphans aged 10-14.*	Not available	Not available	Not available	Please see text section 1.D.
13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing he sexual transmission of HIV and who reject major misconceptions about HIV transmission.	Not available	Not available	50%	Please see text section 1.D.
14. Percentage of most-at-risk populations who both correctly identify ways of preventing he sexual transmission of HIV and who reject major misconceptions about HIV transmission.	SW 2009: 45% SW 2008: 49% SW 2004: 20% MSM 2009: Not available IDU: Not available	Not available	SW: 85% MSM: 85%	MSM: see text section 1.D. IDU: see text section 1.D.
15. Percentage of young women and men who	Not available	Not	Not	Please see text section 1.D.

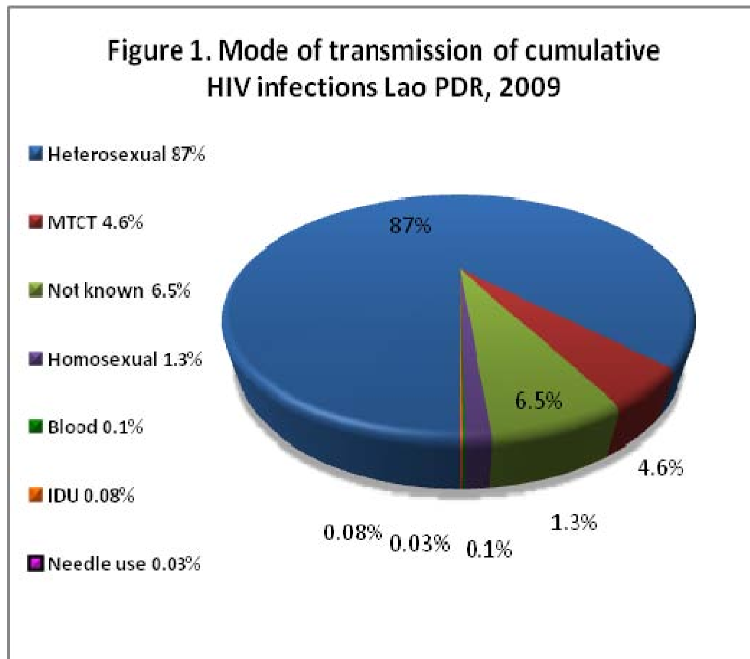
have sexual intercourse before the age of 15.		available	available	
16. Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.	**Not available**	Not available	Not available	Please see text section 1.D.
17. Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse.*	**Not available**	Not available	Not available	Please see text section 1.D.
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client.	**2008: 94%**	80%	95%	
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.	**Not available**	70%	80%	Please see text section 1.D.
20. Percentage of injecting drug users who reported the use of a condom at last sexual intercourse.	**Not available**	Not available	Not available	Please see text section 1.D.
21. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected.	**Not available**	70%	Not available	Please see text section 1.D.
Impact Indicators				
22. Percentage of young women and men aged 15-24 who are HIV infected*	**Not available**	<1%	<1%	Please see text section 1.D.
23. Percentage of most-at-risk populations who are HIV infected.	**FSW 2008: 0.43%** FSW 2004: 2.02% FSW 2001: 0.9% **MSM 2009: 0%** **MSM 2007: 5.6%** **IDU: Not available**	SW: <5% MSM: <5%	SW: <2% MSM<3%	MSM: sero-prevalence survey Vientiane (2007) Louang Prabang (2009) IDU: see text section 1.D.
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	**2009** **Adults: 95%** **Children: 100%** 2007 Adults: 90% Children: 93%	Not available	Not available	
25. Percentage of infants born to HIV-infected mothers who are infected.	**15%**	Not available	Not available	

*N/A = not applicable
**Targets are not available for 2010 because data was not available to determine baseline.
Targets are not available for 2015 as these will be determined during the development of the NSAP 2011-2015.
*** Denominators are based on estimation which is still needed to be validated in the near future.

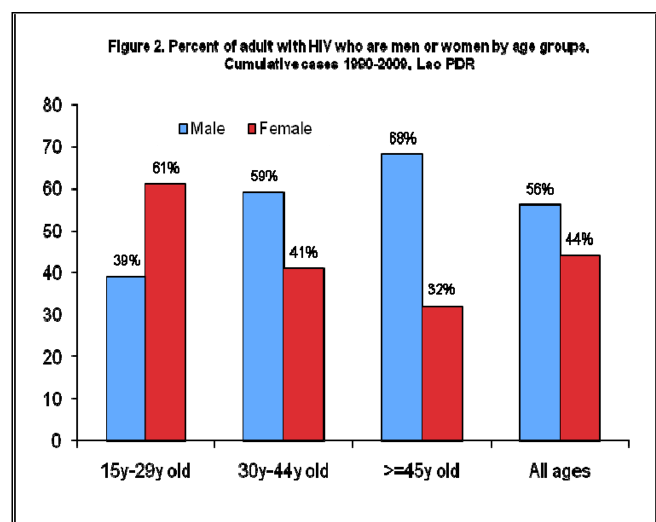
II. Overview of the AIDS Epidemic

A. Overall Summary

Since the first person with HIV was identified in 1990, a total of 3,659 HIV notifications have been reported to CHAS, 189 of which were in children less than 15 (CHAS, 2009). The total estimated number of people living with HIV (PLHIV) is approximately 8,000 based on estimation models, with the current estimated prevalence of adults (15-49) at 0.2%[13]. Eighty-seven percent of transmission is through heterosexual contact, with mother-to-child transmission following at 4.6%, and transmission through anal sex in men who have sex with men emerging at 1.3% [Figure 1] (CHAS, December, 2009). The majority of cases have been identified in three provinces, Savannakhet (40%), the greater capital Vientiane area (33%), and Champasak (9.8%). All these provinces border Thailand with Savannakhet being the corridor between Thailand and Vietnam, and Champasak also bordering Cambodia. These provinces experience much cross-border migration, both of Lao citizens and external migrants. The high amount of movement across the neighboring countries in conjunction with the observation that the largest proportion of notified cases are reported as migrant workers (19%), highlights the role migration plays in Lao's epidemic. The next highest reported occupation of PLHIV is housewives (18%). Although female sex workers are considered as one of the current drivers of the epidemic, only 3% of cases reported themselves as sex workers, suggesting a bias in self-reporting of occupation. It is suspected this group may be hidden under the label of migrants and housewives.



The majority of identified cases, 62%, are within the most productive age groups of 25 years to 39 years. The number of reported AIDS cases rises steadily from 20 years and then peaks in the mid 30's, falling sharply in older age groups. The pattern suggests that the most vulnerable age for onset of HIV is the early to mid-twenties, which has implications for prevention targeting. On the surface there appears to be a fairly equal distribution of reported cases between males (56%) and females (44%), but further breakdown by age and sex reveals a discrepant pattern [Figure 2]. In the two older age groups males dominate at 59%



[13] Methodology described by UNAIDS/WHO Reference Group on Estimates Modeling and Projections: http://www.unaids.org/eng/HIV_data/Methodology/default.asp.

(30y-44y) and 68% (45y and above). However, the opposite is true in the younger age group 15 years to 29 years, where the vast majorities, 61%, are female. One possible explanation is that younger men do not seek testing as often as younger women. Although differential testing patterns in this younger age group maybe contributing to the number of reported male and female cases, one would expect looking historically at the sex-age distribution in past years, to see a similar pattern. However, across all age groups, HIV cases in the 1990s were primarily in men. It is only from 2001 onwards that cases in this younger age group shift to females, suggesting wider implications on the historical progression and current epidemiological situation. There appears an emergence at the beginning of the last decade of a new vulnerable group, young females, as drivers of Lao's epidemic. Like its neighboring countries, the face of HIV/AIDS in Lao PDR is increasingly female.

The first AIDS case was reported in 1992, and since then 2376 AIDS cases have ensued and 1038 deaths (CHAS, December 2009). Most AIDS cases (60%) and deaths (65%) occur in males. In addition, 70% of HIV cases in males have progressed to AIDS as opposed to 58% of female cases progressing to AIDS. Similarly, while 33% of male cumulative cases have died, this value stands at 22% for females. This higher percentage of AIDS progression and deaths in males maybe partly due to the fact that men tend to seek health care (testing and treatment) later than females, presenting to the health system often at CD4 count levels way below 200, hence lowering their survival [see section III.B][14]. This late presentation make account for the fact that even for patients on ART, survival is significantly lower in males (93%) than in females (97%) ($p<0.05$).

Another striking observation is that the reported number of cumulative AIDS cases, as well as the reported number of cumulative deaths, surpasses the estimated cumulative numbers based on models of a country with a prevalence of less than 0.2%[15]. The higher than expected number of deaths could be partly attributed to initial low rates of antiretroviral (ART) coverage in the early years of the epidemic. Another contributor is most likely due to people living with HIV seeking care at the final stages of their illness. The aforementioned behavioral studies have shown overall that HIV testing rates tend to be low in Lao, so PLHIV are most likely discovering their status when they are already sick [see section III.B]. In fact a cohort study of HIV patients from 2003 to present found that 74% presented for the first time to the HIV program at CD4+ counts of less than 200, while 51% presented at CD4+ counts of less than 50, which significantly reduces their survival[16]. In addition, the more detected than estimated deaths is also related to the fact that there is a higher than expected number of AIDS cases.

[14] Second Generation Surveillance 3rd Round on HIV, STI, and Behavior – Lao People's Democratic Republic, 2008.
[15] EPP and Spectrum package has been indicated that it can not provide accuracy for low prevalence country.
[16] Savannakhet HIV Adult Cohort Study, Ministry of Health and Center for HIV/AIDS/STI, 2008.

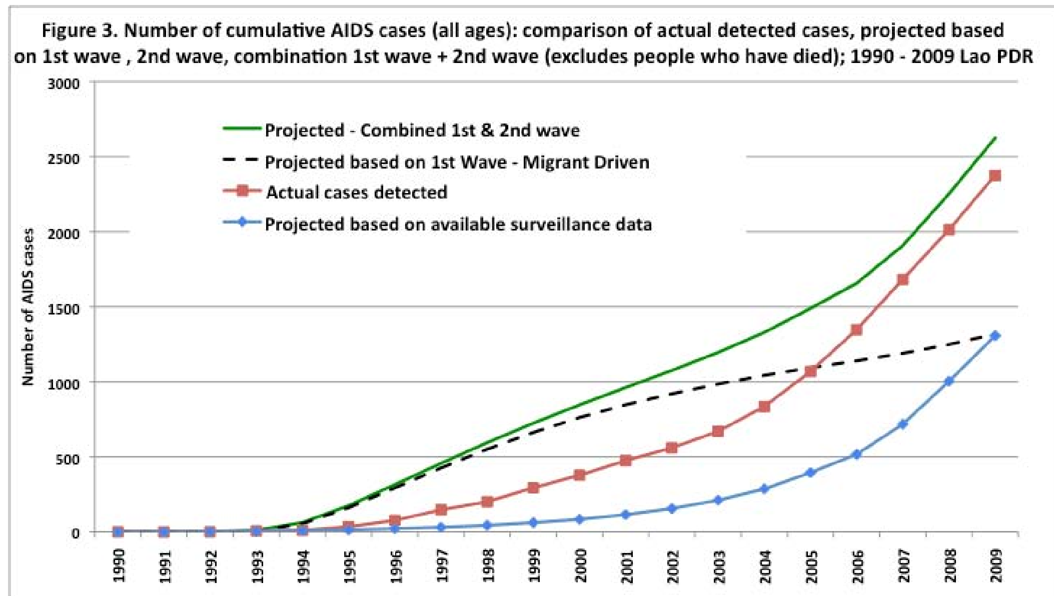


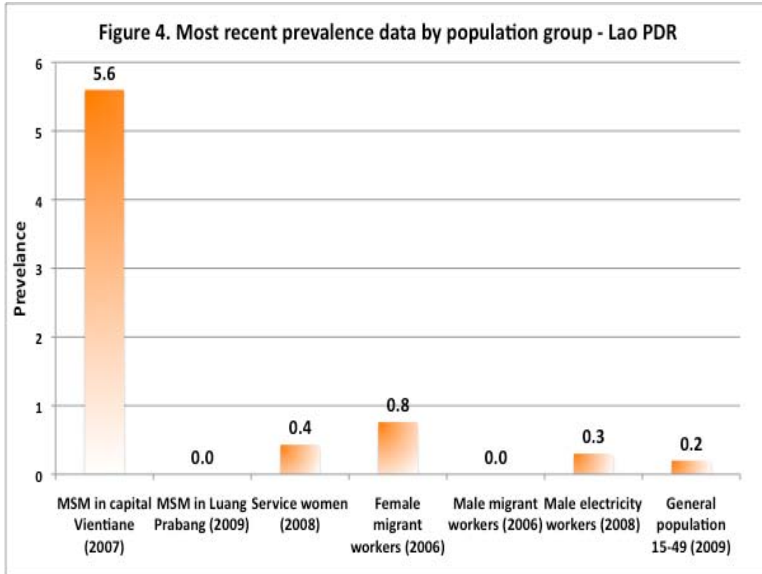
Figure 3 illustrates the number of cumulative AIDS cases (excluding those who have died) that were detected since 1990 and three projected scenarios based modeling. The number of cumulative cases detected represented by the red line is clearly higher than the number of projected cumulative cases based on available surveillance data and an overall prevalence of 0.2% (blue line). The higher number of detected versus expected AIDS cases suggests that either a group with relatively high prevalence was not captured in the sero-surveillance studies thus far, and/or that the spread of HIV/AIDS in Lao PDR started much earlier than assumed. Taking into account Lao's historical age-sex distribution of PLHIV, the more likely scenario is the idea that Lao PDR has in fact experienced its epidemic in two waves. The onslaught of HIV came with male migrants in the mid 1990s, corroborated by the high 2:1 male-female ratio of HIV cases during that decade. A second surge arrived in the early 2000s driven by the female sex worker-client relationship. This theory is consistent with the observed shift to a more even overall male-female ratio among HIV cases as well as the shift of the younger age groups to being predominantly female. In figure 3 the black line represents the 1st wave scenario of a migrant driven epidemic, which up to 2005, shows a higher number of AIDS cases than the red detected cases line. This is not surprising since case detection is known to underestimate the true number of people living with AIDS, especially considering the low outreach and treatment availability during the early years. In 2005 detected cases surpass the 1st wave cases as people infected in the 1990s and early 2000s have died and scale up of detection efforts started. The real life situation for the cumulative numbers of AIDS cases is most likely represented by the green line, the addition of projected cases from the 1st and 2nd wave epidemic scenarios.

B. Drivers of the epidemic

The major risk factor for HIV in Lao PDR is risky sexual behavior, as evidenced by the high STI prevalence (Gonorrhea and/or Chlamydia) across different vulnerable groups, which ranges from 9% in MSM to 22% in female sex workers (2009)[17,18]. Figure 4 shows the latest prevalence estimates available for the general population and four high-risk groups in Lao PDR. Men who have sex with men

[17] Second Generation Surveillance 3rd Round on HIV, STI, and Behavior – Lao People's Democratic Republic, 2008.
[18] Biological and Behavioral Survey among MSM in Vientiane – Lao People's Democratic Republic, 2009.

sampled in Vientiane have the highest prevalence followed by female migrant workers. It is important to note that these data represent results based on small sample studies that are not nationally representative. The sharp contrasts in prevalence between MSM in two cities and between male and female migrants suggest a more complex epidemiological state. In order to formulate a comprehensive understanding of Lao PDR's HIV situation, and how different vulnerable groups overlap and relate to the general population, it is necessary to, in addition to taking into account the historical context of the epidemic, examine the characteristics of each vulnerable group.

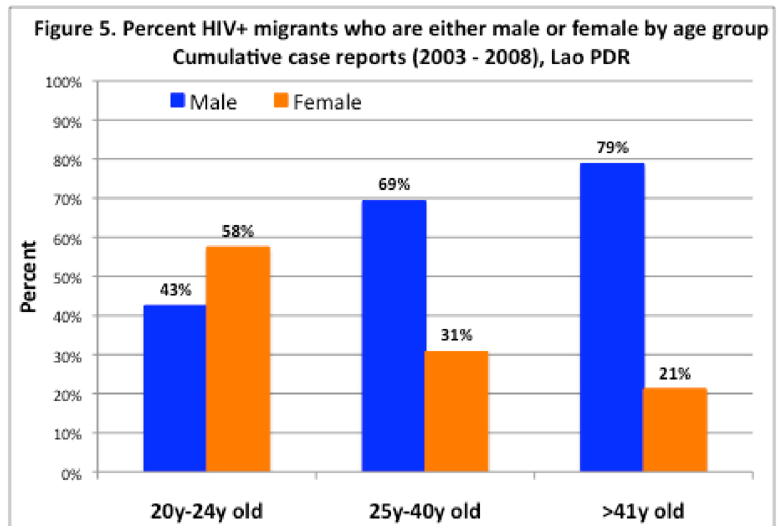


Migrant Workers

As mentioned earlier, the first wave of the epidemic started in the early to mid-1990s with Lao migrant laborers returning home with HIV. Since many of these migrants came from rural areas where there exists a high degree of social control, the assumption is that these men had minimal multi-partner behavior when they returned, passing HIV mainly to their spouses.

Case reports indicate that even though Lao migrant workers currently comprise one fifth of all HIV cases, over 50% of all cases had reported migrating at least once into another country for work. The fact that Lao is bordered by five countries having a high prevalence in their most-at-risk populations and migration is a common way of life highlights the importance of migration in Lao's HIV risk scenario. This has been historically proven considering how HIV made its debut in Lao PDR.

The case of young female migrants - a closer look at the age-sex distribution of cumulative migrant cases shows a similar pattern seen in the entire HIV case population. The younger age group is predominantly female, while males prevail in the older age groups (Figure 5). There are a number of potential explanations for this observation. One possible explanation is that young migrant females are more likely to test than young migrant males. However, since targeted prevention efforts to migrants have not differed for males and females, this does not seem like a major contributing factor. It is also possible that transmission to these young female migrants are from their HIV positive older migrant husbands. Another scenario is that young migrant females are engaging more in high-risk behavior than their male counterparts, for example sex work. It is hard to identify the reason and it maybe a combination of several, but it is clear they are an important group to monitor, conduct more research, and target for intervention.



A biological and behavioral survey in 2006 on migrant workers in 8 border provinces further corroborates that young migrant women are an important sub-group to monitor[19]. The HIV prevalence in female migrants was found to be 0.8%, with the majority being below the age of 30. No HIV was detected in male migrants. Both groups reported engaging in high-risk behaviors, but half of women reporting drug use had injected and of those with non-regular partners, almost none used condoms. These data coupled with case report data suggest that young migrant females are in fact engaging in high-risk behavior making them vulnerable to HIV.

The question is whether these young migrant women are engaging in sex work or IDU, or both. The fact that sex work has such low self-report in cases, that trafficking of young women is a known occurrence, and that groups of Lao young women are known to be engaged in sex work in several border towns in Thailand, all support the possibility that many of these young women might be sex workers hidden under the label of migrant.

External migrants have in recent years also become a potential high-risk group as Lao expands its economic corridors. There is a steady flow of migration into the country for work on transportation routes and construction projects, particularly from Vietnam and China. A recent KAPB study in 2008 on Chinese and Vietnamese migrant workers indicated some level of high-risk behavior, rendering them at risk for HIV and an important group to include in upcoming prevalence studies[20].

Female sex workers

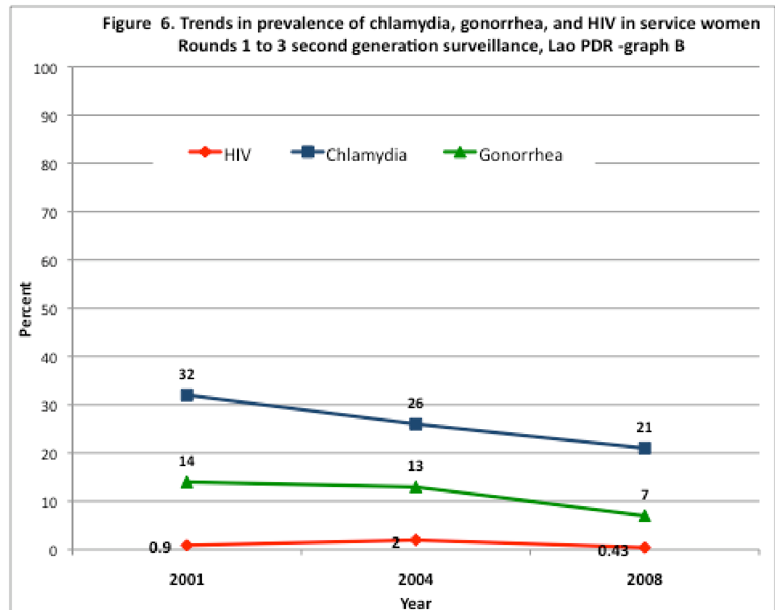
In Lao PDR, sex work is illegal and thus defining and identifying women who sell sex for money poses a challenge. Women who work in small drink shops and nightclubs may engage in commercial sex. These service women have till now been the population sample for 2nd generation surveillance surveys, which have provided prevalence data. The last 2 rounds revealed that 96% of service women surveyed had sold sex in the last 3 months, hence their results are deemed a good approximate of the HIV situation of female sex workers in the country.

For female sex workers in Lao PDR, the HIV rates parallel the STIs rates. Since 2001, there has been a steady decline in both STI and HIV prevalence in service women (figure 6). The latest sero-prevalence results from the 2008 Integrated Behavioral Biological Surveillance (IBBS) study indicated an HIV prevalence of 0.43% in service women all of which were between the ages of 20 and 24[21].

There is evidence that potential clients of female sex workers are experiencing the same stabilized rate as observed in female service women. Prevalence levels were 0.3% in male electricity workers (potential clients) in the same survey.

[19] HIV Prevalence Study among Migrant Workers at 8 Border Provinces of Lao People's Democratic Republic, 2006.
[20] Knowledge, Attitude, Behavior, and Practices (KABP) survey among Chinese Communities in Louangnamtha province and Vietnamese Communities in Champasack and Attapeu provinces, Lao People's Democratic Republic, September 2008.
[21] Second Generation Surveillance 3rd Round on HIV, STI, and Behavior – Lao People's Democratic Republic, 2008.

Even though the HIV response in female sex workers and their clients is considered a success, the growing number of migrant female sex workers, particularly in the Thai border regions, and growing number of male migrants as potential clients poses a new challenge to maintain the current decline in prevalence[22].



Men who have sex with men

A recently emerging high-risk group is men who have sex with men. A 2007 study conducted in the capital Vientiane provided the first data on MSM HIV prevalence, with a result of 5.6%[23]. There were no significant differences in prevalence across ages. The results from a study conducted in 2009 in Luang Prabang, another major urban area, found a prevalence of 0% in respondents[24]. However, the same study found that STI's were quite prevalent, with the existence of rectal Gonorrhea and/or Chlamydia in 9% of MSM. In addition, these men engage in high risk behaviors, with 47% having multiple partners, and 33% having had sex casually with both men and women in the last three months. Only 33% used condoms consistently with casual partners (see section III). The conflicting prevalence data paint a somewhat confusing picture of the MSM epidemiologic situation and in conjunction with the existing high risk behaviors, highlight the need for more studies to better understand the extent risk and the epidemic in this high-risk group.

Injecting Drug Users

The role of injecting drug users in Lao's HIV risk scenario is not deeply understood. There are no studies to date measuring HIV prevalence among drug users. The aforementioned behavioral studies have shown injecting drug use to be prevalent in young people and MSM, and a surprising number of female sex workers and female migrants have reported using drugs, including injecting (see section III). If HIV enters the IDU population, it could quickly spread among IDU networks, especially without harm reduction strategies in place. It is imperative that more research and surveillance be conducted in this important emerging group to better understand the extent of injecting practice and the existence of HIV in this group.

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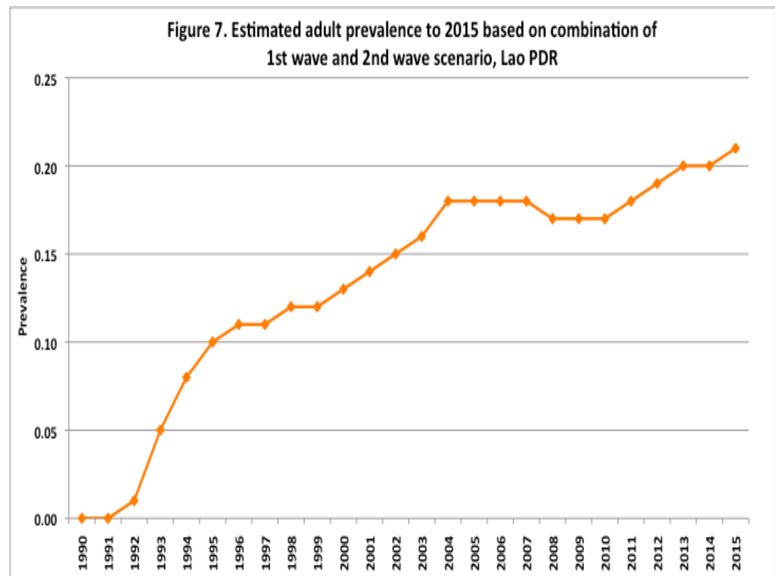
[22] Testimony from stakeholder interviews with key focal points at Center for HIV/AIDS/STI.
[23] Biological and Behavioral Survey among MSM in Luang Prabang Province – Lao People's Democratic Republic, 2007.
[24] Biological and Behavioral Survey among MSM in Vientiane – Lao People's Democratic Republic, 2009.

General population

The most recent antenatal care (ANC) sentinel surveillance data in 2008 from 3 hospitals in Vientiane showed a prevalence of 0.3%. This estimate is limited in its interpretation in that it does not capture the main high-risk groups or other affected parts of the country. In addition, since the majority of pregnant women, 72%, do not access health facilities for ANC, the group detected may have characteristics not representative of all Lao women of reproductive age[25]. For this reason the ANC data has been used predominantly to assist in modeled estimates and projections (Workbook and Spectrum methods, UNAIDS).

Figure 7 shows the projected adult prevalence estimates taking into account all prevalence data and including the the combination of 1st and 2nd wave scenarios described earlier. If we consider the four scenarios of the HIV epidemic for prioritizing interventions as described by the Report of the Commission on AIDS in Asia, at first glance, Lao PDR could be considered to be in a latent stage of the epidemic, due to its low general prevalence[26]. However, this classification provides a superficial view of Lao's HIV situation. In looking at the prevalence pattern, it is evident that the epidemic has occurred in stages, with acceleration, plateau and decline, even if on a smaller scale. The first acceleration of the epidemic has occurred, and a short leveling off around 1998, most likely due to people with AIDS dying. The second surge occurs between 2000 and 2004, which is most likely due to the rapid spread through sex worker-client relationships, again with another levelling off around 2005, due to a major scale up in targeted prevention to these groups. Prevalence is then projected to increase again due to increased survival through provision of ART at higher levels of CD4 count (following the new eligibility requirements for ART at CD4+ 350). In addition, newly emerging high-risk groups such as hard to reach migrants, MSM and IDU may contribute to a sharper increase prevalence from 2011 beyond.

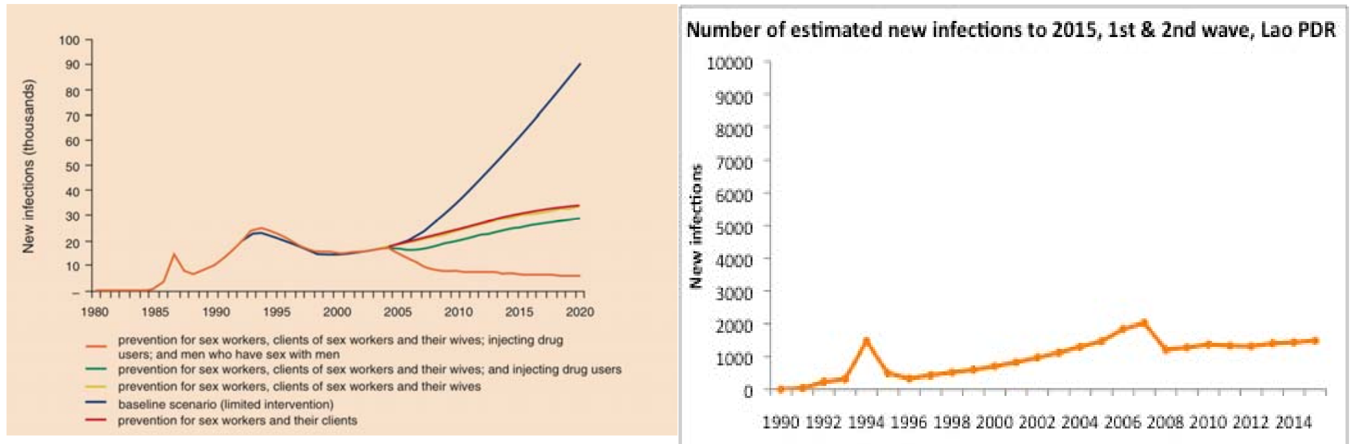


Looking at the number estimated number of new infections provides a clearer picture of Lao's HIV situation. Figure 8 shows a model country in the scenario of a declining epidemic as a result of

[25] The Provincial Report of the Lao Reproductive Health Survey, 2005. Lao PDR Ministry of Planning and Investment, Department of Statistics.

[26] Redefining AIDS in Asia, Crafting an Effective Response; Report of the Commission on AIDS in Asia; Oxford University Press, 2008.

