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LAO PDR COUNTRY PROGRESS REPORT
Global AIDS Response Progress
Country Report, 2015

Foreword

Lao People's Democratic Republic (Lao PDR) has an estimated 0.29% HIV prevalence in 2014, among adults aged 15-49 years.[1] This figure is relatively lower compared with countries in the Greater Mekong Sub-region (GMS). The HIV epidemic in Lao PDR is classified as low prevalence but showing an increasing trend from 0.16% (2003) to 0.29 % (2014) in people aged 15 to 49 years. Sex workers (SW), Men who have Sex with Men (MSM) and Transgender (TG), and people who inject drugs (PWID) form the key affected populations (KAP). The epidemic is based predominantly around these groups.

In the recent years, Lao PDR, has become a "land-linked" country, opening its corridors to its neighbouring countries such as Cambodia, China, Myanmar, Thailand, and Viet Nam with relatively higher HIV prevalence. This increased transit routes provided job opportunities and trade with increased mobility of the people in and out of the country. This increased mobility across borders provided a venue for HIV vulnerability and the emergence of groups at high-risk continuously makes Lao PDR vulnerable to new HIV threat.

The Government of Lao PDR, with its strong political commitment endorsed the Declaration of Commitment at United Nation General Assembly Special Session on AIDS (UNGASS) in 2001 to support a multi-sectoral response, Millennium Development Goal (MDG) 6 and Three Zero Strategy, the 2010 Law on HIV/AIDS Control and Prevention (hereafter refers to as the HIV Law) was approved by the National Assembly and then promulgated by the President of Lao PDR, and the 2011 Political Declaration on HIV and AIDS.

In addition, there were two other milestones that were passed namely: National Strategic and Action Plan for HIV/AIDS and STI Prevention and Control 2011-2015 (NSAP) and in 2014, NSAP 2016-2020 has been developed and is being finalized. These two milestones confirm the commitment of the Government of Lao PDR to reach MDG 6 and the Three Zeros strategy. All partners have been involved in these milestones.

This 2015 marks the end date of both the 2011 Political Declaration on HIV and AIDS and the Millennium Development Goals (MDG). This will be a great opportunity to review the progress made and prepare for the final reporting towards these targets from improved political commitment to an enabling environment, and stronger civil society involvement, to scale up quality and coverage of HIV prevention and treatment services.

As indicated in the 2011 UN Political Declaration on HIV and AIDS, a successful AIDS response should be measured by the achievement of concrete, time-bound targets. However, Lao PDR continues to face a huge challenge in strengthening its HIV and AIDS response in its capacity to monitor and evaluate the current response as well as identifying potential challenges and gaps that can accelerate the spread of the epidemic. Lao as a low-middle income country still continues to benefit from external resources to fund its response on HIV and with the changing of global funding landscape on AIDS due to the down turn of global economy and the requirement of the donor to put up counter-funding, Lao PDR needs to double up its effort to mobilise domestic resources to scale up and sustain its national response.

In attaining and achieving universal access to achieve the MDG Goals and to reach the Three Zeros Strategy – Zero new HIV infections; Zero discrimination and Zero AIDS related death, Lao PDR Government will continuously stay one step ahead of the epidemic by putting up resources domestically with continuous multi-sectoral involvement.

[1] Asian Epidemic Model, 2014

Acknowledgement

The 2015 Global AIDS Response Progress Reporting (GARPR) for Lao PDR was prepared through an inclusive and consultative process, under the leadership of the Centre for HIV/AIDS and STI (CHAS), Ministry of Health, on behalf of the National Committee for the Control of AIDS (NCCA) with funding support from UNAIDS through Technical Support Facility (TSF) and World Health Organization.

The 2015 GARP reporting team includes: I) Guiding Team, Prof. Dr. Eksavang Vongvichit, Minister of Health; Assoc. Prof. Bounkong Sihavong, Vice Minister of Health; Dr. Bounlay Phommasack, Director General of Department of Communicable Disease Control (DCDC); Dr. Sisavath Soutthanirasay, Deputy Director General of DCDC; Dr. Bounpheng Philavong, Director of CHAS ; II) Over-all Responsible Team: Dr. Phouthone Southalack, Deputy Director of CHAS ; Dr. Chanthone Khamsibounheuang, CHAS Deputy Director; III) Technical Team: Dr. Keophouvanh Doungphachanh, CHAS Head of M&E and Surveillance Unit; Dr. Beuang Vang Van, CHAS Head of Planning and Cooperation Unit; Technical Officers of DCDC;, Department of Planning and International Relations; Department of Finance; Dr. Khanthanouvieng Sayabounthavong, CHAS Head of HIV/AIDS and STI Management Unit (MAS); Dr. Bounleuth Vilayhong, CHAS Head of Administration and Finance Unit; Dr. Ketmala Banchongphanith, CHAS Deputy Head of MAS; Dr. Phouthaly Keomoukda, CHAS Deputy Head of EIC Unit; Dr. Bouathong Simanovong, CHAS Deputy Head, M&E and Surveillance Unit; Dr. Khanti Thongkam, Technical Staff of M&E and Surveillance Unit; and Dr. Chanthasouk Bansalith, CHAS Deputy Head of Planning and Cooperation Unit.

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We would also like to thank our national and provincial partners who have contributed and participated in the national response and provided important input throughout the reporting process. These include Departments and Centres of MOH namely CDC; Food and Drugs; Healthcare, CHAS, Centre for Medical Products Supply; TB Centre, MCH Centre; Ministry of Information and Culture; Ministry of Labour and Social Welfare; Ministry of National Defense; Ministry of Public Security; and Ministry of Public Work and Transportation; Lao Red Cross, Lao Youth Organization, Lao Women's Union, Lao Federation for Trade Unions, and Lao Font for National Construction and PCCA.

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List of Abbreviations and Accronyms

ADB Asian Development Bank

AEM Asian Epidemic Model

AIDS Acquired Immune Deficiency Syndrome

ADB Asian Development Bank

ART Antiretroviral Therapy

ARV Antiretroviral

AusAID Australia Agency for International Development

BCC Behaviour Change Communication

CHAS Centre for HIV/AIDS and STI

CSO Civil Society Organisation

DCCA District Committee for the Control of AIDS

DIC Drop in Centre

FHI360 Family Health International 360

FSW Female Sex Worker

GARP Global AIDS Response Progress

GFATM Global Fund to Fight AIDS, Tuberculosis and Malaria

GFATM Global Fund to Fight AIDS, Tuberculosis and Malaria

HIV Human Immunodeficiency Virus

IBBS Integrated Biological and Behavioural Survey

KAP Key Affected Population

LFTU Lao Federation of Trade Unions

LaoPHA Lao Positive Health Association

LCDC Lao National Commission for Drugs Control and Supervision

LNP+ Lao Network of People Living with HIV

LRC Lao Red Cross

LYU Lao People's Revolutionary Youth Union

M&E Monitoring and Evaluation

MDG Millennium Development Goals

MOH Ministry of Health

MSM Men who Have Sex with Men

MtF TG Male-to-Female Transgender

NASA National AIDS Spending Assessment

NCCA National Committee for the Control of AIDS

NCPI National Commitment and Policy Instrument

NGO Nongovernmental Organization

NSAP National Strategy and Action Plan

NCTC National Centre for TB Control

OVC Orphan and Vulnerable Children

PCCA Provincial Committee for the Control of AIDS

PDR People's Democratic Republic

PEDA Promotion for Education and Development Association

PITC Provider Initiated Testing and Counselling

PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Service International
PWID	People Who Inject Drugs
RAR	Rapid Assessment Report
SIDA	Swedish International Development Cooperation
STI	Sexually Transmitted Infection
SW	Sex workers
TB	Tuberculosis
TG	Transgender
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
USCDC	United States Centre for Disease Control
VCT	Voluntary Counselling and Testing
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

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I. Status at a Glance

A. The inclusiveness of the stakeholders in the report writing

The Global AIDS Response Progress Reporting 2015 was conducted through an inclusive consultative process among the HIV stakeholders. Valuable inputs and contributions were inputted from a wide range of stakeholders in Lao PDR including government agencies, civil society organizations (CSO), network of people living with HIV (PLHIV), mass organizations, international and local nongovernmental organizations (INGO), United Nations (UN), bilateral and multilateral agencies. The report was developed and consolidated under the leadership of the National Centre for HIV/AIDS and STI (CHAS) of the Ministry of Health (MOH) and the strategic guidance of the National Committee for the Control of AIDS (NCCA). The UNAIDS Regional Support Team, Asia Pacific supported an international consultant who worked closely with the national team of experts in developing the Lao PDR GARP 2015

The data included in this report were taken from various sources such as the GARPR 2014, Ten Targets Review, Global Fund Concept Note, NSAP 2011-2015, NSAP 2016-2020, Epidemiological Review and Impact Analysis, External Review of selected aspects of Health Sector Response to HIV in Lao PDR, Joint Review Meeting of the NSAP 2011-2015 country reports, Global Fund reports such as the Progress Update Disbursement Request (PUDR), HIV surveillance reports such as the IBBS 2014, HIV behavioural studies, programme and project reports of various stakeholders involved in HIV and AIDS programmes in Lao PDR.

Consultations with key agencies were conducted throughout the report preparation process from briefing of the 2015 GARP Reporting guidelines the design of data collection, drafting of research instruments and validation of data and narrative report presented herein. This report contains the narrative report which details the progress on the data indicators for each of the Ten Targets in the 2011 UN Political Declaration on HIV and AIDS and the National Funding Matrix. The National Composite Policy Index (NCPI) is not part of this report but will be reported every two years, which will be due in 2016.

A validation meeting on the data gathered was conducted on 20 March 2015, chaired by CHAS Director. Participants were: WHO, UNODC, UNICEF, AusAID, USCDC, ADB, LPN+, French Red Cross, Lao Red Cross LaoPHA, NCA, PEDA, Department of CDC, Department of Planning and international Cooperation, APL+, National TB Centre, National Centre for Laboratory and Epidemiology, CIEH, Medical Product Supply Center, Mahosot Hospital, CHAS M&E and Surveillance Unit Head and staff, CHAS HIV/AIDS and STI Management Unit and staff, CHAS Planning Unit head and staff and CHAS IEC Unit Head and staff. The validation meeting was a venue to verify the veracity of the data and discuss further the recommendations and future actions. Further revisions were made taking into consideration the comments and recommendations from the different stakeholders. The NCCA Meeting with partners to consider and endorse the report was conducted on 2 April 2015 and was participated by members of NCCA from line ministries and mass organizations, NCCA focal points, National HIV/AIDS Task Force members, NGO and CSO representatives.

B. The Status of the epidemic

Valuable data were generated in 2014 with the new estimates taken from the updated Spectrum and AEM Projection and new rounds of the Integrated Biological and Behavioural Survey (IBBS) for MSM and FSW.

HIV prevalence among the general population aged 15-49 years old remains low at 0.29% but showed an

increasing trend from 0.16% in 2003 to 0.29 % 2014.[2] The highest prevalence of HIV can be found in key affected populations (KAP) primarily among men who have sex with men at 1.6%[3], followed by drug users at 1.5% and sex workers at 1.4%[4]. Factors that may have contributed to this trend include the rise in cross-border migration especially that there is higher HIV prevalence in nearby countries in the Greater Mekong Sub-region (GMS). Further, the improved economy elevating Lao PDR from lower to lower middle income economy (LMIC), establishment of the ASEAN Economic Community by 2015, improved transport and communication system, and more employment opportunities facilitate the ease of migration.

In 2014, from the reported new HIV cases, there were 53 % of males and 47 % females for a male to female ratio of 1.32, but female PLHIV were younger than male with 54.2 % of female cases less than 30 years old and only 35.4 % of male less than 30 years old. The majority of HIV cumulative cases were identified in border provinces along the Mekong River with 85.9 % of all HIV reported cases in 1990-2014, including in Vientiane Capital (VTC) (35 %), Savannakhet (SVK) (29.3%), Champasak (CPS) (10%), Khammouane (KM) (4.2%), Bokeo (BK) (2.95), Luang Prabang (LPB) (2.6%) and Vientiane Province (VTP) (1.9%)[5]. These areas are the most populated where large urban areas are located along the Mekong River. According to IOM, there is an estimated 200,000 migrant workers officially in the country, mostly in the construction sector. It is estimated that still around 1,000 new HIV infections occur in the country every year.[6]

By the end of December 2014, there were 7,072 reported cases of HIV (AIDS registry) and by the end of 2015, it is estimated that there will be 11,958 PLHIV[7]. At the end of December 2014, a total of 3,336 adults and children were under ARV treatment with a national coverage of 60.6%. [8]

Sexual activity is the primary mode of transmission. Heterosexual contact accounted for the majority of HIV transmission at 88% from 1990-2014.[9] The second most common route of transmission is from mother to child (4.9%), but this figure may not represent the true picture because of limited data.[10]

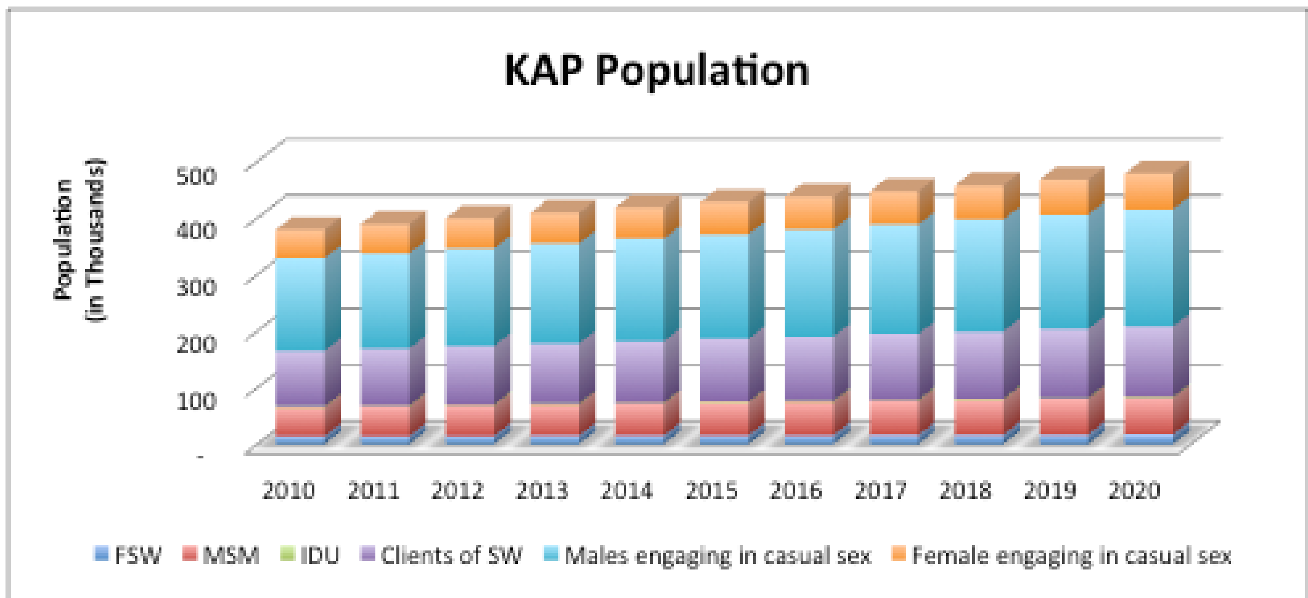
The estimated number of population among KAP is presented in the table below:

Table 1. Number of key affected population, 2014[11]

KAP	Estimated population size	Year of estimate
Female sex workers	14,814	2014
Clients of FSW	108,774	2014
Men who have sex with men (MSM)	56,200	2014
High risk MSM	18,129	2014
People who inject drugs	1,709	2014

Figure 1. Estimated KAP population[12]

[2] MoH, Projection Results AEM and Spectrum, 2014.
[3] MoH, IBBS 2014.
[4] Ibid,
[5] MoH and WHO, HIV Epidemiologic Review and Impact Analysis, p.23.
[6] MoH, Projection Results AEM and Spectrum, 2014.
[7] Ibid,
[8] Progress Update and Disbursement Request Report (PUDR) No. 9.
[9] MoH and WHO, HIV Epidemiologic Review and Impact Analysis, 2014.
[10] Ibid.
[11] MoH, Projection Results AEM and Spectrum, 2014.
[12] Ibid,



C. Policy and programmatic response

At the global stage, the government supports the UN initiated Millennium Development Goals (MDGs) of which HIV is one of the targets for MDG 6 –'to halt and reverse the spread of HIV in the country'. The Government of Lao PDR also endorsed the UNAIDS principle of Three Zeros – Zero new infection; Zero Discrimination and Zero AIDS related deaths. At the local level, the government, with support from development partners, initiated several reviews in 2014, namely: 2014 Global AIDS Response Progress Report, (GARPR) Lao PDR; Epidemiological Review and Impact Analysis (June 2014); External Review of selected aspects of Health Sector Response to HIV in Lao PDR (July – August 2014; and Joint Review of the NSAP 2011-2015. The result of these reviews framed the foundation of this Global AIDS Response Progress Reporting 2015 (GARPR), which focused on reporting specific targets and accomplishments based on the Ten Targets. The Centre for HIV/AIDS and STIs (CHAS) combined the conduct of the MTR of the National Strategic and Action Plan (NSAP) on HIV/AIDS and STI Control and Prevention 2011-2015, the GARPR and the MTR of the Political Declaration Targets.