Figure 8. Declining epidemic scenario: Number of new infections of model country compared to new infections for Lao PDR



successful prevention to sex-workers and their clients. The number of new infections rises early on and then dips as a result of prevention efforts. This is then followed by a number of scenarios depending on what group prevention efforts are targeted towards, with the best scenario being all vulnerable groups being targeted (orange line). Interestingly Lao's estimated new infection scenario follows a similar pattern as the model one with prevention targeted at sex workers, clients and their wives (yellow line), although on much smaller scale. There is a small peak in the early 1990s due to the first wave migrant-spouse epidemic. The spread was most likely contained due to conservative social norms, and as cases died, the number of new cases also dipped. Another, more gradual rise in the early 2000s and peaking in 2006, was due to the second wave of sex worker-client infections. Soon after, a sharp dip is seen, most likely due to aggressive prevention targeting of sex workers and their clients. As new emerging high-risk groups enter the scene, without similar targeted prevention to all these groups, not just sex workers, the number of new cases will rise again as indicated in the green, red and yellow lines scenarios.

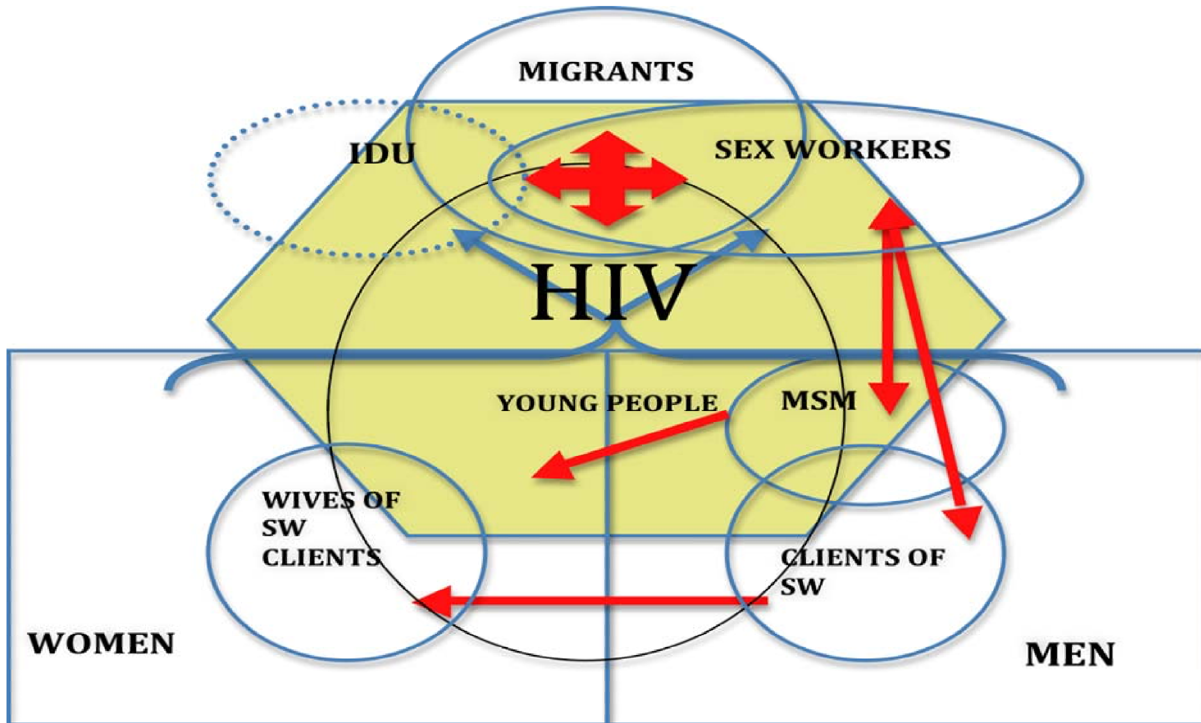
C. Overall dynamics of the epidemic and future trends

As Lao has become more economically integrated into the Mekong region, increased travel and tourism, higher migration, and greater disposable income can provide the forum for HIV to increase in the most-at-risk populations and spread to low-risk population groups. Figure 9 illustrates the underlying dynamics of Lao's HIV vulnerability. High-risk groups are not exclusive and interact with the lower risk general population. HIV may start in the most vulnerable, and often hard to reach or hidden populations, who often overlap as they share multiple high-risk behaviors. Through sexual contact and/or shared risky behavior with persons outside this group, HIV can pass through clients of female sex workers, female partners of MSM, migrants, and young people. Youth are particularly vulnerable, especially those originally coming from rural areas, where outreach is limited and thus awareness of HIV and related risks is low.

Through these "bridge populations" HIV can spread to non-high-risk groups such as partners of these bridge populations, which in turn can increase vertical transmission to children. Lao has already experienced this dynamic during the first wave of the epidemic in the 1990s. It is imperative that the role of newly emerging vulnerable groups is characterized to better understand how they contribute to Lao's HIV vulnerability. Very little is known about injecting drug users (dotted line in graph), the extent

of vulnerability of migrants, and the true risk in youth. Without active monitoring of these groups it will be difficult to target scale-up of prevention measures appropriately to avoid the spread of HIV.

Figure 9: Lao PDR HIV Vulnerability



III. National response to the AIDS epidemic

A. National commitment and action

Lao PDR's commitment to the "Three Ones" principle

Lao has been committed to strengthening the national AIDS response through the practice of the "Three Ones" principle[27]. The last two years has seen much advancement for all three of the "Ones" in policy, organization, increased resource generation, scale up of targeted prevention and treatment activities, and improved monitoring and evaluation. Progress on the first two "Ones" are described below, the last "One" is described in section VIII. All these improvements exemplify the government's commitment and political support as well as the success in coordinating the multi-sectoral partners. These efforts pave the way to tackle any future challenges of the epidemic.

One National AIDS Coordinating Authority

Since 2007, there has been much improvement in the coordination of the national response across partners and within the government. The National Committee on the Control of AIDS is the official coordinating body for the national multi-sectoral response on HIV/AIDS. The NCCA as the oversight committee has the key role of guiding national policy, providing endorsement of new HIV/AIDS initiatives, and reviewing the implementation of the National Strategy and Action Plan (NSAP). In the past, the NCCA was not as active or organized to fulfill its responsibilities. During the last two years, the NCCA's TOR has been updated to clarify roles and responsibilities and members are meeting bi-annually. In addition, more line ministries have taken NCCA membership to provide a wider sector contribution. The current multi-sectoral membership of the NCCA is comprised of fourteen members with representation from seven line ministries including Ministry of Health, Education, Information and Culture, Labour and Social Welfare, National Defense, Public Security and Ministry of Public Work and Transportation. There is also representation of five mass organizations, including Lao Red Cross, Lao Youth Organization, Lao Women's Union, Lao Trade Union, and Lao Font for National Construction. A new structure of NCCA has recently been submitted to the Prime Minister's office for consideration and approval, with adding more members such as focal points of the National Assembly, National Chamber of Commerce and Industry, Buddhist Association and LNP+.

The NCCA has recently established its standing committee to provide guidance and regular monitoring for the Secretariat. The Center for HIV/AIDS/STDs (CHAS) serves as the secretariat which has been entrusted with the responsibility to coordinate the implementation of the NSAP and report to the NCCA on progress made. CHAS also serves as the National AIDS program, implementing most of the health sector activities in the national response.

Management of HIV/AIDS activities reaches down to the district level. The Provincial Committee on the Control of AIDS (PCCA), which sits in the Provincial Health Department (PHD) is also responsible for coordinating HIV/AIDS activities in the provinces. The District Committee on the Control of AIDS (DCCA), which sits in the District Health Office functions the same but at the district level. There is a bottom up reporting mechanism for the DCCA to the PCCA to CHAS and finally to the NCCA.

Beyond the DCCA, there are Village Committees on the Control of AIDS (VCCA) who mainly focus on outreach and education activities. An evaluation of their effectiveness was conducted in 2006 and found that the VCCA's are targeting high-risk groups, but that they needed more capacity, both in skills and

[27] The "Three Ones" in action: Where we are and where we go from here. UNAIDS, 2005.

resources, as well as better communication and coordination with the DCCAs[28]. A second review is scheduled as part of the new NSAP 2011-2015.

The NCCA functions at the policy level, whereas the National Partnership Forum on AIDS (NPFA) deals with the technical aspects of the response. The NPFA is the umbrella for all the thematic groups and report regularly to standing committee of the NCCA. Thematic groups exist under the NPFA to focus on particular areas of work such as sex work, prevention for men who have sex with men, and monitoring and evaluation.

One agreed HIV/AIDS Action Framework

The National Strategy and Action Plan 2006 to 2010 for HIV and AIDS (NSAP) has been the backbone for coordinating the work of all partners. With the overall goal to maintain the present low level of HIV/AIDS in the general population and ensure HIV prevalence in most-at-risk groups is lower than 5%, the plan describes five priority areas:

1) Reaching full coverage of targeted and comprehensive interventions in prioritized provinces/districts in a phased approach
2) Establishment of an enabling environment for an expanded response at all levels
3) Increased data availability to monitor both the epidemic and the response (strategic information);
4) Capacity building of implementing partners at all levels
5) Effective management, coordination, and monitoring of the expanded response

The plan incorporates all the roles and responsibilities of the multi-sectoral response for these priority areas. The strategic components to address are the following:

a. Targeted prevention for vulnerable groups
b. Care and support
c. Policy, legal reform and advocacy
d. Surveillance and research
e. Program management

In 2008, a mid-term review was conducted to determine progress since 2006. Advances were made in all priority areas, and each had a set of constraints identified to work towards remediation by 2010. Section V discusses these in more detail. Beyond the national plan, sectoral HIV plans have been developed for the Lao Women's Union, The Ministry of Public Work and Transport, and the Ministry of Public Security, to provide an expanded strategy for their role in the national response.

The current NSAP will come to an end in 2010. The NCCA is now preparing for an end of term review to inform the development of the next NSAP (2011 - 2015). Targets are being reassessed and based on challenges identified over the last reporting period, remedial actions will help to guide activities for the next five years. The ultimate goal will be reaching the MDG 2015 targets and the priorities will be in line with the nine priority areas described in the UNAIDS Outcome Framework[29].

[28] Preventing HIV in Young People Affected by Population Mobility in Lao PDR, Mid-term Learning Review; World Vision Lao PDR, September, 2006.
[29] Joint Action for Results, UNAIDS Outcome Framework 2009 – 2011. UNAIDS, 2009.

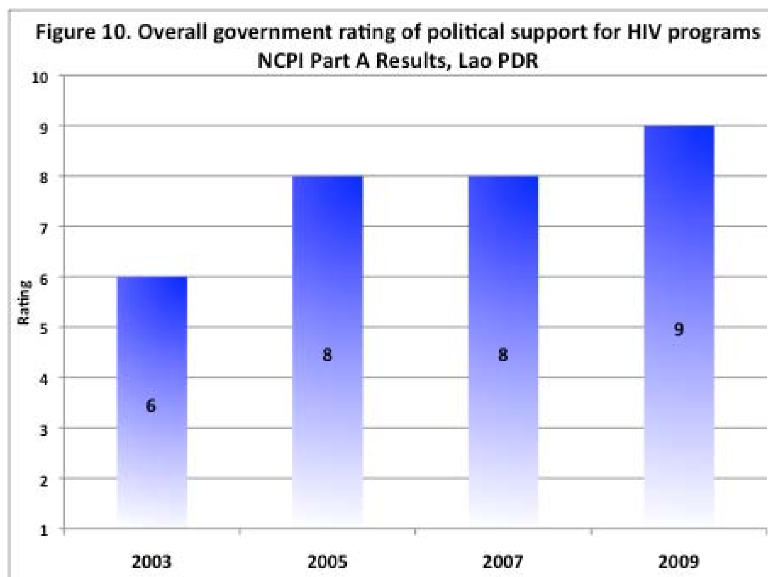
Political commitment

The level of commitment by government has already been exemplified through the work over the last two years to strengthen the “Three Ones”. Since 2003, government representatives have increased the overall rating of their political support for HIV programs from 6 out of 10 to 9 (Figure 10).

There has been a concerted push to integrate HIV into all of the country’s general development plans, including, the Lao’s Poverty Reduction Strategy and the National Development Plan, all of which required mobilized efforts to ensure inclusion with competing country priorities. Another major political step forward is drafting of an HIV Law. The MOH and CHAS appointed a team to draft a law on HIV/AIDS that will be presented to the Lao PDR national assembly in June 2010. The law will provide the framework for all sectors. There was also a review of the existing HIV policy that was updated and approved in December 2009. The policy now has added MSM & IDU as priority target population groups. In 2008, three policies were reviewed, screening and co-treatment of HIV/TB, nutrition, and MSM, to ensure consistency with the national HIV policy.

Political commitment to the national response also extends to other sectors. The Ministry of Public Works & Transportation recently developed their sectoral strategy for HIV. They have one of the few programs in the region that applies the regional recommendation for all development infrastructure projects to dedicate up to 1% of their budget to HIV activities. Through these allocated resources the ministry has been very active in conducting IEC on HIV for infrastructure and construction employees. Evaluation of this program is planned in the near future.

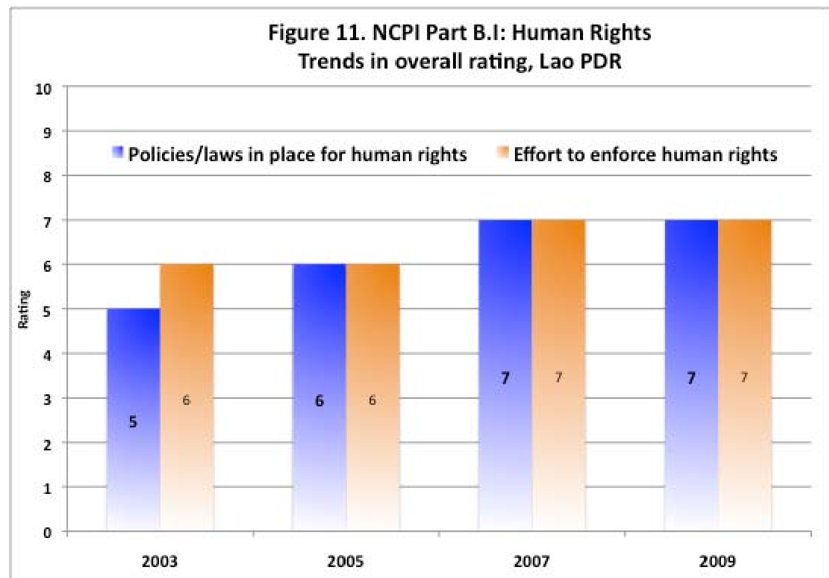
There are a number of examples of extending political commitment through collaboration with the private sector. The Lao Trade Union has a work based HIV project for factories and mining companies (see section on workplace initiatives). In addition a novel partnership with the ILO in 2009 has assisted the program to create a more enabling policy environment by promoting and sensitizing factory managers about the ILO Code of Practice on HIV/AIDS, the Trade Union Law, and the Labor Law. There is also the hotel project lead by the Ministry of Labor & Social Welfare. The project is a manifestation of a new Tripartite Declaration on HIV/AIDS at the Workplace human rights policy (see human rights section), which forbids discrimination in the workplace. The project is now piloting in collaboration with the Lao Trade Union and the National Chamber of Commerce and Industry, targeting ten hotels in Vientiane and five in Louang Prabang to raise awareness and develop hotel policy on HIV in the workplace.



These initiatives not only highlight the extent of political commitment to the national HIV response, they also point to the interest in the human rights aspect of this commitment, an area that has seen much growth over the past few years.

Human Rights

The overall consensus based on non-government responses to the NCPI is that the existence of human rights policies and efforts to enforce them has improved over the years (Figure 11). One of the areas of political commitment where Lao PDR has formerly lagged behind its neighboring countries is the legalization of human rights for people living with HIV. Although laws do not exist to protect most-at-risk populations, to date discrimination and stigmatization are addressed in the national HIV policy, and the Decree of the Prime Minister was issued to implement these policies. There has been significant progress in the last two years with the drafting of the new HIV Law, which will contain provisions to protect PLHIV right.



A new policy was launched, the Tri-partite Declaration on HIV/AIDS at the Workplace, which forbids discrimination in the workplace. Under this rule workers can file a complaint directly to the Ministry of Labor and Social Welfare for any misconduct, which would then be investigated. This policy is now being piloted in fifteen hotels in the two major cities Vientiane and Louang Prabang with the hopes of expanding to other work places following an assessment.

PLHIV - Since 2007, PLHIV have been much more involved in many aspects of HIV programming which can help to address stigmatization & discrimination and improve human rights practice. PLHIV have been recruited to work in ARV treatment centers as peer counselors and are members of the home-based care team. Provincial bodies have significant interaction with PLHIV and provide an avenue for documentation of any discrimination acts. Recently representatives of civil society have become members of the National Ethical Health Research Committee (NEHRC) and members of most-at-risk populations sit on their respective thematic working groups (TWG). There have been more efforts to disaggregate program data in order to monitor inequities. Some respondents to the NCPI felt that PLHIV need to be more involved in the actual design of HIV policies in order to truly capture their needs.

Gender - There has been movement in the area of gender, with a national commission for the advancement of women established to monitor the implementation of the international CEDAW. The Law on Protection of Women directs ministries and mass organizations to ensure that the position of women in Lao society is protected and enhanced. The Lao Women's Union (LWU) has the role to develop policy, monitor its implementation, and promote research for women's role in the community. The LWU works closely with CSOs in Lao to promote gender sensitive and gender responsive practice, with CSO's providing testimony and evidence for situations were gender discrimination is taking place. Despite these advances, there are still concerns from civil society organizations that not enough has been done to raise awareness within the government on gender issues and mainstream gender into its programs and policies. In particular, CEDAW has voiced the concern that the number of women infected with HIV is increasing, with certain groups of women such as migrant women and sex workers the most vulnerable. This vulnerability

may be due to gender-specific norms in the country that can hinder their ability to negotiate safe sexual practices and increase their risk for infection.

Prisoners - Although progress in protective legislation and enforcement has been fruitful, there are still some areas of need. Prisoners are an disadvantage group, both with regards to protection as well as with regards to HIV activities. A formative assessment on prisoner populations has been conducted by the Lao Red Cross and found that male prisoners reported having sex with other males while incarcerated. Interestingly, prevention activities have not been implemented as authorities were worried about the safety of health educators interacting with the prisoners. However, ART treatment is available to prisoners under the provision of the National Strategy of the Ministry of Public Security. There is general consensus that this population group needs to be further addressed, first by understanding their risk through a situational assessment, and then by providing appropriate HIV policy. In addition, building prisoners' capacity as outreach educators could resolve potential security concerns.

Orphans and vulnerable children – The Ministry of Public Security is responsible for OVC in protection of their rights and providing support. Legal and policy environments are being established to protect vulnerable children including children affected by AIDS. For example the enactment of a Law on the Protection of the Rights and Interests of Children passed in late 2007 and the establishment of Child Protection Networks as a formal government strategy will be rolled out in 2010. However, as HIV is not a major contributor to OVC, monitoring them as part of the HIV national response has been limited (see section III.B on OVC support)

Monitoring and enforcement mechanisms for human rights have improved overall, yet they still rate only a 7 out of 10, leaving room for improvement. The fact that there is currently no training of judiciary on HIV and human rights issues will further hinder the ability to ensure better enforcement mechanisms. In addition, there needs to be more effort to communicate and disseminate information to the public on non-discrimination laws so vulnerable groups know their rights.

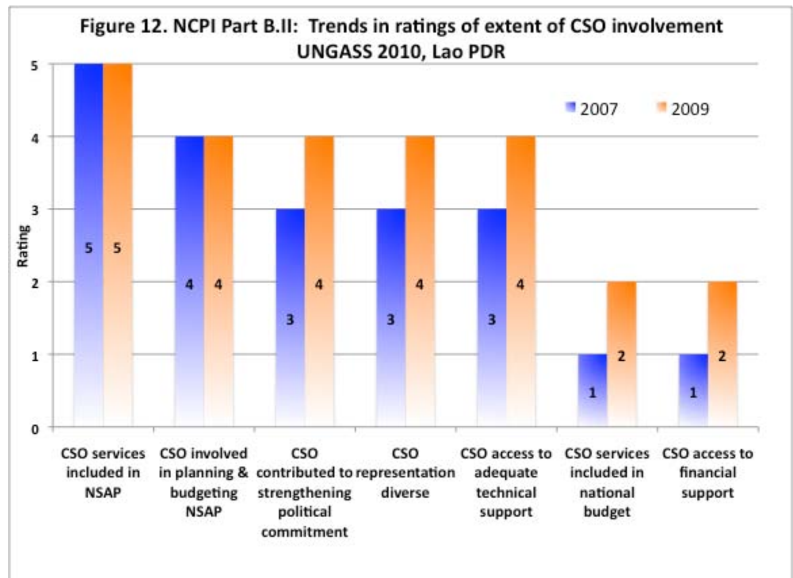
Civil Society Involvement

Until recently, civil society organizations could not obtain legal status. In 2009, the Prime Minister's Decree on Association passed and will provide an opportunity for legal establishment of civil society organizations in Lao. Despite this legal void, the national response to HIV/AIDS has overall been quite receptive of civil society engagement. According to the NCPI responses on the efforts to increase civil society participation, over the past three rounds of UNGASS, the score has remained an 8 out of 10 by non-government respondents.

An extensive network of mass organizations participates in the planning and implementation of HIV/AIDS activities, reaching from the central to the village level. These include the Lao Youth Union, which focuses on out-of-school youth education, the Lao Women's Union, which addresses reproductive health among women with HIV/AIDS, the Lao Trade Union, which conducts IEC campaigns among factory workers, and the Lao Front for National Construction. Each mass organization at the central level has appointed an HIV/AIDS focal person.

Currently eight INGO's and four local CSO's are active in the response indicating some sort of balance between small field based organizations and large capital based organizations. The INGO's mainly focus on implementing large scale outreach programs and some service delivery, each in different parts of the country, to ensure greater coverage. Local NGOs mainly focus on smaller scale outreach and providing training and capacity building at the field level. Included in this are the Lao PDR's Buddhist monks who provide spiritual healing and alternative medicine for PLWHA.

Figure 12 demonstrates that CSO activities in HIV/AIDS are always included in the NSAP. CSO's for the most part are involved in the planning and budgeting of the NSAP (4 out of 5 score), including participating in the mid-term review of the last NSAP (2006-2010). In fact CSO's are main implementing partners, or sub-recipients in GFATM supported activities, and implement up to 50% of activities for targeted prevention to FSW and MSM, reduction of stigma and discrimination, home based care, and programs for OVC.



All areas of CSO involvement have improved in the past two years, according to non-government respondents to the NCPI (Figure 12). For example, there has been an increase in CSO contribution to strengthening political support for HIV/AIDS, moving from a score of 3 in 2007 to 4 in 2009. CSO's had a major role in drafting the new HIV law. Members of CSO have become more visible in thematic groups with increased attendance of national and regional consultations. Through this increased interaction the voiced needs can become more balanced. CSOs represent 33% of NCCA membership.

There is more diverse representation of CSOs since 2007, particularly with reference to PLHIV. At the implementation level PLHIV have expanded their networks from 6 groups in 2007 to 12 groups in 2009, and they are more active at national & provincial levels with networks linked to the PCCA secretariat, reporting to them on their activities and receiving feedback and supervisory support. At the steering committee level there have been two major milestones since 2007, the first being PLHIV membership in the NCCA, and the second being PLHIV membership in the GFATM Country Coordinating Mechanism (CCM). Considering the role PLHIV networks have in peer education activities and working directly with other PLHIV, their representation can provide important insight on priority areas. One issue still persists however, limited capacities can hinder the level of involvement by PLHIV and other CSOs on important appraisals such as GFATM proposal reviews, where documents are in English or information require certain technical knowledge to understand. CSO access to adequate technical support has improved in the last two years, and CHAS has agreed to remediate via capacity building in communication, language, computer and other related skills support.

Two areas that still have a low rating of 2 out of 5, despite having increased from a rating of 1 in 2007, are related to CSO activities inclusion in the national budget and financial access. Even though 20% of national funds were allocated to CSOs according to the National AIDS Spending Assessment (NASA), the perception is that there is still a major gap between available funds and need. One of the reasons maybe due to more stringent screening from development agencies as the economic crisis has tightened available funds. In addition, reliance on GFATM grant money for HIV activities has increased as donors start to pull out of the HIV arena, leaving less funds to draw from.

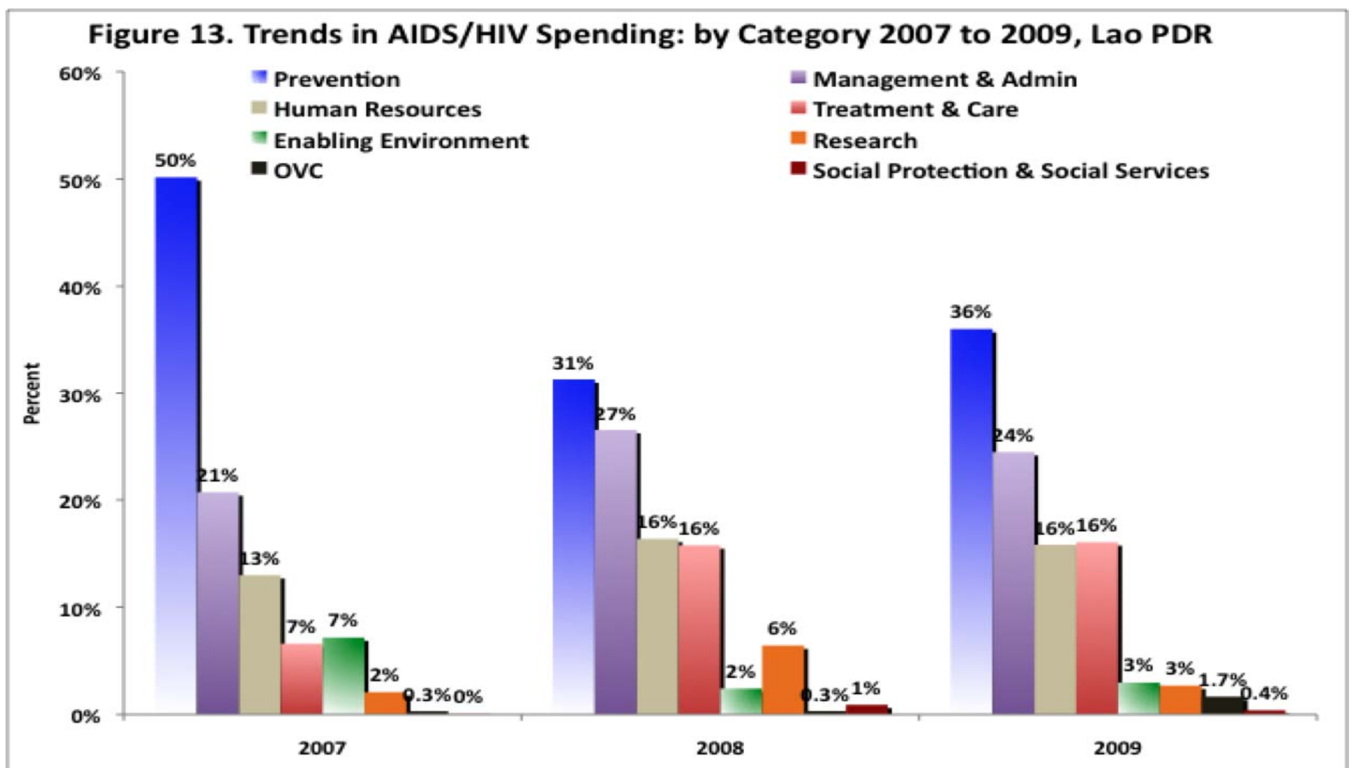
AIDS Spending

Spending on HIV/AIDS has risen about 5% since the last reporting period, from 10.5 million USD for the years 2006 and 2007, to 11 million USD for the years 2008 and 2009. A National AIDS Spending Assessment was conducted in Lao PDR for the years 2007 to 2009. The total amount spent on HIV/AIDS in

2009 was 5.9 million USD, which rose from the 5.1 million USD in 2007. Most funding has come from donors (see section VI), as national spending for HIV/AIDS programs was limited 2% of all monies spent, or 213,260 USD total for 2008 and 2009. In 2007 most expenditure, 81%, was for activities at the provincial and district level, with only 19% spending at the central level. There has been a shift in spending since, to 40% at the central level due to the management costs of procuring the increased number of OI and ARV drugs.

Figure 13 shows the trends in spending by function category. Across all years, the predominant expenditure is on prevention activities, although it has dropped substantially from 50% in 2007 to 36% in 2009 (2.2 million USD). Most of the prevention expenditures were in two areas, blood safety activities and targeted communication for social and behavioral change to most-at-risk populations, migrants, and young people. The second largest spending category was in management and administration, at 24% of all expenditure in 2009, a nominal rise since 2007. Half of the expenditure in this category has been in planning, coordination and program management. Human resources has maintained at less than 20% of all HIV spending. The other decrease in spending besides prevention is in enabling environments through advocacy activities, almost halving in value from 2007.

In 2008, there appeared to be a surge in spending on research, mainly due to implementation of 2 major biological and behavioral surveillance studies. The two areas experiencing the most dramatic increase in spending include treatment and care which almost tripled, rising from 330,095USD 2007 to 961,127USD in 2009. Much of this scale up can be attributed to GFATM round 6, which provided just over 1 million USD for ARV treatment and care for 2008 and 2009. The other major increase, albeit quite small in absolute numbers, is seen with OVC, with an exponential jump from 0.3% of all spending in 2007 to 1.7% of all spending in 2009. An area of least investment is social protection and social services (which does not include OVC), with a total spending in 2009 of 0.4% of the entire budget, mainly on HIV-specific income generation projects.