The implementation of the National Strategic and Action Plan (NSAP) for HIV/AIDS and STI Prevention and Control 2011-2015 and the Law on HIV/AIDS Control and Prevention together with the development of the new NSAP 2016-2020 showed the Lao Government political commitment and support in responding to the HIV epidemic.

While the NSAP 2011-2015 is still being implemented, the new NSAP 2016-2020 is endorsed by NCCA and being finalized . Both NSAPs are aligned with the National Socioeconomic Development Plan (NSEDP) 2011-2015, the 7th Health Sector Plan and integrate global commitments such as the Millennium Development Goals (MDG) in its framework. The NSAP 2011-2015 outlines two goals to be achieved by 2015; maintain the present low level of HIV prevalence in the general population (15-49) below 1% and ensure HIV seroprevalence among KAP is lower than 5%. These goals have been achieved as shown by the 2014 surveillance data below 5% (less than 3%) HIV prevalence among KAP and below 1% (0.29%) HIV prevalence among the general population aged 15-49 years. For the NSAP 2016-2020, Lao PDR aims to further reduce the HIV prevalence among KAP to below 3% while maintaining HIV prevalence among general population below

1%. The new NSAP 2016-2020 aims to scale up the national response in order to minimise the impact of HIV and AIDS on socioeconomic development, and improve the quality of life of people infected with and affected by HIV. The national response will include; increased coverage and quality of HIV prevention services, resulting in 60-70% coverage of most-at-risk populations, increase coverage and quality of HIV treatment, care and support services, resulting in 60.59% coverage of people in need of ART, and a treatment dropout rate of less than 10% and, improve national programme.

D. Indicator data in an overview table

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

Table 2. Summary of indicators

	GARP Reporting Indicator	Source	Value	Remarks
Target 1 – Reduce sexual transmission of HIV by 50% by 2015				
General Population				
1.1	Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	LSIS 2011-2012	All: 25.13% Males: 27.64% Females: 23.98%	No updated data available since previous reporting
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	LSIS 2011-2012	All: 5.24% Males: 2.72% Females: 6.40%	No updated data available since previous reporting
1.3	Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	N/A	N/A	N/A
1.4	Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last	N/A	N/A	N/A
1.5	Percentage of women and men aged 15-49 who received a HIV test in the past 12 months and know their results	LSIS 2011-2012	All: 2.53% Males: 2.54% Females: 2.53%	No updated data available since previous reporting
1.6	Percentage of young people aged 15-24 who are living with HIV	Case report 2014	0.32%	From all provinces in the country
Sex Workers				
1.7	Percentage of sex workers reached with HIV prevention programmes	IBBS 2014	37.9%	
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	IBBS 2014	Female: 92.7%	

1.9	Percentage of sex workers who have received a HIV test in the past 12 months and know their results	IBBS 2014	38.0%	
1.10	Percentage of sex workers who are living with HIV	IBBS 2014	Female: 1.40%	
Men who have sex with men				
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	IBBS 2014	4.1%	
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	IBBS 2014	44.4%	
1.13	Percentage of men who have sex with men that have received a HIV test in the past 12 months and know their results	IBBS 2014	18.1%	
1.14	Percentage of men who have sex with men who are living with HIV	IBBS 2014	1.6%	
Target 2 – Reduce transmission of HIV among people who inject drugs by 50% by 2015				
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	HAARP 2013 Annual Progress Report	Syringes per IDU/year: 246 Number of IDUs: 152	No updated data available since previous reporting
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	Rapid Assessment Report on HIV	N/A	No data representing national situation
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	Rapid Assessment Report on HIV and Drug Use	N/A	No data representing national situation
2.4	Percentage of people who inject drugs that have received a HIV test in the past 12 months and know their results	Rapid Assessment Report on HIV and Drug Use	N/A	No data representing national situation
2.5	Percentage of people who inject drugs who are living with HIV	Rapid Assessment		No data representing national situation
Target 3 – Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths				
3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	Patient records 2014	10.03%	
3.1a	Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding		N/A	

	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Patient records 2014	28.57%	
3.3	Estimated percentage of child HIV infection from HIV-positive women delivering in the past 12 months	Spectrum 2014	35.92%	
Target 4 – Have 15 million people living with HIV on antiretroviral treatment by 2015				
4.1	Percentage of adults and children currently receiving antiretroviral therapy	Patient records 2014	All: 60.59%	Get breakdown Eligibility criteria: less than 350 CD4
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy 4.2B 24 months retention 4.2C 60 months retention	ART Patient Registers Jan-Dec 2014	12 months: 85.22%	Only 12 months retention data available. No disaggregate data by sex and age groups.
Target 5 – Reduce tuberculosis deaths in people living with HIV by 50% by 2015				
5.1	Percentage of estimated HIV positive incident TB cases that received treatment for both TB and HIV	ARV Patient Registers and Estimates from WHO Stop TB	All: 25.32%	No disaggregate data by sex available. 119/470
Target 6 – Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22-24 billion in low- and middle-income countries				
6.1	Domestic and international AIDS spending by categories and financing sources	NASA	7763532	Domestic and International
Target 7 – Eliminating gender inequalities				
7.1	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	N/A	N/A	
Target 8 – Eliminating stigma and discrimination				
8.1	Percentage of women and men aged 15-49 who report discriminatory attitudes towards PLHIV	N/A	N/A	No updated data available since previous reporting
Target 9 – Eliminate travel restrictions				
	Travel restrictions data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed			Lao PDR does not have travel restriction policy for PLHIV
Target 10 – Strengthening HIV integration				
10.1	Current school attendance among orphans and non-orphans aged 10-14			No updated data available since previous reporting
10.2	Proportion of the poorest	N/A	N/A	

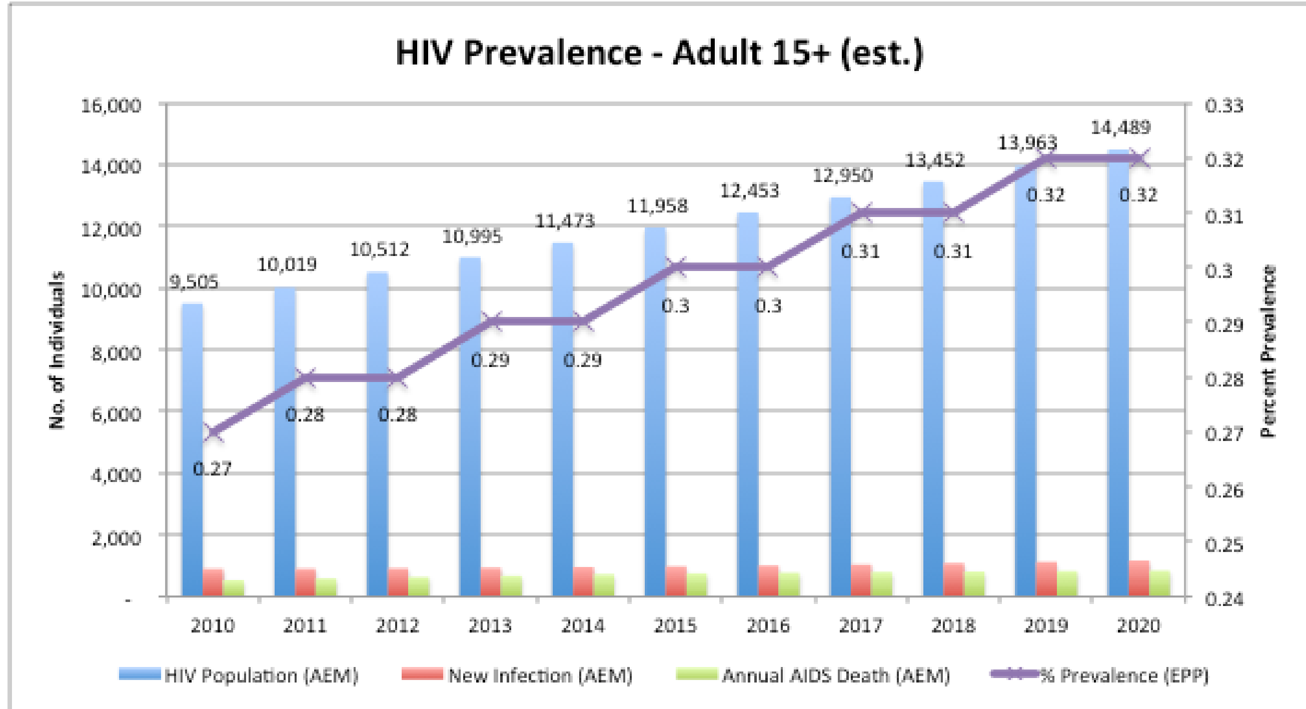
II. Overview of the AIDS Epidemic

This section covers the detailed status of the HIV prevalence in the country during the period January - December 2014 on the latest studies and projections.

A. HIV prevalence in the general population

The national adult HIV prevalence is at 0.29% among 15-49 years old based on the projections using the AEM Model. Figure 2 presents the estimated HIV population in 2014 at 11,473 adults.

Figure 2. HIV Prevalence, Adult 15+ (est.)

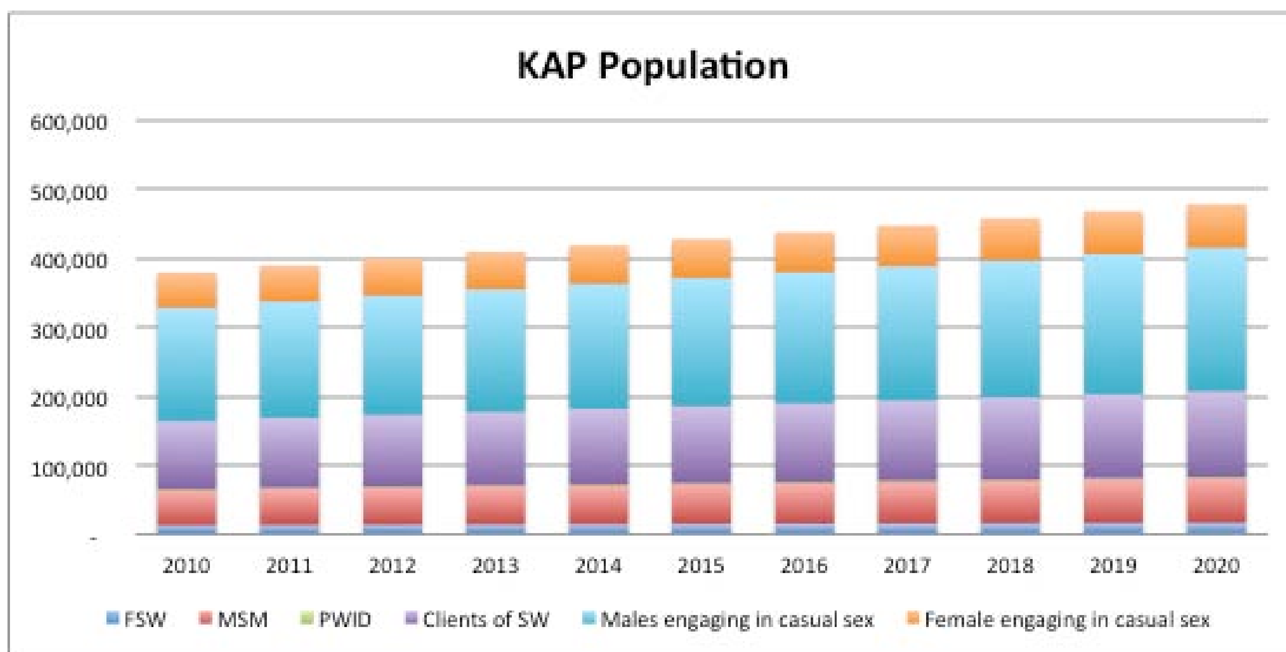


New HIV cases reported in 2014 reached 834 based on AIDS Registry. AEM projection showed an estimated 957 cases of new infections in 2014.

The total deaths reported in 2014 was at 107 (AIDS Registry) while AEM Model projected that it could reach as much as 725 annual AIDS death for this period.

B. HIV prevalence among key affected populations

Most-at-risk population is increasing with an estimated total of 420,353 individuals identified as FSW, MSM, PWID, clients of SW or males and females engaging in casual sex in 2014. The estimated number of KAP was determined using AEM and Spectrum software models with technical assistance from UNAIDS, US East West Center and US CDC. Updates have been made on yearly basis. Efforts have been made to build capacity of NAP in size estimation and projection.



1. Female sex workers (FSW)

It is estimated that there were 14,814 FSW in 2014 in Lao PDR.[13] Overall HIV prevalence in FSW is slowly increasing in the last six years since 2008 from 0.5% in 2008, 1 % in 2011 to 1.4 % in 2014.[14] Provincial-level data showed that HIV prevalence in FSW has increased in Vientiane Capital (VTC), Champasak (CPS) and Savannakhet (SVK) while it remained stable or even decreased in other provinces.[15] The increasing trend was driven mostly by Savannakhet with a rate that more than doubled from 0.7% in 2011 to 1.7% in 2014.[16] In VTC, FSW who reported injecting drugs had an HIV prevalence of 12.5 %.[17] STI prevalence is high with 21.4% for Chlamydia and 7.5 % for Gonorrhoea.[18]

2. Men who have sex with men (MSM)

It is estimated that there were 56,200 men MSM in Lao PDR in 2014.[19] IBBS data showed a decreasing prevalence among MSM at 1.6%. In VTC, this figure dropped from 5.6% in 2007 to 1.8 % in 2014.[20] HIV prevalence among MSM is low across the country but higher in VTC than at the other provinces. IBBS 2014 shows that Chlamydia infections are high among MSM across the country (around 10%) while gonorrhea is low.