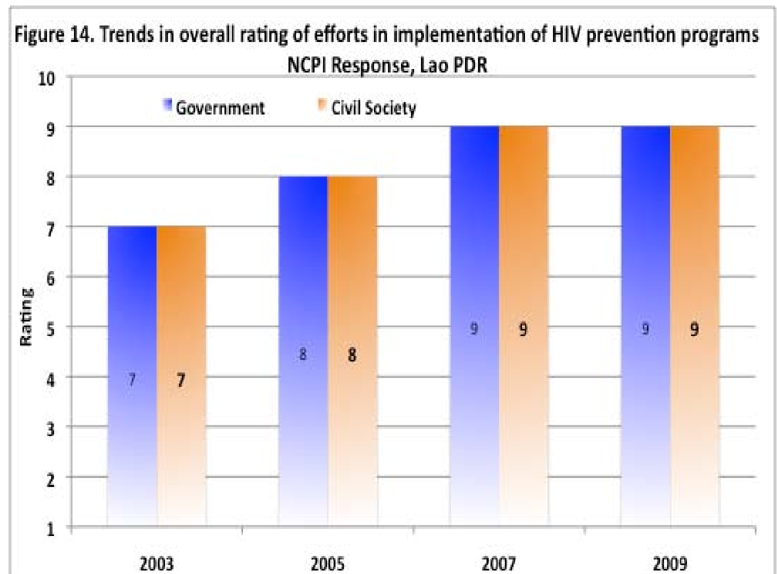


B. National Programs

Lao PDR has made great progress in the last two years on the scale of their national programs, both in terms of range of activities and extent of persons reached. The prevention efforts have branched beyond service coverage for female sex workers and men who have sex with men, extending to the general population via the workplace and schools. In addition, there has been a major roll out of support and treatment programs for PLHIV, with expansion of facility based services and use of these services. There are still high-risk populations that have yet to benefit fully from the scale up experience, including but not limited to out of school youth, migrants, and injecting drug users.

1. Prevention Programs

Given the nature of Lao's HIV situation, targeted prevention has been the key focus of Lao PDR's national response, in order to maintain a low prevalence of HIV in the general population and reverse the spread amongst most-at-risk population groups. Tailored prevention programs have been designed for each target population with a total 2.3million USD spent in 2008 and 2009 on these activities. For example, comprehensive interventions were designed for the most-at-risk groups, essential element packages for the general population, and prevention of mother-to-child transmission for antenatal care attendees. Both government and non-government responses on the NCPI indicated improvement in the implementation of prevention programs since 2003 rising from a rating of 7 to a rating of 9 (figure 14). Most areas of prevention have seen scale up, from service coverage to youth interventions to work place initiatives, however as mentioned earlier, overall spending on prevention decreased with respect to other activities, dropping from 2.6million USD in 2007 to 2.2million USD in 2008.



Program and Service Coverage

Comprehensive package of interventions - The NSAP (2006-2010) defined a set of comprehensive interventions and essential elements package to reach full coverage in prioritized provinces/districts in a phased approach. The set includes peer-led behavior change communication (BCC) with frequent peer contacts in marginalized groups like FSW and MSM, condom distribution and social marketing, improved quality and provision of STI services, referral to voluntary counseling and testing, creation of drop-in centers.

The "peer-led" initiative of the comprehensive package started in late 2007 as the peer outreach program. For female sex workers, trained peers are accessed through beer bars, entertainment establishments and drop in centers. This program has proved a major success as the 2009 BSS study on service women showed 46% reported received their HIV/STI prevention information from peers (BSS, 2009)[30].

[30] Knowledge, Attitude, Behavior and Practices (KAPB) Survey on Female Service Workers in six provinces in Lao PDR. Lao People's Democratic Republic, 2009.

The same program has been set up for MSM with a peer education manual developed. This population group is targeted mainly through drop-in centers and venues they frequent and its success still needs to be evaluated. Since most-at-risk populations are often hard to reach, training members of these groups in HIV prevention creates a peer led BCC that can propagate within the cohort increasing the chance for knowledge and safe behaviors to be established as norm.

100% Condom Use Program – the 100% CUP was piloted in 2003 with support from. The strategy targets the 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. It enlists the aid of provincial administrative and health authorities, governors, the police, sex workers, and the owners and managers of sex establishments to make it difficult for clients to purchase sexual services without using a condom. Implementation has been expanded to a total of 15 provinces in 2008 with plans to expand to the last 2 provinces pending acceptance of the GFATM round 4 rolling continuation channel (RCC) grant. Unfortunately, until this grant approval, there is currently a substantial gap in pledged money for this program, an issue needing priority attention.

Harm reduction - A task force on HIV & Drug Use, as part of the HAARP project co-chaired by the Lao National Commission for Drug Control and Supervision (LCDC) & Department of Medical Care of MOH, was created to initiate programming for injecting drug users through the support of the Australian Government and UNODC. However, overall, little is known about the existing risks of IDUs in Lao to HIV, making it difficult to design a well targeted program. Support has been given by SIDA and WHO to conduct the much needed studies on drug use & HIV, with the hopes of providing the strategic information needed for policy and prevention programs.

MARPs reached with HIV prevention programs – As the comprehensive package of interventions and outreach has been expanded, the number of marginalized MARPs having accessed to various interventions has increased. For female sex workers, a statistically significant difference in percent reached with HIV prevention programs rose from ***45% in 2008 to 70% in 2009 [Indicator 9].*** This indicator has not been measured in men who have sex with men, however 65% of MSM reported receiving prevention information from an outreach worker during the past year (BBS, 2009)[31]. No data is available for injecting drug users, migrant workers, or youth.

Blood safety – Since 2007 the blood safety program has expanded, with increasing funds spent every year to just over half a million in 2009. In 2009, 22,539 blood units were donated, ***100% of which were screened in laboratories that follow standard operating procedures and participate in external quality assurance schemes [Indicator 3].*** Although every province is screening blood and blood screenings that take place at provincial level are following quality assured manner, there are only five districts have that have the same stringent level of screening and more effort is needed to ensure blood screening follows standard operating procedures for quality assurance. Out of all blood units screened, 12 were found HIV positive (0.05%). Despite its expansion in screening, blood safety still comes short of resources every year, which has wider implications for the overall health systems strengthening.

Workplace Initiatives

A number of projects of prevention in the workplace have been implemented since 2007, in particular targeting infrastructure workers. Thousands of workers, mainly men, often separated from their families, live and work together and frequent 'beer shops' that usually set up nearby the operations. The relationship between the workers and the women working in the 'beer shops' can sometimes include transactional sex, which is a high risk activity in the context of low knowledge of HIV and other STIs.

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[31] Biological and Behavioral Survey among MSM in Vientiane – Lao People's Democratic Republic, 2009.

The Asian Development Bank has funded several projects that integrate awareness and risk prevention into road construction operations. The Northern Economic Corridor Project, a road construction operation funded by ADB linking Thailand with the People's Republic of China, has dedicated approximately $340,459 USD of the 95.8million USD project to the HIV/STI, Drug and People Trafficking Awareness and Prevention Education Program. The goal is to mitigate potentially adverse social impacts these construction projects have on increasing the risks of workers and affected communities to HIV/STIs, drugs and human trafficking. Since its inception, a number of similar projects have followed dedicating almost 1% of their overall budget to these education programs.

A general Occupational Health and Safety Project focusing primarily on the wood processing and construction industries, as well as factory workers in border locations with Thailand has incorporated a vital component on HIV awareness. The project also included for workers working on mega projects, such as the Nam Theun II Dam. The awareness and educational strategies include theatre, music and games to teach safer sex behavior.

The Lao Trade Union is responsible for conducting IEC campaigns among factory workers. To date, approximately 29,328 workers, or 39% of all factory workers, in 85 factories in three target provinces have been reached with knowledge and skills on HIV/AIDS[32]. Despite these prevention efforts in the workplace, both government and non-government respondents in the NCPI felt this was still an area of weakness and more needs to be done, especially to target migrant workers.

Youth Interventions

As the majority of new infections are shifting to younger age groups, it has become clear that the risk potential is also starting at an earlier age. In fact youth start to become at risk between the ages of 10-24 years old, when they start engaging in the behaviors that put them at higher risk for HIV infection (UNICEF, 2009). Of particular concern are youth from rural and remote areas, with little exposure to outreach and education, who move to more urban locations that pose higher exposure to risks. It has become well accepted by the Lao government that targeting youth with HIV education efforts in primary and secondary school, as well as to those youth beyond the reach of the public system, is an effective prevention measure for reducing risky behaviors. The last two years has seen much progress in youth targeted interventions.

Life skills-based education – The life-skills based curriculum in Lao PDR was one of the first to be implemented in South East Asia and with full support by the Ministry of Education. HIV-related, reproductive, sexual health and drugs education is incorporated into teacher trainings and at both primary and secondary school curriculum. Since 2007, 11, an increase from 7, of the 17 provinces are providing this education in their school systems. In addition, during this last reporting round, approximately 3,000 teachers have been trained and provided 294,000 boys and girls with the knowledge and skills to make safer life style choices[33]. ***In 2009, 74% of schools provided life skills-based HIV education within the academic year [Indicator 11].***

As a complement to the Ministry of Education's efforts, UNICEF implements Life Skills and Leadership Camps for children and youth in Champasack and Vientiane. A pilot project, led by the Regional Buddhist Initiative and supported by UNICEF, has developed a complementary curricula to the life skills-based in public school. Using Buddhist precepts, life skills are taught to make safer life style choices to secondary school students in 42 schools. The results of the pilot will be used to update the curricula to make it more widespread and effective.

[32] Correspondence with Lao Trade Union, January 2010.
[33] Correspondence with UNICEF, Lao People's Democratic Republic Country Office, January 2010.

The last two years has seen advances in reaching children in the school system, however, very little are known about youth that are out of the school system. These young girls and boys between the ages of 10-24 years old are considered especially vulnerable to HIV infection in comparison to their peers because they have low access to information, low school enrollment rates, maybe out of school, maybe subject to economic and sexual abuse and exploitation, are on the streets, are mobile (migrants) and/or displaced. Their inaccessibility has not stopped the Lao government to proceed with creative ways to reach them.

Toll-free Hotline - out of school youth program – A first of its kind in Lao PDR, a national toll-free gender sensitive Hotline was established in 2007 to reach out of school youth. The hotline provides accurate, emphatic, non-judgmental and confidential information on HIV/AIDS, reproductive health and drugs, as well as referrals to related services. The Hotline's popularity has grown exponentially with monthly calls jumping by over 2000% within the first year, and reaching approximately 12,000 boys and girls between the ages of 10-24 years old[34]. The Hotline has successfully illustrated the keen interest of young people to access this information and highlighted their concerns with respect to their own reproductive health needs, HIV, AIDS, STIs and drugs.

While this accessible and free support has been provided to young people and children nationally, there has been a limited focus on programming for adolescents defined as most vulnerable, particularly those who live in remote areas. In order to achieve a greater scale-up response to cover the hardest to reach population groups such as rural youth, will require adequate resources. In fact youth programs faced the highest gap between needed and pledged funds for activities in 2009 (see section VII). In addition, both government and non -government respondents in the NCPI gave low ratings for implementation of HIV youth programs. For this reason, the NSAP 2011–2015 will prioritize youth targeted prevention both in terms of programming and resource generation.

<u>Prevention outcomes - knowledge and behavior change</u>

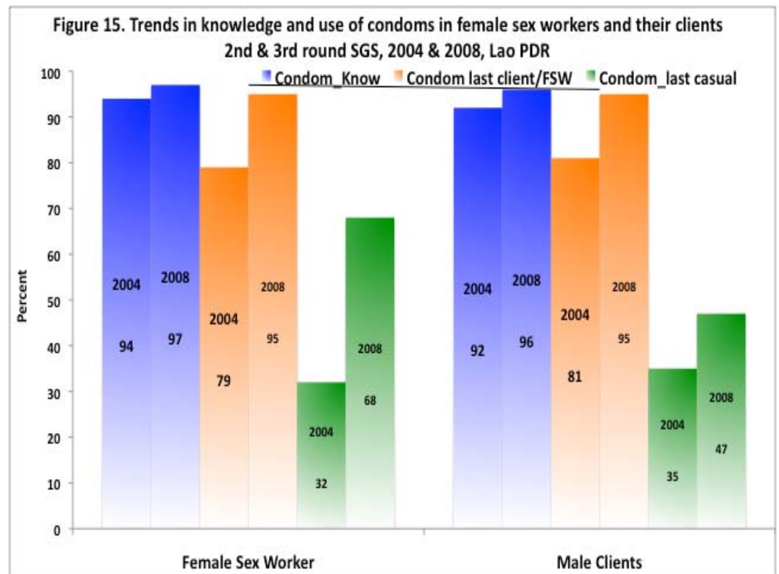
Even with the major scale up of targeted prevention, the outcomes of such efforts are not so clear. Lack of trend data makes it difficult to draw conclusions on whether knowledge and behavior have improved. However, there have been a series of 2nd generation surveillance on sex workers and their clients that allow some observation of change, with less trend information on other vulnerable groups such as MSM, youth, and migrants.

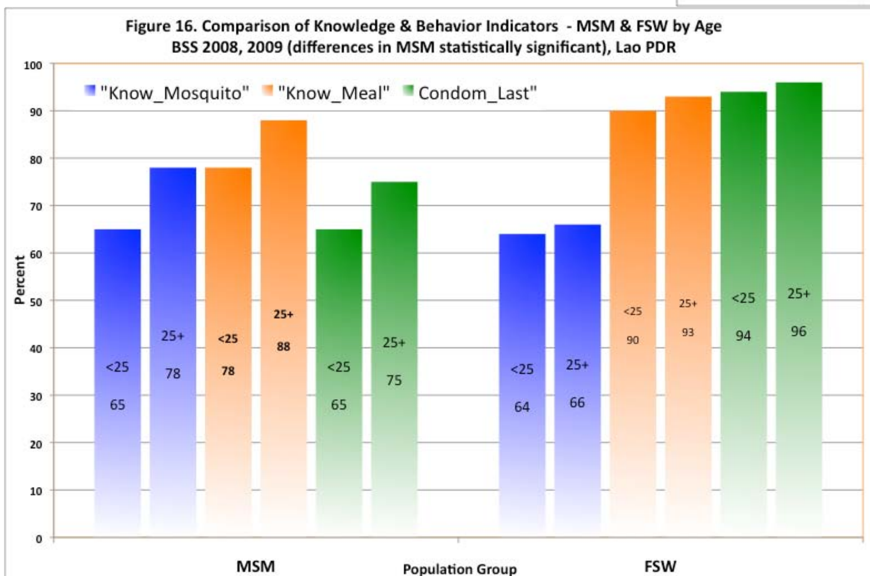
Youth (15-24 years) – very little is known about the knowledge and behavior of youth in Lao PDR, with respect to at-risk behavior and vulnerability to HIV, as few studies and research have been conducted. A study of the Reproductive Health Initiative for Youth in Asia (RHIYA) assessed the changes in knowledge and behavior in youth 15-24 years to determine effectiveness of their outreach and peer education program[35]. The study found that although there was improvement in knowledge and behavior from 2004 to 2006, across all indicators, youth in rural areas scored significantly worse than in the capital (see table 2). The study demonstrates that rural youth are particularly vulnerable to HIV risk, and many of these youth are moving to urban locations that provide more exposure to these risks. The study shows that although targeted programming can improve outcomes, a more aggressive approach is needed to ensure an adequate response to protect and equip this important sub-group.

[34] Correspondence with UNICEF Lao PDR's Country Office, February 2010.
[35] Baseline-Endline Comparative Report – Lao PDR, The EU/UNFPA Reproductive Health Initiative for Youth in Asia, 2006.

Table 2: Indicators	Vientiane		Rural	
	2004	2006	2004	2006
Know ways of preventing STIs	23%	50%	4%	20%
Heard of HIV/AIDS	87%	93%	53%	81%
Sexually active respondents who used contraceptive method (including condoms) at last intercourse	55%	70%	38%	26%

Female sex workers and their clients – Trend data in service women and their male clients[36] shows improvements in both knowledge and behavior over time. In comparing data from the same provinces, comprehensive knowledge on HIV prevention and misconceptions rose in service women from ***20% in 2004 to 49% in 2008 (45% in 2009) [Indicator 14]*** (SGS 2004, 2008; BSS 2009)[37,38]. Knowledge of condom protection against HIV and use of condoms with last commercial sex increased in both female sex workers (service women) and their male clients between 2004 and 2008 to over 95% (***94% in 2009, Indicator 18***) (Figure 14).





However, consistent condom use remains low at 60% of female sex worker using condoms every time with commercial partners in the last 3 months. In addition condom sue with casual partners is quite low for both groups (Figure 14).

Men who have sex with men – Trend data are not available for MSM, since the two studies conducted on this population were in separate parts of the country, 2007 in the capital Vientiane, and 2009 in LouangPrabang[39,40].

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[36] Male clients included long distance transport workers, military men, policeman, and state enterprise workers for 2004, and electricity workers for 2008.

[37] Second Generation Surveillance 2nd Round on HIV, STI, and Behavior – Lao People's Democratic Republic, 2004.

[38] Second Generation Surveillance 3rd Round on HIV, STI, and Behavior – Lao People's Democratic Republic, 2008.

[39] Biological and Behavioral Survey among MSM in Luang Prabang Province – Lao People's Democratic Republic, 2007.

[40] Biological and Behavioral Survey among MSM in Vientiane – Lao People's Democratic Republic, 2009.

However, comparisons in knowledge and behavior can be made within age groups and with female sex workers (Figure 16). Knowledge about misconceptions on whether HIV can be transmitted via mosquitoes or through sharing a meal did not differ greatly between MSM and female sex workers. However, in comparing the use of condoms during last commercial sex with a male client, the MSM fared much worse than FSW, 66% versus 95% respectively.

Another interesting observation is that across all indicators, for MSM younger men perform much worse than older men (statistically significant difference, $p<.05$). These age differences are not seen in FSWs. These age differences were found in most of the MSM knowledge and behavior indicators but not in the FSW indicators. This observation has implications for the implementation of prevention programs targeted at MSM. These differences beg the question if outreach and education efforts are not reaching this sub-group of MSM, of if efforts require specific type of messaging to be effective? More investigation is needed as to why younger men have lower outcomes in knowledge and behavior than their older counterparts. A series of operational research and qualitative studies could provide insight on how to change program practice to improve outcomes in these young men.

Migrants – Data is also limited in this important high-risk group. No trend data exist and only one prevalence study was conducted with limited questions on behavior and knowledge. The most recent study on Lao migrants was conducted in 2006[41]. It was found that risky behaviors exist in both males and females, with more than 75% of females and 56% of males having never used condoms, even with non-regular partners. Knowledge was not assessed in this study. More research is needed to better understand the risks present in this vulnerable group.

External migrants had fairly high knowledge of HIV transmission routes and prevention methods with greater than 80% of Vietnamese migrants and over 75% of Chinese migrants having correct knowledge[42]. Condom use faired less well however, with 54% of Vietnamese migrants, and 60% of Chinese migrants having never used a condom. Questions on sexual behavior with type and number of partners were not asked, but the low condom use would warrant this an important area to research.

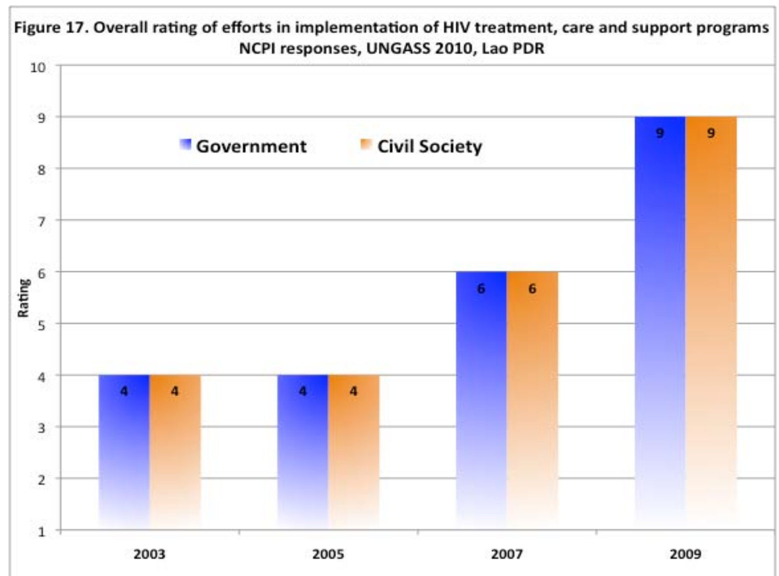
Injecting drug users – neither data on HIV, nor trend data currently exists for injecting drug users in Lao PDR. It is known however that the Lao border region of Vietnam, Son La has a prevalence of 27% HIV in injecting drug users, which underscores the vulnerability of IDU in border regions or the cross over of those from Son La into Lao.

The overlap between IDU and other vulnerable groups is evident. Injecting drug use was reported in 4% of MSM during the past year in LouangPrabang and 0.7% among the 21% of men reported of having taken drugs in the past 3 months in Vientiane. Almost all these men were less than 24 years of age (BBS, 2007 & 2009)[43,44]. Interestingly 22% of those reporting having ever used injecting drugs didn't know that HIV could be transmitted through stained needles. IDU was reported in 1.5% of female sex workers (IBBS, 2008)[45].

The 2009 study on external migrants found that 2% of Chinese migrants and 0% of the Vietnamese migrants engaged in IDU. The 2006 study on Lao migrant workers showed that of the 3.9% of females that used drugs, 50% of these had used injecting drugs. Although the use of drugs was much higher in male

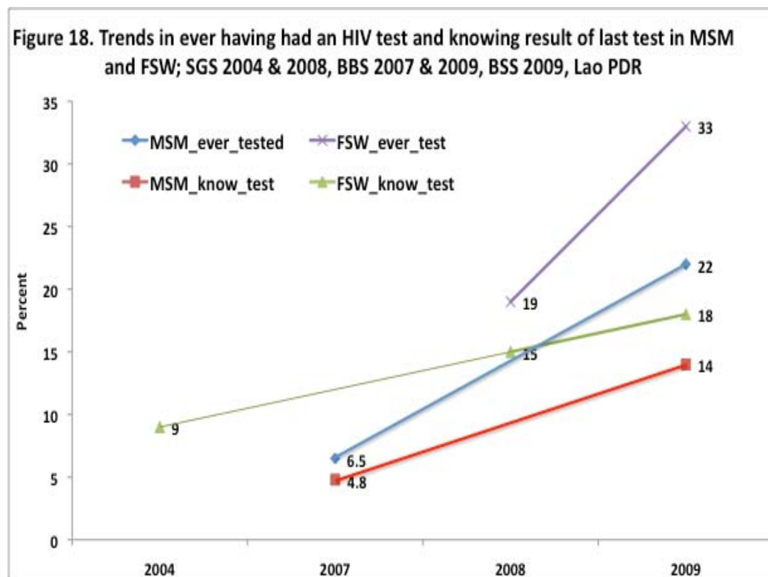
[41] HIV Prevalence Study among Migrant Workers at 8 Border Provinces of Lao People's Democratic Republic, 2006.
[42] Knowledge, Attitude, Behavior, and Practices (KABP) survey among Chinese Communities in Louangnamtha province and Vietnamese Communities in Champasack and Attapeu provinces, Lao People's Democratic Republic, September 2008.
[43] Biological and Behavioral Survey among MSM in Luang Prabang Province – Lao People's Democratic Republic, 2007.
[44] Biological and Behavioral Survey among MSM in Vientiane – Lao People's Democratic Republic, 2009.
[45] Second Generation Surveillance 3rd Round on HIV, STI, and Behavior – Lao People's Democratic Republic, 2008.

migrants (40%), only a small percentage of these, 3%, had used injecting drugs. This suggests that a subset of migrant women maybe susceptible to injecting drug use and need to be targeted to gain access to HIV harm reduction programs.



2. *Care, treatment, and support programs*

There is unanimous agreement among stakeholders in the national response, that implementation of HIV treatment, care and support programs has improved dramatically over the past years (Figure 17). In 2003, the NCPI overall rating was a low 4, rising only in 2007 to a middle 6 rating. The last two years has seen substantial improvements in the provision of services and treatment for HIV and a rise in rating to 9. Through rapid expansion of voluntary testing and counseling and ART sites, more people are able to get the services the need.



Voluntary testing and counseling

Voluntary testing has experienced an impressive scale up since 2007. The number of persons tested increased by 50% since 2007 to 37,900. Testing practice in most-at-risk populations also increased substantially (Figure 18). The percent of MSM ever having had a test more than tripled during this last reporting period to 22% in 2009, and almost doubled over a one-year period to 33% in FSW (SGS 2004 & 2008, BBS 2007 & 2009, BSS 2009) [32,33,34,46]. The percent having had a test and knowing their result also tripled in MSM since 2007 to 14%, and doubled since 2004 in FSW to 18% in 2009 ***(15% for 2008, UNGASS indicator 8)***.

There are a number of reasons that maybe contributing to the increase in testing practice. Spending on VCT increased by 2.5 fold from 2007. One are of this spending was the major expansion in the number of sites available for HIV testing. Figure 19 shows that along with the increase in number of persons testing, the number of testing sites rose from 37 in 2007 to 110 in 2009, a three-fold increase.

Another reason is the range of sites available, both geographically and in type of setting. Although the expansion in testing sites had been mainly focused for HIV "hotspot" areas, with only the most populated provinces having 100% of their districts covered, testing sites are now present in all provinces and 86 districts. Testing is available in a range of settings including all national and provincial hospitals, some clinics, STI clinics, ANC sites and most recently, drop in centers. The latter have also expanded in

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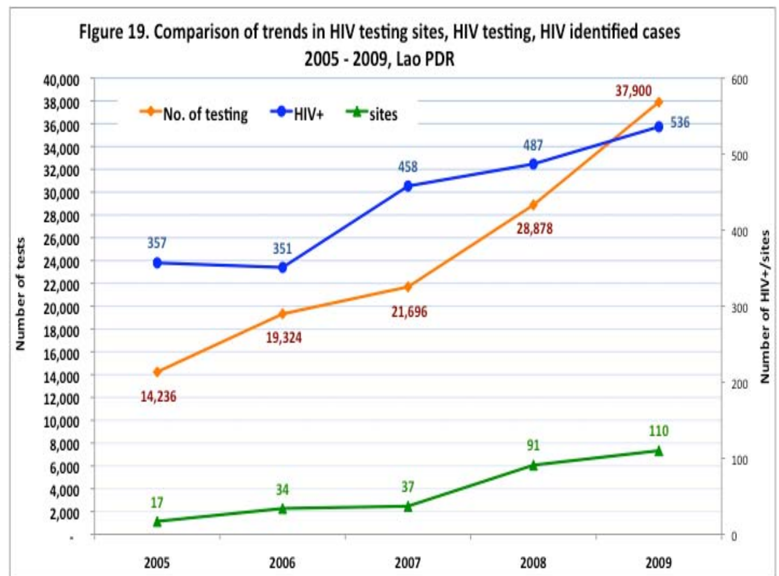
[46] Second Generation Surveillance 2nd Round on HIV, STI, and Behavior – Lao People's Democratic Republic, 2004.

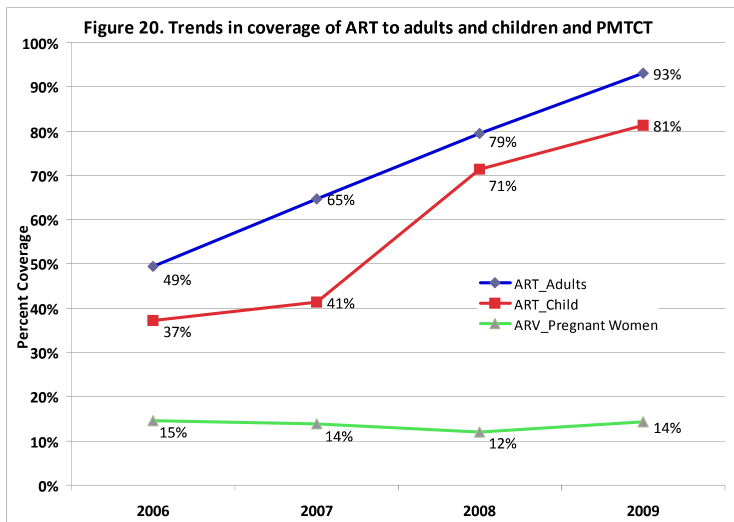
numbers to 7 drop-in centers for FSW and 2 for MSM, allowing for a setting that can provide more targeted interventions for these most-at-risk populations.



One initiative that has allowed for the increase in testing sites is the inception of rapid diagnostic tests (RDT) to test for HIV. Due to grant money from GFATM rounds 4 and 6, a large number of RDTs could be procured to facilities across the country, facilitating the increase in testing.

Outreach efforts to most-at-risk populations as well as improved referral services in TB, STI and ANC, as well as in youth development centers also increased during this reporting period, with the aim at increasing testing. There are however still priority areas that need special attention. Interestingly, in both MSM and FSW, the older population group of 25 years and over was almost twice as likely to have ever had a test than the younger population group of 15-24 years[47,48]. This suggests that young most-at-risk groups may require a different strategy for outreach in order to improve their testing practice.