There is no formal estimation of Transgenders (TGs) in the country as TGs have been included in the group of

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[13] MoH, Projection Results AEM and Spectrum, 2014.
[14] IBBS FSW 2014, slide 51.
[15] IBBS FSW 2014, slide 52
[16] IBBS FSW 2014.
[17] IBBS FSW 2014, slide 16.
[18] IBBS FSW 2014, slide 54.
[19] MoH, Projection Results AEM and Spectrum, 2014.
[20] IBBS MSM, 2007 and 2014.

MSM in general due to their small size for the overall joint interventions. There are no recent data available on TGs with the last one being the Second Round HIV/STI Prevalence and Behavioral Tracking Survey among Male-to-Female Transgender in Lao PDR in 2012.

3. Persons who inject drugs (PWID)

It is estimated that there were about 1,709 persons who inject drugs in the country in 2014 based on the AEM model.[21] In IBBS 2014, 3.2 % of the key populations reported ever injecting drugs showing an increase from IBBS 2011 (0.1%). An evaluation of the project for PWID pilot project conducted in the in Houaphanh and Phongsaly Provinces supported by AusAID and ADB will be conducted in 2015. This will be a follow through to the study conducted in 2010.[22] No further studies were done in 2014.

4. Persons with multiple sex partners

Multiple sexual partnerships are likely to happen among the general population whose jobs require frequent travelling, and have a tendency to seek services of sex workers. Migrants and mobile population are at higher risk for HIV infection. This is supported by the high proportion of new HIV cases in border provinces. Migrants may also engage in sex work, either as providers or consumers.

5. Young people

Lao PDR has a young population with a majority (60%) of its six million inhabitants belonging to the under 25 years age bracket. The Adolescent and Youth Situation Analysis Report[23] published in 2014 provided crucial information on the young people, which synthesized and analysed available data on health, education, employment, protection and participation from existing reports and from primary data obtained through interviews and focus group discussions.

III. National Response to the AIDS Epidemic

The year 2014 provides an opportunity for the National AIDS Authority and its partners to review the achievements and challenges that capped the past four years of the HIV programme implementation set under the NSAP 2011-2015 targets. The National Committee for the Control of AIDS (NCCA) leads the HIV programme while the Centre for HIV/AIDS and STI (CHAS) in the Department of Communicable Disease Control, Ministry of Health is responsible to manage and coordinate the national response. At the provincial and district level, multi-sectoral Provincial Committee for the Control of AIDS (PCCA) and District Committee for the Control of AIDS (DCCA) are responsible for the implementation and coordination of activities.

A. Prevention

The prevention, care, treatment and support services are provided in all levels of the health system at the national, provincial, district, and village-level health facilities.

1. Prevention programmes

This section discusses the HIV and AIDS prevention programme pertaining to condom programming, HIV

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[21] MoH, Projection Results AEM and Spectrum, 2014.

[22] MoH, SIDA, WHO and HAARP/AusAID, Rapid Assessment and Response to Drug Use in Huaphanh and Phongsaly Provinces, 2010.

[23] LYU and UNFPA, Adolescent and Youth Situation Analysis Report.

testing and counselling, and diagnosis and treatment of STI for each of the target groups. Behaviour change as a component of the prevention programme is discussed separately in the succeeding section.

The prevention programme is implemented in 94 priority districts covering 17 provinces. In addition, an extensive network of governmental mass organizations supports in the planning and implementation of HIV and AIDS activities, reaching from the central to the village level. These are the Lao Youth Union, which focuses on out-of-school youth education; the Lao Women's Union, which addresses reproductive health needs of women with HIV and AIDS; the Lao Federation of Trade Unions (LFTU), which conducts IEC campaigns among factory workers; and the Lao Front for National Construction and the Lao Red Cross. In addition, NGOs and CBOs play a key role in service delivery to marginalized groups, which include the FHI 360 (MSM), PSI (MSM, TG, and FSW), NCA (FSW), LaoPHA (MSM) and PEDA (FSW).

On STI services, there were difficulties in increasing demand among KAP to avail of health services. STI prevalence was still high among KAP.

In 2014, the number of HIV tests performed increased to 58,745 with 56,853 received their results (96.8%) from a low 39,000 in 2013, reportedly due to shortage of test kits. There were gaps in targeting as only 20% of KAP had undergone HIV test and know the results in the past 12 months (85% MSM and 51% of TG, 38% for FSW, and below 5% in general population based on 2014 data- this was the distribution of percentages of the 20% of KAP who had undergone testing and know their results in the past 12 months; while none among PWID based on 2010 data). This was way below the target of 80%. By 2013, only 54% of estimated PLHIV have been diagnosed through HIV testing. Promotion of HTC will be prioritized in the new NSAP in high-risk population groups to maximize impact. There is a need to improve procurement and supply chain management to avoid shortages and ensure proper allocation of drugs and reagents to the facilities where the needs are.

HTC had been expanded during the past six years with the current number of testing sites totaling to 165 in 2013 to 172 in 2014. PITC was provided to patients with HIV-suspected symptoms, TB and STIs patients, and pregnant women. The government is undertaking new approaches to expand HTC through the use of mobile point of care testing machine to allow HTC be done in district hospitals and adoption of two rapid tests for HIV diagnosis. National testing guidelines and quality assurance are being developed and implemented to improve services as some facilities were not functional or services have not improved. There was a good start in HIV lab for external quality assurance (EQA) of HIV testing to improve the quality of HIV test. Thai CDC TA has been working closely with the NCLE to set up EQA system by national laboratory team.

a. General population

Efforts to promote HIV prevention among the general population were conducted through continuous training of health providers in health facilities. Due to limited resources, extensive prevention initiatives were concentrated in reaching KAP. Special programmes are being conducted to reach at-risk groups among the general population such as the young people and migrant workers.

Condom programming. The social marketing programme being implemented by PSI in Laos is continued in 2014. A total of 2,300,496 condoms were sold under this programme at 115% achievement over target[24] or an average of four million condoms sold in the market over the past 3.5 years

HIV testing and counseling. There were 172 VCT sites with 58,741 tested and 56,853 knew their results (96.8%) in 2014.[25]

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[24] PUDR No.8.

[25] Ibid.

b. Female sex workers

FSW HIV outcomes in knowledge, prevention coverage and condom use had stagnated or decreased while HIV prevalence had increased from 1% (2011) to 1.4% (2014).[26] Prevention services for FSW through peer education and DIC are implemented in 17 provinces. The health sector remains the main provider of prevention and treatment services. The number of FSW reached decreased to 38% in 2014 from 55% in 2011 according to IBBS. The current figure was also lower than the recorded FSW coverage in 2011 and 2014 at 45% and 41%, respectively. Under the Global Fund (GF) programme, it targeted to reach 11,978 in 2014. As of June 2014, 40.8% of FSW in the GF project sites had been reached by peer educators with HIV and AIDS prevention education.[27]

Condom programming. The percentage of sex workers who report consistent condom use with the most recent client was 92% in 2011 IBBS and 92.7 % in IBBS 2014.

HIV testing and counseling. In 2014, there were 2,773 SW were tested HIV and 2,773 SW received their results. In 2013, 1,806 tested and received their results.

Diagnosis and treatment of STI. The DIC were managed either by PCCAs and or CSOs and mobile peer outreach through the CSOs. In the past the DIC peer educators and the mobile peer educators were considered as volunteers with minimum incentives. This caused the high turnover among these peer educators. A new strategy will be adopted to address the decreasing number of SW reached by prevention programme wherein permanent peer educators will be employed at the DIC and mobile peer educator to prevent rapid staff turnover and ensure continuity of services and follow-ups.

c. Men who have sex with men (MSM)

MSMs are reached with prevention programmes through peer led interventions, DIC, HIV and Sexually Transmitted Infections (STI) testing and counselling as well as referral to antiretroviral treatment (ART). Prevention services for MSM were being implemented in 10 priority provinces. Coverage of prevention programme for MSM reached 25.8% in 2013[28] served by 302 peer educators working with MSM. This number increased to 27.2% or 4,832 out of 17,862 in 2014.

Condom programming. Consistent condom use with non-regular partners had fallen substantially from 37% to 11% based on IBBS results in 2009 and 2014. Free condoms were continuously being provided with the Global Fund support. A total of 216,496 (44% achievement over target) male condoms were distributed to local partners providing prevention education activities to MSM and FSW.

HIV testing and counseling. In 2014, there were 956 MSM tested for HIV and 956 MSM received their results. In 2013, 773 tested and received their results .

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

d. People who inject drugs

In IBBS 2014, 3.2 % of the “key populations” reported ever injecting drugs showing an increase from IBBS 2011

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[26] MoH and WHO, External Review of Selected Aspects of the Health Sector Response to HIV in Lao PDR, 2014
[27] PUDR No.8.
[28] Patient Records 2013.

(0.1%).

Harm reduction. The IDU pilot project called the "Greater Mekong Subregion Capacity Building for HIV and AIDS Prevention Project" implemented in two northern provinces currently supported by AusAID and now by ADB will be concluded at the end of 2014. The objective of the Project is to improve coverage and quality of services for KAP in the eight border provinces of Lao PDR (Attapeu, Saravane, Champasak, Houaphanh, Phongsaly, Luangnamtha, Oudomxay,and Bokeo) and 15 provinces of Viet Nam. Prevention services for PWID were being implemented in 2 priority provinces (Houaphanh, Phongsaly). An evaluation of the project will be conducted and will recommend on how to proceed with the next phase. A more comprehensive study on IDU situation in Lao PDR is planned to be conducted before expanding the project to other provinces to start a new project.
The PWID project was only continued until Jan-April 2014. The government is currently negotiating for the continuation of the PWID Project under the ADB funding.

e. Prevention of mother-to-child transmission

Expected outcomes by 2015 include 50% of ANC attendants receive Provider Initiated Counselling and Testing (PICT), 90% of identified HIV positive pregnant women receive ARV to reduce the risk of mother-to-child transmission and 100% of infants born to identified HIV-infected mothers receive ARV drugs.
HIV testing and counseling. PMTCT HIV testing is offered at ANC to pregnant women including their partners. The proportion of testing in ANC had risen dramatically from 4% in 2008 to 55% in 2013 of all PICT. Due to limited resources, the government followed a phased approach in PMTCT scale up prioritising four provinces (VTC, SVK, LPB and CPS) in 2014-2015 and targets to cover all provinces by 2020. Since 2013, Maternal and Child Health Centre (MCHC) is leading the PMTCT activities through collaboration with CHAS. Once diagnosed women are referred to the ART sites where ARV is provided for mothers.
Prevention of vertical transmission. Infants are also provided with ARV. NSAP 2011-2015 review revealed that the coverage for provider-initiated counselling and testing (PICT) was over 50% of ANC attendees and 90% ARV prophylaxis was provided to those women identified to be HIV positive.

f. Management of TB-HIV co-infection

TB/HIV collaboration is vital in the development of both TB and HIV programme planning and implementation. This is to ensure a coordinated strategy for the adequate management of TB/HIV co-infection in the country. Based on the TB/HIV policy, scaling up of TB/HIV activities is needed in order to make sure that standardised and high quality of services are provided by both programmes to reduce morbidity and mortality linked with this dual infection. This TB/HIV collaboration aims to increase HTC among TB patients, TB screening among PLHIV, and initiation and retention to ART among HIV-positive TB patients and IPT for TB asymptomatic PLHIV. To achieve these, the programme will provide TB screening to all PLHIV and systematic screening of all patients for TB, provision of Izoniazid to all patients and cross checking of referral data on HIV for TB patients. National Tuberculosis Programme (NTP) and National AIDS Programme (NAP) finalised the TB/HIV guidelines[29] and monitoring and reporting with Damien Foundation Belgium (DFB) in 2011 and met quarterly with central, provincial hospitals and governmental and non-governmental partners.
NTP and NAP train health staff of provinces and districts each year on provider initiated HIV testing (PITC) among all TB patients and the implementation of the "3 Is" (Intensified case detection, Infection control and Isoniazid preventive therapy) among PLWH. 56% among TB patients all forms had an HIV test result in 2013

[29] MoH, TB/HIV Co-Infection Manual, 2009.

and 70% in 2014 (6MO). 11% among tested TB patients are HIV positive. 79% of TB-HIV patients received Cotrimoxazole preventive therapy (CPT) in 2013.
Proportion of TB patients under ARV is still not systematically reported and collaboration will be increased between the two programmes to ensure accurate and complete reporting. Isoniazid preventive therapy (IPT) has started in 9 ARTsites and 100 % of people enrolled in HIV care have their TB status assessed over the last 12 months.[30]
Lao PDR has made some progress in the reduction of tuberculosis deaths in PLHIV. The TB-HIV programme and service integration in Lao PDR is on track with successful national coordination and implementation in health facilities. Lao PDR has implemented all necessary UN and WHO guidelines relating to prevention of TB among HIV patients, Management of TB-HIV has improved considerably in Lao PDR, but there are still key challenges that need to be addressed. Whilst medication for OI is free, it is still dependent on external funding which is a major challenge for sustainability. A high proportion of people come to ART sites with advanced stage of HIV infection and opportunistic infections (OI).
The TB-HIV committee chaired the Minister of Health has been reorganised in mid-2013. The committee meets on quarterly basis to update on the progress in the implementation of the TB-HIV co-infections interventions. The joint meetings between medical staff working in ART sites and TB have been conducted on regular basis to consult on technical issues related to TB-HIV co-infection guidelines and practices. The team of CHAS and TBC conducted regular joint field monitoring and visit to the provinces. And development of guidelines. With regard to the collaboration in 3 I's, the following activities have been implemented: Intensified case finding (ICF): medical staff and peer educators have referred TB patients to ART sites; Isoniazid preventive therapy (IPT): Isoniazid has been placed in all ART sites with procurement by TB programme; and all patients in ART sites have been screened for TB.