Antiretroviral treatment (ART)

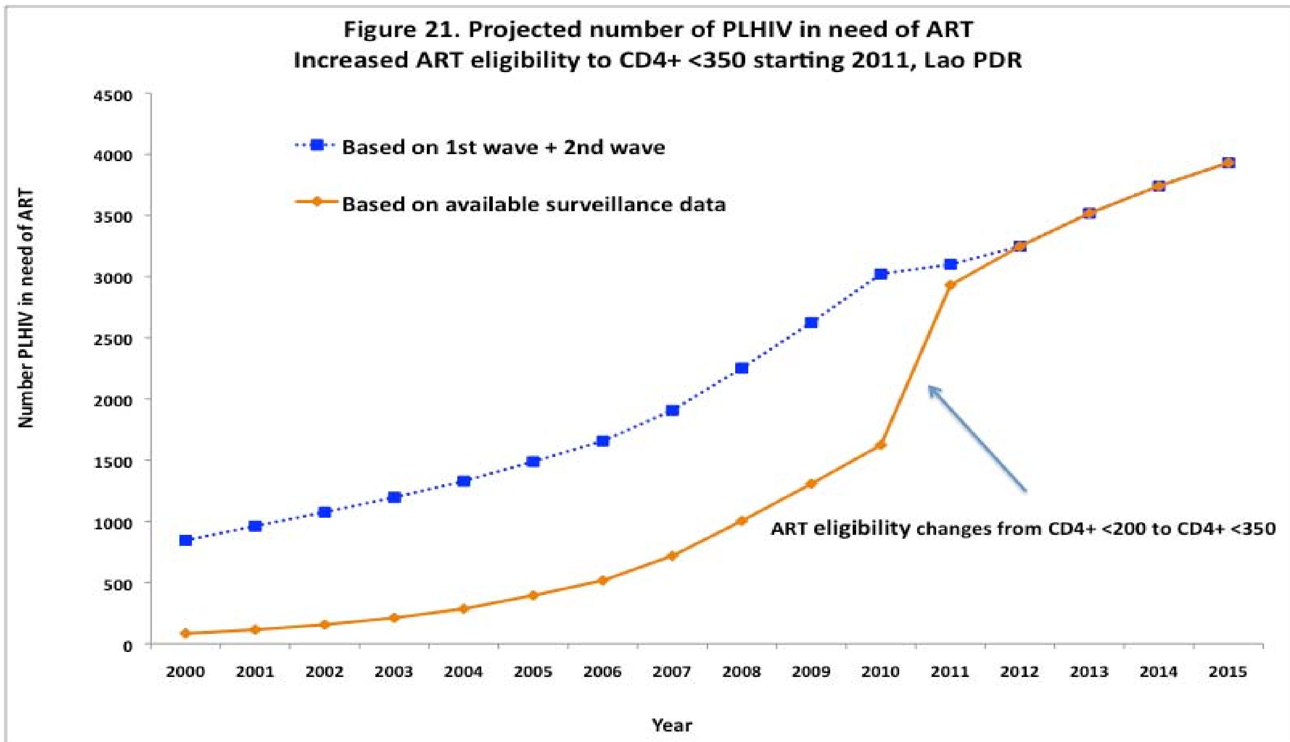


Coverage of ART in adults and children has experienced a magnitude of increase similar to that seen in HIV testing (Figure 20). **In 2009 1,250 adults and 95 children were receiving ART. Since 2006, ART coverage in children rose two-fold to 80% in 2009, and in adults increased to 93%, for a total of 92% coverage *[Indicator 4].*** Scale-up of treatment has been one of the foremost priorities of the NSAP 2006-2010. Funds provided by GFATM HIV round 6 grant have provided more than 1 million USD to procure ARVs for this scale up, with another 1.5 million USD pledged over the next three years. The number of available ART sites expanded from 2 to 5, covering the north (1), central (2), and south (2), as well as 2 satellite sites in the north.

Beyond the expansion of where an HIV positive person in need can go to receive ART, there has also been a concerted effort to raise awareness regarding eligibility and the effectiveness of treatment. PLHIV have been mobilized and trained to provide outreach to other PLHIV centrally and in the provinces. In the past, PLHIV would receive ART at late stages, often at CD4+ levels way below 200, which would lead

[47] Second Generation Surveillance 3rd Round on HIV, STI, and Behavior – Lao People's Democratic Republic, 2008.
[48] Biological and Behavioral Survey among MSM in Luang Prabang Province – Lao People's Democratic Republic, 2007.

to low coverage and low survival rates. Through increased awareness, more PLHIV come to ART sites and they come earlier, increasing their survival. ***In 2009, 12-month survival was 95% in adults and 100% in children [Indicator 24]***.



As more people are identified and survival rates increase, the number of PLHIV in need of ART will also rise. In addition, in 2010, the eligibility requirement in Lao for ART increased from CD4+ count of 250 to 350, in line with WHO guidelines. This change in eligibility will almost double the number of people in need of ART compared to previous estimates. Figure 21 illustrates the future needs of ART based on the change in eligibility requirements. The orange line represents the estimated need based on modeling of available surveillance data. These estimates have been the basis for determining ART need thus far. The jump in numbers starting in 2010 is due to the increase of PLHIV qualifying for ART. The blue line demonstrates the need based on the addition of phase 1 and phase 2 scenarios described in section II. Considering that phase 1 PLHIV levels off by the end of the first decade of 2000's, the change in eligibility requirements continues the increase in need for ART at the same pace as the combined estimates.

In order to meet this demand for ART, a new phase of scale up will be necessary. Human resources both in number and capacity will need to increased and strengthened. Increased access to second line ARV and OI treatment will be necessary. All of these outputs will require increased resources from donors and increased assistance of implementing partners.

Prevention of other-to-child transmission (PMTCT)

The percentage of HIV positive pregnant women receiving anti-retrovirals to reduce the risk of mother-to-child transmission has remained low in the last two years, ***12% in 2008 and 14% in 2009 [Indicator 5]*** [Figure 20]**.** However, looking at this indicator alone does not provide the true picture of the significant achievements towards meeting comprehensive coverage of PMTCT. In recognition of the importance of PMTCT in maternal and child health (MCH) care, one of the most significant achievements was the recent integration of PMTCT into the newly approved Framework for the Integrated Package of

Maternal Neonatal and Child Health Services 2009-2015. To follow-up on this, the NSAP 2011 – 2015 will as a priority task, include the development of a PMTCT strategy for the National Program.

On the programmatic side, over the past two years six provinces were targeted for establishing and integrating PMTCT into all of their ANC/MCH clinics. Health care providers were trained to strengthen their capacity to promote voluntary confidential counseling and make referrals for testing, In addition, emphasis was made to deliver HIV/AIDS and reproductive health information not only to pregnant women but also their husbands. Clinics and outreach teams were equipped with the requisite tools including equipment for outreach activities and information, education and communication materials. In 2008, 17,000 pregnant women, 50% of all pregnant women attending ANC clinics in the six priority provinces and 2,500 of their husbands were recipients of HIV outreach activities from ANC and MCH health facilities.

One program that has gained international recognition and interest is the innovative public information campaign launched by the MOH in 2007 in six target provinces to support an enabling environment to facilitate male involvement in PMTCT. The concept was inspired by the fact that during the pregnancy of their wives, men having sex with sex workers is legitimized since many men believe that sex with their wives may cause and lead to miscarriage. Rather than just one message the public campaign, “Caring Dads” took on a number of issues to dispel misconceptions and focus on the central theme that men have an important role to play in child-care and the well-being of their families. Beyond IEC, the campaign involved the establishment of “Caring Dad” spaces in ANC/MCH clinics. The program will be evaluated during the NSAP 2011 – 2015.

Overall the percentage of infants born with HIV from HIV-infected mothers is lower than seen in high prevalence countries. ***In 2009 the 15% of infants born to HIV positive mothers were also infected with HIV [Indicator 25].*** Although the absolute numbers are low, with 25 HIV positive infants born to 167 infected mothers, the goal is to reach all HIV positive pregnant women in order to provide the appropriate PMTCT coverage and prevent further transmission to newly born infants.

Co-management of HIV and TB

The collaboration between HIV and TB disease programs has been more of a challenge to implement than the scaling up of other service programs. One of the priority activities for GFATM round 6 was to increase the collaboration between TB and HIV programs starting with the creation of a National HIV/TB Coordination Committee in 2008. Since then, CHAS & the National TB Center have started to coordinate and collaborate in order to improve mutual screening and treatment. At the time of writing standard operating procedures are being drafted for the co-management of HIV and TB.

The number of TB patients screened for HIV has increased over the last two years from 293 in 2008 to 594 in 2009. Current policy stipulates that all TB patients must be tested for HIV, and TB practitioners have been trained for referral of patients to VCT sites for testing. If the patient has a CD4+ count of less than 350, they are further referred to ART sites for treatment. Often patients are lost to follow-up as they don’t make it to the VCT sites. To mitigate loss to follow-up in referring to the VCT sites the long term goal is to start including RDT at TB clinics, a priority activity for the NSAP 2011-2015.

The number of HIV patients screened for TB has increased over the last two years from 388 in 2008 to 690 in 2009. For PLHIV, the current recommendation is that all should be screened for TB. Often patients are first referred to one of the five ART sites as priority. As these sites are geographically close to the TB clinics often in the same building, there is close collaboration between the two centers, and patients are consistently referred for TB screening. However, from the VCT sites, referrals are not always made for TB screening and often when they are there is loss to follow-up. For example, drop-in centers will

refer a newly identified HIV positive person to directly to one of the 142 TB sites (each district hospital has one TB site) for screening which the person may never visit.

There are plans to expand the TB/HIV co-management policy. ***Co-treatment of HIV and TB was received by 85 people in 2009 [Indicator 7].*** Estimates are not available for the number of people living with HIV who are also infected with TB for 2009 from WHO. The 2006 value for estimated number of incident TB cases in PLHIV was 161 persons[49].

Care and support

In 2009, CHAS, in partnership with UNAIDS and UNICEF, established a Thematic Working Group on Community Care and Support, to better coordinate and monitor community care and support activities nationally. One of the key outputs stemming from the TWG was an advocacy push for a greater involvement of PLHIV calling for their empowerment to play a more active role in the national response beyond just being recipients of treatment.

Most of the burden of the epidemic is concentrated on poor families who have no cushion against the consequences of AIDS-related illnesses, nor do they have the support of formal social protection systems. During the last two years UNICEF Lao has facilitated small seed grant funds to families affected by HIV and AIDS to initiate small, manageable income generation activities benefiting children. In addition the program has supported two women's groups in the target provinces of Vientiane Capital and Champasack who are either infected with HIV or have been affected. These initiatives have already had a positive impact on the overall improved financial security of the households involved. Children have been able to attend school regularly school and have health care visits. Since 2007, 150 income generation activities valuing at 67,000USD have been supported benefitting approximately 500 children.

Support to orphans and vulnerable children - Expenditure on OVC education increased 17-fold from 2007 to approximately 58,000USD in 2009, and for OVC support to almost 100,000USD in 2009. In addition, OVC community support tripled in its spending from 2007 to 35,000USD. The number of children who have lost one or both parents to AIDS is not known. In 2007, an assessment commissioned by UNICEF to determine the numbers of orphans and children affected by HIV/AIDS and other vulnerable children in the country. It was estimated that there were approximately 85,000 orphans under 15 years old in Lao PDR or 3.5% of the child population, a portion of whom may have lost a parent to AIDS (UNICEF, 2007).

The results of a needs assessment on children and adolescents affected by HIV/AIDS in the country completed in 2006 informed the drafting of a Framework of Action for Children Affected by HIV / AIDS in 2009[50]. The study highlighted that although families have traditionally accepted children who have lost parents, the stigma of AIDS and community isolation have made it more difficult for families to accept children infected with HIV or children affected by AIDS. Many families are already poor and have no support formal social protection or welfare system. Decreased household incomes and a drain on financial resources have meant that children, in the place of parents have become the chief household income earners. Social protection is the area with the least amount of AIDS spending in Lao, comprising only 0.4% of all expenditure and valuing less than 70,000USD for 2008 and 2009.

Limited psychosocial support and family placement strategies exist, however, efforts have been made since 2007 to scale up pilot initiatives that include support and care to families affected by AIDS, the

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[49] Global Tuberculosis control – surveillance, planning, financing. 2008 WHO. Western and Pacific Regional Estimates: http://www.who.int/tb/publications/global_report/2008/en/index.html

[50] Needs Assessment and Children and Adolescents Affected by HIV/AIDS in Lao PDR. UNICEF, Lao PDR Ministry of Health, Save the Children, 2007.

establishment of income generating activities, stigma and discrimination campaigns and psychosocial support to children infected with HIV and affected by AIDS. These include life skills based summer camps and child self-led support groups and networks. These pilot initiatives are a stepping stone to getting an increased commitment and understanding by government decision makers of the needs of children infected with HIV or affected by AIDS.

Coverage of support services to orphans and vulnerable children is estimated at 80% (UNICEF). These are program data and not collected via household surveys, so ***data are not available for indicator 10, support to OVC. Data are also not collected for indicator 12, school attendance between OVC and non OVC.***

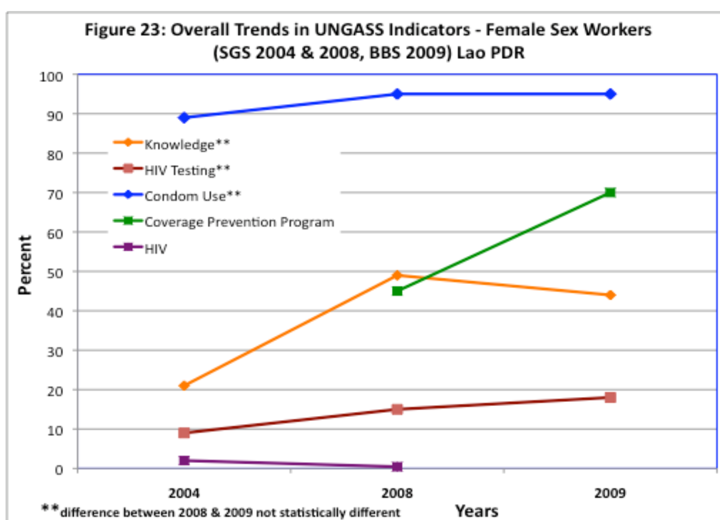
IV. Best practices

Lao PDR is likely on the way to reach the MDG goal 6A of halting the spread and beginning to reverse HIV prevalence. In addition, Lao PDR has demonstrated great progress towards reaching MDG goal 6B of achieving by 2010 universal access to treatment for HIV/AIDS for all those who need it. When the epidemic started to take hold in the early 2000s, the Lao government responded promptly through increased political support, working closely with partners, and mobilizing of funds to expand the multi-sectoral response. The major focus was in priority area 1 of the NSAP 2006-2010 – reaching full coverage of targeted and comprehensive interventions. A combination of factors across the multi-sectoral response has contributed to the success seen so far. The scaling up of different aspects of the response as well as the synergy of the multi-sector efforts can be considered a best practice, particularly in light of the evidence in improved outcomes and impact. In addition, as outreach and access to testing identified more people in need, expansion of ART, care and support followed suit.

A. Improved HIV outcomes - scale-up of targeted prevention

The comprehensive intervention package essentially has a two-pronged approach, scaling up the supply side which covers the range of services including behavior change interventions, condom provision, STI services and VCT, and improving the demand side through increased awareness and an enabling environment, in particular peer-led education outreach efforts by most-at-risk populations and PLHIV within their networks.

Figure 22 demonstrates how the last few years has seen success in scale-up efforts. All provinces except one (16), have more than one of their districts covered by the comprehensive package of services. This exceeds the planned targets shown in Map A that were set out in the NSAP 2006-2010, where only eleven provinces would have coverage. In addition, in provinces that have the comprehensive package implemented, all appear to have met or exceeded their targets as well, with the majority having at least 50% of their districts covered by the comprehensive package. For example, Vientiane Province was targeted to achieve 27% to 29% of its districts having the package, but in actuality, they achieved between 76% and 100% district coverage in 2009. Such a scale-up demonstrates Lao PDR's commitment to achieving universal access of all interventions.



The expansion of the number of drop-in centers, HIV testing sites, 100% CUP, and peer-led outreach most likely contributed to the positive outcomes in percent reached with prevention programs, knowledge, testing behavior, condom use, and consequently, drop in prevalence. Figure 23 illustrates the trends in several UNGASS indicators in female sex workers, all of which show improved results since 2004. In the past five years comprehensive knowledge more than doubled, with condom use at last sex rising despite already being quite high. HIV testing and knowledge of results also almost doubled over the past five years. Access to prevention programs increased substantially in just one year.

Similar patterns are seen in potential clients of sex workers. Condom use at last sex with female sex worker rose from 81% in 2004 to 95% in 2008 in sampled electricity workers. Condom use with last casual partner also rose, albeit at lower levels, from 35% in 2004 to 47% in 2008. Private-public partnerships have provided outreach and education efforts through work place programs in border factories and infrastructure projects. These activities have helped to reach potential clients of sex workers.

It seems hard to imagine such a quick and dramatic impact just from scaling up prevention efforts over a few years. However, the fact that until now the national HIV response was focused on a fairly homogeneous population, and that the high-risk target groups are low in terms of absolute numbers, has probably allowed for these efforts to penetrate more easily and propagate change more quickly. This does not however preclude the fact that Lao PDR has experienced the positive effects of a successful multi-sectoral response that targets both the supply and demand side of HIV services through synergistic and focused planning. This response has extended across the health sector as demonstrated by the success reducing STD rates with scale up of STD services. The success of the HIV response is interlinked with that of the STI response.

B. Improved STI outcomes - scale up of STI services, a systems approach to HIV management

In the early 2000's, the STI rates (infection with Chlamydia and/or Gonorrhea) were reaching close to 45% in female sex workers. It became obvious that without addressing STI's, an exponential HIV spread was not far behind. The Lao government channeled resources to scale-up STI services through monies from GFATM round 1 and 4 grants as well as other donors. The focus was on improving STI services, increasing access of sex workers to STI services and improving health care seeking behavior including implementation of periodic presumptive treatment (PPT) for sex workers in all provinces. The interventions expanded its scope to include voluntary counseling and testing, behavior change communication among clients and STI services for men through kits. By 2005 drop-in centers were established in collaboration with Family Health International (FHI) to complement the government STI services in five provinces, combining all the STI interventions under one roof. Soon after these drop-in centers started to provide voluntary testing and counseling in conjunction with HIV outreach and peer education.

Figure 24 highlights for FSWs the improvements over time in both uptake of STI services, particularly in drop-in centers (red line), reduction in self-treatment and no treatment, and the decrease in STI rates. These improvements mirror the trends seen in HIV testing and prevalence. The expansion of STI services in scope to include HIV prevention and testing, is exemplary of a systems wide approach to managing HIV interventions.

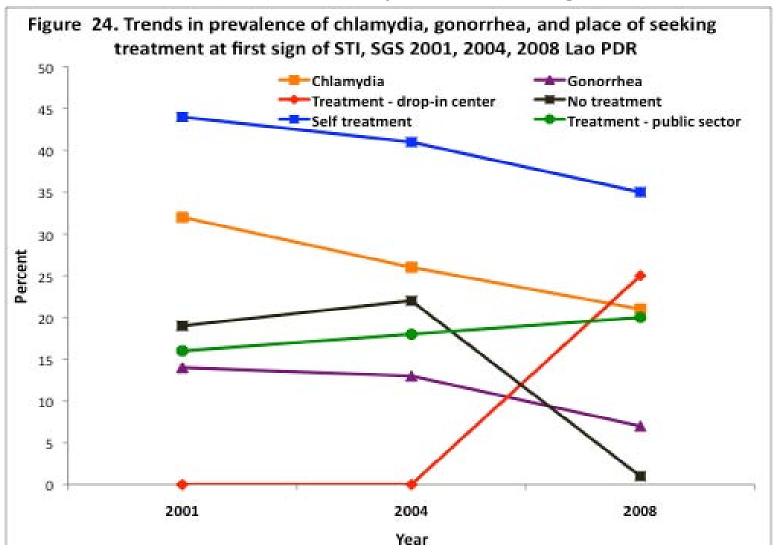


Figure 24. Trends in prevalence of chlamydia, gonorrhea, and place of seeking treatment at first sign of STI, SGS 2001, 2004, 2008 Lao PDR

C. Improved coverage of treatment - scale up of supply and demand side interventions

Scale up of treatment also experienced a major success - over 50% increase in ART coverage in the last reporting period. On the supply side the scale up of ARV drugs due to increased mobilized funds has

played a major role, but as is known, more drugs alone does not lead to improved coverage. The exponential expansion of VCT, has allowed for more cases to be detected and hence receive treatment. The addition of three more ART sites has increased the accessibility to treatment and support services.

There have also been efforts to improve the demand side for these resources. The last few years have seen a major increase in the engagement of PLHIV in the national response, especially through outreach and awareness activities. The expansion of PLHIV networks across the country and in point of entry settings such as drop-in centers and testing sites allowed PLHIV to reach and mobilize other PLHIV to seek treatment. Their role will prove even more important as eligibility requirements have been relaxed to include persons with CD4+ count of 350, and PLHIV can facilitate the communication aspects for seeking treatment earlier.

Addressing health system weaknesses only can't always achieve the results wanted. The success of the ART program has been possible because of the multi-layered approach addressing both the supply and the demand side of HIV care. By increasing the awareness and need for services, the demand is created and the momentum needed to ensure those services continue.

V. Major challenges and remedial actions

A. Progression on previous key challenges

The main challenge thus far in Lao PDR has been centered around maintaining the low HIV transmission. As the evidence in section II and III illustrates, all the right factors exist for concern of a looming epidemic:

- active sex worker-client transactions without 100% consistent condom use, especially with migrants and near the borders,
- the increasing emergence of HIV in men who have sex with men (MSM),
- increasing number of drug users including injecting users across all vulnerable groups and bordering countries with major IDU/HIV problem,
- continued high prevalence of STI in men with gradual decrease in women,
- opening of pathways linking LAO PDR with high prevalence countries,
- increasing influx of external labor migrants from surrounding countries for work on transportation routes and construction projects,
- continuous flow of migrant workers from Laos into and returning from countries having higher HIV prevalence

The focus for alleviating these pressures has been to reach the targets set out in the NSAP 2006-2010, with the ultimate goal of obtaining universal access of interventions to thwart any potential HIV spread. There has been much progress over the last two years to overcome the obstacles in achieving these targets. Table 3 describes the main challenges, whether they have been achieved and if not why, and what the future needs are to achieve the targets. There are three main areas experiencing improvement over the last few years:

1. ***Improved resources and capacity*** - the lack of resources and capacity were the primary obstacles at the onset of the NSAP. Funds from two rounds of GFATM (6 and 8) have been mobilized to provide for the large scale-up seen in prevention and treatment interventions, provide training and supervision, and ensure a better M&E system to provide strategic information on planning and policy.

2. ***Enabling environment*** - Initially political commitment was lagging, but as described in section III, there has been a major turn to a supportive and enabling environment. Improved HIV focused legislation and increased participation of CSO's/PLHIV networks in decision-making has provided the setting to progress in formerly unaddressed areas.

3. ***Improved data*** - it became clear that one of the major obstacles towards addressing these challenges and roadblocks was the lack of information for both understanding the HIV situation and for making evidence based program and policy decisions. Over the last reporting period there has been a big improvement in the amount and breadth of data on HIV. Five behavioral studies have been conducted just in the last three years, with three of them including sero-prevalence data. In addition a functioning M&E system has been established (see section VII).

B. Challenges faced during 2008-2010

Despite the many successes seen during the last two years, with a substantial number of targets met or almost met, table 3 indicates that there are still many that have not been reached or it is not

known if they have been reached. There are two main hiccups in the system that is creating barriers for achieving these goals:

1. ***Continued lack of data*** - as is clear from table 3, for many population groups it is just not known if the targets have been met, because data has not been collected/available to monitor progress.
2. ***Neglected priorities with regards to available resources*** – many of the emerging issues such vulnerability in out of school youth, youth in general, mobile populations, and injecting drug users are not addressed adequately because the resources are not available to monitor and respond to their needs.

There is no doubt of the impressive scale up of services and interventions seen in the past two years, however most of this scale up has been focused on the main drivers of the epidemic. The continued challenge will be to maintain the level of services and monitoring that is already in place while expanding to emerging vulnerable groups and hard to reach populations.

C. Remedial Actions to achieve UNGASS targets

Efforts are underway to fully evaluate the progress made during NSAP 2006 – 2010, the results of which will inform the new NSAP 2011-2015. Table 3 briefly summarized the initial findings with the last column describing specific remedial actions. The priorities for the new NSAP will be three-pronged:

1. ***Achieving the Objective 6 of MDGs halting the spread and beginning to reverse HIV prevalence.***
2. ***Achieving Universal Access of interventions as a means towards priority 1.***
3. ***Addressing the challenges that thwart progress towards priorities 1 and 2.***

The new NSAP will describe the set of objectives that will provide the framework for Lao's HIV response over the next 5 years. There are some areas that need special attention as they are new and imperative to overcoming the current challenges that are hindering progress. The new NSAP must address the following:

A. ***More intensified gender-sensitive and gender-responsive strategy*** - like its neighbors, Lao PDR's epidemic is becoming increasingly female. With the exception of MSM, the evidence shows that the majority of the HIV burden rests in women (FSW, migrant women). In order to effectively reach this population, gender sensitive and gender responsive strategies need to be incorporated into the programmatic response, from training to service delivery to monitoring and evaluation.

B. ***Prioritizing strategic response to emerging vulnerable groups*** – sections II and III described the emerging epidemiological situation and vulnerabilities to HIV. Traditionally resources and program strategy have been focused on the main players of the epidemic – female sex workers and their clients. However, pockets of evidence point to other high risk groups that have already emerged, such as MSM, or are at the risk of emerging, such as migrants, and thus it is important to understand how to expand intervention efforts to reach these groups. Special focus is needed on the following populations during the next NSAP:

- Migrants – once the driving force in Lao's epidemic, they are still highly vulnerable group, in particular young female migrants.
- MSM – now the highest prevalence group, services are not yet scaled up to provide universal access. Special focus and strategy is needed for young MSM as they perform less on outcome indicators.
- IDU – very little is known about their numbers and level of risk in Lao. Efforts to understand their situation is needed in order to ensure proper response.
- Youth – young people are the gateway to HIV prevention. Little is known about HIV

knowledge, attitude, & behavior in general population youth. However, evidence has pointed to young migrants & MSM being the most vulnerable. Rural & out of school youth are particularly neglected and vulnerable.

C. ***Increased M&E, surveillance and research*** – despite its improvements, data is still lacking, particularly in emerging vulnerable groups. Targets were set in the NSAP 2006-2010 without the strategy to monitor their progress. It is imperative that this new NSAP have a detailed plan for M&E, surveillance and research, so that come 2015, it will be possible to fully understand the progress towards MDG targets and universal access. The following are high priority:

- Situational analysis on IDU
- Updated study on migrants, with particular focus on young females
- Study on general population & youth
- Special operational research & specials studies to assess program activities and provide deeper understanding of certain patterns (eg. why young MSM score lower in knowledge & behavior than older MSM, etc)
- Include global indicators (UNGASS) in data collection efforts to facilitate monitoring of global HIV priorities. Be sure to include UNGASS indicators in next reproductive health survey, as well as SGS in MSM

D. ***Mobilizing resources for neglected/deficient priority areas*** – maintaining the current level of response in a low epidemic country is already a challenge, but the real demand will be to obtain resources to address neglected and deficient priority areas, especially in response to the aforementioned emerging issues. In order to be successful it will require strategic thinking and reaching beyond primary donors such as GFATM. A resource mobilization plan is imperative in order to ensure continued and sustained funding as the 2015 MDG date gets closer.

E. ***Mobilizing public-private partnerships*** – to date, joint programs with the private sector have proved invaluable in reaching certain population groups that may not interact with the public sector. Migrant workers and out of school youth can benefit from programs channeled through the private sector, whether profit or not-for-profit based. The goal for the next NSAP is to foster and expand relationships with private organizations and industry so that HIV education and outreach efforts can be streamlined in their policies and employee programs, as well as use their strengths as a means of reaching certain population groups (eg. media).

Table 3: Targets for 2010 as described in NSAP (2006-2010)	Achieved	Comments	Challenges to achieving/ maintaining target	Remedial actions planned to achieving/ maintaining target
A strong overall management structure exists to guide and coordinate an expanded response to HIV/AIDS	Almost	CHAS serves as main coordinator, NCCA developed clear TOR	NCCA remains in background leaving dual role for CHAS	Revise coordination structure. Strengthen secretariat role of the CHAS
A national M&E system is functioning	Almost	M&E system developed with unit, guidelines & 5 year plan	Still low capacity and number of staff No centralized data base	Continue to ensure resources
Consistent condom use in 80% of sexual interactions between female SWs and their clients	Almost	70% consistent condom use	High mobility among FSW	Because of high mobility, need to maintain outreach & peer-led education as well as regular studies
HIV prevalence among SWs remains below 5%	Yes	Latest prevalence at 0.43%	High mobility among FSW	Because of high mobility, need to maintain outreach & peer-led education as well as regular studies

STI prevalence among SWs is reduced to 50% of the 2004 rate	Almost	Gonorrhea dropped 13% to 7%, Chlamydia dropped 26% to 21%	High mobility among FSW	Because of high mobility, need to maintain outreach & peer-led education as well as regular studies
5% of mobile men/migrant workers and their partners use VCT/STI services	Not known	Currently no data has been collected on this population group	Hard to reach population; no current data Mobile women are important target group as latest data show 0.8% prevalence	Conduct study on migrants Develop strategy for outreach to migrants & their partners Need targeted prevention strategy for female migrants
Condom use among targeted mobile men/migrant workers within the Lao PDR will increase from 55% (2004) to 75%	Not known	Currently no data has been collected on this population group	Hard to reach population; no current data Mobile women are important target group as latest data show 0.8% prevalence	Conduct study on migrants Develop strategy for outreach to migrants & their partners Need targeted prevention strategy for female migrants
STI prevalence among targeted mobile men/migrant workers will be reduced by 50% from the 2004 rate	Not known	Currently no data has been collected on this population group	Hard to reach population; no current data Mobile women are important target group as latest data show 0.8% prevalence	Conduct study on migrants Develop strategy for outreach to migrants & their partners Need targeted prevention strategy for female migrants
30% of primary schools and 30% of secondary schools nationwide implement RH/HIV/AIDS/STI education and drug awareness life-skills based education	Yes	74% of all schools implementing life-skills based education (in 11 targeted provinces)		Expand reach of life-skills based education to all districts
40% of out-of school youth in the prioritized provinces are reached by awareness raising campaigns	Almost	29% of out-of school youth reached by awareness campaign (mid-term review 2008)	Major gap in funding needs	Emphasize as priority area & mobilize funds
The most vulnerable out-of-school youth in prioritized provinces will be reached through peer education, IEC material and condom promotion, STI and VCT services and referral and counseling	Not known	No data available Some activities carried out through VTE Youth Drop-in Center and outreach activities	Major gap in funding needs	Emphasize as priority area & mobilize funds
70% of male SWs in selected locations use condoms consistently with clients	No	40% of male SW/MSM use condoms consistently with clients	Young MSM have much lower rates than older MSM	Develop targeted prevention strategy for young MSM
80% of Kathoy in selected locations use condoms consistently	Not known	Currently no data has been collected on this population group	No aggregated data on MSM (e.g. male SW, Kathoy)	Conduct updated study
Evidence based information on MSM and Kathoy is available and programmatically used	Almost	Evidence based information is available with two recent studies (BBS 2007 & BBS 2009), however it is not clear if been used to inform program practice	No trend data exists, just baseline; need updated study on Kathoy; current MSM prevalence data creates confusing picture	Conduct updated study on Kathoy; conduct SGS every 3 years; conduct another SGS on MSM sampling several provinces
At least 70% of injecting drug users will use sterile injecting techniques	Not known	Currently no data has been collected on this population group	A big data gap on IDU	Conduct situational analysis; develop strategy based on this
At least 40% of drug users will be reached with behavior change interventions and counseling	Not known	Currently no data has been collected on this population group	A big data gap on IDU	Conduct situational analysis; develop strategy based on this
Evidence based information on drug use available and programmatically used.	No	Only 1 rapid assessment conducted with minimal data; to date no BSS or	A big data gap on IDU	Mobilize resources to do more situational analysis to determine real situation;

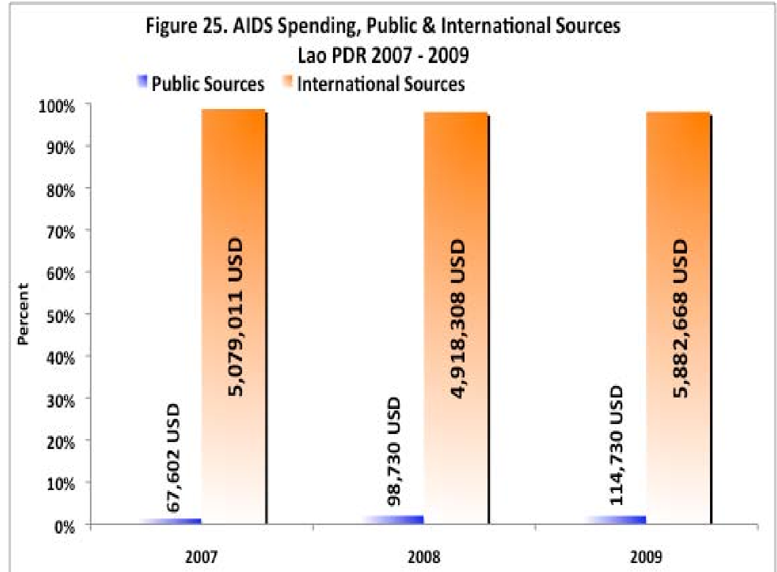
		BBS studies conducted on IDU in Lao PDR.		follow-up with SGS study if group exists
40% of ethnic groups in prioritized locations have correct knowledge on HIV/AIDS/STI	Not known	85% of ethnic groups in project areas reached by awareness campaign (Mid-term review 2008)	Many of these groups are remote & hard to reach	Develop outreach strategy for this population group; conduct studies on this population group
90% of military and police in selected provinces have correct knowledge on HIV/AIDS/STI	Not known	No study during the reporting period (last study was conducted in 2004)	Funding gap	
70% of military and police personnel in selected provinces report consistent condom use with casual sex partners	Not known		Funding gap	
HIV/AIDS prevention is fully integrated into MCH hospital and community programs	Almost	PMTCT fully integrated in 6 provincial hospitals as part of pilot project, expect to expand in 2011-2015	Still very low ANC rates, so even if PMTCT integrated, population may not benefit. No specific PMTCT strategy exists.	Develop PMTCT strategy with 2 year goals Expand PMTCT integration to all MCH hospitals by 2015
At least 4 sites (those that will provide ARV treatment) also provide ARV therapy for PMTCT	Yes	All sites provide ARVs for HIV+ pregnant mothers		
Safe blood services are provided in all provinces	Yes	All provinces (17 provincial blood banks and 5 district blood units) screen blood according to SOP & through quality assurance scheme	Not clear about extent of available safe blood at district level	Operational research at district level to determine screening practices and extent of safe blood
At least 20 VCT sites in prioritized provinces are operational and providing high quality and confidential services	Yes	110 VCT sites as of 2009		
In at least 9 provinces VCT referral systems are established for vulnerable groups with special needs	Yes	All provinces have VCT with referral		Expand outreach & referral to reach remote & hard to reach population groups
VCT service sites are known and used	Yes	94% of FSW know where to get test in 2009; number of testing doubled in past 4 years		Expand testing to reach remote & hard to reach population groups
All target districts have at least 1 site which delivers high quality, confidential STI services	Yes	164 STI service sites (78%) operated (Mid-term review 2008)		
6,000,000 condoms sold per year	Yes	Per GFATM funding & PSI social marketing		
General awareness and knowledge levels increased	Almost	FSW & their clients increased, no data on other population groups	Not data to measure in general population, no trend data on other MARPs	Outreach programs need to be expanded to other vulnerable groups like IDU, migrants & youth. Need to do studies on these population groups
ARV therapy is available in 4 provinces with at least 1000 treatment slots for adults and children	Yes	5 ARV sites and 2 satellites, with 1345 on treatment	Better identification & new eligibility requirements mean more on ART	Expand number of ART sites, ensure continued funding for ARVs & OI, train medical staff on OI & 2nd line regimens
Home based care and support services established in 4 provinces	Yes	Established in 5 provinces		
Strong links established between prevention and care programs	Yes	See section IV, best practices	PMTCT still weak, no national strategy	Develop national strategy for PMTCT
4 support centers for adults and children living with HIV/AIDS are	Yes	Established in 5 provinces		

established in 4 provinces.				
HIV/AIDS is mainstreamed in all national development plans	Yes			
A workplace policy on HIV/AIDS for the private sector is developed and implemented together with the Ministry of Labor, Lao Trade Unions and Employers, and endorsed by private companies	Yes	Tripartite human rights policy (see human rights section) which forbids discrimination in the workplace		
At least 5 line ministries and mass organizations have developed their sectoral HIV/AIDS plans	Almost	3 line ministries developed sectoral plans	Resources for implementation	Mobilize resources to put sectoral plans into action
PLWHA are actively participating and have advisory roles in all HIV/AIDS decision making bodies, including NCCA and CCM	Almost	Members of NCCA, CCM and specify TWG	Limited technical capacity of some PLHIV to be actively involved	Increased training and capacity building, involving PLHIV in areas in decision making process they can contribute
An effective second generation surveillance system is established and implemented	Yes	3 rounds SGS implemented in FSW; 2 SGS started in MSM	Not all data collected needed for programming and global reporting	Harmonize indicators to global standard; ensure collection of needed data to inform NSAP & program questions; continue mobilizing resources for more SGS in target populations like MSM, IDU, migrants
The knowledge base on behavioral and contextual factors contributing to vulnerability towards HIV/AIDS is expanded.	Almost	Have more info on MSM & FSW & their clients	No recent studies on IDU, migrants, and youth Data are no analyzed or used enough for program decisions	Conduct more studies on emerging vulnerable groups Increase capacity to mine, analyze and use data strategically

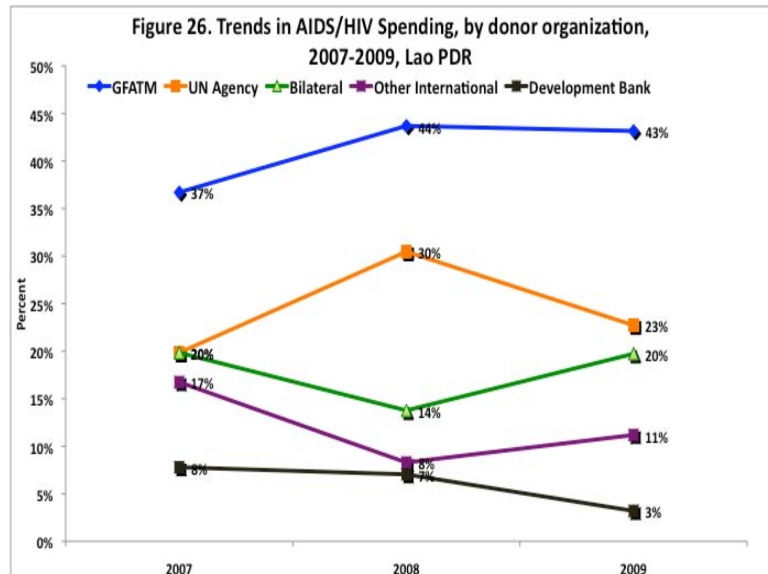
VI. Support from the country's development partners

A. Key support received from development partners

Figure 25 illustrates that the almost all (98%) of AIDS spending in Lao PDR is financed by international development partners (Figure 25). In fact, essentially all HIV/AIDS program activities are supported through donor funding, since spending from national sources is predominantly on administration and transaction costs associated with managing and disbursing funds.



The major development partners include the United Nations Organizations, multi-lateral donors such as the Asian Development Bank (ADB) and GFATM, bilateral donors, and international NGOs such as CARE International and Family Health International (FHI). Figure 26 demonstrates shows the breakdown of AIDS spending by type of external donor agency. Across all years, the contribution by GFATM has been the largest and has steadily risen to 43% of all spent monies. UN Agencies are the second biggest contributor, but the level seems to vary by year. This is followed closely by bilateral donors such as AFD and GTZ. Spending of development bank funds has reduced by 3 fold to 3%, making them the smallest donor. What is evident from the spending trends by donor, is that there is an increased dependency on GFATM to finance Lao's HIV program, as other partners start to have smaller role and eventually pull out of financing for HIV.



United Nations – during the early years of the response, program development and intervention were supported by the WHO under its Global Programme on AIDS. Since then the predominant focus has been providing support in the health sector response and has included IEC, laboratory diagnosis, and basic training for healthcare workers. There has been continued support in recent years for further strengthening of prevention program and establishment of treatment programs, providing technical assistance and medicines to treat opportunistic infections at provincial hospitals as well as promotion of the 100% condom use among the populations at highest risk.

UNAIDS and the United Nations Development Programme (UNDP) have complemented this support by strengthening the capacity of the multi-sectoral response, and in particular the political and

organizational structure of the response. Technical assistance and financial support has been provided to the National AIDS Center and PCCA staffs to implement, manage, and monitor the various programs. UNICEF's focus has been with assisting the Ministry of Education in integrating life-skills and HIV education in the school curriculum, providing support to OVCs, as well as working with WHO to integrate PMTCT in MCH care. UNFPA has focused its support on reproductive health, including the distribution of condoms.

Global Fund to Fight AIDS, Tuberculosis and Malaria —GFATM is the major contributor in funding and has provided monies through 4 grants in the past seven years. GFATM monies have contributed to all function categories, paving the way for a number of prevention initiatives and scale up in services. They are the main funder of ART drugs. GFATM is also the largest donor of funding for program management and human resources.

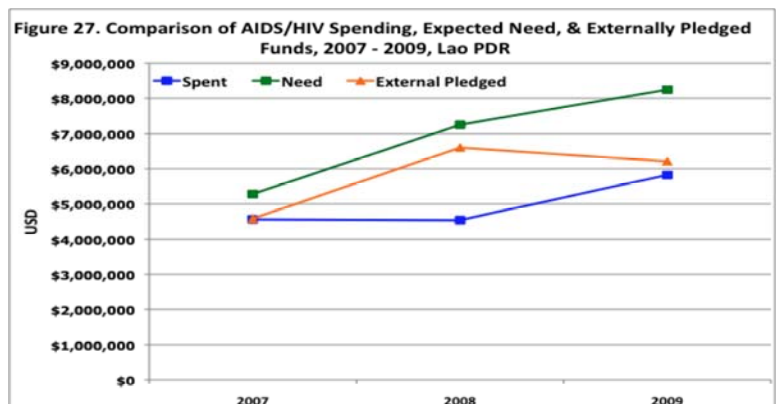
Bilateral - The German quasi-governmental development enterprise, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), is present in three provinces. The Australian agency AusAID supports the Lao Red Cross, while the Burnet Institute, also of Australia, has worked to develop the capacity of the Lao military and police in seven provinces to respond to the spread of HIV/AIDS. The Swedish International Development Cooperation Agency has an HIV prevention program along the site of road rehabilitation projects in Borikhamxay province. HIV, STI, and behavioral surveillance has been implemented with funding from the United States Agency for International Development

INGO's - Norwegian Church Aid has supported PLWHA at the provincial level, while Médecins Sans Frontières has assisted in care and support to PLWHA in Savannakhet province. Family Health International has conducted all three rounds of the Second Generation Surveillance surveys. During the survey implementation FHI provided high-risk male and female participants with condoms, HIV/STI prevention education, STI syndromic management and treatment, and HIV counseling and referrals. FHI continues to provide extensive technical assistance to the CHAS for data management, analysis, and interpretation of the surveillance findings.

Development Banks - ADB aims to alleviate poverty by strengthening infrastructure in countries. ADB has supported many infrastructure projects that incorporate HIV outreach and education to reach migrant workers and workers who are at risk due to the nature of these projects (see Section III workplace initiatives).

B. Actions that need to be taken by development partners

Absorption of funds given by development partners has overall been quite high in Lao PDR. Comparing the spent funds in figure 27 (blue line) and the pledged funds (orange line), they are both almost spot on for 2007 and 2009. Another story presents itself in 2008, with an almost 2million USD difference in what was pledged and what was spent. This appears to be due to the fragility of soft pledges, where the funds are not disbursed as promised. One of the problems encountered in the utilization of foreign funds is that they are not always released in a timely way to the implementers, which often results in delays in activities. Another major challenge has been the limited coordinating mechanisms between the implementing agencies and donors.



Lao's low HIV prevalence can make a hard case for obtaining resources. It's imminent vulnerability to HIV spread renders the need to adequate and continuous resources even more dire. Figure 28 also

shows the differential between the estimated need for HIV resources (green line) and the externally pledged resources (orange line). Between 2007 and 2008 there was about a 1 million USD gap in needed and pledged funds, most of which occurred for blood safety activities and targeted prevention to uniform services and young people. Interestingly, in 2008 there was a 400,000USD gap in funding for STI services, most likely due to the fact that the GFATM round 4 HIV grant, which was focused on STI services, finished in April of that year. Moving into 2009, the gap between pledged and need widens greatly, for a difference of almost 2million USD. Areas that suffer include blood safety, with almost half a million shortage, targeted prevention to sex workers and their clients, uniformed services, and young people.

One of the possible explanations for the increased gap is the increased dependency on GFATM funding in the past couple of years. Although contributions from GFATM are rising, they are not rising enough to cover the drop in funding from other donors, or the fact that some donors who used to provide funding, are now recipients themselves of GFATM funds. In addition, GFATM grants tend to focus on thematic areas, rather than funding the entire program. If a grant runs out and an expected grant to continue funding activities is not accepted, there will be major gaps in resources for core activities. This was seen for the run out of GFATM 4 as the major source of funding for STI services as well as the 100% CUP.

Figure 28 compares estimated funding needs and externally pledged funds for 2010 by spending category. The gap between needs and pledged increases from left to right, with more funds pledged than needed for PMTCT, targeted prevention to MSM, and condom programming (red line above blue line). On the other extreme activities such as targeted prevent to sex workers and their clients, blood safety, STI services and M&E are each at least 300,000USD short of needs. Targeted prevention to youths is consistently an underfunded area and needs to be addressed as they are an increasingly vulnerable group. Of major concern is the large gap for STI services that could jeopardize the major scale up.

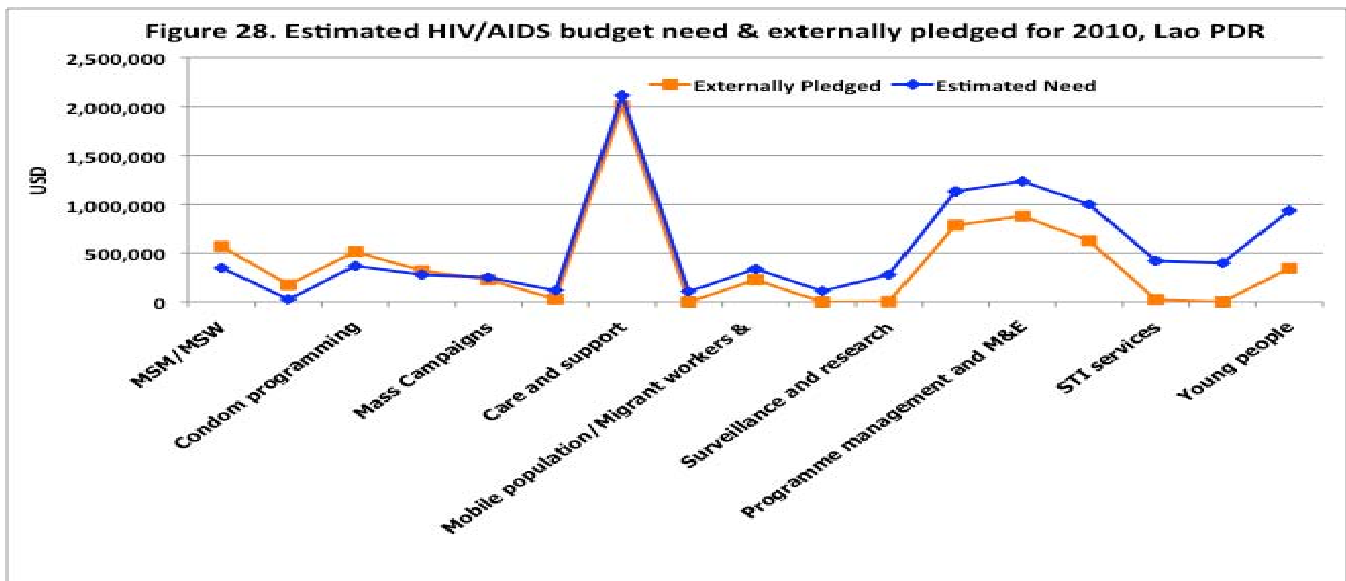


Figure 28. Estimated HIV/AIDS budget need & externally pledged for 2010, Lao PDR

The aforementioned gaps in funding fall within the strategic priorities of the new NSAP (2011-2015). It is imperative that efforts are made to fill financial gaps, particularly in high priority areas, through coordination with development partners. Financing the countrywide requirements for responses to HIV/AIDS is an enormous burden for a developing country like Lao PDR, so a resource mobilization plan is needed to ensure continuous support from existing development partners.

VII. Monitoring and evaluation environment

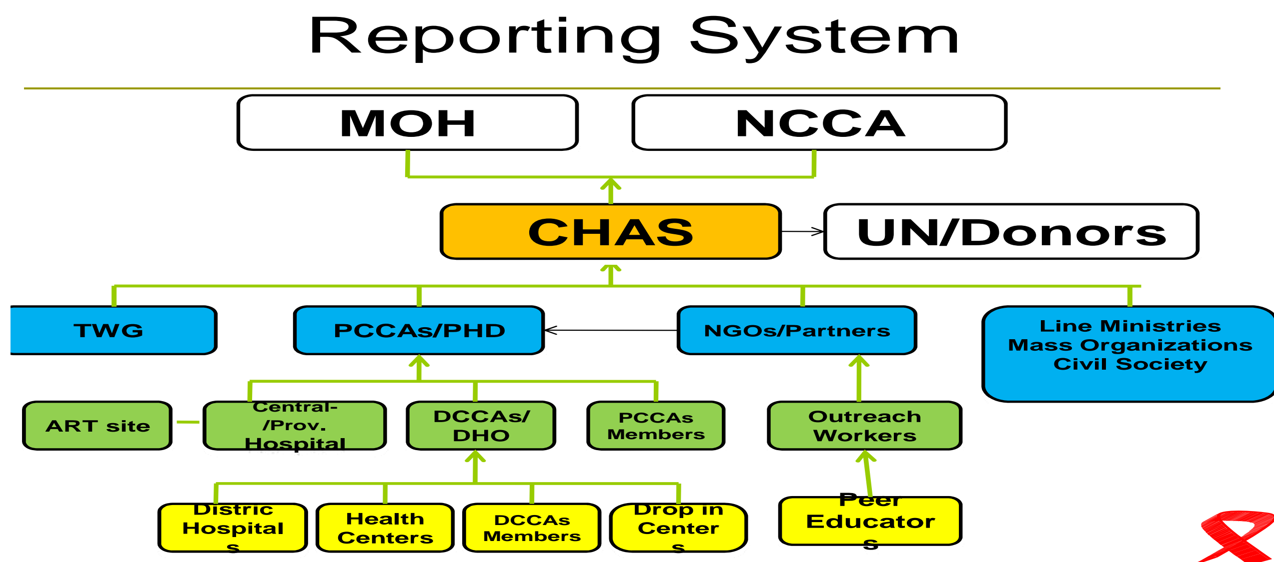
A. Overview of current monitoring and evaluation system–strengthening the third "One"

Lao PDR has made substantial progress since 2007 in the strengthening of their monitoring and evaluation system for the multi-sectoral HIV response. Comparing responses overtime to the M&E section in the NCPI, there has been an increase in rating of overall M&E efforts from 6 out of 10 in 2003 to 9 out of 10 in 2009. In considering the twelve components of a comprehensive M&E system listed in Table 4, at least eleven areas have been markedly improved in the last two years (UNAIDS MERG, 2008).

One of the most substantial advancements was in 2009 with the development of the National M&E Plan by CHAS. This plan is the nucleus for the third "One" – one agreed country level monitoring and evaluation system. The M&E plan provides guidance on core indicators to be collected, describes the roles and responsibilities of all partners in the multi-sectoral response, and includes a cost work plan until 2012.

In order to coordinate and oversee the multi-sectoral M&E efforts, a national functional M&E unit has now been established and sits in CHAS with an increase from two to six permanent staff, all of which have been trained in M&E skills. The M&E unit is responsible for providing direction to partners and strengthening the monitoring of the multi-sectoral response, systematically tracking the progress of the response through the M&E indicator framework, providing timely and accurate strategic information to meet national and international needs. CHAS recently started holding Annual Program Reviews and the National Dissemination Forum to monitor progress towards set targets by reviewing national data.

Figure 29. Reporting Structure



CHAS receives monthly reports on routine program data, STI, VCT, HIV, and co-management of HIV/TB. Currently HIV case reports come from 17 provinces and 6 central hospitals. Figure 29 outlines the reporting structure. District health centers and hospitals report monthly to the DCCA. In some cases where there is donor funded programming, data from the private sectors, such as drop in centers, are also collected. The DCCA compile these reports and sends to the Provincial Committee for the Control of AIDS (PCCA) on a monthly basis.

NGO's and other partners in the response report to PCCAs at the provincial level, while reporting directly to CHAS at the national level. The PCCA has a number of important responsibilities in the M&E system, including supervision such as data quality audits and regular feedback to district health centers. They are also responsible for holding semi-annual workshops for data review and dissemination. Line ministries, mass organizations and other CSOs report directly to the CHAS M&E department, who then produce an annual report which is presented to the NCCA and MOH for endorsement.

Table 4: Lao PDR's status with 12 components of comprehensive M&E system

M&E Component	Progress since 2007*	Continued challenges
1. Organizational structures with HIV M&E functions	-M&E unit now housed in CHAS & fully functional -13% of HIV program budget for M&E activities	-Much of budget for M&E is dependent on external funds
2. Human capacity for HIV M&E	-4 new permanent staff -Trainings @ national & sub-national level	-Still low skill capacity, especially at provincial level -No training at service delivery level
3. Partnerships to plan, coordinate, and manage the HIV M&E system.	-M&E Technical Working Group established -Efforts to align & harmonize M&E indicators	-M&E TWG needs to meet more regularly and set priorities
4. National multi-sectoral HIV M&E plan	-Multi-sectoral M&E plan developed	-Not all sectors aligned or follow
5. Annual costed national HIV M&E work plan	-None	-No costed yearly work plan yet
6. Advocacy, communications and culture for HIV M&E	-Annual M&E reports -Multi-sectoral membership in M&E TWG, including PLHIV	-Not enough mainstreaming of M&E in HIV program activities, particularly with regards of data use -More leadership on M&E advocacy by NCCA
7. Routine programme monitoring	-Monthly reports collected from district to provincial to CHAS	-Appears parallel system for GFATM sub-recipients
8. Surveys and surveillance	-FSW: 2008 IBBS 2009 BBS -MSM: 2009 BBS Luang Prabang -IDU: 2009 HARP Assessment -Migrants: 2008 KAPB on external Chinese & Vietnamese migrants	-No HIV prevalence study in IDU -No updated HIV prevalence/KAPB study on Lao migrants -No updated HIV prevalence/KAPB study on general population
9. National and sub-national HIV database	-National centralized database housing all national HIV data -Clinical management software being piloted HIV CARE	-Access is limited to few staff
10. Supportive supervision and data auditing	-Developed standards for CSO data collection -Planned & costed supervision visits	-Minimal feedback mechanisms to provincial level
11. HIV evaluation and research	-Mid-term evaluation of NSAP in 2008	-Need more research on target population groups, such as young female migrant workers -Evaluation needed on programs such as 100% Condom Use
12. Data dissemination and use	-Use of mid-term evaluation to guide new National Strategic Action Plan -Extensive use of available data for UNGASS 2010 Country Progress Report	-Need more analytical capacity to mine available surveillance & survey data -Not enough use of strategic information for program monitoring, program decisions & policy formulation -Need more active use of data to identify vulnerable sub-groups & inform program priorities
*Based on answers to the NCPI and stakeholder interview		

A total of 803,230USD has been costed for M&E activities until 2012. Over the last two years 13% of the national HIV program budget was dedicated to M&E, underscoring the increased commitment to strengthening the M&E system. Some of the activities include development of a national M&E database

which houses all M&E indicator data, including available UNGASS indicators, piloting of a clinical management software, Care ART Management, in 2 ART centers, to be expanded to 5, and the onset of annual M&E reports and dissemination workshops.

Another area of investment has been the much needed surveillance surveys. An ANC survey was conducted in 3 hospitals in Vientiane. The following studies were conducted since 2007:

IDU

- Rapid Assessment and Response on Drug Use and IDU in Houaphanh Province, Lao PDF, Harm Reduction Project, August 2009

Migrants

- Knowledge, attitudes, practices, and behavior survey among Chinese communities in Louangnamtha province and Vietnamese communities in Champasack and Attapeu provinces, September 2008

FSW

- Second Generation Surveillance 3rd Round on HIV, STI and Behavior, in 6 provinces, 2008
- Behavioral survey among service women in Lao PDR, in 5 provinces, 2009

MSM

- Integrated biological behavioral survey among men who have sex with men in Vientiane, Lao PDR, 2007
- Integrated biological behavioral survey among men who have sex with men in Louang Prabang, Lao PDR, 2009

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

Even though there is now a functional M&E unit with established guidelines and plan, the national M&E system is still young and the challenge will be to foster its growth. Most of the progress made was possible because M&E was one of the objectives in the round 6 GFATM HIV proposal. Approximately 300,000USD were disbursed for M&E activities between 2008 and 2009. It is important to have a real understanding of where the gaps are in order to generate resources. Knowing the strengths and weaknesses of the M&E system, requires an M&E assessment to be conducted such as that recommended by GFATM using the M&E System Strengthening Assessment Tool. The following issues are based on desk review, responses to the NCPI questionnaire, or feedback brought up in the NCPI stakeholder consultation.

Continued challenges

- No formal M&E assessment conducted
- Insufficient M&E skills in personnel, particularly at the provincial and district level
- No training of CSOs in M&E despite their role in providing data
- Reporting system is still fragmented and lags behind schedules
- M&E TWG meets irregularly
- Fairly low rating by CSO regarding involvement in developing national M&E plan and participating in the M&E TWG (3 out of 5).
- Still limited or no recent data on high-risk populations, especially IDU and migrants
- No recent data on general population
- No data available for several key UNGASS indicators
- Difficulty to obtain reliable estimations and projections due to lack of data & sustainable knowledge of modeling techniques

- No operational research or evaluation of programs conducted to determine effectiveness
- Limited capacity to mine and analyze data for monitoring progress and trends
- Minimal use of data for program planning and decision making

Most of these points fall under three main areas, data availability, quality, and use. Although their has been improvement in these areas and rating in the NCPI for use of data on strategic planning, resource allocation, and program improvement scored well (4 on scale of 5), Lao still needs to push forward in order to have an M&E system that can provide the strategic information it needs to stay one step ahead of the epidemic.