2. Care, treatment and support programmes

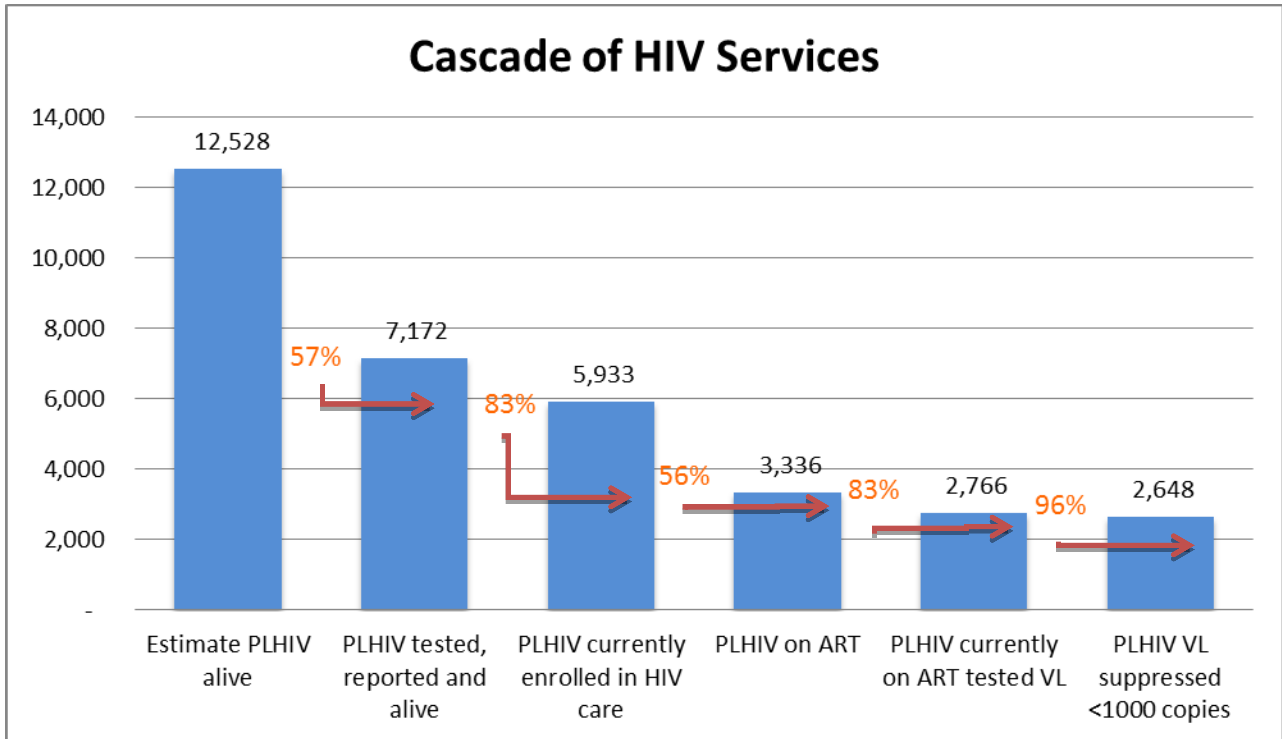
The Treatment, Care and Support programme interventions were centered on ARV and OI management, and care and support for PLHIV. Quality improvement activities have been initiated in all sites where antiretroviral therapy is available to improve the quality of services for care and treatment of HIV and AIDS. There was technical assistance from Thai US CDC and financial support through WHO-CDC Cooperative Agreement.
The programme focused on capacity building of physicians, nurses or counsellors, pharmacists, laboratory technicians including peer counsellors to know about how to identify the issues and barriers of patients receiving good services and kinds of factors needed to resolve these barriers. A tool was adopted for central team that used to monitor and supervise for quality improvement.

a. Care and treatment cascade

The care and treatment cascade showed that only 57% of estimated number of PLHIV was identified, of which 83% were enrolled in care and 17% failed to access care and treatment. With regards to adherence to treatment, 83% were on ART and 96% of them have had VL suppression. A pilot project supported by WHO and CDC had been exploring ways to promote testing and tracking of referrals in Vientiane Province and Vientiane Capital using referral cards for clients use of "Universal Access Codes" to track clients.

[30] PUDR No. 8.

Figure 3. Cascade of HIV services[31]

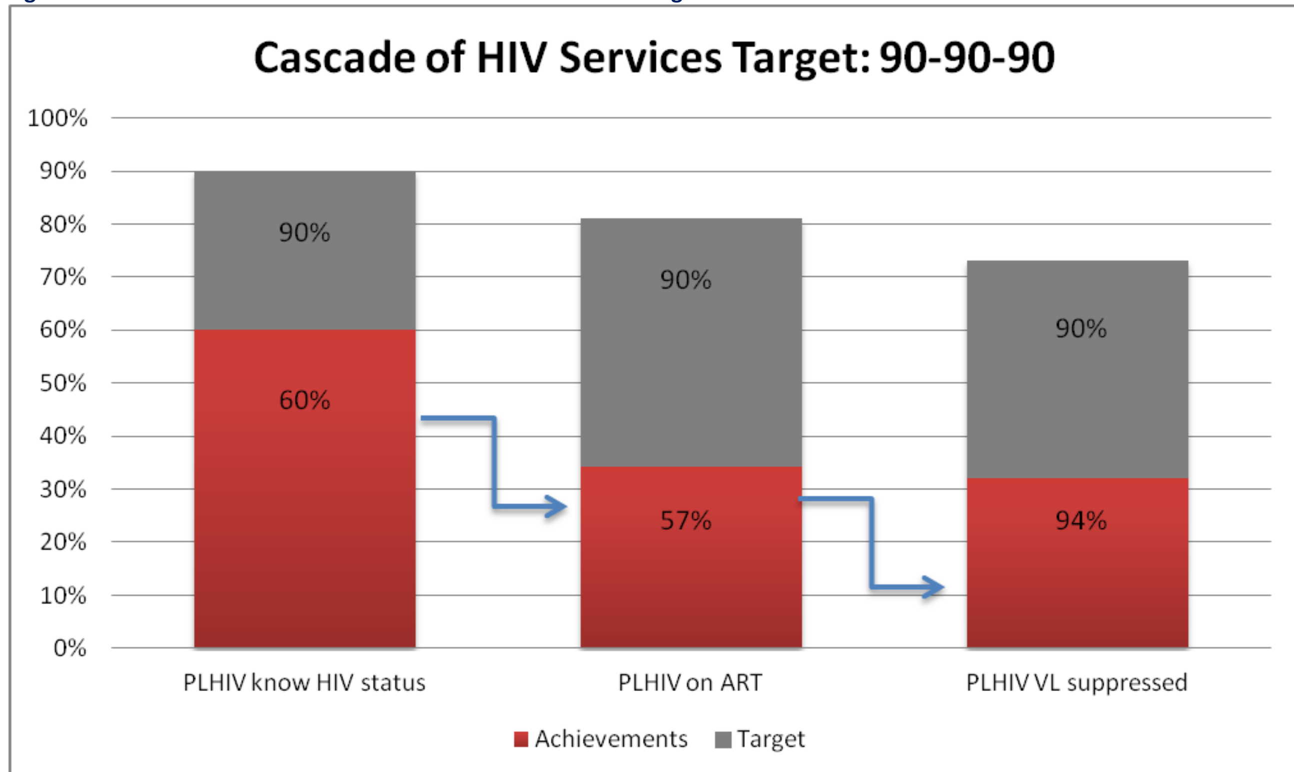


To achieve impact and help end the epidemic, a target of 90%-90%-90% in the cascade of services should be aimed for. This is the treatment target being espoused by UNAIDS[32] for countries to achieve the 2015 deadline for the targets and commitments in the 2011 Political Declaration on HIV and AIDS. This final target should be able to drive the progress towards ending the AIDS epidemic. The government takes on the commitment to do just that. The new target for the HIV treatment scale-up beyond 2015 includes:

- By 2020, 90% of all people living with HIV will know their HIV status.
- By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.
- By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

[31] Patient Record, 2014.
[32] UNAIDS, 90-90-90: An Ambitious Treatment Target to Help End the AIDS Epidemic, 2014.

Figure 4. Recommended cascade of HIV services: 90%-90%-90% target

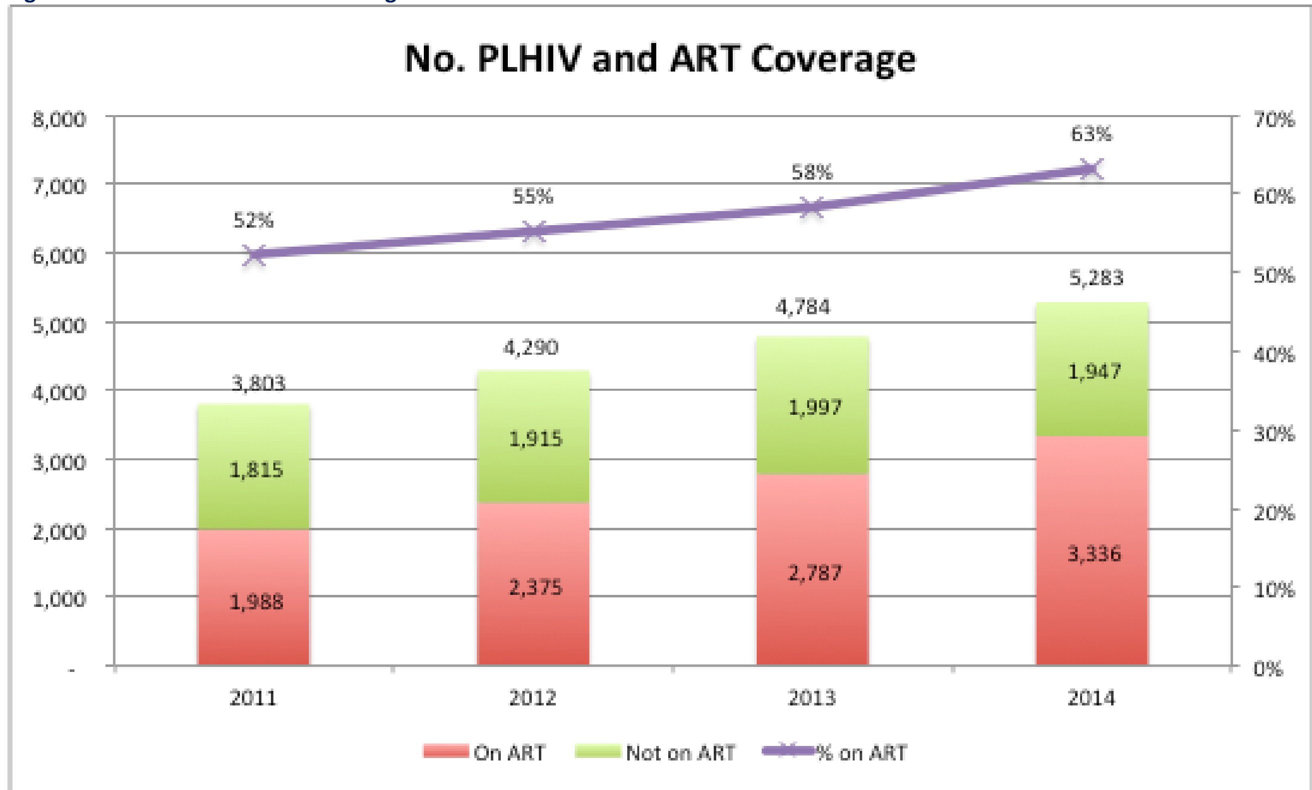


b.

b. Provision of antiretroviral therapy (ART)

New national guidelines for antiretroviral therapy have been updated according to the WHO 2013 guideline for the use of antiretroviral drugs. The implementation of the new guidelines will start in 2016 based on the results from stock analysis for country readiness. There were nine ART sites serving PLHIV, six were reference sites and three satellites, covering seven priority provinces. An additional ART site will be opened in 2015 in Houaphanh.

Figure 5. No. of PLHIV and ART coverage

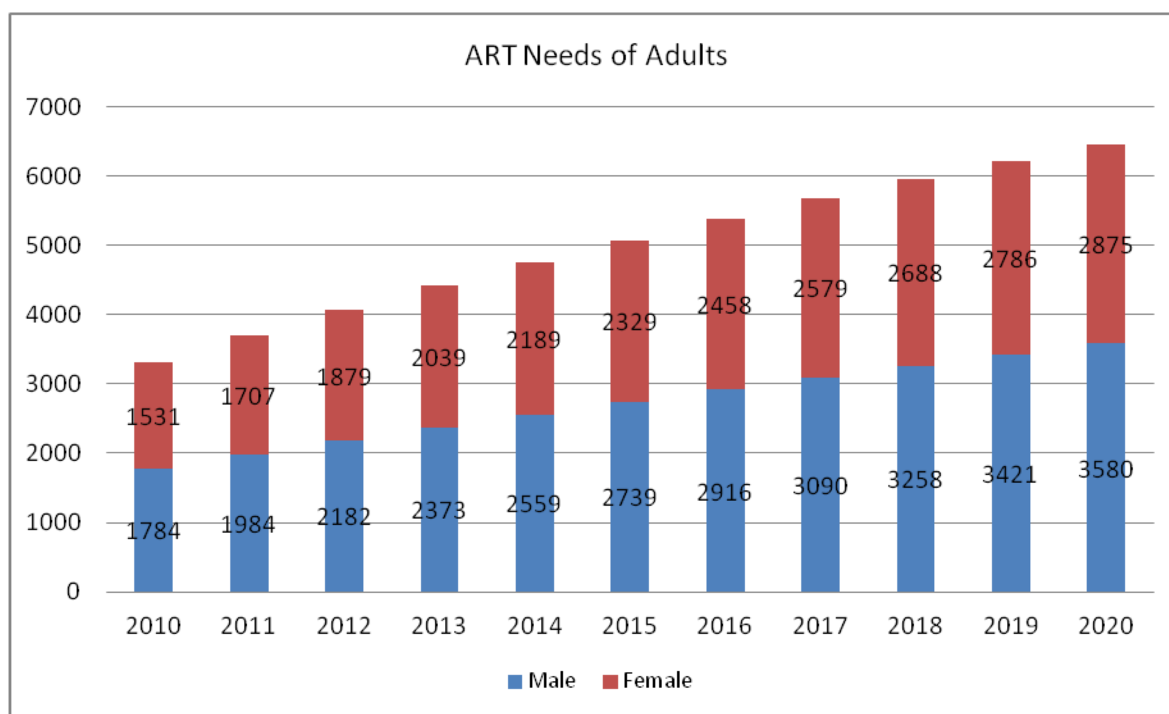


The 2014 patient record revealed that the percentage of adults and children currently receiving antiretroviral therapy was 57.5%, as slight decline from 58.26% posted in 2013. The reason for this is that there new HIV infections not eligible for ARV with CD4 count above 350/cu mm. Global Fund reported ART coverage a total of 3,040 (Jan-June 2014 data) versus its target of 5,283 adults and children. This was higher than the ones achieved in 2011 (52.30%) and 2012 (55.36%) respectively. AEM Model estimates that there were 4,748 adults and children in need of ART in 2014.

The percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy was 85.22% based on ART Patient Registry in Jan-Dec 2014, which showed an increased in ART compliance compared with 83.78% (498 PLHIV) in Jan-Dec 2013. The dropouts from the programme reflected those who died (6.63%) and were lost to follow-up (6.02%).

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

Figure 6. ART needs of adults



Note: ART needs in AEM is computed based on CD4 <350 for all years of projection.