C. Remedial actions planned to overcome challenges

Although responses to the NCPI on overall rating of the M&E system reflect the considerable progress made (4/5), improving from the 2008 report rating (3/5), there are still the significant challenges mentioned above that need to be addressed in order to achieve a comprehensive system.

Many of the aforementioned challenges will be the focus of the newly established M&E TWG, which will provide much of the strategic thinking for strengthening the system. The first task will be to address these issues in the NSAP 2011-2015 that is currently being prepared. What will help to guide improvement is including an M&E strategy with specific objectives in the NSAP. In order to kick start the progress, funding will be requested in the next two GFATM HIV proposals, with the hope that much of the routine activities will be integrated into the system and become sustainable over time. Some remedial actions include but are not limited to the following:

- Conducting formal M&E assessment including multi-stakeholder system
- Providing standardized M&E training at all levels & to CSOs
- Involving CSO's more in the M&E process, from data collection, to quality assurance, data analysis and use
- Expanding capacity building of staff through knowledge and skills transfer with on the job training, mentorship, and hands on training forums
- Resource generation for much needed studies through clear priority on needed strategic information (eg. special study on young female migrant workers)
- Incorporating regular operational research and evaluations in NSAP work plan to determine program effectiveness
- Encouraging evidence based decision making and policy through multi-stakeholder forums and review of annual reports
- Providing sustainable analytical skills through:
    - training staff who will then train others in data analysis, estimations, & projections
    - continued use of strategic information in annual reports and semi-annual progress workshops

D. 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 M&E guidelines and plan. CHAS seeks technical assistance particularly in areas needing expanded expertise, but to date has had limited support from technical assistance. Much of the aforementioned remedial actions will require technical assistance initially until capacity is sustainable. Training curriculum, knowledge and skills transfer, improved strategic information analysis and use, will all benefit from high-level expertise. It is important for the NCCA and CHAS to include technical assistance

and capacity building as part of their core activities so as to ensure a continous funding stream and maintain the momentum of strengthening seen in this last reporting period.

Annex 1: Consultation/preparation process

Table 1: 2010 UNGASS reporting process tentative road map

Timeframe	Process
29-Sep-09	Attending M & E Meeting for the Asia-Pacific Region in Bangkok between 29th September and 2nd October 2009
15-Oct-09	Briefing meeting on UNGASS country report preparation with the key partners concerned at CHAS
16-Oct-09	Briefing meeting on UNGASS country report preparation with the NCCA members at Lao Plaza
19-Oct-09	Collecting data and information from all existing sources
25-Jan-10	Preparation of the 1st Draft of UNGASS country progress report including NCPI and NASA reports
03-Feb-10	Consultation meeting on the 1st draft report with national and international partners
4-Feb- 15 Mar 10	Preparation of the 2nd draft of UNGASS country progress report
12-Mar-10	Consultation meeting on the 2nd draft report with the NCCA members (to be approved by the NCCA Chair)
24-26-Mar-10	Finalizing the UNGASS country report and submission of the report to NCCA Chair for approval
29-Mar-10	Submission of the UNGASS country report to UNAIDS HQ
Apr-10	Following up and addressing the recommendation from the UNGASS 2010.

Annex 2: National composite policy index questionnaire

1) **Country**
   Lao People's Democratic Republic (0)
2) **Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:**
   Center for HIV/AIDS and STI, Ministry of Health
3) **Postal address:**
   Km3 Thadeua Road, Vientiane Capital, Lao PDR
4) **Telephone:**
   Please include country code
   856-21-315500, 856-21-354014
5) **Fax:**
   Please include country code
   856-21-315500, 856-21-354014
6) **E-mail:**
   gfachas.chansy@gmail.com

7) **Describe the process used for NCPI data gathering and validation:**
   Briefing meeting on UNGASS country report preparation with the key partners concerned and for NCCA member. Distributed the NCPI form part A to Government partners and NCPI form part B for International and NGOs partners for answering the question. Data collection from partners and enter data, analysis data. Consultation meeting with all partners on result of NCPI. Correct data by comments and advices from partners and finalyse report.
8) **Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:**
   N/A
9) **Highlight concerns -if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):**

   N/A

10) **NCPI - PART A [to be administered to government officials]**

	Organization	**Names/Positions**	**Respondents to Part A [Indicate which parts each respondent was queried on]**
Respondent 1	Center for HIV/AIDS/STI	Dr. Chansy Phimphachanh, Director	A.I, A.II, A.III, A.IV, A.V

11) | Respondent | Center for | Dr. Chanthone | A.I, A.II, A.III, A.IV, A.V |
|---|---|---|---|

2	HIV/AIDS/STI	Khamsibounheuang, Deputy Director	
Respondent 3	Center for for HIV/AIDS/STI	Dr. Phouthone Souttalack, Deputy Director	A.I, A.II, A.III, A.IV, A.V
Respondent 4	Center for HIV/AIDS/STI	Dr. Keophouvanh Douangphachanh, Head of Administrative and Technical officer	A.I, A.II, A.III, A.IV, A.V
Respondent 5	Ministry of Labor and Social welfare	Focal point for HIV/AIDS	A.I, A.II, A.III, A.IV, A.V
Respondent 6	Ministry of National Defence	Dr. Chanthaphone, NCCA member	A.I, A.II, A.III, A.IV, A.V
Respondent 7	Ministry of Public Security	Mr. Vongdeuane Sengsuriya, Focal point for HIV/AIDS	A.I, A.II, A.III, A.IV, A.V
Respondent 8	Ministry of Public work and Transport	Mr. Xayabandith Insisiengmay, Focal point for HIV/AIDS	A.I, A.II, A.III, A.IV, A.V
Respondent 9	Lao Red Cross	Dr. Soulany Chansy, Focal point for HIV/AIDS	A.I, A.II, A.III, A.IV, A.V
Respondent 10	Lao Women Union	Ms. Lavanh, Focal point for HIV/AIDS	A.I, A.II, A.III, A.IV, A.V
Respondent 11	Lao Youth Union	Mr. Thondeng Sanepraseuth, Focal for HIV/AIDS	A.I, A.II, A.III, A.IV, A.V
Respondent 12	Lao Federation Trade Union	Mr. Vanhkham, Focal pont for HIV/AIDS	A.I, A.II, A.III, A.IV, A.V
Respondent 13	Lao National Front construction	Mr. Saysavath Sayasouth, Focal point for HIV/AIDS	A.I, A.II, A.III, A.IV, A.V
Respondent 14	Ministry of Education	Ms. Phouangkham, Focal point on HIV/AIDS	A.I, A.II, A.III, A.IV, A.V
Respondent 15	Ministry of Information and Culture	Mr. Viyoline Phrasavanh, Focal point on HIV/AIDS	A.I, A.II, A.III, A.IV, A.V
Respondent 16	Department of Hygiene and Preventive, Ministry of Health	Dr. Vankeo Radsabud, Technical	A.I, A.II, A.III, A.IV, A.V
Respondent 17	Department of Curative,	Dr. Hongthong Sivilay, Technical	A.I, A.II, A.III, A.IV, A.V

	Ministry of Health
Respondent 18	
Respondent 19	
Respondent 20	
Respondent 21	
Respondent 22	
Respondent 23	
Respondent 24	
Respondent 25	

12) If the number of respondents to Part A is more than 25, please enter the rest of respondents for Part A in below box.

N/A

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

14)

	Organization	Names/Positions	Respondents to Part B [Indicate which parts each respondent was queried on]
Respondent 1	UNAIDS	Dr. Pascal Stenier, Country coordination of UNAIDS	B.I, B.II, B.III, B.IV
Respondent 2	UNAIDS	Dr. Khamlay Manivong, SMA, UNAIDS	B.I, B.II, B.III, B.IV
Respondent 3	UNDP	Ms. Theresa Diouf, Programme analyst	B.I, B.II, B.III, B.IV
Respondent 4	WHO	Dr. Dominique Ricard, Medical officer on HIV/AIDS/STI	B.I, B.II, B.III, B.IV
Respondent 5	UNICEF	Ms. Verity Ruston , Chief HIV/AIDS section	B.I, B.II, B.III, B.IV
Respondent 6	UNFPA	Dr. Loreto Roquero, HIV/AIDS and RH programme specialist	B.I, B.II, B.III, B.IV
Respondent 7	World Bank	Dr. Phetdara Chanthala, Human development operations officer	B.I, B.II, B.III, B.IV
Respondent 8	UNODC	Mr. Sengdeuane Phomavongsa, NPO	B.I, B.II, B.III, B.IV

Respondent 9	IOM	Ms. Montira INKOCHASAN,Acting Head of Project Office	B.I, B.II, B.III, B.IV
Respondent 10	WFP	Aachal Chand, Programme officer	B.I, B.II, B.III, B.IV
Respondent 11	Burnet Institute	Dr. Niramon, Project Manager	B.I, B.II, B.III, B.IV
Respondent 12	FHI	Miss Phayvieng, Project Manager	B.I, B.II, B.III, B.IV
Respondent 13	PSI	Mr. Rob Gray, Project Manager	B.I, B.II, B.III, B.IV
Respondent 14	APHEDA	Mr. Khampasong Siharath, Lao Programme Manager	B.I, B.II, B.III, B.IV
Respondent 15	AFD	Dr. Marlon Garcia, Consultant	B.I, B.II, B.III, B.IV
Respondent 16	NCA	Ms. Manivanh Pholsena	B.I, B.II, B.III, B.IV
Respondent 17	PEDA	Dr. Santy Douangpaseuth, Director	B.I, B.II, B.III, B.IV
Respondent 18	ARC	Ms. Phonsavanh Manilath, Programme Officer	B.I, B.II, B.III, B.IV
Respondent 19	World Vision	Mr. Mika Niskanen, HIV/AIDS Coordinator	B.I, B.II, B.III, B.IV
Respondent 20	LNP+	Mr. Kynoy Phongdeth, Chair of PLHIV	B.I, B.II, B.III, B.IV
Respondent 21	LYAP	Mr. ViengAkone, Project Manager	B.I, B.II, B.III, B.IV
Respondent 22	ESTHER	Ms. Somchay, Prọect Coordinator	B.I, B.II, B.III, B.IV
Respondent 23	LNP+	Kynoi Phongdeth, Chair of LNP+	B.I, B.II, B.III, B.IV
Respondent 24			
Respondent 25			

15) **If the number of respondents to Part B is more than 25, please enter the rest of respondents for Part B in below box.**

N/a

16) **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 (0)

17) **Period covered:**

2006-2010

18) **1.1 How long has the country had a multisectoral strategy?**

Number of Years

17

19) **1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?**

	Included in strategy	Earmarked budget
Health	Yes	Yes
Education	Yes	Yes
Labour	Yes	Yes
Transportation	Yes	Yes
Military/Police	Yes	Yes
Women	Yes	Yes
Young people	Yes	Yes
Other*	Yes	Yes

20) **If "Other" sectors are included, please specify:**

Information and Culture, Lao Federation Trade Union, Lao Front for National Construction, Lao Red Cross

21) **1.3 Does the multisectoral strategy address the following target populations, settings and crosscutting issues?**

Target populations	
a. Women and girls	Yes
b. Young women/young men	Yes
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex workers	Yes
f. Orphans and other vulnerable children	Yes
g. Other specific vulnerable subpopulations*	Yes
Settings	
h. Workplace	Yes
i. Schools	Yes
j. Prisons	No
Cross-cutting issues	
k.HIV and poverty	Yes
l. Human rights protection	Yes
m. Involvement of people living with HIV	Yes

n. Addressing stigma and discrimination	Yes
o. Gender empowerment and/or gender equality	Yes

22) 1.4 Were target populations identified through a needs assessment?

Yes (0)

23) IF YES, when was this needs assessment conducted?

Please enter the year in yyyy format
2005

24) 1.5 What are the identified target populations for HIV programmes in the country?

Sex workers and Clients, Mobile population/migrant workers&families, Young peoples, MSM/MSW, Drug uses, Ethnic groups, Uniformed services, &PMTCT

25) 1.6 Does the multisectoral strategy include an operational plan?

Yes (0)

26) 1.7 Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	Yes
b. Clear targets or milestones?	Yes
c. Detailed costs for each programmatic area?	Yes
d. An indication of funding sources to support programme?	Yes
e. A monitoring and evaluation framework?	Yes

27) 1.8 Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?

Active involvement (0)

28) IF active involvement, briefly explain how this was organised:

-Active in all step of development of the national strategy plan - provide inputs/comments and the cost in strategy and action plan during the meetings

29) 1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes (0)

30) 1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners (0)

31) 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 (0)

32) 2.1 *IF YES*, in which specific development plan(s) is support for HIV integrated?

a. National Development Plan	Yes
b. Common Country Assessment / UN Development Assistance Framework	Yes
c. Poverty Reduction Strategy	Yes
d. Sector-wide approach	Yes
e. Other: Please specify	No

33) 2.2 *IF YES*, which specific HIV-related areas are included in one or more of the development plans?

HIV-related area included in development plan(s)	
HIV prevention	Yes
Treatment for opportunistic infections	Yes
Antiretroviral treatment	Yes
Care and support (including social security or other schemes)	Yes
HIV impact alleviation	Yes
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes
Reduction of income inequalities as they relate to HIV prevention/treatment, care and/or support	Yes
Reduction of stigma and discrimination	Yes
Women's economic empowerment (e.g. access to credit, access toland, training)	
Other: Please specify	No

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

Yes (0)

35) 3.1 *IF YES*, to what extent has it informed resource allocation decisions?

3 (3)

36) 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 (0)

37) 4.1 *IF YES*, which of the following programmes have been implemented beyond the pilot stage to reach a signifi cant proportion of the uniformed services?

Behavioural change communication	Yes

Condom provision	Yes
HIV testing and counseling	Yes
Sexually transmitted infection services	Yes
Antiretroviral treatment	Yes
Care and support	Yes
Other: Please specify	Yes

38) If HIV testing and counselling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g, indicate if HIV testing is voluntary or mandatory etc):

According to the National Policy, counselling and testing will be voluntary with informed consent and adhere to standards of confidentiality, privacy and non-stigmatization

39) 5. Does the country have non discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes (0)

40) 5.1 *IF YES,* for which subpopulations?

a. Women	Yes
b. Young people	Yes
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex Workers	Yes
f. Prison inmates	Yes
g. Migrants/mobile populations	Yes
Other: Please specify	Yes

41) IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

Enhance community awareness - Strengthen civil societies - National commission for advancement of women has been established to monitor the implementation of CEDAW for other regulation related to the advancement of women

42) Briefly comment on the degree to which these laws are currently implemented:

At all levels: central, provincial and district levels

43) 6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

No (0)

44) 7. Has the country followed up on commitments towards universal access made during the

High-Level AIDS Review in June 2006?

Yes (0)

45) 7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes (0)

46) 7.2 Have the estimates of the size of the main target populations been updated?

Yes (0)

47) 7.3 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 (0)

48) 7.4 Is HIV programme coverage being monitored?

Yes (0)

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

Yes (0)

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

Yes (0)

51) IF YES, for which population groups?

- Sex workers and their clients - Mobile population/Migrant workers and families - MSM - Drug user - Young peoples -Uniformed services - Ethnic groups - ANC - Blood donors

52) Briefly explain how this information is used:

- For follow-up the progress of implementation

53) (c) Is coverage monitored by geographical area?

Yes (0)

54) IF YES, at which geographical levels (provincial, district, other)?

Provincial and district levels

55) Briefly explain how this information is used:

- For follow up the progress of the implementation

56) 7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes (0)

57) Overall, how would you rate strategy planning efforts in the HIV programmes in 2009?

9 (9)

58) Since 2007, what have been key achievements in this area:

- The current national strategy and action plan has been implemented. Many components identified in the plan have fund secured and have been implemented with covered all provinces.
- Three sectoral plans have been developed (Lao Women Union, Public Work and Transport, Military and Police)- UN integrated supported plan

59) What are remaining challenges in this area:

- Needs assessment to identify target populations were conducted in 2005, and partially revised in 2007 and 2009 for GFATM proposal development - Population groups address in strategic plan *Indicates OVC are addressed, but not mentioned in NSAP * IDU – need to be assessed - Lao PDR has evaluated impact of HIV on socio-economic development, but only rated 3 (60%) on using this information for resource allocation decisions - Comprehensive Provincial Strategic Plans need to be developed

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

President/Head of government	Yes
Other high officials	Yes
Other officials in regions and/or districts	Yes

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

Yes (0)

62) 2.1 IF YES, when was it created?

Please enter the year in yyyy format
2003

63) 2.2 IF YES, who is the Chair?

Name	HE. Dr. Ponmek Dalaloy
Position/title	Minister of Health

64) 2.3 IF YES, does the national multisectoral AIDS coordination body:

have terms of reference?	Yes
have active government leadership and participation?	Yes
have a defined membership?	Yes
include civil society representatives?	Yes
include people living with HIV?	Yes
include the private sector?	Yes

have an action plan?	Yes
have a functional Secretariat?	Yes
meet at least quarterly?	Yes
review actions on policy decisions regularly?	Yes
actively promote policy decisions?	Yes
provide opportunity for civil society to influence decision-making?	Yes
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes

65) If you answer "yes" to the question "does the National multisectoral AIDS coordination body <u>have a defined membership</u>", how many members?

Please enter an integer greater than or equal to 1
14

66) If you answer "yes" to the question "does the National multisectoral AIDS coordination body <u>include civil society representatives</u>", how many?

Please enter an integer greater than or equal to 1
6

67) If you answer "yes" to the question "does the National multisectoral AIDS coordination body <u>include people living with HIV</u>", how many?

Please enter an integer greater than or equal to 1
1

68) 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 (0)

69) IF YES, briefly describe the main achievements:

- Task force working group - regular meeting of task force working

70) Briefly describe the main challenges:

-

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

Please enter the rounded percentage (0-100)
20

72) 5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	Yes
Technical guidance	Yes

Procurement and distribution of drugs or other supplies	Yes
Coordination with other implementing partners	Yes
Capacity-building	Yes
Other: Please specify	No

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

Yes (0)

74) 6.1 IF YES, were policies and laws amended to be consistent with the National AIDS Control policies?

Yes (0)

75) IF YES, name and describe how the policies / laws were amended:

National policy on HIV/AIDS/STI and The policy reviewed in year 2008 for additional on MSM,HIV/TB and Nutrition

76) Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

N/A

77) Overall, how would you rate the political support for the HIV programmes in 2009?

9 (9)

78) Since 2007, what have been key achievements in this area:

- NCCA meeting end of 2009 agreed: Set up Standing committee, Designated Secretariat - Expanded membership: - National Assembly, Lao National Chamber Commerce and Industry (Rep. of migrant), Buddhist Association, Medical Department, PLHIV - Updated National policy to include - TB, MSM, Nutrition - Increased enabling environment for advocacy, addressing sensitive areas (MSM, IDU, etc.) which has allowed progress in addressing previously limited areas - Incorporating advocacy efforts into policy such as 100% condom use program (CUP)

79) What are remaining challenges in this area:

- NCCA meeting shall meet as planned (twice a year) - Additional support need to strengthen NCCA's Secretariat

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

Yes (0)

81) 1.1 IF YES, what key messages are explicitly promoted?

Check for key message explicitly promoted (multiple options allowed)

a. Be sexually abstinent (0)
b. Delay sexual debut (0)

c. Be faithful (0)
d. Reduce the number of sexual partners (0)
e. Use condoms consistently (0)
f. Engage in safe(r) sex (0)
g. Avoid commercial sex (0)
h. Abstain from injecting drugs (0)
i. Use clean needles and syringes (0)
j. Fight against violence against women (0)
k. Greater acceptance and involvement of people living with HIV (0)
l. Greater involvement of men in reproductive health programmes (0)
m. Males to get circumcised under medical supervision (0)
n. Know your HIV status (0)
o. Prevent mother-to-child transmission of HIV (0)

82) In addition to the above mentioned, please specify <u>other</u> key messages explicitly promoted:
N/A

83) 1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes (0)

84) 2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes (0)

85) 2.1 Is HIV education part of the curriculum in:

primary schools?	Yes
secondary schools?	Yes
teacher training?	Yes

86) 2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes (0)

87) 2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes (0)

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

Yes (0)

89) 3.1 IF YES, which populations and what elements of HIV prevention do the policy/strategy address?

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

Targeted information on risk reduction and HIV education	Other populations
Stigma and discrimination reduction	Other populations
Condom promotion	Sex workers
HIV testing and counselling	Sex workers
Reproductive health, including sexually transmitted infections prevention and treatment	Other populations
Vulnerability reduction (e.g. income generation)	Other populations
Drug substitution therapy	Injecting drug user
Needle & syringe exchange	Injecting drug user

90) You have checked one or more policy/strategy for "Other populations". Please specify what are "other populations".

- Promotion of 100% condom used, Outreach activities of sex workers Distributionof condom

91) Overall, how would you rate the policy efforts in support of HIV prevention in 2009?

9 (9)

92) Since 2007, what have been key achievements in this area:

- Increase from 37 VCT sites in 2007 to 110 VCT sites in 2009 in all provinces - Almost doubling of HIV testing in FSW since 2007 - 100% CUP expanded to cover 15 provinces - Established peer-led BCC - AIDS prevention mainstreamed into several development projects: * Infrastructure/road work * Dams * Mining * Factories

93) What are remaining challenges in this area:

- Prevention efforts don't reach most remote communities - Awareness capacity is limited to "peer educators" - Financial commitment to for prevention interventions on yearly basis

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

Yes (0)

95) IF YES, how were these specific needs determined?

- Established Committee for Control of AIDS at National, provincial and district levels

96) 4.1 To what extent has HIV prevention been implemented?

	The majority of people in need have access
HIV prevention component	
Blood safety	Agree
Universal precautions in health care settings	Agree

Prevention of mother-to-child transmission of HIV	Agree
IEC* on risk reduction	Agree
IEC* on stigma and discrimination reduction	Agree
Condom promotion	Agree
HIV testing and counselling	Agree
Harm reduction for injecting drug users	N/A
Risk reduction for men who have sex with men	Agree
Risk reduction for sex workers	Agree
Reproductive health services including sexually transmitted infections prevention and treatment	Agree
School-based HIV education for young people	Agree
HIV prevention for out-of-school young people	Agree
HIV prevention in the workplace	Don't agree
Other: please specify	N/A

97) Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

9 (9)

98) Since 2007, what have been key achievements in this area:

Many sectors have fund secured for their activities - 100% CUP has been expanded and covered in 15 provinces - VCT has covered in 17 provinces, 86 districtsand 1 Health center - Drop in center for sex workers and MSM have been established in many provinces - AIDS prevention programme has been mainstreamed into many infrastructure development project (eg: Road and dam constructions) - MSM peer education manual developed - Surveillance has included more targeted population: MSM, ANC - Network PLWHA expanded from 6 networks in 2007 to 12 networks in 2009, VCT sites expanded 91 sites in 2008 and 110 in 2009

99) What are remaining challenges in this area:

- Prevention efforts don’t reach most remote communities - Awareness capacity is limited to “peer educators” - Financial commitment to for prevention interventions on yearly basis

100) 1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes (0)

101) 1.1 IF YES, does it address barriers for women?

Yes (0)

102) 1.2 IF YES, does it address barriers for most-at-risk populations?

Yes (0)

103) 2. Has the country identified the specific needs for HIV treatment, care and support services?

Yes (0)

104) IF YES, how were these determined?

Expand ARV treatment sites 2 sites in 2008 and 4 sites in 2009.

105) 2.1 To what extent have the following HIV treatment, care and support services been implemented?

	The majority of people in need have access
HIV treatment, care and support service	
Antiretroviral therapy	Agree
Nutritional care	Don't agree
Paediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree
Psychosocial support for people living with HIV and their families	Don't agree
Home-based care	Agree
Palliative care and treatment of common HIV-related infections	Agree
HIV testing and counselling for TB patients	Agree
TB screening for HIV-infected people	Agree
TB preventive therapy for HIV-infected people	Don't agree
TB infection control in HIV treatment and care facilities	Don't agree
Cotrimoxazole prophylaxis in HIV-infected people	Agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree
HIV care and support in the workplace (including alternative working arrangements)	Don't agree
Other: please specify	N/A

106) 3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes (0)

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

No (0)

108) Overall, how would you rate the efforts in the implementation of HIV treatment, care and

support programmes in 2009?

9 (9)

109) **Since 2007, what have been key achievements in this area:**

- Increase in ART coverage from 63% to 93% - Expansion of ART sites from 2 in 2007 to 5 plus 2 satellites in 2009 - Decrease in HIV & STI prevalence in FSW since 2004 - Establishment of 7 drop-in centers targeted at female service workers, which mirrors increase in testing

110) **What are remaining challenges in this area:**

- HIV services not yet linked with MCH, to be discussed soon between CHAS and MCHC to strengthen PMCT package - More human resources needed - Need to ensure access to OI & 2nd line treatment

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

Yes (0)

112) **5.1 IF YES, is there an operational definition for orphans and vulnerable children in the country?**

Yes (0)

113) **5.2 IF YES, does the country have a national action plan specifically for orphans and vulnerable children?**

Yes (0)

114) **5.3 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?**

Yes (0)

115) **IF YES, what percentage of orphans and vulnerable children is being reached?**

Please enter the rounded percentage (0-100)
70

116) **Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?**

7 (7)

117) **Since 2007, what have been key achievements in this area:**

Conducted quality study of HIV impact on OVC and there were some initiative intervention to address the OVC issues

118) **What are remaining challenges in this area:**

- Indicates OVC are addressed, but not mentioned in NSAP

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

Yes (0)

120) 1.1 IF YES, years covered:
Please enter the start year in yyyy format below

2006

121) 1.1 IF YES, years covered:
Please enter the end year in yyyy format below

2010

122) 1.2 IF YES, was the M&E plan endorsed by key partners in M&E?

Yes (0)

123) 1.3 IF YES, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes (0)

124) 1.4 IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners (0)

125) 2. Does the national Monitoring and Evaluation plan include?

a data collection strategy	Yes
a well-defined standardised set of indicators	Yes
guidelines on tools for data collection	Yes
a strategy for assessing data quality (i.e., validity, reliability)	Yes
a data analysis strategy	Yes
a data dissemination and use strategy	Yes

126) If you check "YES" indicating the national M&E plan include a data collection strategy, then does this data collection strategy address:

routine programme monitoring	Yes
behavioural surveys	Yes
HIV surveillance	Yes
Evaluation / research studies	Yes

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

Yes (0)

128) 3.1 IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

Please enter the rounded percentage (1-100). If the percentage is less than 1, please enter "1".
13

129) 3.2 IF YES, has full funding been secured?

Yes (0)

130) 3.3 IF YES, are M&E expenditures being monitored?

Yes (0)

131) 4. Are M&E priorities determined through a national M&E system assessment?

Yes (0)

132) IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves:

- Monthly report from partners at both central and provincial levels

133) 5. Is there a functional national M&E Unit?

Yes (0)

134) 5.1 IF YES, is the national M&E Unit based

in the National AIDS Commission (or equivalent)?	Yes
in the Ministry of Health?	Yes
Elsewhere? (please specify)	No

135) Number of permanent staff:
Please enter an integer greater than or equal to 0
8

136) Number of temporary staff:
Please enter an integer greater than or equal to 0
0

137) Please describe the details of <u>all</u> the permanent staff:

	Position	Full time/Part time?	Since when? (please enter the year in yyyy format)
Permanent staff 1	Deputy Director of Center for HIV/AIDS/STI	Full time	2006
Permanent staff 2	Head of planning, M&E and International coordination	Full time	2006
Permanent staff 3	Vice Head of planning, M&E and International coordination	Full time	2006
Permanent staff 4	Technical staff of planning, M&E and International coordination	Full time	2006
Permanent	Technical staff of planning, M&E and	Full time	2008

staff 5	International coordination		
Permanent staff 6	Technical staff of planning, M&E and International coordination	Full time	2009
Permanent staff 7	Local consultant	Full time	2009
Permanent staff 8	Local consultant	Full time	2009
Permanent staff 9			
Permanent staff 10			
Permanent staff 11			
Permanent staff 12			
Permanent staff 13			
Permanent staff 14			
Permanent staff 15			

138) 5.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes (0)

139) IF YES, briefly describe the data-sharing mechanisms:

- Collect monthly report from partners and PCCAs - Developed National Software for M&E

140) What are the major challenges?

The current national M&E system is at an early stage • Insufficient skilled personnel on M&E, especially at the provincial level • Reporting system is fragmented and lacks behind schedules • Limited data on high risk population leading to estimation and projection difficulty

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

Yes, but meets irregularly (0)

142) 6.1 Does it include representation from civil society?

Yes (0)

143) IF YES, briefly describe who the representatives from civil society are and what their role is:

Lao youth union, Lao women union,lao trade union, national Lao Front constructionLao Youth AIDS prevention (LYAP).

144) 7. Is there a central national database with HIV- related data?

Yes (0)

145) 7.1 IF YES, briefly describe the national database and who manages it

M&E unit

146) 7.2 IF YES, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes, all of the above (0)

147) 7.3 Is there a functional* Health Information System?

At national level	Yes
At subnational level	Yes

148) For Question 7.3, you have indicated "Yes" to "subnational level", please specify at what level(s)?
Provincial and district levels

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

Yes (0)

150) 9. To what extent are M&E data used

9.1 in developing / revising the national AIDS strategy?:

4 (4)

151) Provide a specific example:

- Draft of new strategy and action plan 2011-2015 - Monitor the progress of the national response - Track the trend of the epidemic - Information sharing with partners- ARV treatment

152) What are the main challenges, if any?

Insufficiency of data sources - Limitation of data analysis - Limitation of Q&A and Q&C of data - External funding dependency- New software for national M&E is early stage

153) 9. To what extent are M&E data used

9.2 for resource allocation?:

4 (4)

154) Provide a specific example:

- Improve capacity building at all levels - Allocate of financial in the rigth way

155) What are the main challenges, if any?

- Insufficient M&E skills in personnel, particularly at provincial and district levels - Still limited data on high risk populations

156) **9. To what extent are M&E data used**

9.3 for programme improvement?:

4 (4)

157) **Provide a specific example:**

- Improve capacity building at all levels - Allocate of financial in the rigth way

158) **What are the main challenges, if any?**

- HIV M&E system still at early stages - Insufficient M&E skills in personnel, particularly at provincial and district levels - Still limited data on high risk populations - Need mechanisms improve QA & QC of data

159) **10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?:**

Yes, at all levels (0)

160) **10.1 In the last year, was training in M&E conducted**

At national level?	Yes
At subnational level?	Yes
At service delivery level including civil society?	No

161) **Please enter the number of people trained <u>at national level.</u>**
Please enter an integer greater than 0
22

162) **Please enter the number of people trained <u>at subnational level.</u>**
Please enter an integer greater than 0
28

163) **10.2 Were other M&E capacity-building activities conducted other than training?**

No (0)

164) **Overall, how would you rate the M&E efforts of the HIV programme in 2009?**

9 (9)

165) **Since 2007, what have been key achievements in this area:**

- National M&E unit established in CHAS - M&E TWG established - M&E plan for 2010 developed - 13% HIV program funding to M&E activities - Trainings in M&E @ national, sub-national, service delivery level - 3rd round of 2nd generation surveillance & several other studies - Mid-term review in 2008 of NSAP - National M&E database developed & housing indicators - Clinical management software pilot tested in 2 hospitals (Setthathirath & Mahosot) - Monthly & Annual M&E reports - All partners have aligned & harmonized M&E requirements

166) What are remaining challenges in this area:

- HIV M&E system still at early stages - Insufficient M&E skills in personnel, particularly at provincial and district levels - Still limited data on high risk populations - Need mechanisms improve QA & QC of data

Page 82

167) 1. Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifi cally mention HIV, focus on schooling, housing, employment, health care etc.)

No (0)

168) 2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

Yes (0)

169) 2.1 *IF YES,* for which subpopulations?

a. Women	Yes
b. Young people	Yes
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex Workers	Yes
f. prison inmates	No
g. Migrants/mobile populations	Yes
Other: Please specify	No

170) IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

•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 law on the protection of women directs all relevant ministries and mass organisations to ensure that the position of women in Lao society is protected and enhanced .the arm of government which has most responsibility in this area is the Lao women's union .it is their role to promote research ,policy development and monitor the role women in the community .Their links through membership,advocacy,projects, and position in the community,allows them to effectively monitor and report on how this law is being implemented and what future action need to be taken .in addition ,to the women's union, many NGOs conduct activities aimed at promoting the role of women in the community and they are able to work with government an the women's union if there are any incidences which suggest that the law is not being implemented. • The national strategy for HIV/STI prevention program has been delivering services to ensure that women and other group of

population have access to health information, treatment and other social support . • The government should disseminate the law and make it kwon in every setting including in community level so that general public would know ,if people don't know the law they would don't know what to do or where to go to claim for their rights.

171) Briefly describe the content of these laws:

Constitution of the Lao PDR: Article 25. (New) 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. (New) 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. The State must create conditions for children affected by HIV/AIDS to receive policies on health protection and care as follows: 1. Take measures to prevent transmission of HIV/AIDS, particularly mother-to-child transmission of HIV/AIDS; 2. Provide counselling for children infected with HIV/AIDS. Children should not be forced to be tested for HIV/AIDS, and their HIV/AIDS status should be kept confidential; 3. Provide care and treatment to children infected with HIV/AIDS, including providing them with antibiotics and other medicines; 4. Encourage the society and community to support and assist children infected with HIV/AIDS. 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. Article 42. Alternative Care for Children Childcare has many alternatives, and consideration of the use of such alternative care shall be based on the following conditions: 5. The best interests of the child shall be the main factor to be taken into consideration; 6. In appointing the guardian, preference shall be given to members of the family, and close relatives living near the child, except if it is in conflict with the child's best interests; 7. The need to preserve the culture, language, religion and racial background of the child; 8. Placement of the child in a residential care institution, such as an orphanage, boarding-school or other institutional establishment shall be a measure of last resort; 9. The views of the child shall be taken into consideration, based on a balancing evaluation of the age and the discernment of the child; 10. Children affected by HIV/AIDS shall be cared for by their family and should not be isolated from other children and society. • Drug control ,Prevention ,protection, treatment and rehabilitation for addict • Article 2 of the law started that children infected and /or affected by HIV/AIDS are among those children who are in need of special

protection • The Lao national assembly regularly meets and is able to discuss issue related to the implantation of this law .prominent member of the women's union are member of the nation assembly and have a platform to argue for amendments in the law and in the implantation. • Health services such as: drop in center for SW in four hot spot provinces are an example of system in place to ensure that SW have access to health information and service as well as referral to other occupational trainings

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

Although there is no specific HIV law, the National Response to HIV/AIDS/STI is coordinated by the National Committee for the Control of AIDS (NACCA).The National Policy and the National Strategy and Action Plan on HIV/AIDS/STI form the basis for an expanded response to HIV and AIDS, setting clearly defined priorities and targets for the national response. CEDAW recommendations (2009) stated the following 40. While noting the appointment of a National Committee Against AIDS, the establishment of an Anti-AIDS Centre as well as information on a number of existing plans, programmes and measures undertaken to combating HIV/AIDS, the Committee is concerned that the number of women infected with HIV/AIDS reportedly increases at an average rate of 8 per cent per year, that women and girls may be particularly susceptible to such infection owing to gender-specific norms, and that certain groups of women, including women involved in prostitution and migrant women workers are at a high risk of being infected with HIV/AIDS. The Committee is especially concerned that the persistence of unequal power relations between women and men and the inferior status of women and girls may hamper their ability to negotiate safe sexual practices and increase their vulnerability to infection. It is also concerned that current policies and legislation may not adequately take into account gender-specific vulnerabilities and may not sufficiently protect the rights of women and girls affected by HIV/AIDS. 41. The Committee recommends continued and sustained efforts to address the impact of HIV/AIDS on women and girls, as well as its consequences for society and the family. It urges the State party to enhance its focus on women's empowerment and to include a clear and visible gender perspective in its policies and programmes on HIV/AIDS and increase the role of men in all relevant measures. The State party is encouraged to undertake awareness raising campaigns among Government personnel in the prevention of and protection against and maintenance of confidentiality in order to systemize and integrate approaches for multiple government sectors. The Committee recommends that the State party include information on measures taken in this respect, obstacles encountered and results achieved in its next report.

173) 3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

No (0)

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

Yes (0)

175) IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

Current National Policy on HIV/AIDS/STI stated that: • The Lao PDR constructs its HIV/AIDS/STD policy and control activities on the following universal principles: o non-

discrimination, o voluntary approaches with informed consent, o confidentiality and privacy in counseling, testing and care, o empowerment of individuals to take personal responsibility, o gender equity, o accessibility to affordable and acceptable services, o reduction of risk for vulnerable individuals and community groups, and o involvement in decision making of those with and affected by HIV/AIDS. • Discrimination against vulnerable groups is counterproductive to HIV/AIDS/STI control. • People living with HIV or AIDS should not be stigmatized. People with AIDS can be safely cared for in all medical institutions and in the home. Home based care for PLHIV will be encouraged for both humanitarian and cost reasons. Ministry of Labour and Social Welfare, the Lao Federation of Trade Unions and the Lao National Chamber of Commerce and Industry launched the Tripartite Declaration on HIV/AIDS at the Workplace, which based on the key principles stipulated in the ILO's Code of Practice on HIV/AIDS. The declaration will serve as a tool for the employers, workers and other stakeholders to develop its own measures on prevention, caretakers and cure as a tool to address the HIV/AIDS issues at the workplace .

176) 5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?

Yes (0)

177) IF YES, briefly describe this mechanism:

Existing mechanisms to record, document and address cases of discrimination include: - Thematic Working Groups on Sex Workers, MSM and Care and Support; - Network of PLHIV – Lao National Network of PLHIV; - Monthly meeting of PLWHA groups, 11 groups have been established and functioned regularly; • While there is no formal anti- discrimination board or equal opportunity commission in Laos there are still avenue for the recording, documenting and addressing of case of discrimination.chief among these would be the potential role of CHAS .As a national body it is charged with ensuring active and appropriate HIV rule and regulations and the implementation of these .in addition, it has provincial bodies who have significant contact with PLH and would provide an avenue for people to make complaints about discrimination.In addition to these ,discrimination experienced in the work place is now forbidden in the Tri-parties Declaration ,under this document workers are able to complaint to the ministry of labour and social welfare or LFTU about any discrimination and these to bodies should investigate the issue .As well as formal Lao avenue, many INGOs work in HIV sector in the HIV sector and come in to contact with PHL who have experienced discrimination. Their role and contact with Lao bodies and agencies can also provide an avenue for the reporting ,addressing of cases of discrimination .Local organizations such as LNP+ would also be able to monitor issue relating to discrimination.

178) 6. Has the Government, through political and fi nancial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

Yes (0)

179) IF YES, describe some examples:

- MSM, Sex workers, PLHIV represented in thematic working groups - Representatives of PLWHA are member of Country Coordination Mechanism (CCM) for GFATM and some PCCAs -

Civil society (including PLWHA) are actively involved in development of the national AIDS strategy, policy and guidelines - PLWHA have been empowered and build their capacities in various aspects. - (To check if the new ToR of the NCCA includes the PLWHA) • The representative from self-help group of PLWA and drug users have been invited to participate number of national workshop, training, meeting. This illustrates their participation in decision making on HIV/AIDS related matters. • The good example of this includes an inclusion of SW in the planning, Implementation and monitoring support for HIV/STI intervention programm. Additionally, PLWA are also participating in the national strategic planning and assist the provision of STI/HIV service at the Drop-in Centre for SW. • HIV people now being more involved in HIV work such us in implementation of activities, working in the hospital to provide peer counseling, speak in community to raise HIV awareness. HIV people still not very actively involve in HIV policy design, However one LNP+ member who is a presentative of PLHA has become a member of CCM (GF). • Ask people to be involved in planning and evaluating programs.

180) 7. Does the country have a policy of free services for the following:

a. HIV prevention services	Yes
b. Antiretroviral treatment	Yes
c. HIV-related care and support interventions	Yes

181) IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

The national Strategic and Action Plan on HIV and AIDS forms the basis for an expanded response to HIV and AIDS, setting clearly defined priorities and targets for the national response. The targets are regularly revised, and the costed action plan forms the basis for resource mobilization in the country. • Through donor funding, government have established the ART centre in Vientiane, Luangprabang, Savanaket and Chanpasack provinces of Laos (ther are the HIV/STI/AIDS four hot spot provinces in country). • Despite some resource constraint, CHAS has build up a broad net work throughout the country , working with local hospital to provide care and treatment for PLWA, while these are not the widely disbursed as needed, service are increasing . the Lao government is also using many INGOs to help in their delivery of care, support, prevention and treatment for PLWA. • HIV prevention and care support service should being promoted and extend to winder and remote communities. Awareness raising should be extended and on going activities Implementation of the HIV Prevention Policies: The NSAP identifies a “minimum package” of activities to increase safe sexual behaviour among the key populations at higher risk. It consists of peer-led behaviour change communication, free condoms and lubricants, free STI services tailored to the needs of the respective groups, and referral to VCT. Other main prevention activities in implementation include, among others, social marketing of condoms, 100% Condom Use Programme in 15 provinces, life skills education at schools (which includes HIV messages) and reproductive health services for young people in and out of school. HIV prevention related restrictions: - VCCT might not be of expected quality and uptake remains to be increased. - Counselling and psychological support capacity is relatively low. - Condom free distribution doesn’t cover all areas. Implementation of ART Policies: ART started in 2003 with one treatment site in Savannakhet province. Since then it has expanded to two more sites in Vientiane Capital, and

in 2009, one additional treatment site was opened in Luangprabang province. At present, all people who are known to be in need of ART and OI receive treatment. Community support activities include strengthening of PLHIV self help groups and the National Network of PLHIV (LNP+). Currently self help groups exist in 10 provinces, providing psychosocial support to PLHIV and their family members. The involvement of Buddhist Monks contributes to scaling up community mobilization activities for HIV prevention and to reduce stigma towards PLHIV. Anti-retroviral treatment related restrictions - ARV available only in 4 sites. - ARV treatment is free but doesn’t cover all patients (e.g.: OI treatment) - ARV service delivery model should be finalized. Implementation Care and Support Policies: HIV-related care and support interventions related restrictions - Continuum of Care rarely implemented at district and community levels Most of fund are from international assistance which might create barrier for sustainability and ownership. Transportation is a recurrent issue.

182) 8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes (0)

183) 8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes (0)

184) 9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes (0)

185) IF YES, briefly describe the content of this policy:

Different official documents makes clear reference to equal access for MARPs, for example: “The needs of women will be addressed as regards control of HIV/AIDS/STDs. Measures that promote gender equity and decrease the relative poverty of women are important in controlling HIV/AIDS/STDs and to development in general”. ; “Focusing HIV prevention efforts on vulnerable groups has been shown to be effective in reducing transmission of HIV to general population. Discrimination against vulnerable groups is counterproductive to HIV/AIDS/STD control”. • Now discriminatory and gender equity ,Promote prevention service at public heath facilities but a new private (New lucrative ,Non profit sector) • Every one has access different organization ,How ever all men, women and children (PHA) can have equal access • In the national strategy plan ,Vulnerable subpopulation are being focus on such as MSM, work worker ,how ever after groups are also equal access include men ,women and children and PHA

186) 9.1 IF YES, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

Yes (0)

187) IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

Tailored services for specific needs of different most-at-risk populations (e.g.: STI treatment, STI kits, drop-in centre for sex workers and MSM, male condom for sex worker clients and

lubricant for MSM, and mass campaign for general population). • MARP specific service (i,e .VCT for MSM+STI/HIV service for FSW) • Not written in the policy however in practice people living in the more remote support areas are provided with additional transport ,accommodation to ensure equal access. • Most at least risk population have given to first priority to receive support from an intervention program.

188) 10.Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes (0)

189) 11.Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes (0)

190) 11.1 IF YES, does the ethical review committee include representatives of civil society including people living with HIV?

Yes (0)

191) IF YES, describe the approach and effectiveness of this review committee:

• The ethical review committee reviewed and approved all research protocols on AIDS and STI. • Members of the ethical committee include representatives from various sectors, e.g. Ministry of Health, University of Health Sciences, LWU, Central Party Office, Ministry of Justice, and National Council of Sciences. • The view committee have so far been ensuring that human right of people participating in the survey are protected and that they will not be harm by the research protocols .An example of research include the conduction of HIV/AIDS /STI surveillance survey where all written consent are obtained procedure are clearly understood and confidentiality are maintained.

192) – 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

No (0)

193) – Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

No (0)

194) – Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

No (0)

195) 13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?

No (0)

196) – Legal aid systems for HIV casework

No (0)

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

No (0)

198) – Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes (0)

199) 15. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes (0)

200) IF YES, what types of programmes?

Media	Yes
School education	Yes
Personalities regularly speaking out	Yes
Other: please specify	Yes

201) Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

7 (7)

202) Since 2007, what have been key achievements in this area:

• On going activities such revision of national policy and preparation of a law on HIV and AIDS are likely to substantially contribute to stigma and discrimination reduction.. • Disaggregation of data and establishment of a national M&E framework will allow for closer follow up in policy implementation. • The Increased involvement of network of people living with HIV. • Policy update ,comity for law development • More cooperation with UNAIDS ,Organization ,NGOs and the government this has reduced • Quality of program have been improve since 2007,however program need to be improved What are remaining challenges in this area? • Law ,specific regulation for private sector (100 %CUP),accreditation and quality assurance of heath product • PHA access to service with out discrimination • Law and regulation need become clear and better know • Community work shop • Support PHA self help group meeting

203) What are remaining challenges in this area:

- No training to member of judiciary on HIV & human rights - No workplace policy for HIV - More effort needed to address HIV and gender - Political and financial support for law dissemination and enforcement

204) Overall, how would you rate the efforts to enforce the existing policies, laws and regulations

in 2009?

7 (7)

205) Since 2007, what have been key achievements in this area:

• Several sensitizing meetings/training on HIV (including policy) were organized for various sectors (e.g. National Assembly, Ministry of Public Security, …) • Specific actions were taken by the government and its partners to address human right and HIV • On going revision of existing laws and legislation which may present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable sub-populations. • There is a policy and strategic plan with protective principle • Have cooperate between ,Government, INGO to reduce overlapping and spreading the support service to community • PHA involve more in HIV program, LNP+ recognize in HIV sector

206) What are remaining challenges in this area:

• Finalization of the revision of national policy is a lengthy process • Role of the NCCA should be further expanded so to bring multi-sectoral partners up to speed

207) 1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

4 (4)

208) Comments and examples:

CS has become more noticeable in thematic groups, national and regional consultations, etc. However, competency and English language remains a barrier for some CS in active participation. • The application of peer approach in reach target group and delivering HIV prevention intervention Indicate that the view and network of the target group have been taken into account when the strategy/policy was developed. • Civil society is not get obtain legal states in Laos and actively involve much strategy /policy formulation • Association of PHA ,promote their point of new central, provincial forum but remain irregular and need more support

209) 2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

4 (4)

210) Comments and examples:

CS Representatives have actively participated in the Mid term review of the NSP. A new five year planning exercise will being launched early next year and participation of the CS Representative is expected

211) a. the national AIDS strategy?

5 (5)

212) b. the national AIDS budget?

4 (4)

213) c. national AIDS reports?

2 (2)

214) Comments and examples:

Reference to funding analysis of the NSAP, a proportion of funds allocated to the Civil Society is around 20% of total budget (for 2008) community base program conducted by NGO trough peer indicator /out reach activities report to CHAS and are included when updating NSAP

215) a. developing the national M&E plan?

3 (3)

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

4 (4)

217) c. M&E efforts at local level?

4 (4)

218) Comments and examples:

M&E UNIT within the CHAS structural framework has been established and functioned since early 2009. M&E framework was developed, which particularly focussed on the GFATM granted project at the beginning stage. The CS has been involved in all level of M&E activities, e.g. M&E planning, consultation, mid-term review of NSAP. • National M&E plan ,developed by public sector • Some participation at the CCM level (meeting) • Several NGO,association work at local level and have M&E system

Page 106

219) 5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

4 (4)

220) Comments and examples:

Overall, few number of Civil Societies are registered in the Lao PDR. A Prime Minister's Decree on Association recently issued will provide an opportunity for establishment of the civil society organization in the future. So far, the CS which have been involved in the national AIDS programme included: Lao Youth Union, Lao Women Union, Lao Trade Union, Lao Front for National Construction, Lao Red Cross, Faith-based organizations, Local NGO, and PLHIV groups/network

221) a. adequate financial support to implement its HIV activities?

1 (1)

222) b. adequate technical support to implement its HIV activities?

3 (3)

223) Comments and examples:

Human capacity and to various degree expertise constitutes a barrier for CS in accessing financial support and implementing HIV related programme. The Government and its international partners (including UN, and INGOs) provide both financial and technical assistance to strengthen the capacity of the CSO and substantial progress have been recorded while programme management and AIDS competency still remains a challenge

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

Prevention for youth	25-50%
Prevention for most-at-risk-populations	
- Injecting drug users	25-50%
- Men who have sex with men	<25%
- Sex workers	25-50%
Testing and Counselling	<25%
Reduction of Stigma and Discrimination	25-50%
Clinical services (ART/OI)*	<25%
Home-based care	25-50%
Programmes for OVC**	51-75%

225) Overall, how would you rate the efforts to increase civil society participation in 2009?

8 (8)

226) Since 2007, what have been key achievements in this area:

All existing CS has been encouraged to be part of the national AIDS programme. For example: the Country Coordinating Mechanism (CCM) for the GFATM has called for submission of expressions of interest (EOI) from all interested partners in scaling up HIV interventions. Civil societies are main implementing partners in GFATM supported activities

227) What are remaining challenges in this area:

• Low capacity of the civil society • Small number of civil society registered in the Lao PDR. • Technical and financial capacity of this civil society organization. participation limited to meeting

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

Yes (0)

229) IF YES, how were these specific needs determined?

Based on the available epidemiological information and the review of the 2002-2005 National Strategic Plan, the following priorities are defined in the current NSAP: • Reaching full coverage

of targeted and comprehensive interventions in prioritized provinces/districts in a phased approach; • Establishment of an enabling environment for an expanded response at all levels; • Increased strategic information availability to monitor both the epidemic and the response; • Capacity building of implementing partners at all levels; • Effective management, coordination, and monitoring of the expanded prevention response; • Tailored prevention programmes have been designed for each target populations. For example: comprehensive interventions were designed for the most-at-risk groups, essential element package for general population, PMCT for ANC groups, etc . • Base epidemically s tudies and behavioral studies and surveillance . the finding of these studies informed the decisions on response to HIV epidemics .eg, the strategies out lined in national strategy and action plan on HIV/AIDS/STI

230) 1.1 To what extent has HIV prevention been implemented?

	The majority of people in need have access
HIV prevention component	
Blood safety	Agree
Universal precautions in health care settings	Don't agree
Prevention of mother-to-child transmission of HIV	Agree
IEC* on risk reduction	Agree
IEC* on stigma and discrimination reduction	Agree
Condom promotion	Agree
HIV testing and counselling	Agree
Harm reduction for injecting drug users	Don't agree
Risk reduction for men who have sex with men	Agree
Risk reduction for sex workers	Agree
Reproductive health services including sexually transmitted infections prevention and treatment	Agree
School-based HIV education for young people	Agree
HIV prevention for out-of-school young people	Don't agree
HIV prevention in the workplace	Don't agree
Other: please specify	Don't agree

231) Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

8 (8)

232) Since 2007, what have been key achievements in this area:

• Funds have been mobilized and secured for scaling up comprehensive interventions to reach the national targets of the most-at-risk populations, especially from the GFATM for SW and clients and MSM, and recently from Australian Government for DU/IDU and HIV harm reduction programme. • Blood safety programme has been expanded. • Other interventions (such as: life skills education for in-school youth, PMCT, VCT and STI services, Drop-in centers, 100% condom promotion and condom social marketing, mass campaign, etc.) have been extended with quality improved. • Peer educator targeted prevention • In Vientiane access to information has

improved

233) What are remaining challenges in this area:

• Additional human resources are needed in order to scaling up the intervention • Capacity of the implementing partners needs to be strengthened. • Awareness capacity limited to peer educator • More open political support is need • Access to remote communities regular basis • Coordinate between different organization working on HIV • Although the intervention had been piloted before scaling up the meaningful M&E are required to ensure the effectiveness • Financial commitment for prevention intervention should not be on yearly basis if the result at impact level are to be achieved

234) 1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes (0)

235) IF YES, how were these specific needs determined?

The national AIDS authority has put its effort, in consultation with various partners in identifying the specific needs for HIV treatment, care and support. The estimation and projection were made based on spectrum and other methods (e.g. ART needed assumption made by Bill Clinton Foundation's expert team). • Provide the most cost-effective and accessible combination of care and support for adults and children infected and affected by HIV/AIDS, especially community and home-based care • Ensure that all adults and children living with HIV/AIDS have access to adequate medical services and treatment • Ensure that all health staff are fully aware of universal precautions and have the skills and means for protection. • Gap analysis during GF proposal • Strategic plan meeting • CCM meetings • According to regional estimation and projections • Care and treatment unit are regionally distributed to increase access to most remote area. • Specifically trained doctors and nurse on HIV treatment • ARV and HIV/AIDS treatment center should extend to district level and cover all province . • Confidentially and discrimination medical service should be taken into account more seriously .

236) 1.1 To what extent have the following HIV treatment, care and support services been implemented?

	The majority of people in need have access
HIV treatment, care and support service	
Antiretroviral therapy	Agree
Nutritional care	Don't agree
Paediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree
Psychosocial support for people living with HIV and their families	Don't agree
Home-based care	Don't agree
Palliative care and treatment of common HIV-related infections	Don't agree
HIV testing and counselling for TB patients	Don't agree
TB screening for HIV-infected people	Don't agree

TB preventive therapy for HIV-infected people	Don't agree
TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in HIV-infected people	Agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree
HIV treatment services in the workplace or treatment referral systems through the workplace	Don't agree
HIV care and support in the workplace (including alternative working arrangements)	Don't agree
Other: please specify	N/A

237) Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

7 (7)

238) Since 2007, what have been key achievements in this area:

- Increase in ART coverage from 63% to 93% - Expansion of ART sites from 2 in 2007 to 5 plus 2 satellites in 2009 - Decrease in HIV & STI prevalence in FSW since 2004 - Establishment of 7 drop-in centers targeted at female service workers, which mirrors increase in testing

239) What are remaining challenges in this area:

- HIV services not yet linked with MCH, to be discussed soon between CHAS and MCHC to strengthen PMCT package - More human resources needed - Need to ensure access to OI & 2nd line treatment

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

Yes (0)

241) 2.1 IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes (0)

242) 2.2 IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes (0)

243) 2.3 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes (0)

244) IF YES, what percentage of orphans and vulnerable children is being reached?

Please enter the percentage (0-100)
70

245) Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other

vulnerable children in 2009?

4 (4)

246) Since 2007, what have been key achievements in this area:

- Conducted quality of HIV impact on OVC and there were some initiative intervention to adress the OVC issues.