B. Knowledge and behaviour change

1. Knowledge about HIV prevention and sexual behavior

a. Young people

The introduction of life skills education in secondary schools in Vientiane Capital and Savannakhet province paved way to the expansion of similar initiative. The expansion was well-received especially that the overall knowledge regarding transmission of HIV in Lao PDR remains low. The Lao Social Indicator Survey (LSIS) 2011-2012 found only 25.13% young women and men aged 15-24 were able to give correct answers to all five questions regarding HIV transmission. More males than females were able to provide correct information at 27.64% and 23.98%, respectively.[33]

The survey measured the number of respondents who gave correct responses to the following questions: (1) Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?; (2) Can a person reduce the risk of getting HIV by using a condom every time they have sex?; (3) Can a healthy-looking person have HIV?; (4) Can a person get HIV from mosquito bites?; and, (5) Can a person get HIV by sharing food with someone who is infected? Common misconceptions remain prevalent with only 41.71% correctly answering on the question of HIV transmission through mosquito bites and only 60.42% correctly answering HIV transmission from sharing food with someone who is infected. There were 75% who were able to correctly identify that the risk of getting HIV is reduced by having sex

[33] Lao Social Indicator Survey. HIV Knowledge, Attitudes and Behaviour in Lao Households

with only one uninfected partner and by using a condom every time they have sex, there is still a need to improve understanding among young people on HIV prevention.[34]

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

Early sexual onset is positively correlated among those with no education and belonging in poorest wealth quintile. Those from Northern Lao PDR more frequently reported early onset of sexual activity. Young women from households where the language spoken was Hmong-Mien[35] more frequently reported early sex than those in other language groups. Rural dwellers have earlier onset of sexual activity for both males (3.20% rural vs. 1.40% urban) and females (8.20% rural vs. 2.10% urban).

b. Female sex workers

The past and ongoing strategy focuses on peer-led interventions, including installing permanent peers in DICs and engaging mobile peers in community with the CSOs, INGO and PCCA. Each peer would have to reach a certain number of SWs per year which will be followed up throughout the year. Specific intervention activities include BCC, condom programming, STI, HTC and referral services. Strong emphasis is on referral to HTC, STI, ART sites as needed and follow up in community. This also includes coordination with health system and self-help group. The programme on knowledge about HIV prevention and sexual behavior has been designed. Infor mation woulr be given to sex workers during their visit at DICs and during a monthly gathering.

c. MSM

The past and on-going intervention through the MSM mobile peer outreach is focused in providing information and awareness raising on the four basic areas, behaviour change communication (BCC), HIV, AIDS and STI, condoms and HIV testing and counselling (HTC). The BCC activity provides IEC materials that show the risks that will lead the individual to acquiring the HIV and STI infections. HIV, AIDS and STI basic information is provided to the peer that includes signs and symptoms, modes of transmission, prevention of transmission, myths and misconceptions.

d. PWID

A more comprehensive study on PWID situation in Lao PDR is planned to be conducted before expanding the project to other provinces to start a new project. Baseline survey on the knowledge, attitudes, practices, and behavior is planned under the ADB Project

2. Gender equality

The Government of Lao PDR supports upholding gender equality. However, there is little data available regarding gender inequality and gender based violence in the country. The Gender Assessment was conducted in 2013 where workshop participants noted a poor community understanding of gender (in)equality and very

[34] MTR 2013
[35] Ibid

little understanding of the challenges associated with tackling gender inequality in Lao PDR. There is also little data available on gender inequality in the country.

Lao PDR is committed to eliminating gender inequalities and has incorporated gender issues into the HIV response. The NSAP 2016-2020 outlines gender considerations as one its guiding principles of the national response. Lao PDR ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and continues to implement the convention through the Lao National Commission for Advancement of Women (NCAW). The Law on Development and Protection of Women was promulgated in 2004 and commits to "guarantee and promote the roles of women, to define the fundamental contents of, and measures for developing and protecting, the legitimate rights and interests of women.

The Government of Lao PDR has established inter-agency mechanisms to promote and protect human rights of women such as the NCAW, the National Commission for Mothers and Children, and the Lao Women Union. The constitution, the laws of Lao PDR, the national socio-economic development plan, the National Strategic Plan for concerned sectors including the second five-year National Strategy for the Advancement of Women (2011-2015) and the National Strategy for Mothers and Children (2011-2015) are all examples of this.

Domestic gender based violence is mainly addressed by these organizations. However, the national HIV/AIDS and STI policy adopted in 2011 does not include a specific strategy on domestic gender-based violence. The main policy to reduce HIV transmission focuses on promotion of safer sex, including abstinence before marriage, faithfulness in marriage and relationships, and maintenance of healthy social lifestyles. All these indirectly address gender-based violence.

Various sectors, organisations and local authorities have been actively involved in the movement opposing violence against women and children in Laos. The Party and the government have always given importance to the roles of women and protecting the rights and interests of women and children of all ethnicities, as per Party and government policy. Lao Women Union (LWU) has been very active in the promoting HIV awareness through their network from central to village level using their own resources. They organized several fora on HIV and AIDS for members of LWU, Lao Youth Union (LYU), Lao Federation of Trade Unions (LFTU) and espouses of high-level government officials.

In addressing gender inequality and gender based violence the National AIDS Programme needs to strengthen its collaboration with all these above mentioned organisations/Commissions to developed a join-work plan. A planning workshop has been recently conducted to develop the line ministries/organisations HIV work-plans. CHAS will assist them in finalising their work plans to ensure that the gender issue is included. Resource mobilization will be sought from the domestic fund.

3. Stigma and discrimination

Lao PDR has made progress in addressing stigma and discrimination including the introduction of a Law on HIV/AIDS Control and Prevention (2010) that addresses the rights of most-at-risk populations (although sex work and drug use remains illegal). The LSIS conducted in 2012 , which has a component that measures stigma and discrimination against HIV among the general population showed a high level of stigma and discrimination against people living with HIV. Overall, the previous study pointed to a greater proportion of women than men express accepting attitudes on all indicators, although women have poorer knowledge of HIV.

The percentage of people expressing positive attitudes towards people who are living with HIV/AIDS regarding all four indicators asked about was very low (17 per cent of women and 14 per cent of men).

This was highlighted during the gender assessment of the HIV/AIDS response workshop as a major area of

concern for PLHIV and among vulnerable group.[36] The elimination of stigma and discriminations in all forms is an important target for Lao PDR. The NSAP 2016-2020 lists the principles of respect for human rights as one of its guiding principles.

This reflects the reality that the national HIV response recently focused mainly in priority geographical urban areas and key affected populations, whilst the LSIS was the household survey and conducted in community level including rural and remote areas where HIV interventions might have not been implemented. The design of the LSIS survey included several questions that the interviewees have to correctly answer to all of them to be considered as correct. In some rural areas the interviewees among ethnic groups might have difficulties understanding the questions. This might be one of the reasons why the level stigma and discrimination toward PLHIV is high in this household survey. Additionally, LSIS did not include the questions on stigma and discrimination toward sex workers and MSM/TGs.

However, in the urban settings where sex workers and MSM/TGs are more seen, the level of stigma and discrimination toward them is low as the community is more aware of HIV and AIDS and the issue of stigma and discrimination because there are more frequent HIV awareness campaigns for many years in the community, school settings and factories.

Sex work and drugs use remain illegal in Lao PDR, hence KAP are typically hidden and difficult to reach. However, sex workers who are working in entertainment establishment and in the service sectors, such drink shops, karaoke bars, and guesthouses are easier to reach as they form a SW networking and collaborate with our intervention team. They also take part in peer education work and participated in the survey.

After the assessment, some human rights activities to identify the human rights barriers (Legal Environment Assessment or legal review); training with health care providers reducing stigma and discrimination, rights-training with police, among others will be planned. Fund could be sought from domestic fund and/or donors, particularly from ADB project, which has a planned activity on improving quality of health services to increase access to HIV prevention and treatment services for vulnerable groups of peoples.

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

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

C. Impact alleviation

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

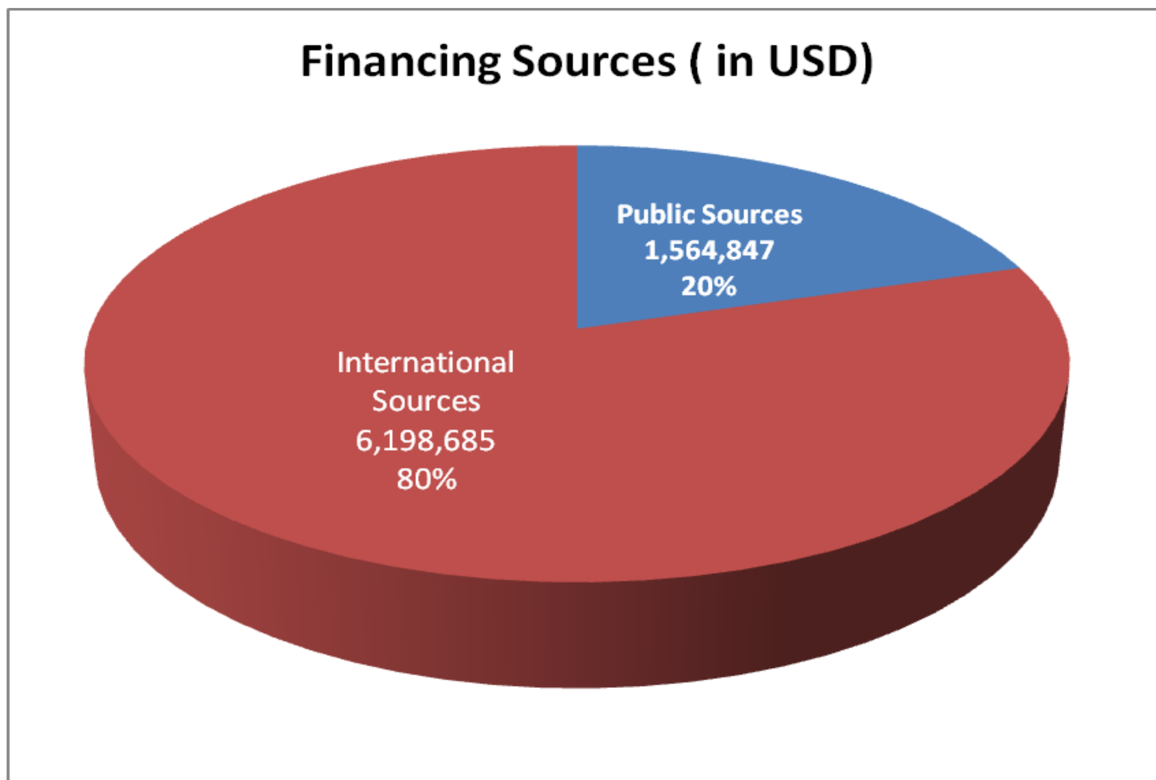
Accompanying this overall plan, a series of sub-sectoral plans and strategies have been developed, which include the Health Information Systems; Human Resources for Health; Health Financing Strategy; Reproductive Health Strategy. The main areas of linkage to the national health strategy centers on the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

Apart from the government's investments in health, international sources support the achievement of

[36] Gender Assessment of the National Response in the Lao PDR, 2013.

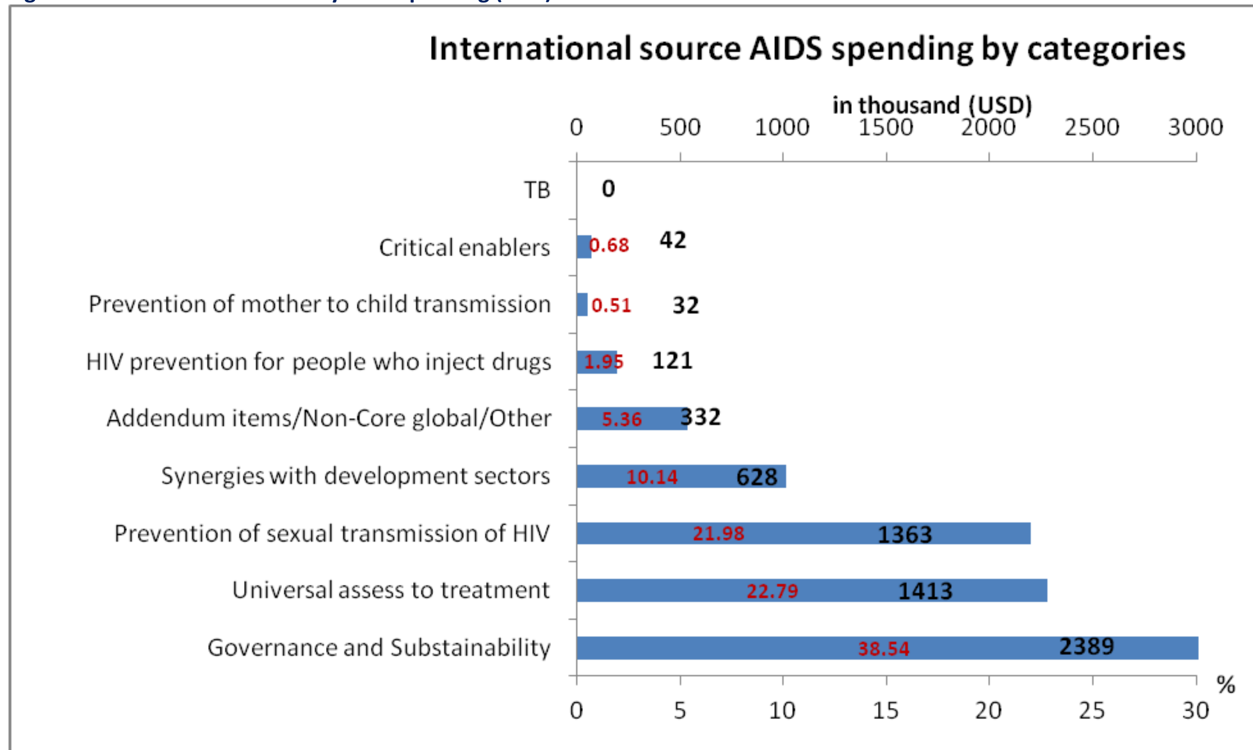
improved health outcomes. The current GF programme supports the majority of the HIV programme being implemented. These provided linkages with the three diseases in terms of joint planning processes, coordination structures, procurement standards and protocols and reporting mechanisms. The public sources accounted to 20% or USD 1.56 million in expenditure in HIV while international sources contributed 80% or USD 6.19 million.

Figure 7. Total expenditure on AIDS in 2014 by source (USD)



AIDS spending from international sources were mostly on Governance and Substainability (38%), Universal assess to treatment (23%), Prevention of sexual transmission of HIV (22%) and Synergies with development sectors (10%). The least-focused expense components were on Addendum items/Non-Core global/Other (5.4%), HIV prevention for people who inject drugs (1.95%), Critical enablers (0.7%), Prevention of mother to child transmission (0.5%), and TB with funding allocation in other activities.

Figure 8. International sources by AIDS spending (USD)



IV. Best Practices

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

A. Political leadership and policy support

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

It has provided strong political commitment by endorsing the Declaration of Commitment at United Nation General Assembly Special Session on AIDS in 2001 to support a multi- sectoral response. It has passed the National Strategic and Action Plan for HIV/AIDS and STI Prevention and Control 2011-2015 (NSAP) and supported the development of NSAP 2016-2020. It has provided support to the development of the Concept Note for the New Funding Model of the Global Fund. It has continuously disseminated the Law on HIV/AIDS Control and Prevention (hereafter refers to as the HIV Law) which was approved by the National Assembly and then promulgated by the President of Lao PDR in 2010. The Law is progressive in terms of addressing stigma and discrimination and promoting equity.