247) What are remaining challenges in this area:

-Indicates OVC are addressed, but not mentioned in NSAP

Annex 3: AIDS Spending Matrix

YEAR: 2007 — **National Funding Matrix**

Calendar Year: No — **AIDS Spending Categories by Financing Sources**

Fiscal Year: 1st Sep. 2006 to 30 Oct. 2007

Currency used in Matrix: US$

Average Exchange Rate for the year: 10,616 Lak

	Financing Sources																	
		Public Sources						International Sources							Private Sectors (Optional for UNGASS Reporting)			
										Multilaterals								
AIDS Spending Categories	Total	Public Sub-Total	Central/National	Sub-National	Dev. Bank Reimbursable (e.g. Loans)	Social Security	All Other Public	International Sub-Total	Bilaterals	UN Agencies	Global Fund	Dev. Bank Non-Reimbursable (e.g. Grants)	All Other Multilateral	All Other International	Private Sub- Total	For-profit institution/Corporation	Household Funf	All Other Private
1. Prevention-related activities	2,581,581	0	0	0	0	0	0	2,581,581	596,736	519,955	1,266,323	91,713	0	106,854	0	0	0	0
1.01 Communication for social and behavioural change	393,042	0	0	0	0	0	0	393,042	80,271	0	223,594	55,914	0	33,263	0	0	0	0
1.02 Community mobilization	49,294	0	0	0	0	0	0	49,294	3,270	689	21,600	22,958	0	777	0	0	0	0
1.03 Voluntary counselling and testing	25,832	0	0	0	0	0	0	25,832	0	25,832	0	0	0	0	0	0	0	0
1.04 Risk-reduction for vulnerable and accessible populations	8,220	0	0	0	0	0	0	8,220	8,220	0	0	0	0	0	0	0	0	0
1.05. Prevention - Youth in school	125,655	0	0	0	0	0	0	125,655	75,151	50,504	0	0	0	0	0	0	0	0
1.06 Prevention - Youth out-of-school	176,089	0	0	0	0	0	0	176,089	118,297	14,812	41,894	0	0	1,086	0	0	0	0
1.07 Prevention of HIV transmission aimed at people living with HIV	149,748	0	0	0	0	0	0	149,748	0	149,748	0	0	0	0	0	0	0	0
1.08 Prevention programmes for sex workers and their clients	407,827	0	0	0	0	0	0	407,827	309,011	0	85,975	12,841	0	0	0	0	0	0
1.09 Programmes for men who have sex with men	26,057	0	0	0	0	0	0	26,057	0	0	0	0	0	26,057	0	0	0	0
1.10 Harm-reduction programmes for injecting drug users	9,500	0	0	0	0	0	0	9,500	0	9,500	0	0	0	0	0	0	0	0
1.11 Prevention programmes in the workplace	78,761	0	0	0	0	0	0	78,761	0	61,377	0	0	0	17,384	0	0	0	0
1.12 Condom social marketing	517,393	0	0	0	0	0	0	517,393	0	0	492,393	0	0	25,000	0	0	0	0
1.13 Public and commercial sector male condom provision	43,557	0	0	0	0	0	0	43,557	0	0	43,557	0	0	0	0	0	0	0
1.14 Public and commercial sector female condom provision	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.15 Microbicides	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.16 Prevention, diagnosis and treatment of sexually transmitted infections	5,385	0	0	0	0	0	0	5,385	0	5,385	0	0	0	0	0	0	0	0
1.17 Prevention of mother-to-child transmission	188,796	0	0	0	0	0	0	188,796	0	187,108	0	0	0	1,688	0	0	0	0
1.18 Male Circumcision	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.19 Blood safety	372,310	0	0	0	0	0	0	372,310	0	15,000	357,310	0	0	0	0	0	0	0
1.20 Safe medical injections	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

1.21 Universal precautions	2,516	0	0	0	0	0	0	2,516	2,516	0	0	0	0	0	0	0	0	0
1.22 Post-exposure prophylaxis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.98 Prevention activities not disaggregated by intervention	1,599	0	0	0	0	0	0	1,599	0	0	0	0	0	1,599	0	0	0	0
1.99 Prevention activities not elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2. Treatment and care components	339,095	0	0	0	0	0	0	339,095	77,325	63,322	16,448	0	0	0	0	0	0	0
2.01 Outpatient care	275,176	0	0	0	0	0	0	275,176	76,728	0	16,448	0	0	182,000	0	0	0	0
2.01.01 Provider- initiated testing and counselling	46,588	0	0	0	0	0	0	46,588	38,364	0	8,224	0	0	0	0	0	0	0
2.01.02 Opportunistic infection outpatient prophylaxis and treatment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.03 Antiretroviral therapy	182,000	0	0	0	0	0	0	182,000	0	0	0	0	0	182,000	0	0	0	0
2.01.04 Nutritional support associated to ARV therapy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.05 Specific HIV-related laboratory monitoring	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.06 Dental programmes for people living with HIV	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.07 Psychological treatment and support services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.08 Outpatient palliative care	38,364	0	0	0	0	0	0	38,364	38,364	0	0	0	0	0	0	0	0	0
2.01.09 Home-based care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.10 Traditional medicine and informal care and treatment	8,224	0	0	0	0	0	0	8,224	0	0	8,224	0	0	0	0	0	0	0
2.01.98 Outpatient care services not disaggregated by intervention	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.99 Outpatient Care services not elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.02 In-patient care	63,919	0	0	0	0	0	0	63,919	597	63,322	0	0	0	0	0	0	0	0
2.02.01 Inpatient treatment of opportunistic infections	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.02.02 Inpatient palliative care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.02.98 Inpatient care services not disaggregated by intervention	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.02.99 In-patient services not elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.03 Patient transport and emergency rescue	597	0	0	0	0	0	0	597	597	0	0	0	0	0	0	0	0	0
2.98 Care and treatment services not disaggregated by intervention	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.99 Care and treatment services not-elsewhere classified	63,322	0	0	0	0	0	0	63,322	0	63,322	0	0	0	0	0	0	0	0
3. Orphan and Vulnerable children --OVC	15,292	0	0	0	0	0	0	15,292	115	9,192	2,250	0	0	0	0	0	0	0
3.01 OVC Education	3,315	0	0	0	0	0	0	3,315	115	0	0	0	0	0	0	0	0	0
3.02 OVC Basic health care	535	0	0	0	0	0	0	535	0	0	0	0	0	0	0	0	0	0
3.03 OVC Family/home support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.04 OVC Community support	11,442	0	0	0	0	0	0	11,442	0	9,192	2,250	0	0	0	0	0	0	0
3.05 OVC Social services and administrative costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.06 OVC Institutional care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.98 OVC services not disaggregated by intervention	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

3.99 OVC services not-elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4. Program Management and Administration	1,065,492	67,602	12,602	55,000	0	0	0	997,890	112,306	256,508	314,480	55,754	0	584,985	0	0	0	0
4.01 Planning, coordination and programme management	634,812	0	0	0	0	0	0	634,812	33,418	254,008	170,423	33,621	0	202,166	0	0	0	0
4.02 Administration and transaction costs associated with managing and disbursing funds	132,172	67,602	12,602	55,000	0	0	0	64,570	16,039	0	0	7,419	0	100,283	0	0	0	0
4.03 Monitoring and evaluation	119,359	0	0	0	0	0	0	119,359	18,225	2,500	68,707	11,130	0	41,112	0	0	0	0
4.04 Operations research	40,507	0	0	0	0	0	0	40,507	4,822	0	0	0	0	12,488	0	0	0	0
4.05 Serological-surveillance (Serosurveillance)	0	0	0	0	0	0	0	0	0	0	0	0	0	28,936	0	0	0	0
4.06 HIV drug-resistance surveillance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.07 Drug supply systems	78,934	0	0	0	0	0	0	78,934	0	0	75,350	3,584	0	182,000	0	0	0	0
4.08 Information technology	21,584	0	0	0	0	0	0	21,584	3,584	0	0	0	0	0	0	0	0	0
4.09 Patient tracking	0	0	0	0	0	0	0	0	0	0	0	0	0	18,000	0	0	0	0
4.10 Upgrading and construction of infrastructure	21,863	0	0	0	0	0	0	21,863	21,863	0	0	0	0	0	0	0	0	0
4.11 Mandatory HIV testing (not voluntary counselling and testing)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.98 Program Management and Administration Strengthening not disaggregated by type	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.99 Program Management and Administration Strengthening not-elsewhere classified	16,261	0	0	0	0	0	0	16,261	14,355	0	0	0	0	0	0	0	0	0
5. Human resources	668,018	0	0	0	0	0	0	668,018	83,754	301	233,237	213,668	0	141,373	0	0	0	0
5.01 Monetary incentives for human resources	108,205	0	0	0	0	0	0	108,205	13,017	0	49,577	9,209	0	70,687	0	0	0	0
5.02 Formative education to build-up an HIV workforce	0	0	0	0	0	0	0	0	0	0	0	0	0	36,402	0	0	0	0
5.03 Training	414,795	0	0	0	0	0	0	414,795	62,379	301	47,000	204,459	0	0	0	0	0	0
5.98 Incentives for Human Resources not specified by kind	36,200	0	0	0	0	0	0	36,200	4,785	0	31,415	0	0	34,284	0	0	0	0
5.99 Incentives for Human Resources not elsewhere classified	108,818	0	0	0	0	0	0	108,818	3,573	0	105,245	0	0	0	0	0	0	0
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	1,279	0	0	0	0	0	0	1,279	0	1,279	0	0	0	0	0	0	0	0
6.01 Social protection through monetary benefits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6.02 Social protection through in-kind benefits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6.03 Social protection through provision of social services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6.04 HIV-specific income generation projects	1,279	0	0	0	0	0	0	1,279	0	1,279	0	0	0	0	0	0	0	0
6.98 Social protection services and social services not disaggregated by type	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6.99 Social protection services and social services not elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Enabling Environment	368,895	0	0	0	0	0	0	368,895	137,549	116,314	0	11,705	0	17,178	0	0	0	0
7.01 Advocacy	252,581	0	0	0	0	0	0	252,581	137,549	0	0	11,705	0	15,589	0	0	0	0
7.02 Human rights programmes	0	0	0	0	0	0	0	0	0	0	0	0	0	1,589	0	0	0	0
7.03 AIDS-specific institutional development	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7.04 AIDS-specific programmes focused on women	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7.05 Programmes to reduce Gender Based Violence	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

AIDS Spending Categories	Total	Public Sub-Total	Central/National	Sub-National	Dev. Bank Reimbursable (e.g. Loans)	Social Security	All Other Public	International Sub-Total	Bilaterals	UN Agencies	Global Fund	Dev. Bank Non-Reimbursable (e.g. Grants)	All Other Multilateral	All Other International	Private Sub- Total	For-profit institution/Corporation	Household Funf	All Other Private
7.98 Enabling Environment and Community Development not disaggregated by type	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7.99 Enabling Environment and Community Development not elsewhere classified	116,314	0	0	0	0	0	0	116,314	0	116,314	0	0	0	0	0	0	0	0
8. Research excluding operations research	106,961	0	0	0	0	0	0	106,961	0	52,512	31,769	22,680	0	0	0	0	0	0
8.01 Biomedical research	24,030	0	0	0	0	0	0	24,030	0	0	24,030	0	0	0	0	0	0	0
8.02 Clinical research	51,472	0	0	0	0	0	0	51,472	0	51,472	0	0	0	0	0	0	0	0
8.03 Epidemiological research	21,639	0	0	0	0	0	0	21,639	0	0	7,739	13,900	0	0	0	0	0	0
8.04 Social science research	1,040	0	0	0	0	0	0	1,040	0	1,040	0	0	0	0	0	0	0	0
8.05 Vaccine-related research	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8.98 Research not disaggregated by type	900	0	0	0	0	0	0	900	0	0	0	900	0	0	0	0	0	0
8.99 Research not elsewhere classified	7,880	0	0	0	0	0	0	7,880	0	0	0	7,880	0	0	0	0	0	0
Grand Total	5,146,613	67,602	12,602	55,000	0	0	0	5,079,011	1,007,785	1,019,383	1,864,507	395,520	0	850,390	0	0	0	0

YEAR: 2008

National Funding Matrix

AIDS Spending Categories by Financing Sources

Calendar Year: No

Fiscal Year: 1st Sep. 2007 to 30 Oct. 2008

Currency used in Matrix: US$

Average Exchange Rate for the year: 9,600 Lak

		Financing Sources																
		Public Sources						**International Sources**							**Private Sectors (Optional for UNGASS Reporting)**			
										Multilaterals								
AIDS Spending Categories	**Total**	Public Sub-Total	Central/National	Sub-National	Dev. Bank Reimbursable (e.g. Loans)	Social Security	All Other Public	International Sub-Total	Bilaterals	UN Agencies	Global Fund	Dev. Bank Non-Reimbursable (e.g. Grants)	All Other Multilateral	All Other International	Private Sub- Total	For-profit institution/Corporation	Household Funf	All Other Private
1. Prevention-related activities	1,571,338	0	0	0	0	0	0	1,571,338	366,287	1,102,063	102,988	0	0	0	0	0	0	0
1.01 Communication for social and behavioural change	211,348	0	0	0	0	0		211,348	3,677	146,067	61,604	0	0	0	0	0	0	0
1.02 Community mobilization	41,384	0	0	0	0	0		41,384	0	0	41,384	0	0	0	0	0	0	0
	78,994	0	0	0	0	0		78,994	15,327	63,667	0	0	0	0	0	0	0	0
1.04 Risk-reduction for vulnerable and accessible populations	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0
1.05. Prevention - Youth in school	191,866	0	0	0	0	0		191,866	191,866	0	0	0	0	0	0	0	0	0
1.06 Prevention - Youth out-of-school	240,660	0	0	0	0	0		240,660	6,231	234,429	0	0	0	0	0	0	0	0
1.07 Prevention of HIV transmission aimed at people living with HIV	42,930	0	0	0	0	0		42,930	0	42,930	0	0	0	0	0	0	0	0
1.08 Prevention programmes for sex workers and their clients	74,089	0	0	0	0	0		74,089	0	74,089	0	0	0	0	0	0	0	0
1.09 Programmes for men who have sex with men	27,723	0	0	0	0	0		27,723	0	27,723	0	0	0	0	0	0	0	0
1.10 Harm-reduction programmes for injecting drug users	5,000	0	0	0	0	0		5,000	5,000	0	0	0	0	0	0	0	0	0
1.11 Prevention programmes in the workplace	89,977	0	0	0	0	0		89,977	89,977	0	0	0	0	0	0	0	0	0

1.12 Condom social marketing	28,807	0	0	0	0	0		28,807	0	28,807	0	0	0	0	0	0	0	0
1.13 Public and commercial sector male condom provision	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0
1.14 Public and commercial sector female condom provision	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0
1.15 Microbicides	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0
1.16 Prevention, diagnosis and treatment of sexually transmitted infections	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0
1.17 Prevention of mother-to-child transmission	49,209	0	0	0	0	0		49,209	49,209	0	0	0	0	0	0	0	0	0
1.18 Male Circumcision	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0
1.19 Blood safety	489,351	0	0	0	0	0		489,351	5,000	484,351	0	0	0	0	0	0	0	0
1.20 Safe medical injections	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0
1.21 Universal precautions	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0
1.22 Post-exposure prophylaxis	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0
1.98 Prevention activities not disaggregated by intervention	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0
1.99 Prevention activities not elsewhere classified	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0
2. Treatment and care components	790,596	0	0	0	0	0	0	790,596	48,637	50,618	427,596	3,400	0	260,345	0	0	0	0
2.01 Outpatient care	769,331	0	0	0	0	0	0	769,331	35,560	50,618	427,596	3,400	0	252,157	0	0	0	0
2.01.01 Provider- initiated testing and counselling	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.02 Opportunistic infection outpatient prophylaxis and treatment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.03 Antiretroviral therapy	643,098	0	0	0	0	0	0	643,098	0	0	427,596	0	0	215,502	0	0	0	0
2.01.04 Nutritional support associated to ARV therapy	13,424	0	0	0	0	0	0	13,424	577	0	0	0	0	12,847	0	0	0	0
2.01.05 Specific HIV-related laboratory monitoring	23,808	0	0	0	0	0	0	23,808	0	0	0	0	0	23,808	0	0	0	0
2.01.06 Dental programmes for people living with HIV	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.07 Psychological treatment and support services	8,704	0	0	0	0	0	0	8,704	8,704	0	0	0	0	0	0	0	0	0
2.01.08 Outpatient palliative care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.09 Home-based care	13,865	0	0	0	0	0	0	13,865	10,465	0	0	3,400	0	0	0	0	0	0
2.01.10 Traditional medicine and informal care and treatment	2,700	0	0	0	0	0	0	2,700	2,700	0	0	0	0	0	0	0	0	0
2.01.98 Outpatient care services not disaggregated by intervention	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.99 Outpatient Care services not elsewhere classified	63,732	0	0	0	0	0	0	63,732	13,114	50,618	0	0	0	0	0	0	0	0
2.02 In-patient care	21,265	0	0	0	0	0	0	21,265	13,077	0	0	0	0	8,188	0	0	0	0
2.02.01 Inpatient treatment of opportunistic infections	768	0	0	0	0	0	0	768	0	0	0	0	0	768	0	0	0	0
2.02.02 Inpatient palliative care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.02.98 Inpatient care services not disaggregated by intervention	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.02.99 In-patient services not elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.03 Patient transport and emergency rescue	8,597	0	0	0	0	0	0	8,597	1,177	0	0	0	0	7,420	0	0	0	0
2.98 Care and treatment services not disaggregated by intervention	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

2.99 Care and treatment services not-elsewhere classified	11,900	0	0	0	0	0	0	11,900	11,900	0	0	0	0	0	0	0	0	0
3. Orphan and Vulnerable children --OVC	15,721	0	0	0	0	0	0	15,721	400	10,041	5,280	0	0	0	0	0	0	0
3.01 OVC Education	400	0	0	0	0	0	0	400	400	0	0	0	0	0	0	0	0	0
3.02 OVC Basic health care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.03 OVC Family/home support	5,280	0	0	0	0	0	0	5,280	0	0	5,280	0	0	0	0	0	0	0
3.04 OVC Community support	10,041	0	0	0	0	0	0	10,041	0	10,041	0	0	0	0	0	0	0	0
3.05 OVC Social services and administrative costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.06 OVC Institutional care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.98 OVC services not disaggregated by intervention	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.99 OVC services not-elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4. Program Management and Administration	1,330,453	98,730	33,730	65,000	0	0	0	1,231,723	178,792	180,190	892,581	94,215	0	46,448	0	0	0	0
4.01 Planning, coordination and programme management	721,739	0	0	0	0	0	0	721,739	59,896	180,190	410,967	49,988	0	20,698	0	0	0	0
4.02 Administration and transaction costs associated with managing and disbursing funds	323,536	98,730	33,730	65,000	0	0	0	224,806	96,338	0	101,491	11,227	0	15,750	0	0	0	0
4.03 Monitoring and evaluation	122,959	0	0	0	0	0	0	122,959	22,455	0	100,504	0	0	0	0	0	0	0
4.04 Operations research	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.05 Serological-surveillance (Serosurveillance)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.06 HIV drug-resistance surveillance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.07 Drug supply systems	139,000	0	0	0	0	0	0	139,000	0	0	106,000	33,000	0	0	0	0	0	0
4.08 Information technology	10,103	0	0	0	0	0	0	10,103	103	0	0	0	0	10,000	0	0	0	0
4.09 Patient tracking	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.10 Upgrading and construction of infrastructure	13,116	0	0	0	0	0	0	13,116	0	0	13,116	0	0	0	0	0	0	0
4.11 Mandatory HIV testing (not voluntary counselling and testing)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.98 Program Management and Administration Strengthening not disaggregated by type	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.99 Program Management and Administration Strengthening not-elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5. Human resources	820,842	0	0	0	0	0	0	820,842	82,831	10,667	483,514	167,752	0	76,078	0	0	0	0
5.01 Monetary incentives for human resources	97,145	0	0	0	0	0	0	97,145	13,970	0	73,575	9,600	0	0	0	0	0	0
5.02 Formative education to build-up an HIV workforce	53,039	0	0	0	0	0	0	53,039	0	0	38,039	0	0	15,000	0	0	0	0
5.03 Training	355,297	0	0	0	0	0	0	355,297	68,861	10,667	80,139	154,552	0	41,078	0	0	0	0
5.98 Incentives for Human Resources not specified by kind	315,361	0	0	0	0	0	0	315,361	0	0	291,761	3,600	0	20,000	0	0	0	0
5.99 Incentives for Human Resources not elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	44,734	0	0	0	0	0	0	44,734	0	44,734	0	0	0	0	0	0	0	0
6.01 Social protection through monetary benefits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6.02 Social protection through in-kind benefits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6.03 Social protection through provision of social services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

6.04 HIV-specific income generation projects	44,734	0	0	0	0	0	0	44,734	0	44,734	0	0	0	0	0	0	0	0
6.98 Social protection services and social services not disaggregated by type	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6.99 Social protection services and social services not elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Enabling Environment	121,316	0	0	0	0	0	0	121,316	0	85,361	15,700	2,255	0	18,000	0	0	0	0
7.01 Advocacy	23,356	0	0	0	0	0	0	23,356	0	3,101	0	2,255	0	18,000	0	0	0	0
7.02 Human rights programmes	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7.03 AIDS-specific institutional development	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7.04 AIDS-specific programmes focused on women	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7.05 Programmes to reduce Gender Based Violence	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7.98 Enabling Environment and Community Development not disaggregated by type	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7.99 Enabling Environment and Community Development not elsewhere classified	97,960	0	0	0	0	0	0	97,960	0	82,260	15,700	0	0	0	0	0	0	0
8. Research excluding operations research	322,039	0	0	0	0	0	0	322,039	0	15,015	221,623	78,745	0	6,656	0	0	0	0
8.01 Biomedical research	8,962	0	0	0	0	0	0	8,962	0	0	8,962	0	0	0	0	0	0	0
8.02 Clinical research	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8.03 Epidemiological research	305,834	0	0	0	0	0	0	305,834	0	9,015	212,661	78,745	0	5,413	0	0	0	0
8.04 Social science research	7,242	0	0	0	0	0	0	7,242	0	6,000	0	0	0	1,242	0	0	0	0
8.05 Vaccine-related research	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8.98 Research not disaggregated by type	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8.99 Research not elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	**5,017,038**	**98,730**	**33,730**	**65,000**	**0**	**0**	**0**	**4,918,308**	**676,947**	**1,498,689**	**2,149,282**	**346,367**	**0**	**407,526**	**0**	0	0	0

YEAR: 2009

National Funding Matrix

Calendar Year: No

AIDS Spending Categories by Financing Sources

Fiscal Year: 1st Sep. 2008 to 30 Oct. 2009

Currency used in Matrix: US$

Average Exchange Rate for the year: 8,540 Lak

AIDS Spending Categories	Financing Sources																	
		Public Sources						International Sources							Private Sectors (Optional for UNGASS Reporting)			
										Multilaterals								
	Total	Public Sub-Total	Central/National	Sub-National	Dev. Bank Reimbursable (e.g. Loans)	Social Security	All Other Public	International Sub-Total	Bilaterals	UN Agencies	Global Fund	Dev. Bank Non-Reimbursable (e.g. Grants)	All Other Multilateral	All Other International	Private Sub- Total	For-profit institution/Corporation	Household Funf	All Other Private
1. Prevention-related activities	2,159,991	0	0	0	0	0	0	2,159,991	381,620	674,200	891,762	70,034	0	142,375	0	0	0	0
1.01 Communication for social and behavioural change	405,978	0	0	0	0	0	0	405,978	105,185	23,000	158,869	57,642	0	61,282	0	0	0	0
1.02 Community mobilization	8,824	0	0	0	0	0	0	8,824	2,493	0	0	3,685	0	2,646	0	0	0	0

1.03 Voluntary counselling and testing	83,210	0	0	0	0	0	0	83,210	0	18,141	40,069	0	0	25,000	0	0	0	0
1.04 Risk-reduction for vulnerable and accessible populations	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.05. Prevention - Youth in school	149,868	0	0	0	0	0	0	149,868	0	143,949	0	5,919	0	0	0	0	0	0
1.06 Prevention - Youth out-of-school	187,653	0	0	0	0	0	0	187,653	0	182,208	5,445	0	0	0	0	0	0	0
1.07 Prevention of HIV transmission aimed at people living with HIV	63,552	0	0	0	0	0	0	63,552	0	0	63,552	0	0	0	0	0	0	0
1.08 Prevention programmes for sex workers and their clients	258,999	0	0	0	0	0	0	258,999	250,402	0	5,809	2,788	0	0	0	0	0	0
1.09 Programmes for men who have sex with men	73,881	0	0	0	0	0	0	73,881	0	0	67,434	0	0	6,447	0	0	0	0
1.10 Harm-reduction programmes for injecting drug users	10,071	0	0	0	0	0	0	10,071	10,071	0	0	0	0	0	0	0	0	0
1.11 Prevention programmes in the workplace	211,573	0	0	0	0	0	0	211,573	10,224	201,349	0	0	0	0	0	0	0	0
1.12 Condom social marketing	82,000	0	0	0	0	0	0	82,000	0	0	35,000	0	0	47,000	0	0	0	0
1.13 Public and commercial sector male condom provision	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.14 Public and commercial sector female condom provision	3,245	0	0	0	0	0	0	3,245	3,245	0	0	0	0	0	0	0	0	0
1.15 Microbicides	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.16 Prevention, diagnosis and treatment of sexually transmitted infections	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.17 Prevention of mother-to-child transmission	100,553	0	0	0	0	0	0	100,553	0	100,553	0	0	0	0	0	0	0	0
1.18 Male Circumcision	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.19 Blood safety	520,584	0	0	0	0	0	0	520,584	0	5,000	515,584	0	0	0	0	0	0	0
1.20 Safe medical injections	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.21 Universal precautions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.22 Post-exposure prophylaxis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.98 Prevention activities not disaggregated by intervention	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1.99 Prevention activities not elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2. Treatment and care components	962,127	0	0	0	0	0	0	962,127	291,669	98,393	491,181	0	0	80,884	0	0	0	0
2.01 Outpatient care	707,001	0	0	0	0	0	0	707,001	39,163	98,393	491,181	0	0	78,264	0	0	0	0
2.01.01 Provider- initiated testing and counselling	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.02 Opportunistic infection outpatient prophylaxis and treatment	25,459	0	0	0	0	0	0	25,459	664	0	0	0	0	24,795	0	0	0	0
2.01.03 Antiretroviral therapy	502,698	0	0	0	0	0	0	502,698	0	11,517	491,181	0	0	0	0	0	0	0
2.01.04 Nutritional support associated to ARV therapy	8,664	0	0	0	0	0	0	8,664	150	0	0	0	0	8,514	0	0	0	0
2.01.05 Specific HIV-related laboratory monitoring	41,222	0	0	0	0	0	0	41,222	518	0	0	0	0	40,704	0	0	0	0
2.01.06 Dental programmes for people living with HIV	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.07 Psychological treatment and support services	14,751	0	0	0	0	0	0	14,751	10,500	0	0	0	0	4,251	0	0	0	0
2.01.08 Outpatient palliative care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.09 Home-based care	13,076	0	0	0	0	0	0	13,076	13,076	0	0	0	0	0	0	0	0	0
2.01.10 Traditional medicine and informal care and treatment	560	0	0	0	0	0	0	560	560	0	0	0	0	0	0	0	0	0

2.01.98 Outpatient care services not disaggregated by intervention	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.01.99 Outpatient Care services not elsewhere classified	100,571	0	0	0	0	0	0	100,571	13,695	86,876	0	0	0	0	0	0	0	0
2.02 In-patient care	255,126	0	0	0	0	0	0	255,126	252,506	0	0	0	0	2,620	0	0	0	0
2.02.01 Inpatient treatment of opportunistic infections	254,986	0	0	0	0	0	0	254,986	252,366	0	0	0	0	2,620	0	0	0	0
2.02.02 Inpatient palliative care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.02.98 Inpatient care services not disaggregated by intervention	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.02.99 In-patient services not elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.03 Patient transport and emergency rescue	140	0	0	0	0	0	0	140	140	0	0	0	0	0	0	0	0	0
2.98 Care and treatment services not disaggregated by intervention	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.99 Care and treatment services not-elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Orphan and Vulnerable children --OVC	99,248	0	0	0	0	0	0	99,248	1,065	1,036	97,147	0	0	0	0	0	0	0
3.01 OVC Education	57,932	0	0	0	0	0	0	57,932	1,065	0	56,867	0	0	0	0	0	0	0
3.02 OVC Basic health care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.03 OVC Family/home support	5,280	0	0	0	0	0	0	5,280	0	0	5,280	0	0	0	0	0	0	0
3.04 OVC Community support	35,450	0	0	0	0	0	0	35,450	0	450	35,000	0	0	0	0	0	0	0
3.05 OVC Social services and administrative costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.06 OVC Institutional care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.98 OVC services not disaggregated by intervention	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.99 OVC services not-elsewhere classified	586	0	0	0	0	0	0	586	0	586	0	0	0	0	0	0	0	0
4. Program Management and Administration	1,465,904	114,730	44,730	70,000	0	0	0	1,351,174	460,332	289,769	440,504	41,435	0	119,134	0	0	0	0
4.01 Planning, coordination and programme management	679,424	0	0	0	0	0	0	679,424	66,833	268,487	230,919	39,097	0	74,088	0	0	0	0
4.02 Administration and transaction costs associated with managing and disbursing funds	514,161	114,730	44,730	70,000	0	0	0	399,431	348,877	0	25,400	0	0	25,154	0	0	0	0
4.03 Monitoring and evaluation	157,522	0	0	0	0	0	0	157,522	34,000	21,134	86,158	2,338	0	13,892	0	0	0	0
4.04 Operations research	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.05 Serological-surveillance (Serosurveillance)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.06 HIV drug-resistance surveillance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.07 Drug supply systems	83,988	0	0	0	0	0	0	83,988	0	0	77,988	0	0	6,000	0	0	0	0
4.08 Information technology	10,622	0	0	0	0	0	0	10,622	10,622	0	0	0	0	0	0	0	0	0
4.09 Patient tracking	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.10 Upgrading and construction of infrastructure	20,039	0	0	0	0	0	0	20,039	0	0	20,039	0	0	0	0	0	0	0
4.11 Mandatory HIV testing (not voluntary counselling and testing)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.98 Program Management and Administration Strengthening not disaggregated by type	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.99 Program Management and Administration Strengthening not-elsewhere classified	148	0	0	0	0	0	0	148	0	148	0	0	0	0	0	0	0	0
5. Human resources	948,495	0	0	0	0	0	0	948,495	26,104	142,005	460,204	69,787	0	250,395	0	0	0	0

5.01 Monetary incentives for human resources	257,112	0	0	0	0	0	0	257,112	17,976	28,400	189,176	8,460	0	13,100	0	0	0	0
5.02 Formative education to build-up an HIV workforce	37,440	0	0	0	0	0	0	37,440	0	34,157	0	0	0	3,283	0	0	0	0
5.03 Training	441,332	0	0	0	0	0	0	441,332	8,128	49,782	90,783	58,627	0	234,012	0	0	0	0
5.98 Incentives for Human Resources not specified by kind	212,611	0	0	0	0	0	0	212,611	0	29,666	180,245	2,700	0	0	0	0	0	0
5.99 Incentives for Human Resources not elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	23,047	0	0	0	0	0	0	23,047	0	3,173	19,874	0	0	0	0	0	0	0
6.01 Social protection through monetary benefits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6.02 Social protection through in-kind benefits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6.03 Social protection through provision of social services	918	0	0	0	0	0	0	918	0	918	0	0	0	0	0	0	0	0
6.04 HIV-specific income generation projects	22,129	0	0	0	0	0	0	22,129	0	2,255	19,874	0	0	0	0	0	0	0
6.98 Social protection services and social services not disaggregated by type	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6.99 Social protection services and social services not elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Enabling Environment	177,593	0	0	0	0	0	0	177,593	0	98,693	20,700	5,182	0	53,018	0	0	0	0
7.01 Advocacy	90,688	0	0	0	0	0	0	90,688	0	29,488	3,000	5,182	0	53,018	0	0	0	0
7.02 Human rights programmes	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7.03 AIDS-specific institutional development	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7.04 AIDS-specific programmes focused on women	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7.05 Programmes to reduce Gender Based Violence	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7.98 Enabling Environment and Community Development not disaggregated by type	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7.99 Enabling Environment and Community Development not elsewhere classified	86,905	0	0	0	0	0	0	86,905	0	69,205	17,700	0	0	0	0	0	0	0
8. Research excluding operations research	160,993	0	0	0	0	0	0	160,993	0	29,580	117,523	1,501	0	12,389	0	0	0	0
8.01 Biomedical research	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8.02 Clinical research	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8.03 Epidemiological research	117,523	0	0	0	0	0	0	117,523	0	0	117,523	0	0	0	0	0	0	0
8.04 Social science research	41,969	0	0	0	0	0	0	41,969	0	29,580	0	0	0	12,389	0	0	0	0
8.05 Vaccine-related research	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8.98 Research not disaggregated by type	1,501	0	0	0	0	0	0	1,501	0	0	0	1,501	0	0	0	0	0	0
8.99 Research not elsewhere classified	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	5,997,398	114,730	44,730	70,000	0	0	0	5,882,668	1,160,790	1,336,849	2,538,895	187,939	0	658,195	0	0	0	0