Some of the activities it has spearheaded included the conduct of HIV educational mass campaign among schools such as Pakpasak Technical School, Done Nok Khoum Teaching School, Law School, and Military Medical School. It also conducted mass campaign among the 10 ministries to disseminate, policy, AIDS Law

and STI awareness. It initiated a mass HIV educational campaign in 2012-2013 among the youth through skit and song contest and established a roadmap to the development of the Concept Note through inclusive multi-sector approach.

The strong political leadership of NCCA and CHAS to improve multi-sectoral response to HIV ensured efficiency through active collaboration with various stakeholders both the government and the civil society. This was geared towards enhancing national AIDS response.

The following is the “road map” to the development of the CN for the New Funding Model submitted to the GF to support the National AIDS Programme. This proves the political leadership of NCCA, MOH and CHAS to mobilise resources for the programme.

Table 3. Summary of activities that shows political leadership and policy support

Activities	Timeframe	Budget and Source of funding	Participants	Comments
1. Global AIDS Response Progress (GARP) Report 2014	Jan-Mar 2014	- UNAIDS, WHO	NCCA,MOH, PR, CHAS, UNAIDS. WHO, NGO, CSO, ADB, NPLHIV	Completed
2.Integrated Biological and Behavioral Survey (IBBS) for Female Sex Workers (FSW)	Jan-April 2014 Report finalized by July 2014	- GFATM - CDC-WHO - Technical support by CDC Bangkok and MOPH Thailand	MOH, PR, CHAS, NGO, CSO, WHO, PCCA, KAP, PLHIV, FSW, CDC, MOPH Thailand	-Data collection completed in April 2014 -Need data analysis and report writing
3. Integrated Biological and Behavioral Survey (IBBS) for Men who Have Sex with Men (MSM)	May- July 2014	- GFATM -CDC-WHO - Technical support by CDC Bangkok and MOPH Thailand	MOH, PR, CHAS, NGO, CSO, WHO, PCCA, KAP, PLHIV, MSM, TG, CDC, MOPH Thailand	-Data collection completed -Preliminary data analysis and final report by July 2014
4. Sero-prevalence and Behavioral Epidemiology Risk Survey (SABERS) in Lao People's Army (LPA)	September 2014	US Army	MOH, CHAS, MOD	Completed
5. Establishment and meetings of HIV/AIDS Task Force	May 2014	MOH	MOH, CHAS, NGO, CSO, PCCA, ART sites	-Completed -First meeting conducted on 9 May 2014 - 2nd Meeting: 12 June 2014
6.Finalization of M&E Operational manual	May - June 2014	-GFATM	MOH, PR, CHAS, Partners (NGOs, CSOs), PCCA, WHO, CDC	Final draft completed
7. Mapping of National AIDS Response/Activities	May- July 2014	-WHO	MOH, PR, CHAS, NGOs, CSOs, NCCA, PCCA, WHO	WHO short-term Consultant
8.. Epi review, mapping of targets, estimation and projection, identification of data gaps	11-20 June 2014	WHO	MOH, PR, CHAS, NGOs, CSOs, NCCA, PCCA, WHO, CDC	-WHO short-term Consultant - WHO TA Team - Conclusion Meeting: 20 June 2014
9. Review of National AIDS Spending Assessment (NASA) and financial analysis	May- June 2014	WHO	MOH, PR, CHAS, NGOs, CSOs, NCCA, PCCA, WHO	WHO short-term Consultant

10. Quantification and stock review , quantification of investment needs	June 2014 (TBC)	CDC-WHO MOPH Thailand	MOH, PR, CHAS, MPSC, PCCA, ART sites, CDC, WHO, MOPH Thailand	-Technical support from CDC Bangkok and MOPH Thailand -Focal points assigned to work with CHAI and PR
11. WHO (WPRO) review team on national AIDS response	28 July- 7 August 201		All partners	Completed, dissemination meeting on 7 Aug 2014
12. Joint Review of National Strategic and Action Plan (NSAP) for HIV/AIDS/STI Control and Prevention (2011-2015)	12-14 August TBC	36,368 US$ (GFATM) -WHO: epi review, TA for review workshop, assessment of peer led interventions and VCT - 5% FEI: TA	MOH, PR, CHAS, NCCA PCCA, ART sites, Partners (UN, WHO, UNICEF, UNFPA, UNAIDS, UNODC), NGOs, CSOs, MOF, KAP, PLHIV	Completed
13. Planning Meeting of project supported by USAID	27-29 Aug 2014			Completed
14. Meeting on PMTCT	9 September		CHAS, MCH centre, WHO, CDC Bangkok, UNICEF	Completed
15.Stakeholders Meeting on IBBS (FSW, MSM), SABERS and consensus meeting of NSAP Joint review results	- Sept 2014	- ADB-18,000 US$ - Some from GF for TA (act3.1.2 dissemination results of national surveillance)	MOH, PR, CHAS, NCCA PCCA, ART sites, Partners (WHO, UNICEF, UNFPA, UNAIDS, UNODC) NGOs, CSOs, MOF, KAP, PLHIV	Completed
16. Pre-Meeting of Development of new NSAP 2016-2020	12 September		Key selected stakeholders, HIV Task Force, NCCA focal Points	Completed
17. National Consultation on Development of NSAP (2016-2020)	23-26 September 2014	- 61,231 US$ (GFATM) – savings from 2013 and/or from other SRs 2014 work plan. - UNAIDS : one TA	MOH, PR, CHAS, NCCA PCCA, ART sites, Partners (WHO, UNICEF, UNFPA, UNAIDS, UNODC) NGOs, CSOs, MOF, KAP, PLHIV, Mass organizations	Completed

		- 5% FEI: TA		
18. Participation at the TB Meeting	03 October			Dr Khanthanouvieng and Dr Carlos Calica
19. Meeting with MOPH Thailand and Raksthai Foundation to discuss cross-border collaboration and referral system	06 October			Completed
20. Meeting to discuss follow-up on NSAP Meeting 23-26 Sept and prepare plan to write new NSAP	10 Oct Morning		Mr Litou, Dr Soulany, Dr Khamlay, Mr Kana - 5% FEI: TA	All CHAS staff
21. Participation in CCM EXCOM meeting	10 Oct Afternoon			To discuss CSO proposed activities for HIV
22. Workshop on the use of ARV based on WHO 2013 Guidelines	15-17 October	GF CHAI	MOH Departments, MCHC, TBC, CHAS, ART sites, Selected PCCA, LaoPHA, APL, PSI, NCA, LRC	Completed
23. Meeting on M&E for MSM	14-15 Oct	CDC-WHO		Thalat- Completed
24. Meeting on 2014-2015 plan for project supported by ADB	16-17 Oct	ADB	8 target provinces, Department of CDC, Depart of Planning, CHAS	Completed
WHO TA: Ms Viviane Leu – Starting day				
25. Meeting to discuss plan for NSAP 2016-2020 and Concept note writing	21 Oct		WHO, WHO consultants, CCM Sec, PR, CHAS, CHAI	CHAS
26. Planning meeting for project supported by USAID through FHI 360	27-28 Oct	USAID FHI 360	USAID, FHI 360, CHAS, 3 target provinces	CHAS

27. Meeting to review MSM activities	30-31 Oct	CDC-WHO	CHAS, WHO, USCDC, PCCA VTC, PCCA VTP, MSM peers	Thalat
TA: Dr Carlos Calica. Starting day				
28. Consensus Meeting on NSAP 2016-2020 and discussion on draft concept note	07 November			Completed
29. Revise and finalize NSAP 2016-2020	November			
30. Concept note writing continued	November			
31. Series of meetings with individual partners (CSO, partners) on key issues of the concept note	November			Merieux, NBTC, LaoPHA, NCA, APL, LRC , CHAI, WHO, MCHC, TB, HSS
32. HIV Task Force and NCCA focal points meeting to discuss 1st draft of concept note	14.November		HIV Task Force, NCCA Focal Points	Confirmed
33. Submission of draft concept note for RMC for consideration	19 Nov			
34. Meeting to present draft HIV concept note to RMC	21 November			TBC
35. Submission of HIV Concept note	28 November			Confirmed
36. HIV team attends the meeting in Geneva	8-12 December			
37. Revise and finalize of Concept note	Dec 2014	CHAS	MOH, PR, CHAS, NCCA WHO, Partners	
38. Stakeholders' Meeting /Dialogue on final draft Concept note for NFM	End Dec 2014		MOH, PR, CHAS, NCCA, PCCA, ART sites, Partners (WHO, UNICEF, UNFPA, UNAIDS, UNODC), NGOs, CSOs, MOF, KAP, PLHIV, Mass organizations	

39. Submission of final draft of concept note to RMC and CCM for consideration	End Dec 2014	None		TBC
40. CCM meeting to consider HIV and HSS Concept note	Beginning January 2015			
41. Submission of Concept note to the GF	15 Jan 2015	None	CCM	Online submission by CCM with assistance from PR and national HIV programme

B. Strengthening HIV prevention program for MSM targets- a joint initiative by CHAS/WHO/CDC

Since 2009 up to the present, WHO-CDC Technical has been supporting the linkage of outreach to STI and VCT services in/from public facilities in Vientiane province and Vientiane Capital. It supported the MSM national program and MSM GF activities, which include the capacity building of MSM outreach, HIV counselling and testing service quality improvement, MSM clients receiving VCT services and linkage to care, M&E system, linkage from outreach to health care facilities using Unique Identifier Code (UIC).

One of its remarkable achievements in 2014 was the adoption and promotion of the essential tools and manual for monitoring quality of MSM outreach work. This include improving quality data and data management of outreach work; linking data from outreach to HTC services in MERS in MSM sites; and, conducting regular progress update of the linkage in public facilities in provincial quarterly meetings.
The roadmap in FY2015, aimed to increase on HTC uptake for MSM clients through the use of mobile HTC services, conduct MSM mapping in Vientiane Capital and Vientiane province, and capacity building for HTC counsellors and STI managers in districts.

C. PLHIV self-help groups

The PLHIV self-help groups (SHG) provide psycho-social support both at the ART sites and community level. People living with HIV, who receive care and support services from self-help groups administered by communities of people living with HIV, are more likely adhere to treatment and improve medical outcomes with high level of CD4 and low level of VL. SHGs also give services to the community organisation as outreach workers and as peer educators. In providing the services SHG are more likely to improve their interpersonal, communication, analytical and professional skills, which contribute to the country's human resources development.

Evidences showed that KAP, such as MSM and TG, have better knowledge of HIV and Tuberculosis after being exposed to SHG outreach workers and prevention services provided in collaboration with other community organizations, as supposed to those who have never been reached out. Community organization and services are serving as auxiliary units in addition to services provided by the government, which leads to improved access to essential social and health services among vulnerable group and underrepresented population. A notable example was the work of the Mettatham Buddist Monks in two provinces, together with SHG; they provide social support and meditation to influence target groups to veer away from drug use and risky behavior. It also provided livelihood support to members wherein monthly meetings of SHG were also utilized to train and produce handicraft to support the family of KAP and sell to PLHIV families.

V. Major Challenges and Remedial Actions

A. Progress made on the key challenges reported

The challenges on size estimation of KAP population were responded to by an effort to get a more accurate population size estimation and projection through the technical support from UNAIDS, US East West Centre and USCDC using a recognised software model, such as AEM and Spectrum. To improve the technical capacity of MOH, CHAS staff were being sent to attend workshops on these software model on a regular basis. However, with limited fund, surveys were conducted in limited locations while some aspects of the interventions were carried out nationally.

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

Integrating HIV related health services are a challenge that requires a paradigm shift. The need to integrate services in a continuum of care is valued by the government. Mainstreaming of HIV interventions into the regular health systems, example nutrition, to ensure there are no missed opportunities and services are given in stages of the life cycle of a PLHIV and prevention programmes for all types of population. The HIV programme still fell short of its targets due primarily in providing the cascade of the continuum from prevention to treatment and in particular from diagnosis to treatment. There is a need to simplify processes, make services available and accessible, improve technical and organizational capacity, create demand among most-at-risk groups, and promote compliance to treatment.

B. Challenges faced throughout the reporting period

The main constraints identified include sustaining the operations of peer education. This is an effective strategy to reach KAP and PLHIV but the challenge was mostly rooted in how to engage and sustain the peer educators. More so, mobile peer educators (MPEs) strategy showed limitations as there were challenges to recruit, monitor, supervise and maintain new MPEs.

Another challenge was the inadequate linkages between community workers, DICs, VCTs and ARTs services, leading to low uptake of HTC, STI services and lost to follow up. Services were provided with little coordination between them. This might also been due to prioritization of HIV prevention services to high risk population and geographical areas due to low HIV prevalence and limited fund.

Lastly, maintaining real-time data proved to be difficult and in utilizing the data to inform programme operations. One critical aspect was the LMIS weakness that needed to be addressed, which had led to inadequate procurement and stock system; but this has been improved recently with the assistance from the Clinton Health Access Initiative (CHAI) and better coordination between the central and provincial level.

C. Concrete remedial action

In addressing the above, a new strategy will be employed in sustaining the operations of the mobile peer educators. These include the recruitment of permanent peers as regular staff of the health facilities. Other techniques founded on global best practices include recruiting diverse types of peer educators, employing full time outreach workers, conducting supportive supervision and other innovative means to train outreach workers, conducting micro mapping to systematically identify target individuals and plan for specific interventions, tracking service utilisation through follow-ups and directly accompanying clients when availing services, establishing referral mechanism across.

Inadequate linkages across the continuum of care for target groups will be addressed through increasing and more strategic participation of peer educators and outreach workers in long-term tracking of clients, accompanying them in accessing health services and reducing lost-to-follow up. Offering a comprehensive package of services and providing multiple access points such as DICs and availability of services in regular health facilities will also be implemented. Another initiative is the participation of mass organizations such as Lao Women's Union (LWU), Lao Youth's Union (LYU), and Lao Front Union (LFU) because they have all networks that cover all society in the country including the avoidance of stigma and discrimination among SW. Banking on the successes of SHGs in maintaining constant communication with PLHIV to improve compliance to treatment will also be undertaken.
New initiatives will be piloted, including screening of MSM by using oral tests and mobile VCT for MSM in selected provinces .

Strengthening the M&E system includes the use of more rigid estimation process, automation of HMIS, local data utilisation and standardisation and regularity of M&E reporting, and data analysis will be conducted more efficiently to immediately respond to local needs. Support from international partners in providing capacity building and technical assistance will be continued with the ongoing projects.

VI. Support from the Country's Development Partners

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

ADB is supporting HIV and AIDS response focused on blood safety through Lao Red Cross and NBTC for the period 2014-2015. European Union, through ADB, supports various projects on programme management, prevention, OI and STI, collaboration and PWID from 2013-2017.
European Union provides support to Lao Red Cross to implement a project to establish SHG for MSM/TGs in Vientiane Capital, Champasak and Houaphanh in 2015-17.
The GF SSF LAO-H-GFMOH approved implementation period 2 is supporting the core HIV/AIDS response for the period January 2013-December 2015. Primary programme implementers from GF SR are PSI, NCA, LaoPHA, PEDA and WHO receives direct support from GF.
UNFPA works on counseling network and also jointly support Lao Women's Union with UNICEF on RH needs.
UNICEF supports various programmes of Lao Youth Union, WHO-US CDC, CHAI on various components of HIV programme such as prevention, TCS, PMTCT, M&E, and PSM chain.
US Army supports GF NFM on prevention, TCS, programme management and blood safety.
USAID, through Family Health International 360 (FHI 360), supports MSM/TG programme, peer-led interventions and DIC.

WHO provides regular and ad hoc technical assistance such as programme review, guidelines development, NSAP and proposal development to the National HIV and AIDS Programme.
US army has been supporting Lao PDR through the US Department of Defense HIV/AIDS Prevention Programme (DHAP) project with collaboration with Ministry of Defense of Lao PDR and CHAS to address HIV transmission in the military sector by establishing VCT network in military hospitals at central and provincial level, conduct HIV sentinel surveillance and capacity building for the Lao Military sector. CHAS provide technical and M&E support to the project.
WHO-US CDC: USCDC Thailand Global HIV and AIDS Asia Regional Office have worked in Laos since 2009, with the goal of providing technical assistance (TA) to strengthen the country's HIV response. The focus is on HIV prevention in men having sex with men (MSM), quality services for counselling and testing and for care and treatment, laboratory capacity, HIV surveillance, health information systems, and mother-to-child transmission. Activities have included development of training curricula, guidelines, and standard operating procedures; field supervision; and data use for programme planning and decision-making.
The table below shows the national HIV and AIDS response at country level with support from different donors/partners.

Donors/ supporters	Organizations / partners	Main interventions	Provinces	Last implementation period
ADB	Lao Red Cross/NBTC	Blood safety	All	2014-2015
European Union	ADB	Programme management; Prevention; OI, STI; cross-border collaboration, PWID in two provinces.	8 provinces: PSL, HP, LNT, ODX, BK, CPS, SRV, AT,	2013-2017
GF SR	PSI	Prevention, Peer-led outreach for MSM/TG	VTC, LPB, KM	2014-2015
		Prevention, Peer-led outreach for FSW, DIC	VTC, LPB, XYB, VTP, CPS, HP, ODX	2014-2015
	NCA	Prevention, peer-led outreach for FSW	BK, LNT, SRV, AT, SK	2014-2015
		Care and support for PLHIV	BK, LNT, LPB	2014-2015
	LaoPHA	Prevention, peer-led outreach for MSM/TG	VTP, SVK, SRV, CPS	2014-2015
		Care and Support	VTC, KM, SVK, CPS	2014-2015
	PEDA	Prevention, peer-led outreach for FSW	VTP, XK, BRK, KM	2014-2015
GF	WHO	Technical assistance	All	On going
UNFPA		Referral counselling network	VTC	Ongoing
UNICEF/ UNFPA Government	Lao Women's Union	RH needs	All	Ended in 2014

UNICEF	Lao Youth Union	Education, life skills	VTC	2012-2014
	WHO-US CDC	Prevention MSM, HTC, TCS, HIS, M&E, PMTCT	Selected provinces	2009-2015
	CHAI	PSM chain	M supply piloted in SVK and KM TA for CHAS, TBC, CMPE and MPSC on PSM	2014-2015
	UNICEF	PMTCT, TCS	Selected provinces	Ended in 2014
US Army	GF NFM	Prevention, VCT, Treatment, care and support, programme management, blood safety	All or selected province based on interventions	2014-2015
USAID	FHI 360	Prevention MSM/TG, peer-led interventions, DIC	Vientiane Capital, Champasack, Savannakhet	2015-2017
USCDC	Lao Red Cross	Prevention, MSM, care and support PLHIV network; Self-help group	Houaphanh, VTC CPS	2015-2017
WHO	DHAP	VCT, Education, Survey	All	2013-2015

B. Actions that need to be taken by development partners to ensure achievement of targets

The proposed Global Fund investment addresses part of the needs for the implementation of HIV/AIDS response identified in the NSAP 2016-2020. Proposed investment under the NFM is strategically set to address the needs of KAP (sex worker, MSM and TG) in 6 priorities provinces for HIV surveillance, prevention, care and treatment.These provinces (Vientiane Capital, Vientiane Province, Savannakhet, Champasack, Luangprabang and Khammouane), situated along the Mekong River, are the most populated and experience much cross-border migration. At the administrative side is the government's fund allocation which supports the provision of salaries for health staff, maintenance and operating expenses of offices at central, provincial and district levels.

USAID through FHI 360 is expected to continue its pilot project for MSM and TG in Vientiane Capital, Champasack and Savannakhet. This project might be extended to additional provinces.

ADB will continue the implementation of its support in remote areas and border provinces. ADB may support the implementation of PMTC in some of these provinces to complement what is being proposed under the NFM.

WHO will continue its regular technical support to CHAS and its ad hoc support as needed. In 2014, WHO has supported the HIV Epidemiologic Review and Impact Analysis, the External review of health sector response to HIV, the development of NSAP and CN under the NFM. Furthermore WHO will continue capacity building of the national programme through WHO/CDC support.

Since early 2014, Clinton Health Access Initiative (CHAI) is supporting the PR-MOH and the three national programme to strengthen the PSM chain (quantification, forecasting and LMIS). However this support is initially for one year and there is still no insurance of continuation.
For program areas that have significant funding gaps, planned actions to address these gaps:
The first step will be to finalise the National HIV and AIDS Strategy Action Plan 2016-2020 emphasising priorities to improve prevention, treatment, care and support for impact among KAP and vulnerable populations. A detailed and costed action plan will be developed for 2016-2018. This will serve as the basis to guide strategic investment among other donors.

VII. Monitoring and Evaluation Environment

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

A national M&E and Surveillance Unit was established in mid-2012 by CHAS and approved the Ministry of Health in early 2013 as part of the new structure of CHAS. The M&E System is guided by the M&E Strategy and Action Plan for 2011-2015. It facilitated the development of a unified national M&E system to measure the progress made in key health indicators including that of HIV. The Unit oversees the routine reporting system, collects information from PCCA and from other partners, coordinates with other department within CHAS to collate data at national level for reporting to NCCA and MOH, and provide final information for global reports such as the GARPR and Universal Access (UA) report and conduct assessment studies and research.

The M&E and Surveillance Unit at CHAS reported having six full-time government permanent staff tasked primarily for M&E functions. Their tasks include overseeing the reporting system, coordinating final national data as well as supportive supervision to provincial level sites. The staff complement have specific qualifications such as epidemiology, IT and data management. HIVCAM is a locally designed software used as a reporting tool that has been developed by CHAS to record clinical data such as ARV and OI drugs used by patients at the ART sites. This software has been continuously upgraded by USCDC/Bangkok in collaboration with WHO. It is now called the HIVCAM plus which has been piloted in mid-2014. Currently nine sites are using this software. CHAS has trained the staff at the ART sites and started to generate the data.

Logistic and management information system (LMIS) including stock reporting was weak at central and provincial level leading to inadequate procurement and supply of drugs and commodities. In 2014, CHAI has been contracted to support the PSM with the three disease programmes supporting the initiative. The implementation of LMIS (forecasting, planning and distribution) in the geographic priorities areas identified for the HIV concept note and in the ART sites will be supported through the HSS proposal to GF. HSS will address as well quality assurance, rationale drugs use and pharmaco-vigilance. Focus will be on expanding the electronic logistic information at central and provincial level supported by CHAI.

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

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

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

C. Remedial actions planned to overcome the challenges

In relation to the objective of establishing an enabling environment, Strategy Component 1 of the NSAP 2016-2020, Health Information Systems and M&E will be strengthened as reporting mechanisms from the field to going to the national level. HMIS strengthening will be done through standardization of routine reporting, improving data analysis through dissemination of results and using them to inform programme decisions at the local level and automation of medical recording and reporting at the facility level. Standard forms will be used from the field and submitted routinely to the district, provincial and national levels.
Data utilisation will be emphasised to ensure data is collected not only for compliance but to monitor and evaluate service uptake in the facility and district level. Use of electronic data recording such as HIVCAM will also standardised recording and speed up data generation and reporting.

Strengthen the overall M&E system, which include streamlining the framework, reporting system, tools, and software models. This will require building the capacity at provincial level to facilitate and linking with HSS component.

CHAS has facilitated the completion of the SOP and Handbook that will be used to develop the training plan for its use at the national and local level. However, there is a need to review further whether disaggregation of data covers sex, age, ethnicity and geographical location.

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

At the provincial level, there is a need to have a plan for building capacity in line with the national plan, once it's made and conduct routine staff performance assessment/appraisal. There is a need to strengthen the role of PCCA. Specifically, it requires at least one full-time staff is responsible for M&E duties, with clear TOR, including support for the DCCA on M&E related activities and informing the DCCA about the M&E reports and follow-up actions. The new reporting forms will improve the accuracy and flow of reporting from District to Province and will form part of the M&E Handbook. There is also a need to strengthen Information Technology (IT) System for central and provincial level, such as online reporting and improve email communication.

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

A capacity building plan was developed by CHAS through the assistance of the TA hired through TSF in October 2013. USCDC Bangkok supported training on HIVCAM, critical data management and data entry at the ART sites and at CHAS. There was also the software developed for reporting on prevention activities through the TA of WHO. Training on forecasting for ARV drugs was provided by CHAI.

Training needs assessment for the M&E unit at the central and provincial level needs to be conducted in order to identify the type of training needed by the M&E staff. There is a need to further strengthen the M&E and

Surveillance Unit and maintain second-generation surveillance for impact/outcome monitoring, and continue to engage international technical assistance for design and analysis and strengthen the knowledge, skills, and abilities of the M&E staff through training.

VIII. ANNEXES

Annex 1: Consultation/preparation process for the country report on monitoring the process towards the implementation of the Declaration of Commitment on HIV and AIDS

The process of preparation for the 2015 GARP Reporting was initiated during the third week of February 2015 when the CHAS Director, Dr. Bounpheng Philavong requested UNAIDS Regional Investment and Efficiency Adviser Dr. Ma. Elena Borromeo for the financial support for the TA who will support in the data gathering and writing the report. Dr. Borromeo agreed to the request to recruit a consultant to assist the whole process of the Global AIDS Response Progress Reporting (GARPR) for Lao PDR. The process of recruitment and approval though the UNAIDS Technical Support Facility (TSF) of the consultant took less than one week. Immediately after, the Terms of Reference (T O R) was put into action. The engagement of the TA was a total of 15 days.

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

Phase 1: Desk/Literature Review /Briefing with CHAS Team (2-3 March 2015)

Two days (2-3 March 2015) was given to the consultant to do desk/literature review of various documents necessary for the preparation of the 2015 GARPR Report. The documents reviewed were but not limited to: Global AIDS Response Progress Reporting 2015 Guidelines which deals with construction of core indicators for monitoring the 2011 United Nations Political Declaration on HIV and AIDS; Global AIDS Response Progress Country Report, Lao PDR, 2014; Reports from High Level Meeting Targets, External Review, Mid-term Review of the High-Level Ten Targets, 2013 ; Global Fund Concept Note for the New Funding Model; National Strategic and Action Plan (2011-2015) for HIV/AIDS and STI Prevention and Control; National Strategic and Action Plan (2016-2020) for HIV/AIDS and STI Prevention and Control; Reports from High Level Meeting Targets, External Review, Mid-term Review of the High-Level Ten Targets, 2013; and other relevant reports used in consultation with UNAIDS, WHO and CHAS such as project reports on specific information on HIV surveillance activities and programmes from NGOs, CSOs and other stakeholder groups.

The initial meeting with the TA together with the CHAS Team was also conducted on 2 March 2015 at CHAS Conference Room. The TA presented his TOR and the including the timelines which led to the development of the road map for data collection and the scheduling of the activities of the reporting process including the series of meetings and the Teams involved in the process. The road map for Data Collection served as a guide in identifying the processes in the collection and validation of monitoring data, coming up of HIV estimates and drafting and finalizing the narrative report for the Global AIDS Response Progress Country

Report for Lao PDR for 2015.

The minutes of the 2 March 2015 meeting are as follows: The meeting was chaired by Dr. Bounpheng Philavong, CHAS Director at CHAS Conference Room. The purpose of the meeting was to brief on the new guidelines for 2015 GARP Reporting. Present during the meeting were: Dr. Phouthone Southalack, Deputy Director; Dr. Khanthanouvieng Sayabounthavong, CHAS Head of HIV/AIDS and STI Management Unit; Dr. Beuan Vang Van, CHAS Head of Planning and Cooperation Unit; Dr. Bouathong Simanovong, CHAS Deputy Head, M&E and Surveillance Unit; Dr. Phouthaly Keomoukda, CHAS Deputy Head of EIC Unit; Dr. Khanti Thongkam, Technical Staff of M&E and Surveillance Unit; Dr. Bounleuth Vilayhong, CHAS Head of Administration Unit and Dr. Carlos L. Calica, TA supported by UNAIDS through the Technical Support Facility.

The TA presented the background of the GARP Reporting, salient points of the 2015 GARP guidelines and reporting process which is an inclusive involving all stakeholder of the National AIDS Response and the annexes which include the formats and the templates.

The introduction to the 2015 GARP Reporting articulates that this 2015 marks the end date of both the 2011 Political Declaration on HIV and AIDS and the Millennium Development Goals (MDG) and a great opportunity to review the progress made and prepare for the final reporting towards these targets. The 2011 Political Declaration on HIV and AIDS builds on two previous political declarations namely: the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political declaration on HIV/AIDS. This declaration reflected global consensus on a comprehensive frameworks to achieve the MDG Goal 6: halting and beginning to reverse the HIV epidemic by 2015.

As to the salient points of the 2015 GARPR Guidelines, it emphasizes the progress made on the Ten Targets and the core indicators and inclusive participation of stakeholders including the appendices such as: Country Progress Report template, National Funding Matrix and Sample checklist for Country Progress Report among others.

The contents of the 2015 GARP Report include the following:

I. Status at a Glance
    A. The inclusiveness of the Stakeholders in the Report Writing Process
    B. Status of the Epidemic
    C. Policy and Progammatic Response
    D. Overview of the GARP Indicator Data
II. Overview of the AIDS Epidemic
    A. HIV Prevalence in the General Population
    B. HIV Prevalence among Key Affected Population
        1. Sex Workers (SW)
        2. Men who have sex with men (MSM)
        3. Persons who inject drugs (PWID)
        4. Persons with multiple partners
        5. Young people
III. National Response to the AIDS Epidemic
    A. Prevention
        1. Prevention programmes
        1.1 HIV Education and condom use programme

2. Care, treatment and support programmes

B. Knowledge and behavior change

1. Knowledge about HIV prevention and sexual behavior
2. Gender equality
3. Stigma and discrimination

C. Impact Alleviation

IV. Best Practices

V. Major Challenges and Remedial Actions

A. Progress made on the key challenges reported
B. Challenges faced throughout the reporting period
C. Concrete remedial actions

VI. Support from the Country's Development Partners

A. Key Support Received from Development Partners to Ensure Achievement of GARP Targets
B. Actions that Need to be taken by Development Partners to Ensure Achievement of Targets

VII. Monitoring and Evaluation Environment

A. Overview of the Current Monitoring and Evaluation (M&E) System
B. Challenges Faced in the implementation of a Comprehensive M&E System
C. Remedial Actions Planned to Overcome the Challenges
D. The Need for M&E Technical Assistance and Capacity Building

Dr. Bounpheng shared the frequently asked questions and its responses regarding GARP Reporting:

The purpose of this document is to provide guidance to national AIDS programmes and partners actively involved in the country response to AIDS on use of core indicators to measure and report on the national response.

The "2011 UN Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS" (General Assembly resolution 65/277), which was adopted at the United Nations General Assembly High Level Meeting on AIDS in June 2011, mandated UNAIDS to support countries to report on the commitments in the 2011 UN Political Declaration on HIV and AIDS.

The Global AIDS Response Progress Reporting (GARPR) indicators (before 2012 known as UNGASS indicators) were until 2012 reported at the global level every second year. However, from 2013 data have been collected every year.

To assess progress made against the targets, the collection and reporting of indicator data is an important part. Countries are strongly encouraged to integrate these core indicators into their on-going monitoring and evaluation activities. These indicators are designed to help countries assess the current state of their national response and progress in achieving their national HIV targets. They will contribute to a better understanding of the global response to the HIV pandemic, including progress towards the global targets set in the 2011 UN Political Declaration on HIV and AIDS and the Millennium Development Goals.

The National Commitment Policy Index (NCPI) will not be part of the 2015 GARP Report. NCPI will be reported every two years. The next reporting period will be on 2016.

During the meeting, the 2015 GARP Reporting Team was organized spearheaded by Dr. Bounpheng Philavong. This was based on the Decree that was formulated last year:

I. 2015 GARP Reporting Guiding Team

1. Prof. Dr. Eksavang Vongvichit, Minister of Health
2. Assoc. Prof. Bounkong Syhavong, Vice Minister of Health
3. Dr. Bounlay Phommasack, Director General Communicable Disease Control
4. Dr. Sisavath Southaniraxay, Deputy Director General Communicable Disease Control
5. Dr. Bounpheng Philavong, CHAS Director

II. Over-all Responsible Team
    1. Dr. Phouthone Southalak, CHAS Deputy Director
    2. Dr. Chanthone Khamsibounheuang, CHAS Deputy Director
III. Technical Team
    1. Dr. Keophouvanh Douangphachanh, CHAS Head of M&E and Surveillance Unit
    2. Dr. Beuang Vang Van, CHAS Head of Planning and Cooperation Unit
    3. Technical Officer of CDC – to be identified
    4. Technical Officer, Department of Planning and international Relation – to be identified
    5. Technical Officer, Department of Finance – to be identified
    6. Dr. Khanthanouvieng Sayabounthavong, CHAS Head of HIV/AIDS and STI Management Unit
    7. Dr. Bounleuth Vilayhong, CHAS Head of Administration Unit
    8. Dr. Ketmala Banchongphanith, CHAS Deputy Head of HIV/AIDS and STI Management Unit
    9. Dr. Phouthaly Keomoukda, CHAS Deputy Head of EIC Unit
    10. Dr. Bouathong Simanovong, CHAS Deputy Head, M&E and Surveillance Unit
    11. Dr. Khanti Thongkam, Technical Staff of M&E and Surveillance Unit
    12. Dr. Chanthasouk Bansalith, CHAS Deputy Head of Planning and Cooperation Unit
IV. UN Team Coordination
    1. WHO
    2. UNAIDS
    3. UNICEF
    4. UNFPA
    5. UNODC
    6. UNWOMEN
    7. WFP
V. CSOs/NGOs/Donors Coordination
    1. LaoPHA
    2. PEDA
    3. PSI
    4. NCA
    5. LRC
    6. French Red Cross
    7. BI
    8. FHI 360
    9. USAID
    10. USCDC
    11. ADB
    12. WB
    13. Metthatham
    14. NCCA Focal Point
    15. HIV Task Force

Main Activities

1. Familiarise with 2015 GARP Reporting Guidelines
2. Literature Review:
    a. GARPR 2014
    b. Ten Targets Review

c. Global Fund Concept Note
d. NSAP 2011-2015
e. NSAP 2016-2020
3. Consultations/Interviews with Key partners
4. Collect Data from PCCA for the NASA
5. Review/Update Core Indicators including Annexes and Appendices of the 2015 GARP Report
6. Series of meetings with Partners
   a. Briefing/Introduction/Orientation on the 2015 GARP Reporting
      - Invite partners
      - Present guidelines, contents of reports
      - Mechanism for gathering data

Teams for Data Gathering and Conduct of Activities:

A. M&E Indicator Core Team
   1. Dr. Keophouvanh Douangphachanh, CHAS Head of M&E and Surveillance Unit
   2. Dr. Bouathong Simanovong, CHAS Deputy Head, M&E and Surveillance Unit
   3. Dr. Khanti Thongkam, Technical Staff of M&E and Surveillance Unit
B. NASA Core Team
   1. Dr. Beuang Vang Van, CHAS Head of Planning and Cooperation Unit
   2. Dr. Chanthasouk Bansalith, CHAS Deputy Head of Planning and Cooperation Unit
   3. Dr. Panina Phoumsavanh, CHAS Deputy Head of Administration Unit
C. Logistics and Administration Core Team
   1. Dr. Bounleuth Vilayhong, CHAS Head of Administration Unit
   2. Dr. Panina Phoumsavanh, CHAS Deputy Head of Administration Unit
   3. Dr. Khanthanouvieng Sayabounthavong, CHAS Head of HIV/AIDS and STI Management Unit
   4. Dr. Phouthaly Keomoukda, CHAS Deputy Head of EIC Unit

Preparatory Schedule

Date/Day	Activity	Status/Remarks
March 1- Sunday	Arrival of Consultant	Done
March 2- Monday	CHAS preparation meeting with the Consultant; Organise writing team	Done
March 3- Tuesday	Work on Core Indicators with Dr. Buoathong and Dr. Khanti	Meeting with Dr. Bouathong and Dr. Khanti at CHAS
March 4- Wednesday	Work on Core indicators with Dr. Buoathong and Dr. Khanti	Worked with Dr. Khanti at CHAS; meeting with Dr. Dominique and Dr. Somkhane, WHO
March 5- Thursday	Work on Core indicators with Dr. Buoathong and Dr. Khanti	Worked with Dr. Khanti at CHAS
March 6- Friday	Briefing/Introduction/Orientation with Key Stakeholders Logistics/Admin Team Dr. Bounleth, Dr. Panina, Dr. Nou, Dr. Phouthaly	Briefing with partners chaired by CHAS Director, CHAS Conference Room
March 9- Monday	Consultant – start initial write-up of	Initial write up

	the GARP Reporting Process	
March 10- Tuesday	Consultant – meetings/interviews with key partners	Meeting with Dr. Khanthanouvieng; Meeting with Dr. Somkhane, WHO
March 11- Wednesday	Consultant – meetings/interviews with key partners	Worked with Dr. Bouathong, contacted UNFPA and UNODC, requested updates from UNODC, LaoPHA, UNFPA
March 12- Thursday	Update of the Core Indicators with CHAS Team	Worked with Dr. Bouathong and Dr. Khanti
March 13- Friday	Update of NASA data with CHAS Team	Worked with Dr. Beaung
March 16- Monday	Report Writing	Collected Data inputted to the narrative report
March 17- Tuesday	Report Writing	Report writing
March 18- Wednesday	Report Writing	Report writing
March 19- Thursday	Report Writing	Report writing, assisted in the power point presentation
March 20- Friday	Validation meeting on key findings with the partners	Validation meeting with stakeholders chaired by Dr. Bounpheng
March 21- Saturday	Consultant leaves Vientiane	Consultant had transit in Bangkok, Arrived Manila, 22 March
March 23-26	Updated draft and edit	Dr. Bounpheng edits final draft
March 27- Friday	Finalisation Meeting- Chaired by the Minister of Health of the Draft Report	Meeting Chaired by the Minister of Health and Chair of NCA
March 30- Monday	On-line report by CHAS	On-line reporting led by Dr. Bounpheng and CHAS M&E and Surveillance Unit
March 31- Tuesday	On-line report by CHAS	On-line reporting led by Dr. Bounpheng and CHAS M&E and Surveillance Unit
2 April	NCCA Meeting with partners to consider and endorse the GARP 2015	
3-15 April	Continue on-line report by CHAS	

a. Phase 2: Gathering of Data/Country Consultations/Validation /Consensus Meeting (4 March – 2 April 2015)

The Country Consultation Phase involved the conduct of meetings with key stakeholders with the support of CHAS, Ministry of Health (MOH). As agreed during the initial briefing with CHAS and at the briefing orientation with the key stakeholders, the TA will conduct a series of meetings and interview the key stakeholders about the data gathering for 2015 GARP Reporting.

The purpose of the meetings was to gather, review and validate the indicator data and narrative report. The review of data was undertaken in consultation with the Lao PDR GARP stakeholders. The consultation provided inputs to gather additional guidelines from implementing partners on data review and collection processes including a review on expectation, operational issues, processes used for determining final responses reflected in the report. Stakeholders that were involved in the indicators needed were requested to provide the information. The data gathered were used to validate relevance of indicators for inclusion in the report. The stakeholders may opt not to report prescribed indicator data and should inform the reason for non-reporting. The proposed questions for further discussions with stakeholders were presented.

The actual collection of data was done through the support of CHAS Team who wrote the PCCA for the domestic AIDS Spending matrix data and the CHAS accounting section for the international donor support to the programme. The consultant had daily consultations with the of the data collection with the CHAS Team. For the indicators, CHAS M&E Surveillance Unit and the CHAS HIV/AIDS and STI Management Unit provided the inputs based on various sources such as the IBBS 2014, Global Fund PUDR and Population-based Survey such as the LSIS.

The report writing of the 2015 GARP included the presentation of indicator data and narrative report based on the country reports and other information sources, including analysis and interpretation of data. The Country Progress Report followed the template as prescribed in the GARPR Guidelines 2014 and incorporating the changes in the 2014 reporting round. The report reflected the core indicators and narrative country progress report. A report on the AIDS spending National Funding Matrix submitted. The report outline followed the Country Progress Report Template.

A validation meeting with stakeholders representing the government agencies, international development partners, non-government organizations and civil society organizations was conducted on 20 March 2015. The purpose of which was to have the stakeholders review the compiled indicator data and review the narrative report.

Dr. Bounpheng Philavong presented the data gathered and the body of 2015 GARP Reporting as follows (Annex):

Outline of the presentation

1. *Introduction*
2. *The 2011 Political Declaration Targets (Ten Targets)*
3. *Lao PDR HIV Profile*
4. *Overview of the AIDS Epidemic in Lao PDR*
5. *National Response to the AIDS Epidemic*
6. *Best Practices*
7. *Major Challenges and Remedial Actions*
8. *Key Support Received from Development Partners to Ensure Achievement of GARP Targets*
9. *Overview of the Current Monitoring and Evaluation (M&E) System*
10. *Overview of GARP Indicators*

The validation meeting was received by the stakeholders and has expressed satisfaction with the 2015 GARP Reporting.

The finalisation Meeting for the 2015 GARP Reporting Lao PDR draft was chaired by the Chaired by the Minister of Health on 27 march 2015.

Consensus Meeting, 2 April 2015

The Consensus Meeting was held on 2 April 2015. This was a NCCA Meeting with partners and chaired by H.E Prof. Dr. Eksavang Vongvichit, Minister of Health and Chair of NCCA. The meeting was attended by 53 participants, including members of NCCA, NCCA Secretariat and focal points, representatives of line-ministries, international organizations (UNAIDS, WHO), NGOs and CSO. At the meeting, Dr Bounpheng Philavong, Director of CHAS and Head of NCCA Secretariat presented the draft GARP 2015 Reporting followed by discussions and inputs by the participants. The meeting in principle endorsed GARP 2015 Reporting.

Phase 2: On-line 2015 GARP Reporting (31 March -15 April 2015)

The Director of CHAS led the on-line reporting of the 2015 GARP, Lao PDR assited by the and the CHAS M&E and Surveillance Unit on 30-31 March 205..

Annex 2. National Funding Matrix

NATIONAL FUNDING MATRIX
Annex 2: National Funding Matrix 2015
Points discussed on the contents of the 2015 GARP Reporting were: “Joint 2015 Global AIDS Response Progress Reporting and Health Sector Reporting Processes”, in close collaboration with WHO and UNICEF including verification of the Health Sector response indicators; revision of the M&E Action Plan as part of the Global Fund requirement; reporting of the 2011 Political Declaration, needs to be carefully written what were achieved, core indicators, results of which can be used for the New Funding Model for the Global Fund and UN Family.

<table>
<tr><td colspan="7">Country: Lao PDR</td></tr>
<tr><td colspan="7">Reporting cycle (calendar or fiscal year):</td></tr>
<tr><td colspan="7">Start of the reporting cycle (mm/yyyy):</td></tr>
<tr><td colspan="7">End of the reporting cycle (mm/yyyy):</td></tr>
<tr><td colspan="7">Currency of the report (local currency or US dollars):</td></tr>
<tr><td colspan="7">Amounts expressed in (units, thousand or million):</td></tr>
<tr><td colspan="7">Reporting period average exchange rate (local currency or 1 US dollar):</td></tr>
<tr><td colspan="7">Date measurement methodology / tool:</td></tr>
<tr><td>TEN TARGETS:
2011 United Nations General Assembly Political Declaration on HIV/AIDS</td><td></td><td>Programme codes</td><td>Public Sources</td><td>Private Sources</td><td>International Sources</td><td></td></tr>
</table>

	HIV and AIDS programmes	of the previous National Funding Matrix	Total Public	Total Private	Total International	TOTAL
Target 1. Reduce sexual transmission of HIV by 50 percent by 2015	1. Prevention of sexual transmission of HIV					
Target 2. Reduce transmission of HIV among people who inject drugs by 50 percent by 2015	2. HIV prevention for people who inject drugs					
Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths	3. Prevention of mother to child transmission					
Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral by 2015	4. Universal access to treatment					
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015	5. TB					
Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$22-24 billion in low- and middle-income countries	6. Governance and sustainability					
Target 8. Eliminate stigma and discrimination against people living with and affected	7. Critical enablers					

by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms. Target 9. Eliminate HIV-related restrictions on entry, stay and residence						
Target 7. Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves for HiV Target 10. Eliminate parallel system for HIV-related services to strengthen integration of the AIDS response in global health and development efforts, as well as to strengthen social protection systems.	8. Synergies with development sectors					
	Addendum items / Non-core global / Other					

Annex 3. Selected Bibliography

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MoH, Projection Results AEM and Spectrum, 2014
MoH. Single stream of funding progress update and disbursement request, number 8, 2014. Report submitted to GFATM.

National Strategic and Action Plan (NSAP), 2015-2020.

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MOH/CHAS. Integrated biological and behavioural surveillance survey among men who have sex with men in Lao PDR, 2014.

MOH/CHAS. Routine report, 2011-2013.

MOH/CHAS. AIDS registry, 2014.

MOH/CHAS. Lao PDR HIV Response progress against 2011 political declaration: Background document for 2013 Mid-Term Review.

MOH/CHAS, National HIV monitoring and evaluation strategy and action plan, 2012-2015.

MOH/CHAS. National strategic and action plan on HIV/AIDS/STI control and prevention 2011-2015

MOH/CHAS. Program records/spectrum estimates 2010-2020.

UNFPA. (2014). Adolescent and Youth Situational Analysis in Lao PDR